NHS
Tees Valley
Clinical Commissioning Group

Corporate	CCG CO02 Complaints Policy

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EQUALITY IMPACT ASSESSMENT

Date	Issues
May 2018	See Section 10

POLICY VALIDITY STATEMENT

Policy users should ensure that they are consulting the currently valid version of the documentation. The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every 3 year period.

ACCESSIBLE INFORMATION STANDARDS

If you require this document in an alternative format, such as easy read, large text, braille or an alternative language please contact tvccg.enquiries@nhs.net

Version Control

Version	Release Date	Author	Update comments
V1	April 2020	Clinical Quality Manager, Commissioning Support Unit (CSU)	New policy template.
V2	February 2021	Clinical Quality Manager, Commissioning Support Unit (CSU)	5.6.1, 5.7.1, 5.7.2.5, 5.7.3.1, 5.9.2 5.9.6, 5.9.7, 5.10.2, 5.11.3, 5.15.2, 5.16, 5.20, 5.21.2, 4 & 6, 5.22.2, 5.26, 9.1, Appendix 2: Rewording for clarity purposes/to reflect current practice
			5.1.5, expansion to reference clarification on whether complainant is a suitable representative 5.3.2, addition of process to follow when callers wish to discuss a complaint directly with a CCG officer, as opposed to CSU staff 5.3.3, expansion to reference emails in lieu of physical signature 5.7.1.2, removal of reference to risk rating, to reflect practice 5.7.8 to 5.7.10, addition to reflect process for managing complaints from MPs 5.19.3, revision to reflect correct process for receiving complaint reports 5.21.2, expansion to reference situations where complainant declines to provide consent to pass complaint to provider organisation 5.21.5, expansion to clarify process where complaint includes allegations of a safeguarding nature 5.23.5, inclusion of reference to allegations of criminal activity including fraud

Approval

Role	**Name**	**Date**
Approval	Combined Management Group	10th March 2020 (1)
Approval	Executive Committee	February 2021 (2)

Contents

1. Introduction

For the purposes of this policy NHS Tees Valley Clinical Commissioning Group will be referred to as "the CCG".

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

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

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

The CCG is very keen to ensure that complaints are used as learning opportunities and that trends are analysed and reported on. It is essential that information we gain from complaints is used to improve the quality and safety of the services we commission.

This policy has been written in accordance with the 'Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*'.* Reference is also made to the Department of Health guidance in complaints handling 'Listening, Responding, Improving', Parliamentary and Health Service Ombudsman's 'Principles of Good Complaints Handling', the NHS Constitution (2008) and 'A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture' (Right Honourable Ann Clwyd MP and Prof Tricia Hart, 2013).

2. Status

This policy is a corporate policy.

3. Purpose and scope

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

The policy also includes the process used for complaints received relating to commissioned services such as NHS Trusts, Community NHS Services, Ambulance Trusts, independent contractors (general practices, dental practices, pharmacies and opticians) and independent sector providers.

The purpose of this policy is to ensure that the CCG promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The

CCG also adheres to the NHS Constitution including the five rights covering complaints and redress.

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

4. Definitions

The following terms are used in this document:

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

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

4.3 **Independent Complaints Advocacy (ICA)**: is the organisation that provides independent help and support for people pursuing an NHS complaint.

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

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

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

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

5. NHS complaints procedure and process

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

There are two stages to the NHS complaints procedure:

- Stage One: Local resolution of complaint through investigation and response by the CCG or provider
- Stage Two: Independent Review of complaint by the Parliamentary and Health Service Ombudsman

5.1 Who can complain?

5.1.1 Anyone who is receiving, or has received, NHS treatment or services or who is affected or is likely to be affected by an action, omission or decision can complain. This includes services provided by independent providers as part of an NHS contract.

5.1.2 If a patient (including a child over the age of 13, in line with General Data Protection Regulations) does not wish to complain themselves then someone else, usually a relative, friend or other representative, can complain on their behalf providing written authorisation is given.

5.1.3 If a complainant is the parent or guardian of a child under the age of 13 (to whom the complaint relates) the organisation must be satisfied that there are reasonable grounds for the complaint being made by the representative instead of the child. Where the child is aged 13 to 18, their written consent should be provided for a parent/guardian or other representation to act on their behalf with regard to the complaint.

5.1.4 If a patient is unable to act, for instance due to physical incapacity or lack of capacity within the meaning of the Mental Capacity Act (2005) their authorisation is not required. A consent form should be completed by the complainant showing the reason why the patient is unable to act. In such situations, a suitable representative may pursue the complaint on their behalf, however, evidence of their authority to act will be required. Guidance from the Information Governance Team will be obtained as required in relation to consent/authority to act.

5.1.5 If a complaint is raised concerning a patient who is deceased, this must be made by a suitable representative, for example next of kin. Where clarification is required on whether the complainant is a suitable representative, guidance should be obtained from the information governance team and/or the CCG's complaints lead. If the Complaints Team/CCG does not consider that the complainant is a suitable representative, they may decline to deal with the complainant and recommend that another person acts on the deceased patient's behalf.

5.2 Support for persons making a complaint

ICA provides a free, impartial and independent service for people wishing to make a complaint about the NHS. All complainants will be provided with information about the ICA. Information regarding other specialist advocacy services will be provided, as required.

5.3 Process for verbal complaints

5.3.1 Clear information about the complaints process is made available to patients, the public and staff via the CCG's website.

5.3.2 Complaints can be made verbally to a member of the CSU complaints team and in this instance a written statement will be taken from the complainant ensuring all salient points requiring a response are documented. Where a complainant telephones the CCG to raise their complaint and does not wish to be transferred to the CSU, CCG staff should take details of the complaint during the call and subsequently email notes of this to the CSU complaints team.

5.3.3 The written statement will be sent to the complainant asking them to make any changes to ensure it is an accurate reflection of their complaint. The complainant will then be asked to sign and return the statement to the CSU complaints team. The complainant will be advised that their complaint will not be processed until the signed statement is returned; this can be by post or email, in which case the email will be accepted in lieu of a physical signature.

5.3.4 There may be instances when it is not appropriate to take a formal complaint over the telephone, for example, if the concerns raised are complex. In cases such as this a face to face or online/virtual meeting will be offered to clarify the complaint or with the complainant's permission a referral can be made to ICA. Face to face appointments with the CSU Complaints Team are by appointment only.

5.4 Time limit for making a complaint

5.4.1 The timescale within which an NHS or social care complaint must be made is 12 months from the date on which a matter occurred, or the matter came to the notice of the complainant.

5.4.2 The regulations set out that the organisation has the discretion to investigate beyond this time, especially if there is good reason for a complaint not being received within the 12 months. The time limit can, and should, be waived if it is still practical and possible to investigate the complaint, for example, the records still exist and the individuals concerned are still available to be questioned.

5.4.3 When a complaint is made outside these limits and the time limits are not waived, the CCG (or complaints team on behalf of the CCG) will advise the complainant of their rights to request that the Parliamentary and Health Service Ombudsman consider their case.

5.5 Issues that cannot be addressed within the complaints procedure

This policy and procedure does not address:

5.5.1 A complaint made by a responsible body to another responsible body. For example disputes on contractual matters between providers and the CCG should not be handled through this procedure. However, the issues raised should still be subject to a thorough investigation and appropriate action taken for service improvement.

5.5.2 Complaints regarding privately funded treatment.

5.5.3 Complaints which are made verbally and resolved to the satisfaction of the complainant no later than the next working day after the complaint was made.

5.5.4 Complaints regarding an alleged failure to comply with a request for information under the Freedom of Information Act (2000) or complaints about Access to Health Records Act 1990 requests and Subject Access Requests. These will be dealt with via information governance processes.

5.5.5 A complaint made by an employee about any matter relating to his/her employment. These matters will be handled via human resources procedures.

5.5.6 Complaints that have already been locally investigated under the complaints regulations or which are being, or have been, investigated by a Local Commissioner under the Local Government Act 1974 or the Health Service Commissioner under the 1993 Act.

5.5.7 If the organisation decides that a complaint meets any of the criteria detailed in sections 5.5.1 – 5.5.6 the complainant will be notified in writing of this decision and the reasons why.

5.5.8 Complaints disputing a funding decision or eligibility criteria/policy; these will be managed via the appropriate appeals process (where applicable) or other agreed process.

5.6 Written complaints received

5.6.1

Formal complaints received by CCG staff must be forwarded within one working day to the CSU generic email account, necsu.complaints@nhs.net.

5.6.2 For complaints relating to the services/care given by a provider commissioned by the CCG, the complainant has a choice of complaining directly to the CCG as commissioner rather than to the organisation which provided the care. The final decision on who will investigate the complaint rests with the CCG once all mitigating circumstances are taken into account. Complaints about primary care should be directed to NHS England/Improvement, see para 5.9.7

5.6.3 This will include taking into consideration the complainant's wishes and the seriousness of the complaint, for example where there has been a poor record of complaints handling or the complaint suggests a significant risk to patient safety or there appears to be a trend. Please refer to section 5.9 for guidance on how provider complaints are handled.

5.7 Process for complaints handled by the CCG

5.7.1 Acknowledging the complaint

5.7.1.1 Upon receipt of a complaint (received either directly from the complainant or via the CCG) the CSU Complaints Team will assess the issues raised for wider governance issues, such as patient safety issues, safeguarding or potential poor performance concerns.

5.7.1.2 All complaints received will be acknowledged verbally or in writing by the CSU complaints team within three days of receipt or from when the signed verbal statement is received. This may be via telephone or email/letter.

5.7.1.3 At the time of acknowledging the complaint the CSU complaints team must offer to discuss and agree the following with the complainant:

- An action plan for handling the complaint.
- When the investigation is likely to be completed.
- What reasonable outcome is desired.
- When the response is likely to be sent.
- Offer a local resolution meeting if appropriate.
- Advise the complainant of advocacy services, such as ICA.

5.7.1.4 The agreed action plan and timescales for response will be confirmed in writing to the complainant.

5.7.1.5 If the complainant does not take up the offer of a discussion, the CSU complaints team should determine the response period and the complainant will be notified of this in writing.

5.7.1.6 As outlined in 5.6.2, where it is agreed that the CSU on behalf of the CCG will handle the complaint rather than the provider or where it has been agreed that the CCG will co-ordinate the response, consent will be required from the complainant to obtain access to relevant medical records and/or to seek a response from the provider organisation(s). The complaints team will request the relevant consent from the complainant.

5.7.1.7 If the complainant fails to provide written consent they will be notified in writing of the elements of the complaint that are unable to be investigated and responded to.

5.7.8 Where a complaint about an individual's care/treatment/funding is received by the CCG from a member of parliament (MP), this should be forwarded to both the CSU complaints team (necsu.complaints@nhs.net) and the CSU communications and engagement Team (necsu.info-comms@nhs.net) within one working day. Both teams will liaise to identify whether the case is already recorded on the complaints system and the most appropriate route for its management ie via the complaints procedure or via MP enquiry process. This agreement will be reached in conjunction with the CCG. Complaints which fall within the remit of CCG will be coordinated by the CSU complaints team in line with the Complaints Policy. Where the complainant has provided consent, a copy of the complaint response will be shared with the MP.

5.7.9 Where a complaint relates to a provider organisation, the CSU communications and engagement team will provide advice to the MP on which organisation to contact or redirect the complaint, if appropriate.

5.7.10 Communication received from an MP of a more general nature, ie not specific to an individual constituent's care, will be managed via the MP enquiry process and are not required to be shared with the CSU complaints team.

5.7.2 Investigation

5.7.2.1 The investigation will be conducted in a timely manner, proportionate to the complaint.

5.7.2.2 The CSU complaints team, on behalf of the Accountable Officer will:

- Forward the complaint to the appropriate lead for investigation, with details of the issues to be investigated and agreed in the action plan.
- Send a copy of the complaint to the investigating officer.
- Identify at an early stage whether it would be helpful to offer a local resolution meeting.
- Keep the complainant up to date with the progress of the investigation.

5.7.2.3 The investigating officer will:

- Establish what happened, what should have happened and who was involved and make written records of the investigation/staff statements.
- Make sure a sincere and appropriate apology is made as appropriate.
- Identify what actions can be implemented to ensure that there is no recurrence and address any training issues and learning points.
- Draft a report addressing the issues raised by the complainant and comment on what action is being taken to prevent a recurrence in the future.

5.7.2.4 Staff involved in a complaint:

- Will be made aware of the complaint and asked to prepare written statements as part of the investigation.
- Are required to co-operate with the Complaints Policy as part of their terms of employment. Where an employee refuses to give an interview or a written account without reasonable grounds, this should be considered a disciplinary offence.

5.7.2.5 Where the complaint relates to a clinical matter, written reports from any appropriate clinician should be obtained. These reports form part of the complaint record which can potentially be disclosed to the complainant via a Subject Access Request; therefore documents must be written in plain English and without jargon or abbreviations.

5.7.3 The Response

5.7.3.1 The written response will incorporate the investigation report (where appropriate) and will:

- Address all the issues raised by the complainant
- Provide explanations and apologies, where appropriate.
- Indicate lessons learned from the complaint.
- Include what steps have been taken to prevent a recurrence.
- Outline what options are available if the complainant is not satisfied with the response, including details of the Parliamentary and Health Service Ombudsman.

5.7.3.2 The CSU complaints team will forward the formatted written response, including the investigation report, for approval to the investigating officer and any other relevant staff involved in the complaint.

5.7.3.3 The response will then be forwarded for final approval to the accountable officer (or nominated deputy).

5.7.3.4 If for any reason a response cannot be made within the agreed timescale (for example a person involved in the complaint is absent from work) the complainant will be contacted by the CSU complaints team and an extension to the specified revised timescale will be agreed.

5.7.3.5 If the complainant is satisfied with the response the case will then be closed. Implementation of any changes made to practice or procedures as a result of the investigation will be monitored by the Complaints Team.

5.7.3.6 If a complainant is dissatisfied with the response, every effort will be made to achieve a satisfactory outcome at local level by:

- identifying outstanding issues
- arranging further meetings
- providing a further written response
- involving a conciliator, where appropriate.

5.7.3.7 If, following all attempts to resolve the complaint locally, the complainant remains dissatisfied they will be notified that local resolution (Stage One) is at an end and that they can ask the PHSO to consider their case in line with Stage Two of the NHS Complaints Procedure. Information on the PHSO will be routinely given to complainants at the completion of local resolution.

5.8 Conciliation Process

5.8.1 A conciliation service with access to trained lay conciliators is available to assist in the resolution of complaints. Arrangements for conciliation will be made via the CSU complaints team throughout the complaints process, as required.

5.8.2 The lay conciliator will report back to the CSU complaints team on outcomes and agreed action points but will not disclose the substance of any discussions.

5.8.3 The conciliation process is confidential. However, where information is raised within that process regarding safeguarding children or adults or a general patient safety issue, the conciliator may have to seek further advice from the manager responsible for complaints.

5.9 Process for complaints received about NHS providers

5.9.1 In the majority of cases when a complaint is received by the CCG, the provider will normally be given the opportunity to respond to the complaint directly. The complaint will be acknowledged verbally or in writing within three working days and consent will be sought by the CSU Complaints Team to forward the complaint to the provider.

5.9.2 When consent is received, the complaint will be passed to the provider who will handle it in accordance with the NHS complaints procedure. A letter confirming that the complaint has been passed to the provider will then be sent to the complainant. The CSU complaints Team will request that a copy of the complaint response is shared with the CCG/NECS.

5.9.3 There may be occasions when the CCG considers it appropriate to handle the complaint rather than the provider. This decision will be taken once all mitigating circumstances have been taken into account, including the complainant's wishes, seriousness of complaint or significant patient safety issues or where there appears to be a pattern.

5.9.4 In such cases both the complainant and provider will be notified and the complaint will be processed in accordance with section 5.7.

5.9.5 The CCG will ensure, via contractual agreement, that all NHS providers and any private provider with whom it has a contract or service level agreement have arrangements in place for handling complaints made about services they provide that is comparable with the NHS complaints procedure.

5.9.6 Providers routinely share with the CCG information on the number and nature of complaints, concerns, comments and compliments received along with details of lessons learned and improvements to services to prevent a reoccurrence of similar complaints.

5.9.7 Where a complaint is received about a Primary Care Contractor (ie GP practice, dentist, community pharmacy, optician), the CCG or CSU Complaints Team will advise the complainant to send their complaint to NHS England for investigation and response or offer to forward the complaint to NHS England with the complainant's consent.

5.10 Process for handling joint NHS and local authority complaints

5.10.1 When complaints are received about both health and local authority services, with the complainant's consent, the organisations involved will co-operate with each other to deal with the aspects of the complaint that relates to them. Both agencies will agree who will lead on the complaint and will aim to provide a single co-ordinated response.

5.10.2 The accountable officer (or nominated deputy) of the lead organisation will sign the response. Irrespective of lead responsibility each organisation retains its duty of care to the complainant and must handle its part of the complaint in accordance with its own procedures.

5.11 Process for complex complaints that span several NHS organisations

5.11.1 Where a complaint is received that spans a number of NHS provider organisations the CSU, on behalf of the CCG, will seek assurance that there will be a co-ordinated approach, to the handling of the complaint across the various parties involved, prior to passing the complaint to the lead organisation.

5.11.2 The organisation to lead on the handling of the complaint will be agreed following discussion with the parties involved. This decision will be made taking into account the organisation that has the greater part in the complaint as well as the complainant's wishes.

5.11.3 Where the complaint is particularly complex or where serious patient safety issues have been identified, instead of the provider co-ordinating the response and leading in the investigation of the complaint, the CCG may choose to do this with the complainant's consent.

5.12 Process for handling complaints about non NHS services

Occasionally complaints are received about services not provided by the NHS, e.g. private treatment. In such cases, wherever possible, the CSU complaints team will advise the complainant of the correct agency to contact and will offer to forward the complaint for investigation. Beyond this the organisation will have no further input.

5.13 Staff support during the complaints process

It can be very stressful for those involved in the complaint process and advice and support is available to staff. Information is available from the CSU complaints team.

5.14 Equality and diversity

5.14.1 Making a complaint does not mean that a patient/complainant will receive less help, or that things will be made difficult for them or that the quality of their care will be compromised.

5.14.2 Every complainant will be treated fairly and equally regardless of age, disability, race, culture, nationality, gender, sexual orientation and faith.

5.14.3 In line with NHS England's Accessible Information Standard, for people who require language or signed interpreting this will be made available throughout the complaints process.

5.15 Disciplinary procedures

5.15.1 The Complaints Policy is concerned with resolving complaints to the satisfaction of complainants and learning lessons for improvement and not for investigating disciplinary matters.

5.15.2 A complaint investigation may occasionally reveal the need for an investigation under the disciplinary policy. In such an event the CSU complaints team will not be involved in any disciplinary investigation.

5.16 Serious incidents (SIs) and complaints

5.16.1 The procedure for investigating SIs is separate from the Complaints Policy and is managed in accordance with the Serious Incidents Policy. If during the course of investigating a SI, a complaint is also received, the serious Incident process will normally take precedence in terms of the investigation.

5.16.2 If a complaint investigation reveals the need to take action under the SI Policy the serious incident process will normally take precedence in terms of investigation.

5.16.3 In these circumstances the complainant will be notified of the SI investigation and will be kept updated on the progress by the CSU complaints team. It should be remembered that the issues raised in a complaint will not always be exactly the same as those investigated under the SI policy and, in those circumstances, a separate and full response to the complaint will be required.

5.17 Process for dealing with anonymous complaints

All anonymous complaints received will be investigated if there is enough information to carry out an investigation. Investigating officers will be requested to report to the Accountable Officer (or nominated deputy) and make appropriate recommendations based on the allegations raised.

5.18 Withdrawal of a complaint

If a complainant withdraws a complaint at any stage in the procedure, which involves issues raised against an individual, those complained against will be informed. In such circumstances, the relevant head of service or line manager will consider if/how to address issues highlighted in the complaint.

5.19 Learning and monitoring of complaints

5.19.1 The CCG's philosophy for the management of complaints is to recognise their positive value through the effective monitoring of complaints. In applying these principles and sharing the learning we can all effect change.

5.19.2 The CCG will use the intelligence gained from complaints information (individual complaints received and provider annual complaints reports) to develop a greater awareness of services commissioned and where these may not meet quality standards.

5.19.3 Monthly reports will be provided to the CCG complaints lead by the CSU complaints team. The relevant quality committee will receive quarterly complaints reports as part of governance and performance reporting. The reports will identify any trends and patterns arising from complaints, and any subsequent action taken as a result of lessons learned.

5.19.4 An annual report will be prepared for the Governing Body on the handling and consideration of complaints, outlining actions, monitoring compliance and outcomes.

5.20 Recording of complaints

5.20.1 Accurate and up to date records will be maintained in accordance with the Records Management Policy . The Safeguard Incident Reporting and Management System (SIRMS) will be used to record and collate all complaints information.

5.20.2

5.20.3 The complaints record will not be filed within a clinical record but held within a separate complaints file.

5.21 Confidentiality/consent

5.21.1 Care will be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/service user is confined to that which is relevant to the investigation of the complaint. Information will only be disclosed to people who have a demonstrable need to know it for the purpose of investigating the complaint or ensuring that the complaints process is followed.

5.21.2 In transferring complaints between agencies (including the PHSO) confidentiality will be maintained at all times. Every effort will be made to obtain the patient/service user (or their representative's) consent before sharing confidential information with another body or organisation. Consent will be obtained in writing or where this is not possible the CSU complaints team will seek further advice from the Caldicott Guardian, if required. Where a complainant declines to provide consent for their complaint to be shared with another organisation, the CSU complaints team will provide them with contact details in order that they can make direct contact themselves.

5.21.3 It is recognised that there may be circumstances in which the nature of, or aspects of, a complaint indicate safeguarding or wellbeing concerns about a child or adult. In these circumstances a complaint will be escalated as necessary and in line with the CCG and Local Safeguarding Children and Adults Boards safeguarding procedures and such information contained in the complaint disclosed in the best interests of the complainant/patient.

5.21.4 If the receiving manager or member or the CSU Complaints Team is made aware of safeguarding children or adult concerns they must consult with the Head of Quality and Adult Safeguarding or the Head of Safeguarding Children as appropriate for advice the same day.

5.21.5 Where a complaint refers to allegations against a member of staff of a safeguarding children or adult nature, the section within the Safeguarding and Looked After Children or Safeguarding Adults Policy relating to managing allegations against staff must be followed: https://teesvalleyccg.nhs.uk/wp-content/uploads/sites/9/2020/10/HR40-Managaing-Allegations-Against-Staff.pdf. This will either supersede the Complaints Policy where such concerns form the whole of the process, or where only part of the complaint, the two processes occur simultaneously with decisions about response times and involvement of the member of staff being taken jointly. Where the Safeguarding Policy is invoked, the complainant must be notified immediately.

5.21.6 Following the identification of safeguarding concerns within a complaint,the complainant will be notified within one working day of the escalation and rationale for disclosure of information. Where safeguarding concerns form only part of a complaint the complainant will be informed of how the differing aspects of the complaint will be handled.

5.22 Access to personal information/medical records

5.22.1 Under the General Data Protection Regulation (GDPR), individuals (both service users and employees) have certain rights regarding the way information about them is used. These include having the rights to see information that is recorded about them (subject access request) and to have any part of it that they do not understand explained.

5.22.2 Where clinical records are used in a complaint investigation, investigating officers must comply with regulations for sharing of information across services or external agencies (incorporating the Code of Practice on Openness in the NHS).

5.22.3 Any requests received for access to complaint documentation will be sent to the information governance department for appropriate action.

5.23 Complaints and Litigation and complaints involving potential fraud or other criminal offences

5.23.1 On receipt of a complaint in which legal action is being taken or the police are involved the CCG should continue to resolve the complaint unless there are clear legal reasons not to do so.

5.23.2 Advice will be sought from relevant authorities (such as legal advisors or NHS Resolution) to determine whether progressing the complaint might prejudice subsequent legal action.

5.23.3 If there is likely to be any prejudice to the legal case the complaint will be put on hold and the complainant will be advised of this in writing and provided with an explanation.

5.23.4 Paperwork relating to the complaints investigation can be used in a court of law.

5.23.5 Where a complaint includes allegations of a criminal offence, the CSU complaints team/member of CCG staff will immediately notify the relevant CCG director who will comply with the requirements of the CCG's Counter Fraud, Bribery and Corruption Policy (CO06). ~~who will decide whether the Police should be involved, depending upon the nature of the offence. Fraudulent activity which is identified via a complaint or complaint investigation will be reported to NHS Counter Fraud Authority.~~

5.24 Complaints about Freedom of Information

Complaints about Freedom of Information requests, Access to Health Records Act 1990 requests and Subject Access Requests are not dealt with through the NHS complaints procedure. Any complaint of this nature will be forwarded to the appropriate information governance officer for investigation through relevant channels.

5.25 Dealing with media interest

All enquiries from the media must be immediately referred to the communications department ensuring that confidentiality is maintained at all times.

5.26 Retention of complaint records

Complaint files will be retained securely for a minimum of 10 years in accordance with the Records Management Policy.

5.27 Habitual and/or persistent complaints

5.27.1 Some complainants find it difficult to accept the findings following an investigation even when it has been to the second stage of the complaints procedure. The difficulty in managing such complaints places a strain on resources and causes undue stress for staff.

5.27.2 In such cases, it is important to ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of the complaint has been overlooked or inadequately addressed.

5.27.3 The procedure on how to handle unreasonable and persistent complainants is attached at Appendix 1.

6. Implementation

6.1 This Policy will be available to all staff for the effective management of all complaints received by the organisation in accordance with NHS complaints regulations.

6.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

7. Training Implications

The CSU complaints team will provide or arrange coaching or training in complaints handling and good customer care. Managers should ensure that appropriate staff in their areas who require such support contact the CSU complaints team to arrange training.

Complaints awareness is included in the corporate induction programme for all new members of staff.

8. Related Documents

8.1 Other related policy documents

- Safeguarding and Looked After Children Policy
- Safeguarding Adults Policy
- Records Management Policy
- Serious Incidents & Management Policy
- Managing Allegations Against Staff Policy

8.2 Legislation and statutory requirements

- General Data Protection Regulation (GDPR), 2018.
- Cabinet Office. (2006) *Equality Act 2006.* London. HMSO.
- Cabinet Office. (2005) *Mental Capacity Act 2005.* London. HMSO.
- Cabinet Office. (2000) *Freedom of Information Act 2000.* London. HMSO
- Cabinet Office. (1990) *Access to Health Records Act.* London. HMSO.
- Cabinet Office. (2018) *Data Protection Act 2018.* London. HMSO.
- Cabinet Office. (1998) *Human Rights Act 1998.* London. HMSO.
- Department of Health. (2009) *Local Authority Social Services and National Health Service Complaints (England) Regulations.* London. HMSO.
- Department of Health. (2009) *The NHS Constitution for England.* London. HMSO.
- HM Government (2015): *Channel Duty Guidance – protecting vulnerable people from being drawn into terrorism* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf
- HM Government (2015):*Prevent Duty Guidance* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417943/Prevent_Duty_Guidance_England_Wales.pdf
- HM Government (2015):*Working Together to safeguard Children* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- HM Government (2015): *Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf
- The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- HM Government (2011): *The Prevent Strategy* *http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted*

8.3 Best practice recommendations

- NHS England. (2015) *Accessible Information Standard*
- Independent report, Ann Clwyd and Professor Tricia Hart. (2013) review of *NHS hospitals complaints system: Putting Patients Back in the Picture*
- Department of Health. (2009) *Listening, Responding, Improving*
- HMSO. (2009) *A guide to better customer care*
- PHSO. (2009) *Principles of Good Administration*
- PHSO. (2009) *Principles of Remedy*
- PHSO. (2008) *Principles of Good Complaint Handling*
- Department of Health. (2008) *Records Management: NHS Code of Practice.* London: DH.
- NHS Litigation Authority. (2008) *Risk Management Standard for Primary Care Trusts.* London: NHSLA.
- Healthcare Commission. (2007) *Spotlight on Complaints.*

9. Monitoring, Review and Archiving

9.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy..

9.2 Review

9.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

9.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Accountable Officer or nominated officer will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

9.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsoring manager and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

9.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: Code of Practice for Health and Social Care 2016.

10. Equality Analysis

A full Equality Impact Assessment has been completed;

Equality Impact Assessment

Initial Screening Assessment (STEP 1)

As a public body organisation we need to ensure that all our current and proposed strategies, policies, services and functions, have given proper consideration to equality, diversity and inclusion, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership).

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Katharine Humby
Job Title: Clinical Quality Manager
Organisation: North of England Commissioning Support Unit (NECS)

Title of the service/project or policy: Complaints Policy (2)

Is this a;
Strategy / Policy ☒ **Service Review** ☐ **Project** ☐
Other Not applicable

What are the aim(s) and objectives of the service, project or policy:
This policy describes the systems in place to effectively manage all complaints received by the organisation in accordance with NHS complaints regulations. It outlines the responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of the organisation, its staff and services.

The policy also includes the process used for complaints received relating to commissioned services such as NHS trusts, independent contractors (general practices, dental practices, pharmacies and opticians) and independent sector providers.

The purpose of this policy is to ensure that the CCG promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Every complainant will be treated fairly and equally regardless of age, disability, race, culture, nationality, gender, sexual orientation and faith. The patient/complainant will not receive less help, will not have things made difficult for them and will not have the quality of their care will be compromised as a result of a complaint. For people who require language or signed interpreting this will be made available throughout the complaints process.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Staff** ☒
- **Service User / Patients** ☒
- **Other Public Sector Organisations**☒
- **Voluntary / Community groups / Trade Unions** ☒
- **Others, please specify** N/A

Questions	Yes	No
Could there be an existing or potential negative impact on any of the protected characteristic groups?	☐	☒
Has there been or likely to be any staff/patient/public concerns?	☐	☒
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could this piece of work affect the workforce or employment practices?	☐	☒
Does the piece of work involve or have a negative impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing quality of opportunity • Fostering good relations between protected and non-protected groups in either the workforce or community	☐	☒

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

Click here to enter text.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document

Accessible Information Standard	Yes	No
Please acknowledge you have considered the requirements of the Accessible Information Standard when communicating with staff and patients. https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf	☒	☐
If any of the above have not been implemented, please state the reason: N/A		

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Approval	Executive Committee	February 2021 TBC

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

Equality Impact Assessment: Policy – Strategy – Guidance (STEP 2)

This EIA should be undertaken at the start of development of a new project, proposed service review, policy or process guidance to assess likely impacts and provide further insight to reduce potential barriers/discrimination. The scope/document content should be adjusted as required due to findings of this assessment.

This assessment should then be updated throughout the course of development and continuously updated as the piece of work progresses.

Once the project, service review, or policy has been approved and implemented, it should be monitored regularly to ensure the intended outcomes are achieved.

This EIA will help you deliver excellent services that are accessible and meet the needs of staff, patients and service users.

This document is to be completed following the STEP 1 – Initial Screening Assessment

STEP 2 EVIDENCE GATHERING

Name(s) and role(s) of person completing this assessment:

Name: Katharine Humby
Job Title: Clinical Quality Manager
Organisation: North of England Commissioning Support (NECS)

Title of the service/project or policy: Complaints Policy (2)

Existing ☒ **New / Proposed** ☐ **Changed** ☐

What are the intended outcomes of this policy/ service / process? (Include outline of objectives and aims;
As outlined in the screening document above.

Who will the project/service /policy / decision impact?
(Consider the actual and potential impact)

- **Consultants** ☒
- **Nurses** ☒
- **Doctors** ☒
- **Staff** ☒
- **Service User / Patients** ☒
- **Others, please specify** N/A

Current Evidence / Information held	Outline what current data / information is held about the users of the service / patients / staff / policy / guidance? Why are the changes being made?
(Census Data, Local Health Profile data, Demographic reports, workforce reports, staff metrics, patient/service users/data, national reports, guidance ,legislation changes, surveys, complaints, consultations/patient/staff feedback, other)	Complaints / Incidents

STEP 3: FULL EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 covers nine 'protected characteristics' on the grounds upon which discrimination and barriers to access is unlawful. Outline what impact (or potential impact) the new policy/strategy/guidance will have on the following protected groups:
Age *A person belonging to a particular age*
Neutral
Disability *A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities*
Information about the complaints procedure is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face to face meetings with complainants. Complaints literature/web content is being reviewed/amended to ensure that staff and service users are aware of the facilities available for meeting a complainant or patient's communication requirements.
Gender reassignment (including transgender) and Gender Identity *Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.*
Neutral
Marriage and civil partnership
Neutral

Pregnancy and maternity *Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.*
Neutral
Race *It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.*
Information about the complaints procedure is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face to face meetings with complainants. Complaints literature/web content is being reviewed/amended to ensure that staff and service users are aware of the facilities available for meeting a complainant or patient's communication requirements.
Religion or Belief *Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.*
Neutral
Sex/Gender *A man or a woman.*
Neutral
Sexual orientation *Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes*
Neutral
Carers *A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person*
Neutral
Other identified groups relating to Health Inequalities *such as deprived socio-economic groups, rural areas, armed forces, people with substance/alcohol abuse and sex workers.* *(Health inequalities have been defined as "Differences in health status or in the distribution of health determinants between different population groups."* *Health inequalities can therefore occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical locations.)*
Neutral

STEP 4: ENGAGEMENT AND INVOLVEMENT

Have you engaged stakeholders in testing the policy/guidance or process proposals including the impact on protected characteristics? **Guidance Notes** • List the stakeholders engaged • What was their feedback? • List changes/improvements made as a result of their feedback • List the mitigations provided following engagement for potential or actual impacts identified in the impact assessment.
Not applicable.
If no engagement has taken place, please state why:
Not applicable

STEP 5: METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform service users/staff about the policy/strategy/guidance?
☐ Verbal – meetings ☐ Verbal - Telephone ☐ Written – Letter ☒ Written – Leaflets/guidance booklets ☐ Written - Email ☒ Internet/website ☐ Intranet page ☒ Other – Staff Briefing If other please state: In addition to sharing the changes to the policy via websites and information leaflets, other specific methods of communication will be considered case by case.

Step 6 – Accessible Information Standard Check

From 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf

Tick to confirm you have you considered an agreed process for:
☒ Asking people if they have any information or communication needs, and find out how to meet their needs. ☒ Have processes in place that ensure people receive information which they can access and understand, and receive communication support they need it.
If any of the above have not been implemented, please state the reason: NA

STEP 7: POTENTIAL IMPACTS IDENTIFED; ACTION PLAN

Ref no.	Potential/actual Impact identified	Protected Group Impacted	Action(s) required	Expected Outcome	Action Owner	Timescale/ Completion date
1	Access to information in other formats, including access to interpreters	All	Complaints literature/web content is being reviewed/amended to ensure that staff and service users are aware of the facilities available for meeting a complainant or patient's communication requirements.	Information about the complaints procedure is available in other languages and formats upon request. Interpreters, including BSL interpreters, will be provided as required for face to face meetings with complainants. Although this arrangement is already in place, it is not referenced in complaint literature or in website content.	Complaints Team	2020/21

GOVERNANCE, OWNERSHIP AND APPROVAL

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Approval	Executive Committee	February 2021

Presented to (Appropriate Committee)	**Publication Date**
Executive Committee	February 2021

Appendix 1

Duties and Responsibilities

Council of Members	The Council of Members has delegated responsibility to the Governing Body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of delegation for the formal review and approval of such documents.
Accountable Officer	The Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
CSU Complaints Team	The CSU Complaints Team is responsible for the day-to-day handling of complaints and will be readily available to receive complaints, support staff with the local resolution process and to give information and advice where required. Where appropriate, the CSU complaints team will also arrange a conciliation service to assist in the resolution of complaints. Information will also be relayed to the complainant regarding advocacy services that are available. The CSU complaints team will co-ordinate and collate all the information required in order to produce a draft response to the complainant. All actions arising as a result of a complaint investigation will be monitored by the CSU complaints team to ensure implementation, in conjunction with line managers and heads of service. The CSU complaints team is responsible for entering information onto the risk management database and producing appropriate reports as required, including the collection of data to enable the annual complaints return to the Department of Health. The CSU complaints team will keep up to date with current legislation and advise others as appropriate. In cases that involve the PHSO, the CSU complaints team will be the point of contact for the Ombudsman and will liaise with them in any investigation.

Investigating manager	The investigating manager is responsible for undertaking the detailed investigation of complaints, to provide information in order that the CSU complaints team can draft the written response for signature by the accountable officer (or nominated deputy). The investigating manager will establish the underlying causes of complaints and ensure that these are properly understood, lessons are learned and where appropriate, improvements are implemented. The investigating manager is also responsible for ensuring that any actions arising from complaints are implemented and the outcome is fed back to the CSU complaints team.
Senior Management Team	The senior management team is responsible for ensuring that complaints are investigated in accordance with this policy; working with the CSU complaints team to ensure satisfactory resolution of complaints, including the implementation of any lessons learned.
CSU Staff	Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures of their employing organisation.
All staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

Appendix 2

Procedure for Handling Habitual and/or Persistent Complaints

1 Introduction

The organisation is committed to dealing effectively and empathetically with people who complain about NHS services and also to learning from the findings of complaints investigations. However, sometimes organisations need to deal with persistent complainants. Handling such complaints can place a strain on time and resources and cause undue stress for staff - some may need support in difficult situations. NHS staff are trained to respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further that can reasonably be done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling complainants there are two key considerations. The first is to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that habitual or persistent complaints may have issues which contain some genuine substance. The need to ensure an equitable approach is crucial. The second is to be able to identify the stage at which a complainant has become habitual or persistent. A recognised approach to this is to have an approved procedure.

It is important to note that implementation of such a procedure would only occur in exceptional circumstances.

2 Purpose of the Procedure

Complaints are processed in accordance with NHS complaints procedures and the CCG's Complaints Policy and procedures. During this process staff inevitably may have contact with a small number of complainants who can absorb a disproportionate amount of NHS resources in dealing with their complaints. The aim of this procedure document is to identify situations where the complainant might be considered too habitual or persistent and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try to resolve complaints following the NHS complaints procedures, for example, through local resolution, conciliation, or involvement of the relevant independent complaints advocacy service as appropriate. Judgement and discretion must be used in applying the criteria to identify potential habitual or persistent complainants and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration by, and with authorisation of, the Governing Body Chair and Accountable Officer (or nominated deputy) of the organisation. Where deputies are used, the reason for the non-availability of the Chair or Accountable Officer should be recorded on file.

3 Definition of a Habitual or Persistent Complaint

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or persistent complainants where previous or current contact with them shows that they meet **TWO OR MORE** of the following criteria:

Where complainants:

i Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (eg where investigation has been denied as "out of time", where the Ombudsman has declined a request for independent review or has already investigated the matter).

ii 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 any new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints).

iii Are unwilling to accept documented evidence of treatment given as being factual, eg drug records, manual or computer records, nursing 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.

iv Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of NHS staff and, where appropriate, the independent complaints advisory service to help them specify their concerns, and/or where the concerns identified are not within the remit of the organisation to investigate.

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

Vi Have threatened or used actual physical violence towards staff or their families or associates at any time. This will in itself, cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidents should be reported via SIRMS).

Vii Have in the course of addressing a registered complaint, had an excessive number of contacts with the organisation 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 the specific circumstances of each individual case).

Viii Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment and report via SIRMS).

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

x Display unreasonable demands or patient/complainant expectations and fail to accept that these may be unreasonable (eg insist on response to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

4 Options for Dealing with Habitual or Persistent Complaints

Where complainants have been identified as habitual or persistent in accordance with the above criteria, the Accountable Officer and (or appropriate deputies in their absence) will determine what action to take. The Accountable Officer (or nominated deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as habitual or persistent complainants and the action to be taken. A copy this procedure should be shared with them along with advice to take account of the criteria in any further dealings with the organisation; This notification may be copied for the information of others already involved in the complaint, eg practitioners, mediators, conciliators, ICA, MP. A record must be kept for future reference of the reasons why a complainant has been classified as habitual or persistent. It may also be appropriate to suggest that complainant seeks advice in processing their complaint, eg through the relevant independent advocacy service for their area.

The Accountable Officer and chair (or deputy) may decide to deal with complainants in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed "agreement" with the complainant (and if appropriate involving the relevant member of staff in a two-way agreement) which sets out a code of behaviour for the parties involved if the organisation is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action as indicated in this section.
-
- Decline contact with the complainants either in person, by telephone, by fax, by letter/email or any combination of these, provided that one form of contact is maintained or alternatively restrict contact to liaison through a third party. (If staff are to withdraw from a telephone conversation with a complainant it may be helpful for them to have an agreed statement available to be used at such times).
- Notify the complainants in writing that the Accountable Officer has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.
- Temporarily suspend all contact with complainants or investigation of a complaint whilst seeking legal advice or guidance from relevant agencies.

5 Withdrawing 'Habitual or Persistent' Status

Once complainants have been determined as "habitual or persistent" there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Staff should previously have used discretion in recommending "habitual or persistent" status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Accountable Officer and chair (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

6 Review of the Procedure

This procedure will be reviewed as appropriate and at any time there is a review of The Local Authority Social Services & NHS Complaints [England] Regulations 2009 or the CCG's Complaints Policy.