NHS
Harrogate and Rural District
Clinical Commissioning Group

POLICY FOR THE REPORTING AND MANAGEMENT OF PATIENT COMPLAINTS

February 2014

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The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet
	E Vickerstaff	Addition of Appendix 5 – procedure for unreasonable persistent contacts	13.6.14	

CONTENTS

1 INTRODUCTION

The Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) is committed to working in partnership with patients, the public and other key stakeholders for the improvement of health across the local community.

This policy is based on the current national regulations issued by the Department of Health (DH) in 2009 and the best practice guidance as outlined in the 'Making Experiences Count' (MEC) document (2007). Recognising that the information gained from complaints, concerns, comments and compliments contribute to the provision of high quality care for patients this document outlines the commitment of the HaRD CCG to co-operate with the wider health and social care community to ensure a patient centred outcome focused response to complaints is maintained

With a growing population of approximately 160,000 people, it is acknowledged that people will occasionally be dissatisfied with the services or the care they receive. We recognise the importance of using the information gained through complaints, concerns, comments and compliments to improve and develop services with the aim of maintaining and improving safety, improving effectiveness and thereby improving patient experience.

To achieve this HaRD CCG has embraced the approach developed through the Department of Health using its flexibility to respond to patient complaints on an individual basis, encouraging a culture that seeks to work with complainants in an open and honest way to achieve positive outcomes.

2 ENGAGEMENT

The policy has been developed by NYHCSU patient relations service in partnership with managerial staff in NHS HaRD CCG, NHS SR CCG, NHS VoY CCG, NHS HRW CCG, NHS NL CCG, NHS Hull CCG, NHS ERY CCG and NYHCSU. The Policy follows statutory regulation and best practice guidelines as per the following:

- The Local Authority Social Services and National Health Service Complaints
- (England) Regulations 2009
- NHS Litigation Authority Risk Management Standards
- National Reporting and Learning Service Being Open Process
- Clwyd Report (2013)
- NHS Guide to Good Handling of Complaints for CCGs (May 2013)

3 IMPACT ANALYSES

3.1 Equality

In developing this policy an equalities impact analysis has been undertaken. As a result of performing the analysis, this policy does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. HaRD CCG is committed to ensuring that patients

whose first language is not English receive the information they need and are able to communicate appropriately with healthcare professionals. All information in relation to the complaints process is available in alternative languages and formats upon request.

Every complainant is dealt with as an individual and spoken with to agree their preferred outcome and how we will maintain contact. Adjustments are made on an individual basis.

We seek views of complainants at the end of the process for their input on whether the complaints process was followed to their satisfaction. An equality and diversity monitoring form accompanies the survey which is completed voluntarily.

A copy of the completed Equality Impact Analysis can be found at Appendix 2.

3.2 Sustainability

The Sustainability Impact Assessment identifies two positive impacts in relation to this policy or the CCG's sustainability themes. These relate to teleconferencing and electronic documentation and meeting management. See Appendix 3

3.3 Bribery Act 2010

The Bribery Act is particularly relevant to this policy. Under the Bribery Act it is a criminal offence to :

- bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so; and
- be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and other related policies and documentation (as detailed on the CCG intranet) when considering whether to offer or accept gifts and hospitality and/or other incentives.

Anyone with concerns or reasonably held suspicions about potentially fraudulent activity or practice should refer to the Local Anti-Fraud and Corruption Policy and contact the Local Counter Fraud Specialist

There are no requirements to the provisions of the Bribery Act 2010 within this policy. See Appendix 4

4 SCOPE

The scope of this policy is defined as patients who have been in receipt of NHS commissioned care commissioned by NHS HaRD CCG, or their relatives, carers, family members or members of the public who wish to provide feedback or raise a concern or formal complaint. For the purpose of this policy an NHS patient is defined as a person receiving care or treatment under the NHS Act 1977".

The responsibilities of this document apply to NHS HaRD CCG staff who should make themselves aware of their responsibilities in this document as part of their duties.

NHS HaRD CCG will also support those who wish to complaint about NHS services not commissioned by NHS HaRD CCG where this is appropriate or necessary to do so, however complainants will be directed to the service about which they wish to give feedback or raise a complaint, in the first instance.

5 POLICY PURPOSE AND AIMS

The aim of the Complaints Policy is to ensure a robust framework is in place for the management of patient complaints to maximise learning and inform and influence service redesign and future commissioning decisions. This policy and accompanying HaRD CCG Complaints Procedure aims to support staff to provide an outcome focused response to complainants concerns whilst ensuring fairness to practitioners and staff.

5.1 Strategic Objectives

Ensure a complaints system is in place which ensures ease of access by the population of HaRD CCG.

- Increase people's confidence that their complaints will be taken seriously and dealt with in a confidential, courteous and conciliatory manner.

- Promote a simple, consistent unified approach to be used across Health and Social Care ensuring an open and honest culture is maintained across the HaRD CCG promoting fairness to people using and delivering services.

- Promote early and effective resolution of issues ensuring that the information from complaints will be used to improve services incorporating a clear process for feedback regarding lessons learnt.

6 DEFINITIONS

A complaint can be defined as 'an expression of dissatisfaction or annoyance requiring a response'. This can include expressions as letters, emails, telephone calls, and face to face discussions.

7 ROLES / RESPONSIBILITIES / DUTIES

The Chief Officer as the Accountable Officer for the CCG is responsible for ensuring that HaRD CCG has a process for the management of patient complaints in accordance with the DH complaints regulations in relation to CCG functions.

The Head of Commissioning will ensure that the CCG agreed process for complaints management and investigation is appropriately implemented and regularly reviewed.

HaRD CCG will delegate authority to other organisations where there are contractual and governance arrangements in place with a clear line of accountability from the delegate back to the CCG, to investigate and manage complaints, with the requirement

to report to CCG as per contractual arrangements. Delegated authority is formally agreed for The Director of the Partnership Commissioning Unit. Delegated organisations will implement systems for ensuring that all investigations into complaints are tracked and monitored and target dates for responses are met. (Appendix 1)

Investigating managers will be responsible for the management of the complaints investigation and response in line with the HaRD CCG Complaints Procedure.

All staff are responsible for being aware of their obligations with regard to complaints as outlined in the HaRD CCG complaints procedure.

8 IMPLEMENTATION

HaRD CCG has documented a framework for staff to utilise when managing complaints. This procedure includes the management of complaints received by HaRD CCG with regard to its commissioning functions and those regarding independent contractors.

HaRD CCG has adopted the approach outlined in the DH Regulations which aims to resolve the issue at the most local level

Should the complainant remain dissatisfied following receipt of the final written response they have the option to contact the Parliamentary and Health Service Ombudsman for an external review.

It is important that staff are aware of the timescales which are regulated by the DH and are outlined in the HaRD CCG Complaints Procedure to ensure that complaints are acknowledged, investigated and responded to in a timely way. These timescales will also be monitored and reported as an element of the HaRD CCG Organisational Performance targets.

A complaint must be made not later than 12 months after the date the incident occurred, however in exceptional circumstances the time limit may be waived if it is considered by the Chief Officer that the complainant had good reason for not making the complaint within the timeframe and it is possible to investigate effectively and fairly.

8.1 Commissioned Services

All services commissioned by HaRD CCG are required to have established systems and processes for complaints handling in line with DH requirements. HaRD CCG will monitor complaints in commissioned services as outlined in the HaRD CCG Integrated Commissioning Plan. HaRD CCG may consider that a complaint is indicative of a wider concern or trend which, through the contracting arrangements, may prompt an in-depth review.

8.2 Being Open with Patients and Relatives

HaRD CCG is committed to improving communication with patients and carers. When things go wrong, it is essential that the relevant parties are kept fully informed and feel supported. The being open process underpins the local resolution stage of the complaints process.

Being open involves :

- apologising and explaining what happened to patients and or their carers
- conducting a thorough investigation into the complaint and reassuring patients and/or their carers that lessons will be learned to prevent reoccurrence
- providing support for the patient, relative or carer to cope with the physical and psychological consequences of what happened and ensures communication is open, honest, and occurs as soon as possible after a complaint is received.

HaRD CCG will also ensure that the actions taken as a result of complaints are published annually in our annual report.

This policy will be placed on the CCG internet and will be shared with staff.

9 TRAINING AND AWARENESS

HaRD CCG will ensure that staff have relevant training at the appropriate level and should aim to attend one complaints training session upon appointment. Statistics on the number of staff attending the training will be collated and reported annually to the Quality and Performance Committee and the Communication and Engagement Committee.

10 MONITORING AND AUDIT

All information from patient complaints is collated and recorded onto a management database from which anonymised reports are produced for internal and external reporting. The Quality and Performance Committee and the Communication and Engagement Committee will routinely receive these reports in order to triangulate patient feedback with other insight gathered by HaRD CCG, such as incidents, comments, compliments and user feedback.

Complaints information will be proactively considered as part of all service re-design projects to ensure patient feedback is routinely used to improve services and inform commissioning intentions.

10.1 Organisational Performance Targets

HaRD CCG will :

- acknowledge all complaints within three working days, verbally or in writing.
- negotiate with complainant :
    - the manner in which the complaint is to be handled
    - the period in which the investigation of the complaint is likely to be completed
- provide a full written response to the complainant documenting if the complaint has been upheld/not upheld within the time period agreed with the complainant.

Where the response cannot be provided within the timeframe above this will be discussed with the complainant. Agreement for an extension to the timescale must be obtained from the complainant and the relevant extended period to be confirmed in writing.

11 POLICY REVIEW

This policy will be reviewed biennially and no later than April 2016. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation / guidance, as instructed by the senior manager responsible for this policy.

12 REFERENCES

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
NHS Litigation Authority Risk Management Standards
National Reporting and Learning Service Being Open Process
Clwyd Report (2013)
NHS Guide to Good Handling of Complaints for CCGs (May 2013)

13 APPENDICES

Appendix 1

Scheme of Delegation
Governance arrangements for delegation of complaints to other organisations:

NHS Harrogate and Rural District CCG CO delegates authority to:

Partnerships Commissioning Unit (PCU) Director for the following areas

- Continuing Health Care Complaints
- Mental Health and Children's commissioning.

The PCU must consult with SR CCG as the employing organization and with the CCG to which the complaint relates, and the PCU consults with the specified CCG, prior to a final response being sent in relation to any complaint. The following are the CCGs which are covered by this Scheme of Delegation:

- NHS Harrogate and Rural District CCG
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Vale of York CCG
- NHS Scarborough and Ryedale CCG

Final letters must be sent out in the name of the PCU Director and the specified CCG, on CCG letter-headed documentation.

PCU will provide effective processes for monitoring, management and reporting of complaints, including annual report of complaints to the above listed CCGs. This process can be in partnership with North Yorkshire and Humber CSU that provides monthly patient relations reports, as per contract between above listed CCGs and NYHCSU.

NYHCSU provides a complaints management service for complaints made by patients, families and carers, or the general public to the above named CCGs and PCU, but has no delegated authority to act on behalf of CCGs.

NYHCSU can be delegated to lead on a complaints investigation by HaRD CCG and present the investigations findings and recommendations to the CCG.

Appendix 2

1. Equality Impact Analysis	
Policy / Project / Function:	Complaints Policy
Date of Analysis:	11 February 2014
This Equality Impact Analysis was completed by: (Name and Department)	Liz Vickerstaff RGN RMN Quality Lead Quality and Outcomes Team NYHCSU
What are the aims and intended effects of this policy, project or function ?	Reporting and Management of Serious Incidents in NHS commissioned services for the population of NHS HaRD CCG
Please list any other policies that are related to or referred to as part of this analysis?	
Who does the policy, project or function affect ? Please Tick ✔	Employees x☐ Service Users x☐ Members of the Public x☐ Other (List Below) ☐

2. **Equality Impact Analysis: Screening**					
	Could this policy have a positive impact on…		Could this policy have a negative impact on…		Is there any evidence which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
Race	☐	x☐	☐	x☐	
Age	☐	x☐	☐	x☐	
Sexual Orientation	☐	x☐	☐	x☐	
Disabled People	☐	☐	x☐	☐	Where complainants may require support to make a complaint, an advocacy service is offered as part of the process
Gender	☐	x☐	☐	x☐	
Transgender People	☐	x☐	☐	x☐	
Pregnancy and Maternity	☐	x☐	☐	x☐	
Marital Status	☐	x☐	☐	x☐	
Religion and Belief	☐	x☐	☐	x☐	

Reasoning	Complaints are managed in line with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and NHS Litigation Authority Risk Management Standards. The benefits of receiving and managing complaints is to support the complainant in reaching satisfaction and to enable the organisation to benefit from wider learning which can be shared across one or many organisations As a result of performing this analysis, the policy, project or function does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. NHS HaRD CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity.
If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7	

3. **Equality Impact Analysis: Local Profile Data**	
Local Profile/Demography of the Groups affected (population figures)	
General	
Age	
Race	
Sex	
Gender reassignment	
Disability	10,490 persons where day-to-day activities limited a lot
Sexual Orientation	
Religion, faith and belief	
Marriage and civil partnership	
Pregnancy and maternity	

4. **Equality Impact Analysis: Equality Data Available**	
Is any Equality Data available relating to the use or implementation of this policy, project or function? Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.* Examples of *Equality Data* include: (this list is not definitive) 1. Application success rates *Equality Groups* 2. Complaints by *Equality Groups* 3. Service usage and withdrawal of services by *Equality Groups* *4.* Grievances or decisions upheld and dismissed by *Equality Groups* **5.** *Previous EIAs*	Yes ☐ No ☐ Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).
List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function	
Promoting Inclusivity **How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation**	

5. Equality Impact Analysis: Assessment Test

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Gender (Men and Women)	X			
Race (All Racial Groups)	X			
Disability (Mental and Physical)			x	Some complainants, as a result of disability may require support to make a complaint. Advocacy services are offered as part of the policy and process, and records held to ensure audit demonstrates equity of access
Religion or Belief	X			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	X			

What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?

Protected Characteristic:	No Impact:	Positive Impact:	Negative Impact:	Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists
Pregnancy and Maternity	X			
Transgender	X			
Marital Status	X			
Age	X			

6. Action Planning

As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010*

Identified Risk:	Recommended Actions:	Responsible Lead:	Completion Date:	Review Date:
Some complainants, as a result of disability may require support to make a complaint. Advocacy services are offered as part of the policy and process, and records held to ensure audit demonstrates equity of access	Ensure staff recognize where a complainant requires support from advocacy services	Zoe Wray, NYHCSU, as service manager	November 2013	At new staff induction, and when policy due for review 2015

7. Equality Impact Analysis Findings				
Analysis Rating:	□ Red	□ Red/Amber	□ Amber	xGreen

		Actions	Wording for Policy / Project / Function
Red **Stop and remove the policy**	**Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.	**Remove the policy** Complete the action plan above to identify the areas of discrimination and the work or actions which needs to be carried out to minimise the risk of discrimination.	No wording needed as policy is being removed
Red Amber **Continue the policy**	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.	**The policy can be published with the EIA** • List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE). • Consider if there are any potential actions which would reduce the risk of discrimination. • Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists which justifies the use of this policy and further professional advice. ***[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]***

Equality Impact Findings (continued):			
		Actions	Wording for Policy / Project / Function
Amber **Adjust the Policy**	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document.	**The policy can be published with the EIA** • The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination. • Any changes identified and made to the service/policy/ strategy etc. should be included in the policy. • Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning s*ection of this document. ***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]***
Green **No major change**	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.	**The policy can be published with the EIA** Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Brief Summary/Further comments	

Approved By		
Job Title:	Name:	Date:
CCG to complete		

Appendix 3

SUSTAINABILITY IMPACT ASSESSMENT

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the document		**NHS HaRD CCG Complaints Policy**		
What is the main purpose of the document		**Management of feedback, concerns and complaints**		
Date completed		**14 February 2014**		
Completed by		**Liz Vickerstaff**		
Domain	**Objectives**	**Impact of activity** Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	**Brief description of impact**	**If negative, how can it be mitigated?** **If positive, how can it be enhanced?**
Travel	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home? Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities for all groups?	1	Use of teleconference facilities for meetings	
Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives?	0		

	Will it promote ethical purchasing of goods or services? Will it promote greater efficiency of resource use? Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)? Will it support local or regional supply chains? Will it promote access to local services (care closer to home)? Will it make current activities more efficient or alter service delivery models			
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	1	All documentation processed electronically, and meetings conducted using “e” technology.	
Workforce	Will it provide employment opportunities for local people? Will it promote or support equal employment opportunities? Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)? Will it offer employment opportunities to disadvantaged groups?	0		
Community Engagement	Will it promote health and sustainable development? Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	0		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)? Will it increase safety and security in new buildings and developments?	0		

	Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)? Will it provide sympathetic and appropriate landscaping around new development? Will it improve access to the built environment?			
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other weather extremes)?	0		
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes? Will it promote prevention and self-management? Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	1	Feedback, concerns and complaints may result in improvements to care models and pathways.	

Appendix 4

Bribery Act 2010 Guidance and Bribery Prevention Checklist

Areas for action	Expected Action	Evidence of Compliance / Assurance
1. Governance and Top Level Commitment	The Chief Officer should make a statement in support of the anti-bribery initiative and this should be published on the organisation's website. The Governing Body members should take overall responsibility for the effective design, implementation and operation of the anti-bribery initiatives. The Governing Body should ensure that senior management is aware of and accepts the initiatives and that it is embedded in the corporate culture.	
2. Due Diligence	This is a key element of good corporate governance and involves making an assessment of new business partners prior to engaging them in business. Due diligence procedures are in themselves a form of bribery risk assessment and also a means of mitigating that risk. It is recommended that at the outset of any business dealings, all new business partners should be made aware in writing of the organisation's anti-corruption and bribery policies and code of conduct.	

Areas for action	Expected Action	Evidence of Compliance / Assurance
3. Code of conduct	The organisation should either have an anti-bribery code of conduct or a general code of conduct for staff with an anti-bribery and corruption element. The organisation should revise the Standards of Business Conduct Policy (or equivalent) and Declaration of Interests guidance (see point 4 below) to reflect the introduction of the Bribery Act.	
4. Declaration of Interests/Hospitality	The organisation should have in place a declaration of business interests/gifts and hospitality policy which clearly sets out acceptable limits and also a mechanism to monitor implementation.	
5. Employee employment procedures	Employees should go through the appropriate propriety checks e.g. CRB (Criminal Records Bureau) and/or a combination of other checks before they are employed to ascertain, as far as is reasonable, that they are likely to comply with the organisation's anti-bribery policies.	
6. Detection procedures	The organisation should ensure Internal Audit / Counter Fraud check projects, contracts, procurement processes and any other appropriate systems where there is a risk that acts of bribery could potentially occur.	
7. Internal reporting procedures	The organisation should have internal procedures for staff to report suspicious activities including bribery.	
8. Investigation of Bribery allegations	The organisation should have procedures for staff to report suspicions of bribery to NHS Protect (previously NHS Counter Fraud and Security Management Service) and the organisation's Local Counter Fraud Specialist for investigation/referral to the appropriate authorities.	

Areas for action	Expected Action	Evidence of Compliance / Assurance
9. Risk assessment	MoJ (Ministry of Justice) guidance states"…organisations should adopt a risk-based approach to managing bribery risks…[and] an initial assessment of risk across the organisation is therefore a necessary first step". The organisation should, on a regular basis, assess the risk of bribery and corruption in its business and assess whether its procedures and controls are adequate to minimise those risks.	
10. Record keeping	The organisation should keep reasonably detailed records of its anti-fraud and corruption initiatives, including training given, hospitality given and received and other relevant information.	
11. Internal review	The organisation should carry out an annual internal review of the anti-bribery and corruption programme.	
12. Independent assessment and certification	Proportionate to risks identified, the organisation should commission, at least every three years, an independent assessment and certification of its anti-bribery programme.	
13.Internal and External communications	The organisation should publicise the NHS Fraud and Corruption Reporting Line (FCRL) and on-line fraud reporting facility. The organisation should publicise the Security Management role (theft and general security issues) and reporting arrangements. The organisation should work with its stakeholders in the public and private sector to help reduce bribery and corruption in the health industry.	

14.Awareness and training	The organisation should provide appropriate anti-bribery and corruption awareness sessions and training on a regular basis to all relevant employees.	
15. Monitoring: • Overall Responsibility • Financial / Commercial Controls	• A senior manager should be made responsible for ensuring that the organisation has a proportionate and adequate programme of anti-fraud, corruption and bribery initiatives. • The organisation should ensure that its financial controls minimise the risk of the organisation committing a corrupt act. • The organisation should ensure that its commercial controls minimise the risk of the organisation committing a corrupt act. These controls would include appropriate procurement and supply chain management, and the monitoring of contract execution.	

Appendix 5

PROCEDURE FOR UNREASONABLE PERSISTENT CONTACTS

1.1 Introduction

Unreasonable persistent contacts are becoming an increasing problem for NHS staff. The difficulty in handling such contacts is placing a strain on time and resources and is causing undue stress for staff that may need support in difficult situations. NHS staff are trained to respond with patience and sympathy to the needs of all contacts but there are times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

In determining arrangements for handling such contacts, staff need to consider the following:

- Where the individual has raised concerns, all appropriate support and advice has been offered and the individual has been given the opportunity to raise a formal complaint
- Formal complaints have been managed according to procedure, and that this 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 even unreasonable persistent contacts may have issues which contain some genuine substance.

In all situations, the need to ensure an equitable approach is crucial.

1.2 Purpose of this Procedure

The CCG, and the patient relations service have contact with a small number of individuals who absorb a disproportionate amount of NHS resources . The aim of this procedure is to identify situations where the contact might be considered to be unreasonable 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 issues and complaints.

Judgement and discretion must be used in applying the criteria to identify potential unreasonable or persistent contacts and in deciding action to be taken in specific cases.

The procedure should only be implemented following careful consideration by, and with the authorisation of the Chief Officer.

Where deputies are used, the reason for the non-availability of the Chief Officer or the Clinical Commissioning Group Clinical Chair should be recorded on the file.

1.3 Definition of an Unreasonable Persistent contact

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

Where individuals :

- Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as out of time).

- Change the substance of a complaint or concern, continually raise new issues or seek to prolong contact by continually raising further concerns or upon receipt of a response whilst the complaint or concern is being addressed. (Care must be taken not to discard new issues which are significantly different from the original contact. These might need to be addressed as separate concerns or complaints).

- Are unwilling to accept documented evidence of treatment given as being actual, e.g. drug records, General Practitioner 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.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the CCG or patient relations staff and, where appropriate, the Independent Contacts Advocacy Service to help them specify their concerns, and/or where the concerns identified are not within the remit of the CCG to investigate.

- 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 this criteria).

- 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 individual and/or their representatives to be discontinued and the contact will, thereafter, only be pursued through written communication. (All such incidents should be documented).

- Have in the course of addressing a concern or formal complaint, an excessive number of contacts with the CCG / patients relations service placing unreasonable demands on staff. (A contact may be in person or by telephone, email, letter 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).

- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their concern or complaint, or their families or associates. (Staff must recognise that individuals 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).

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

- Display unreasonable demands or expectations and fail to accept that these may be unreasonable (e.g. insist on responses to contacts or enquiries being provided more urgently than is reasonable or normal recognised practice).

1. 4 Options for Dealing with Unreasonable Persistent contacts

Where individuals have been identified as unreasonable or persistent in accordance with the above criteria, the Chief Officer will determine what action to take. The Chief Officer will implement such action and will notify individuals in writing of the reasons why they have been classified as unreasonable persistent contacts and the action to be taken. This notification may be copied for the information of others already involved in the concern or complaint, e.g. practitioners, ICA, Member of Parliament.

A record must be kept for future reference of the reasons why an individual has been classified as unreasonable or persistent.

The Chief Officer may decide to deal with individuals in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed agreement with the individual which sets out a code of behaviour for all involved if the CCG or CSU is to continue processing the concern or complaint.

- If these terms are contravened by the individual consideration would then be given to implementing other action as indicated in this section.

Once it is clear that any individual meets any one of the criteria above, it may be appropriate to inform them in writing that they may be classified as unreasonable persistent contacts, copy this procedure to them, and advise them to take account of the criteria in any further dealings with the CCG or CSU. In some cases it may be appropriate, at this point, to copy notification to others involved in the concern or complaint and to suggest that individuals seek advice in processing their concern or complaint, e.g. through ICA.

Decline contact with the individual either in person, by telephone, by fax, by letter, by email or any combination of these, provided that one form of contact is maintained, or alternatively to restrict contact to liaison through a third party. (If staff are to withdraw from a telephone conversation with the individual it may be helpful for them to have an agreed statement available to be used as such times).

Notify the individual in writing that the Chief Officer has responded fully to the points raised and has tried to resolve the concern or complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose.

The individuals should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered. Inform the individual that in extreme circumstances the CCG reserve the right to pass unreasonable or persistent contacts on their legal team and temporarily suspend all contact with the individual or investigation of a complaint whilst seeking legal advice or guidance from NHS England, or other relevant agencies.

1.5 Withdrawing Unreasonable Persistent Contact Status

Once individuals have been determined as unreasonable or persistent there needs to be a mechanism for withdrawing this status at a later date if, for example, they subsequently demonstrate a more reasonable approach or if they submit a further concern or complaint for which normal procedures would appear appropriate. Staff should previously have used discretion in recommending unreasonable 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 Chief Operating Officer Subject to their approval, normal contact with the individual will be resumed.

When an individual has been classified as an Unreasonable Persistent Contac for one year, a review of the classification will be undertaken by the CCG / patients relations service to see if the classification is still appropriate. The individual will be advised of the outcome of review and any change to their status. A further review will be held annually.