

Communications and Engagement Strategy 2016-17

(June 2017 DRAFT pending internal review)

Setting the Context – The City and Hackney

City and Hackney demographic data shows that the population continues to grow. This is particularly the case for the working age population and the over 65's, a group expected to grow fastest in the next 25 years. Fertility rates continue to decline, while life expectancy continues to rise. According to 2012 Census, the population of Hackney is 252,119 whilst the neighbouring City of London Corporation has 7,604 full time residents, although hundreds of thousands commute to and from the area daily (City and Hackney JSNA, 2014 update).

The population of Hackney is characterised by a diverse mix of ethnicities and cultures as well as over 100 spoken languages. 39% of the people in Hackney are born outside UK and two thirds of the population come from non-white ethnic backgrounds. Hackney also has the largest Charedi Orthodox-Jewish community outside New York and Israel, significant Turkish and Kurdish speaking communities, as well as Caribbean, Vietnamese, Chinese, African and Eastern European populations. City of London Corporation attracts people from outside the UK with US, Australian and Western European residents well represented in the area. In terms of ethnicity, City population is largely white (78.6 %) with Asian population representing 12.7% (City and Hackney JSNA, 2014 update). The health and wellbeing of the population in City and Hackney, as well as the common health issues and risk factors in the area reflect the diverse population as well as socio-economic factors, including deprivation, age, gender and ethnicity.

Whilst significant deprivation exists in Hackney, it is worth acknowledging that the area, along with neighbouring London boroughs such as Newham and Tower Hamlets have become relatively less deprived. There has been a change from 42 per cent of neighbourhoods in Hackney being highly deprived on the Index of Multiple Deprivation 2010 to 17 per cent in the 2015 update. Significant differences exist between different areas within Hackney and prosperity and deprivation live closely together and impact of gentrification in Hackney is clearly visible in parts of the borough.

Introduction

Our Communications and Engagement Strategy is driven by the Vision and Values set out in our Constitution. These are shown in full at the end of this document but it is worth highlighting two of our values which particularly underpin our commitment to communications and engagement.

- Creating a strong and equal partnership between our patients, public and clinicians, working in an open and transparent manner.
- Operating in an open and democratic manner, with GP consortia and other representative groups electing their representatives and involving all interested parties at all stages of our thinking and our decisions.

Our Vision and Values were themselves developed through an extensive process of engagement during the inception of the CCG, involving all of our member practices, representatives of patients and the public and other key stakeholders such as Local Authorities and providers.

We are also conscious of our legal responsibilities under Section 14ZT of the 2006 Act inserted by Section 26 of the 2012 Act namely:

We are responsible for making arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements. This includes ensuring that individuals to whom the services are being provided for, or may be provided for in the future, are involved, informed and consulted on in the planning, development and decision making processes.

These duties are delegated to our Governing Body who will abide by the following principles:

Working in partnership with patients, carers and the local community to secure the best care for them;

Adapting engagement activities to meet the specific needs of different patient groups and communities;

Publishing information about health services on the CCGs website and through other media;

Encouraging and acting on feedback;

One of our key aims as a CCG is to reduce health inequalities in City and Hackney. Clearly we cannot achieve this without securing the fullest possible engagement of our patients and our local communities nor can we achieve it without engaging with Local Authorities, community groups, neighbouring CCGs and other bodies which influence the determinants of health and well-being.

We want to use our commissioning powers to provide the health and social care services which our patients want and need. To achieve this, we need to involve patients and carers in designing the services which they will use and we need to listen to them respond rapidly and effectively to the feedback they provide.

Delivering a health service which is financially sustainable requires us to work with our patients and their families in ways which encourage and enable them to take personal responsibility for their own health and well-being rather than being passive recipients of the services which professionals think best for them. Engagement at the point of consultation is, therefore, an important aspect of our communications and engagement strategy.

As a membership organisation founded on democratic principles, effective two way communication with our constituent practices and securing their engagement in all aspects of our decision-making are fundamental to our being effective as a CCG which is clinically led and patient-centred.

Effective communication and engagement with our partners, provider organisations, local authorities, the NHS England and community organisations, are critical to our success in delivering worthwhile change for our patients and our communities.

We have established a Patient and Public Involvement Committee with a Lay Chair and two Clinical Leads to take forward the development and implementation of our Communications and Engagement Strategy. The committee has 26 members including patient and service user representatives, members of Healthwatch Hackney and Healthwatch City of London, Patient Experience teams in provider organisations and representation from a number of community groups. The group is supported by Programme Director for PPI and the CCG's Engagement Manager. In addition, there are three other members of the in house communications team which work across channels, issues and stakeholders.

For City and Hackney CCG, communications and engagement is fundamental to what we want to achieve and how we want to achieve it. We are pleased to have had our PPI structures rated 'good' and 'outstanding' as part of the NHS England's PPI assurance process for three consecutive years and really value in the strong relationships and trust that we have built with local communities during this time. We in particular take pride in the number of engagement projects that have been co-facilitated with patients and residents, including

- NHS Community Voice, a patient led engagement project facilitating regular open meetings in the community on a number of issues identified by local patients and residents.
- City and Hackney Innovation Fund, a 400k community grants scheme aimed at finding new and different solutions to local health needs and awarded as the winner of Patient Experience Network National Awards 2017 for Commissioning for Patient Experience.

We were delighted to see in the recent report on our 360 survey results that we are performing well in:

- Overall Engagement – 84% of stakeholders are satisfied with the way in which the CCG has engaged with them over the past 12 months
- Commissioning Services – 86% of stakeholders have confidence in the CCG to commission high quality services for the local population
- Leadership – 91% of stakeholders have confidence in the leadership of the CCG to deliver improved outcomes for patients

Whilst we cannot rest on our laurels we are pleased by the feedback and feel this supports the need to continue our current strategy and initiatives.

This strategy sets out how we will achieve effective communications and engagement with:

- Our patients, their families and their informal care-givers.
- Our local communities and the wider public.
- Our practices, GP's and staff working there.
- Our partners in the health and social care system.

The City and Hackney CCG is also at a key stage in developing a new way of working and commissioning our services, otherwise known as Integrated Commissioning. This new approach means working closely with our local authority partners at the London Borough of Hackney and the City of London, to pool and align budgets so that health and social care work is more joined up and outcomes improved for our residents.

A new and updated communications and engagement strategy will be developed before the end of 2017, in support of the work of Integrated Commissioning. This will aim as set out above, to achieve effective communications with key audiences and stakeholders, as well as support each of the new planned workstreams. The new workstreams currently being set up are: planned care, unplanned care, children and young people and prevention.

Our vision for engagement

We are responsible for making arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements. We do this by involving local patients and members of public in our decision making processes from planning and procurement through to evaluating the effectiveness of services and by ensuring that the providers we work with also measure and act on patient feedback.

The two-fold Patient and Public Involvement (PPI) duty states, that as well as ensuring collective involvement throughout the commissioning cycle, all CCGs must take steps to ensure that the services they commission enable patients to look after themselves, make choices about the care and treatment they receive, self-manage their conditions and take personal responsibility for their health and wellbeing where possible. These statutory duties are further detailed in the below guidance documents, which underpin all aspects of our engagement activities.

- [Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England](#)
- [Involving people in their own health and care: Statutory guidance for clinical commissioning groups and NHS England](#)

It is our aim to reflect the diverse populations and their needs in the way that services are commissioned. Over the recent years we have focused on ensuring that the appropriate involvement structures are in place, enabling us to inform, involve and consult with people. We are committed to working for, and with, the local public and patients.

We believe that working in partnership with members of public as well as the local government, voluntary organisations and the wider community is the way to achieve best outcomes for residents. Both City and Hackney have vibrant community and voluntary sectors and their role in our involvement structures cannot be emphasised enough. We recognise that having involvement structures in place alone is not enough. We want to make involvement opportunities relevant, meaningful and accessible. In particular, we want to continue to make sure that the voices of vulnerable and hard to reach and seldom heard groups are represented, noted and responded to.

Engagement with patients at the Practice level.

The Individual Patient

There is no time at which effective and empathetic communication and engagement matters more to the individual patient than at the point of contact with their GP or another health care professional. As clinicians, we are increasingly aware that care is something we do with patients rather than to patients. We are increasingly seeing our practices becoming more engaged with their patients, looking at new and varied ways to communicate with them, at various touch points

With CCG's taking on the role for primary care commissioning from NHS England, the CCG has an increasing role to play in promoting the highest standards of practice in our member practices. Primary Care commissioning now sits with the CCG – a new role we have taken on in the past year.

We recognise that every interaction between our patients and our GPs provides rich information about the quality of what we commission. It's vital that our GPs discuss these issues with their consortia to triangulate the views expressed and we have a generic email address for GPs to alert us to what they hear. Information about individual patient experiences provides quality feedback and can help us identify specific commissioning priorities. This has led to our Programme Boards commissioning services a number of services, such as our Prescribing Programme Board commissioning a service for End of Life Care and Provision of palliative care medicines, in and out of hours. Our Mental Health Programme Board have commissioned the Crisis café and SUN groups as a response to requests for 'non-medical' crisis help. Also a Psychosexual service as there was no local service available prior to it being set up. Our Maternity Programme Board commissioned a tongue tie clinic service and targeted antenatal classes were set up in direct response to patient feedback.

The communities which we serve are culturally and linguistically diverse. In promoting excellent communication and patient engagement we will need to attend to matters such as the skills and availability of interpreting and advocacy services and ensuring that practitioners are skilled in working with diverse populations and are sensitive to people with specific needs. By 31 July 2016 all organisations that provide NHS or publicly funded adult social care must have fully implemented and conform to the Accessible information Standard. This standard is in place to ensure that everyone

has access to information that they can understand, including people with sensory impairments and people with learning disabilities. We are working with our practices to support them to meet these requirements.

Our GPs also promote choice in their interactions with patients - discussing the pros and cons of different providers. Being in Central London there is significant choice available for patients. Whilst many patients choose the Homerton we try to pick up changes in patient choice decisions and in referral practice and reflect these choices in our commissioning and contracting decisions. We are committed to making the relationships between patients and clinicians more equal. To achieve this, we are working with local patients and clinicians to increase opportunities for shared decision making and are reviewing clinical pathways to ensure they include accessible and useful information for patients.

In setting and monitoring quality standards for the providers from whom we commission, we will ensure that effective two way communication and patient engagement in decision-making about their own care feature prominently.

For a number of years we have been running a diverse range of training courses and workshops. We have a long running partnership with Homerton Hospital consultants to provide education, guidance updates and pathway launches covering a broad range of topics on Fridays. We also run three masterclass courses for GPs every year (most recently we have hosted Orthopaedic and Neurology masterclasses) and support GPs and Practice Nurses in meeting their yearly safeguarding requirements by hosting 'safeguarding adults and children' training updates.

The Practice Population

Each of our 43 practices has a practice based Patient Participation Group, which consists of registered patients and provides feedback on the services patients receive and which provide a forum through which patients and their carers can be involved in planning the future of the practices they use. The Groups also provide a process through which patients can be formally or informally consulted about plans and proposals initiated at practice level and on plans and proposals developed by the CCG.

Whilst many of the issues raised are about practice issues they provide useful information about service quality and gaps and we encourage our consortia to share what has emerged and to highlight any specific trends.

The practice based Patient Participation Groups form an important part of how the CCG engages with local patients and residents and we are committed to supporting their work by providing regular updates, training opportunities and by signposting and raising awareness of the role of the groups.

Engagement with patients at the CCG level

Patient and Public Involvement structures and resources

The Patient and Public Involvement (PPI) team consists of a Lay PPI Chair, 2x PPI Clinical Leads, PPI Programme Board Director and Engagement Manager.

The team works closely with internal and external communications departments as well as the CCG's membership engagement colleagues. The PPI Lay Chair tenure is for two years at a time and the sessional commitment for the role is five meetings per month, representing one for the CCG Governing Body and one for the Clinical Executive, as well as the Prioritisation and Investment Committee, Audit Committee and PPI Committee.

Engagement through the Programme Boards

The eight multi-professional Programme Boards are the principle mechanisms through which we drive change in how needs are met and services delivered. They also have an important role in monitoring the quality of particular groups of services and in initiating action where there are concerns about quality.

Each board is responsible for commissioning a specific service area:

- Long Term Conditions
- Primary Care Quality
- Planned Care
- Maternity
- Children
- Mental Health
- Medicines Management and Prescribing
- Unplanned Care

Each Programme Board works with patients and service user representatives who are recruited from the local communities and who play an important role in helping to ensure that services are:

- Communicating with patients in an accessible and effective way
- Involving service users in service delivery and decision making
- Providing sufficient information to allow informed decision making at all times
- Providing good quality care

Patient and service user representatives attend Programme Board meetings, raise issues important to local residents about healthcare services, maintain links with other user groups, current and recent users to ensure their views are heard on the Programme Board. It is their role to comment on issues from a broader user perspective providing an impartial and independent view and engage with wider CCG activities such as events and public meetings to capture issues relevant to and affecting the Programme Board.

Patient and Public Involvement Committee

All Programme Board representatives come together as the CCG's PPI Committee which has a Lay Chair and representation also from GP practice based patient participation groups, community and voluntary sector groups, local Healthwatch branches and statutory partners. PPI Committee is a formal sub-committee of the CCG's Governing Body and it plays an important role in ensuring that all CCG decisions are informed by patient voice.

In addition to the other processes for engagement described in this strategy, all proposals and plans developed by the CCG are discussed at an early stage with the PPI Committee and their comments and advice will form a critically important part of the CCG's decision-making process.

The PPI Committee also reviews feedback from patients and service users gathered through our engagement activities, through reports from Healthwatch, through comments received by our clinicians and through an analysis of complaints. It acts as both a champion and a resource for our PPI activities. Above all the PPI Committee will feedback on our actions to those who raise concerns - "you said – together we did".

NHS Community Voice

NHS Community Voice is a patient led involvement forum, funded by the CCG and facilitated and co-ordinated by Healthwatch Hackney. The service delivers monthly open meetings on a number of health issues identified by local patients and residents and the feedback from these meetings is shared with relevant bodies who are asked to respond accordingly. NHS Community Voice also acts as a link between the CCG and the GP practice based patient participation groups, gathering feedback, passing on information and signposting people to them.

Readers' Group

We regularly ask local patients and residents to work with us to ensure that our patient information is understandable – co-creation and testing of materials is key to making sure what we are putting out reaches our target audiences using the right tone, messaging and channels.

Our infrastructure for engagement and patient and public involvement

Delivering the Forward View: NHS planning guidance 2016/17- 2020/21 identifies prevention, patient activation, choice, control and community engagement as key enablers for addressing the national challenges around 1) closing the health and wellbeing gap, 2) closing the quality gap and 3)

achieving financial balance. Achieving these aims requires working in partnership with patients and the wider community in a range of different ways which are reflected in 'The Six Principles of Engagement and involvement' designed to support CCGs with their plans for the next five years.

As well as the two PPI duties outlined above, our PPI activities are aligned to these six principles:

- Care and support is person centred: personalised and empowering
- Services which are created in partnership with citizens and communities
- Focus is on equality and narrowing health
- Carers are identified, supported and involved
- Voluntary, community, social enterprise and housing sectors as key partners
- Volunteering and social action are recognised as key enablers

We want people to feel that they are being listened to and that their views are making a valuable contribution in setting health priorities for City and Hackney. To achieve this we have tried to make a wide range of options available for people who would like to have their say and help shape local health services.

People can:

Join the PPI Committee

The Patient and Public Involvement Committee is formally a sub-committee of the Clinical Commissioning Group's Governing Body and it is directly accountable to the CCG Board.

The primary role of the Committee is to ensure that patients and the public are involved and that their views and voices influence every stage of the clinical commissioning cycle.

Take part in local and national consultations

We ensure that information on local and national consultations is circulated to our PPI representatives and where relevant to the CCG, and discussed at the PPI Committee.

Become Programme Board representatives

Local patients and residents with an interest in particular services or with lived experience of specific conditions can apply to become PPI representatives for one of our Programme Boards.

Attend meetings such as those organised by their GP practice patient participation group, NHS Community Voice and the CCG's PPI Committee. We facilitate a number of regular meetings, through which people can have their say on NHS services.

Attend events – We host regular public events aimed at discussing local services, commissioning intentions, future plans, service changes and more.

Provide feedback about services and where applicable make a complaint. We recognise that making a complaint is one way that helps organisations to learn lessons from their mistakes and prevent them from happening to anyone else. We welcome all feedback and can signpost and provide guidance to people wishing to make a complaint.

Apply for grant funding

City and Hackney CCG Innovation Fund has been running since 2014, providing an opportunity for local grassroots groups and organisations as well as individuals able to demonstrate sufficient skills and knowledge, with an opportunity to access grant funding to deliver and test out new and different ways of meeting local health needs. We also fund a number of targeted involvement projects in the community. These include City and Hackney Older People's Reference Group, Health and Social Care Forum, Hackney Refugee Forum, Children's Disability Forum and joint Mental Health Service User Forum with London Borough of Hackney.

In addition to the above, engagement takes place through

Engagement through the Clinical Executive

The membership of the Clinical Executive includes our appointed Lay Member who leads on Public and Patient Involvement for the CCG and who is also a member of the CCG Board. As the Clinical Executive is the body where the work of the Programme Boards comes together, it is particularly important that the voices of patients, carers and the public should be heard at this forum. They play a key role in informing discussions and also identifying issues and barriers to good engagement.

Engagement through the CCG Governing Body

The Constitution requires the Board to have two lay members. One, who is the Lay Chair for Public and Patient Involvement (PPI) is also a member of the Clinical Executive. The other lay member of the Board acts as Vice Chair of the Board and also has an important role to play in ensuring that the voices of patients, carers and the public are heard at Board level.

The Governing Body meetings are also attended by representatives of the local Healthwatch branches, who make an important contribution to our discussions and help triangulate the quality and safety information about our commissioned services.

Capturing and acting on feedback from patients and carers

Our Complaints Procedure (see attached with this document) is designed to ensure that

“The approach to handling complaints is engagement led, focussed on developing effective relationships, able to support accessible, timely, clear, improvement focussed resolution which embeds learning for patients, providers and commissioners.”

Additionally, the Procedure states that

“The role of CH CCG is to make the complaints process accessible, timely and clear, focussing on people not processes and ensuring that making a complaint has no adverse consequences for the on-going care of the complainant.”

While we regard the Complaints Procedure as an important source of feedback from patients and carers, we recognise that many patients and carers choose not to complain formally even when they have serious concerns about some aspect of their care. We also recognise that there is much to learn from positive feedback from patients and carers; what works well which we could apply to other services and situations.

Through our model of practice-led engagement, complemented by the CCG PPI Group and other sources, we aim to have a steady stream of patient and carer feedback informing the work and thinking of individual practices and practitioners, the Programme Boards, the Clinical Executive and the CCG Board. We expect feedback from patients and carers to be extremely influential in shaping our commissioning decisions and the contracts we place on behalf of our patients. We have also established a “hot line” service which enables GPs in our member practices to raise issues immediately with the senior management team and the clinical leaders of the CCG.

It is important that patients, carers and the public believe that their feedback makes a difference. We will always acknowledge the feedback we receive and report back the action we have taken as a result. In communicating commissioning decisions, we will make clear how feedback from patients, carers and the public have influenced those decisions. In this way we hope to create a virtuous cycle of feedback, action and response which will encourage deeper and wider engagement in the work of the CCG.

Feedback from quality monitoring

In placing contracts with providers, we will always want to be assured that their quality management systems include the systematic capture of feedback from patients and carers and processes for learning from and acting upon such feedback.

We also expect our providers to share feedback with us to help us to improve both the services we provide and the services we commission. Often feedback will be shared through the representation of providers on our multi-professional Programme Boards.

Keeping the public informed

The Vision and Values embedded in our Constitution state that we will make our decisions and conduct our business in an open and transparent fashion.

We will do this by:

- Committing to involving the public, patients and our members in our decisions, consulting and testing out our plans and ideas via our website, formal consultation, meetings and other appropriate routes.
- Publishing our Board papers and decisions in minutes on our website and documenting contract decisions in line with the Information Commissioners Office Model Publication Scheme.
- Being transparent in the decisions we make and how we make them, making as many decisions as possible in public and resisting being bound by conditions of commercial confidentiality.

We will draw on the expertise of our in house communications manager, local authority partners, community groups and our member practices to identify the channels of communication which are most effective for the different segments of our diverse communities. If necessary, we will commission additional research to help us to understand better the media through which our communities learn about what is going on locally which is significant to them.

On the basis of this knowledge, we will develop and implement communications and media plans that keep people informed, encourages comments and feedback and stimulates debate about important health and social care issues. The better local people are informed, the better they can engage with the work of the CCG.

Although a professional, well-designed and up to date website is a good starting point for keeping the public informed and engaged, we recognise that it is by no means sufficient. Many members of our local communities do not have internet access and others may not find documents written in English to be appropriate to their needs.

Although we make full use of social media such as Twitter, web news stories, email newsletters and Blogs to keep the public informed and engaged the same caveats about access and equity apply. It may be that “low tech” methods such as posters and face to face interactions in practices, libraries and community centres will have an equally important part to play.

We do not want our CCG to be a faceless body; although our own GPs and their practice staff will in many ways be the “face” of the CCG, we will also encourage the clinical and managerial leaders of the CCG to be out and about in the community meeting with community groups, listening to what they have to say and explaining the ambitions, plans and ideas of the CCG. GPs are great speakers, not bureaucratic or managerial in their words and know how to talk to people and bring out their ideas and thoughts and we will capitalise on this

We will also “piggy-back” on the very well established channels of communication which our local authority colleagues have developed over the years for communicating with their electorates. They have successfully recently increased the response rate by local people in the census and we are exploring a campaign with them in January about the importance of registering with a GP.

We see patient and public representatives as being two-way communicators, explaining the work of the CCG to their “constituencies” as well as bringing insights to the work of the CCG.

Transparency in decision-making

We are committed to being as transparent as possible about the decision we make and the reasoning behind those decisions. Wherever possible, important decisions will be taken in public.

We will resist strongly any attempt to impose contractual conditions which might compromise our freedom to take decisions transparently and to disclose all the information pertinent to those decisions. Our predecessor organisation published all its council papers on the website and we have a strong history of transparency and openness

We recognise that transparency is an active rather than a passive process. We need to make sure that our public meetings are interesting and accessible and that any documents which we publish

are written in a style which is clear and engaging. We have a clear conflicts of interest policy, recognise that we cannot commission services from practices without due process and external scrutiny and our register of interests is published in our Board papers and on our website

We will develop and implement clear processes which allow the public to ask questions about our decisions and to challenge them.

Being held to account

We have a strong sense of being accountable to the local communities which we serve. This means that we must be prepared to share with them our plans, our achievements and our failures and to explain to them what we have done and why we have done it. We should not expect everyone to agree with everything we have done, but we should expect to explain and to be open to challenge.

As a first step, we intend to publish a “user-friendly” report each year accounting for our actions and decisions and laying out our broad intentions and ambitions for the following year and beyond.

We recognise the important role of local authority scrutiny and welcome their input – more locally we want our PPI Committee to play a similar role in scrutinising how we are acting on what we have been told.

Consulting with the public

We are committed to consulting with the public about ideas, proposals and plans which might affect the ways in which they experience the services they use or might use in the future. We believe that one of the keys to successful consultation is to consult at the earliest stage possible; consulting on the nature of the problem and on possible solutions rather than merely inviting comment on firm proposals.

We see the practice-level Patient Participation Groups as important forums through which to consult with patients and the public. Through working with our local authority colleagues we will develop joint approaches when proposals have implications for both health and social care. As one of our goals is to improve the integration of health and social care through Integrated Commissioning, we anticipate that this will become part of our day to day approach in working together.

Although the channels through which we consult are important, what matters more is that we consult with a range of groups that truly represent our population, with open minds and a genuine wish to hear other voices and ideas for improvements.

Ensuring equity

We have already referred to the diverse nature of our communities and the challenges which that may present in achieving equity in our communications and engagement activities. We will continue

ensuring that our PPI activities are inclusive and accessible to the diverse population we serve. To do this, we will:

- Continue funding the NHS Community Voice with specific focus on involving groups that are considered hard to reach and seldom heard
- Work closely with Healthwatch Hackney and Healthwatch City of London who are able to provide valuable information and insight into local communities
- Maintain a close relationship with the community and voluntary sector in the area
- Commission targeted projects, such as those delivered through the Innovation Fund and the CCG's non-recurrent funding stream, aimed at hearing from vulnerable groups and raising awareness of service provision and involvement opportunities
- Ensure that the membership of our involvement forums is reviewed regularly and that it reflects the local population

Our Equality & Diversity Policy Statement, [available here](#), outlines our broader ambitions around equalities.

Particular issues around communications and engagement we will need to address as we put this strategy into action include:

- Reaching out to marginalised or “hard to reach” groups who may not be registered with any of our member practices.
- Making sure that documents are written in an accessible way without unnecessary managerial or clinical jargon.
- Making sure that we meet the diverse linguistic needs of our communities.
- Adapting to the needs of people living with disabilities.
- Recognising and working around the “digital divide” with younger residents becoming increasingly “tech savvy” but this not spreading to all communities.

We are also very conscious that we serve two distinct communities in the City of London and London Borough of Hackney and seek through our work to ensure an approach that is tailored to and reaches each community.

The challenges in ensuring equity in communications and engagement are significant and it is something that we are determined to remain vigilant on. We will regularly audit the effectiveness of our channels and processes for communication and engagement and take action where it is apparent that parts of our communities are systematically excluded or disadvantaged.

Engaging patients in their own care

As well as ensuring that collective engagement and involvement takes place we have a duty to support people and enable patients to feel in control of their own health and the choices they make when it comes to the care and treatment they receive. This means making sure that information, tools and support are available so that patients can make informed decisions about their care.

The priorities for the CCG around the individual duty are (1) Self-Management, (2) Shared decision making and (3) Personalised care planning and health budgets. We have continued our work to embed these areas in the way that services are planned, but also in what we look for in terms of reporting from providers. Whether it is ensuring that information and advocacy services are available to people and making sure that those who are entitled to Personal Health Budgets can do so and have the appropriate support in place or ensuring that patients can feel that their care is well co-ordinated and focused around their needs, we are committed to involving our residents and patients in their own care

Engaging with our constituent practices

Our 43 practices are the bedrock of the CCG. Their clinical knowledge, ideas and delivery arrangements are critical to our success. Each practice has a nominated lead for all CCG interaction and communications.

All our practices meet monthly at the Clinical Commissioning Forum where we debate our clinical ambitions and test out ideas as well as outlining the delivery of new pathways.

These are chaired by the CCG chair and are used by our Programme Boards to test out ideas at an early stage and ensure our plans remain grounded in the reality of local practice and will make a difference.

Our 43 practices come together in 6 consortia:

- South West
- North East Hackney
- North West Hackney
- Rainbow & Sunshine
- Klear
- Well

The consortia are our hubs for clinical engagement where practices come together to challenge each other on clinical behaviour, debate ideas, for education, for 2 way communication and for consultation. Each consortium elects or selects a lead GP to represent the consortium within the CCG and provide the consultation and engagement link between the CCG and individual practices.

The 6 consortium leads are the core of the Clinical Executive. This meets monthly to develop and drive our clinical ambitions and plans and to ensure “we make a difference and benefit patients” in our work.

Programme Boards and the Clinical Executive exchange information with Practice Representatives through the Consortium Leads. We also undertake an annual practice visit to discuss issues and get feedback.

We are currently trialling a consortia buddying system, where a representative of a Programme Board is assigned to a consortia and attends their meetings. The aim is to add Programme Board knowledge to debates, to speed up the 2 way communication channels, and it also gives Programme Boards valuable insight into how practices work which could influence commissioning decisions.

The Practice Representatives come together in a Members’ Forum which comprises of all the Practice Representatives. The role of the Members’ Forum is to:

- Consider and agree any changes to the Constitution including changes in the membership of the CCG.
- Ratify all appointments to the governing body.
- Consider any issue of no confidence in the governing body members either individually or collectively.
- Debate any concerns regarding discussions and decisions by the governing body.

Keeping constituent practices informed

A monthly member’s newsletter is distributed to all member practices. This is produced by the CCG with input from the chief officer and CCG chair who writes a welcome note. We aim to keep the newsletter short, punchy and very practical, with dedicated sections titled for action, for information, news, education and event, and information for practices to tell their patients.

Our Head of Engagement has a specific remit to facilitate communication and engagement with member practices. The role is to ensure that when we agree that consortia need to discuss something this actually happens and feedback gets pushed to the correct channels.

We also use the CCG Intranet to keep constituent practices informed about our work, and is the go to place for practices to source information such as pathways, referral forms, consultant advice, service contact details, prescribing information, education events, clinical lead vacancies and more. We also have a dedicated section for Practice Manager support.

Listening to constituent practices

The Practice Representative structure complemented by the Consortium structure and the Clinical Commissioning Forum is designed as a two-way communications channel. Member practices are encouraged to feed through information, concerns and questions which can then be responded to by the appropriate part of the CCG.

Within our constitution, our Members Forum allows both consortia leads and the CCG Board to call a forum meeting if it is felt that significant further discussion and consultation is needed with the GP body beyond consortia discussions about particular issues and resolutions they agree are binding on our Board.

We also work with the LMC, recognising their role in representing practices as providers, particularly where we are commissioning services from practices or where our pathways have implications for primary care.

We share our Board and Clinical Executive forward plan with practices and use the Clinical Executive as a “clearing house” for issues, testing out with the group what would be the right communication and consultation mechanism with practices, what questions we need answering and ensuring we don’t overload practices with too many demands.

We are particularly conscious that we need to plan our Board business in such a way that it facilitates practices to comment on plans and issues and our Business Coordinator is critical in ensuring we have a manageable well timed and joined up programme, linking Programme Board initiatives and CCG Board items with consortia agendas and newsletters.

We have a Programme Board whose main focus is improving the quality of primary care - when we develop our long term conditions strategy as many of the interventions which will make a difference are in primary care; similarly many of our pathways and integrated care plans involve case reviews, audit, education, consultant outreach at practice level. Our Primary Care Quality Programme Board maintains an oversight of these initiatives and ensures they are coordinated and manageable.

Engaging with our other constituents

Both our Practice Nurses and Practice Manager elect a lead onto our Clinical Executive and we treat their input in the same way as a consortium – testing out ideas, getting feedback on issues, ensuring wider engagement in our plans as well as feeding back on topics due for discussion at the Board. They are key roles in our work – our Practice Manager Representative is helping us to define the GP ICT service which we will be commissioning from our CSU and our Practice Nurse has a key role in championing nurse education in our new pathways.

Engaging with partners

Across the system

In a system as complex as the health and social care system, the success of the CCG in achieving its goals is heavily dependent on securing real engagement from a wide range of partners including Health and Wellbeing Boards, Healthwatch, provider organisations, educational institutions, neighbouring CCGs, the NHSCB and local community groups.

Each of our multi-professional Programme Boards includes representatives from relevant partners so that they are able to engage fully with us in service redesign, priority setting and improving safety and quality.

We work collaboratively with our two Health and Wellbeing Boards sharing, where appropriate, resources and expertise and developing joint approaches to identifying needs through the Joint Strategic Needs Assessment (JSNA) and to integrating health and social care; one of the aspirations set out in our Vision and Values.

With our providers

Providers and statutory partners We work in partnership with our providers, including Homerton University Hospital (HUH), East London Foundation Trust (ELFT), GP Confederation, multidisciplinary teams and others. We regularly invite the patient experience teams from these providers to attend PPI meetings and to provide updates on their work.

Through the North East London wide Sustainable Transformation Plan we are now also collaborate with the surrounding CCGs in Tower Hamlets, Waltham Forest, Newham, Redbridge, Havering and Barking.

We have a long history of working with our local providers at both clinical and managerial levels. In 2006 we established a Joint Leadership Programme with Homerton Hospital which brought together GP clinical leads and hospital consultants in pairs to consider how best to improve services. We agreed that our strategy should be to share perspectives about what each felt should change to make real improvements – and we agreed that a comprehensive clinical audit programme was the best tool to help us understand current practice and therefore how best to influence and change clinical behaviour.

We used audit to inform what good referral and management pathways should look like based on best practice, and what we needed to change to implement these. Our clinical pairs become the leaders for these pathways, promoting their use, running education sessions, offering support and advice. This programme led to the development and implementation of nearly 40 pathways for the

City & Hackney clinical community which resulted in improved patient care, containment of costs and closer working between clinicians

On the back of audit we have introduced a system whereby consultants give feedback to the GPs on the quality of their referral and pathway adherence and we have a similar alert system to the Homerton Medical Director for any GP concerns.

We are keen to continue to use peer challenge and audit as our main vehicle to change practice and improve services – we are working closely with our CSU to ensure that we get better benchmarked information and are keen to explore whether the clinical senates when established may offer the potential to bring in an external clinical perspective

Community and voluntary sector groups

The various community and voluntary sector organisations in City and Hackney are important partners to us. Working together with a number of local grass roots groups enables us to reach out and engage with groups considered vulnerable and hard to reach, including Black, Minority Ethnic and Refugee (BAMER) groups, those with long term conditions or mental health problems and older people, as well as children and young people, people with disabilities, those caring for others and many more.

We currently work closely with a number of community and voluntary sector groups and not-for-profit organisations including City and Hackney Older People's Reference Group, Health and Social Care Forum, Hackney Refugee Forum, The Huddleston Trust and Family Action, plus a number of projects funded through the City and Hackney Innovation Fund, to represent user voice, carry out targeted involvement projects and initiatives to support local residents stay healthy and well and access the right service at the right time.

Community and voluntary sector are also key partners in various CCG work streams and alliance service models, including work around Patient and Public Involvement, Early Years Strategy, Mental Health Alliance, and Better Care Fund. Our Maternity Programme Board are looking into the possibility of a 'Maternity Alliance' or similar, that would bring together community and voluntary sector services working with mothers. The Prescribing and Medicines Management Programme Board are working closely with the community and voluntary sector to ensure that community pharmacists have information and can signpost to local services. We are also in the process of setting up an Involvement Alliance, bringing together the various user voice and involvement groups with local peer support and self-management projects to work towards a shared set of aims.

With our partner CCGs

As part of our overall organisation development plan, we are building relationships with neighbouring CCGs to:

- Share learning.
- Share resources.

- Undertake joint commissioning.
- Share risk.

Resourcing and implementing the strategy

Given the importance which the Board and the CCG as a whole give to communications, it has set up a team to help deliver this important part of our work.

This team is supported by the CCG Programme Director for Patient and Public Involvement and by the CCG Engagement Manager who works in house. We have also commissioned CSU to provide us with communications support and are working with them to ensure the offer meets our needs.

In addition, GP and member practice engagement has a full time manager role dedicated to it, as well as a full time officer to support this area. The officer helps to deliver general communications, including newsletters, social media and our website and intranet management.

Communications and Engagement is an area in which there is real added value in working collaboratively with our local authorities to capitalise on their expertise in communications and engagement. We have recently employed a full time, in house communications manager, who is contracted to us through the Hackney Council communications team. This role manages day to day internal and external communications, communications work with key stakeholders, developing strategic plans and campaigns and handling media and reputational responses or issues. In addition, with them being based partly in Hackney Town Hall, the approach to working with and seeking the support of local authority communications channels and advice has developed further.

We are currently operating with a budget of £180k to support our direct public engagement work and will keep this under review as our plans develop.

The communications and engagement team will be working together to create, develop and deliver a new strategy, once Integrated Commissioning has been put in place and is operational. It is envisaged that this strategy will support both the launch of, and day to day communications and engagement work of the CCG under the Integrated Commissioning model.

Our Vision, Values and Aims

What do we believe in?

- We will transform the way services are delivered so that we can reduce health inequalities for our patients at the same time as improving quality and access, aspiring to provide the best healthcare to those living in the City of London and Hackney.

- We want to ensure that our patients have easy access to a full range of services which all deliver a consistently high standard of patient experience and excellent clinical outcomes.
- We will adopt a whole person approach to what we commission, integrating NHS and social services where this makes clinical and financial sense.
- We will commission patient centred treatment and care that is grounded in dignity and mutual respect.
- We commit to commissioning and procuring services in a fair and ethical manner.
- We will ensure that all our plans and decisions will benefit our patients and that all the work we engage in will really make a difference.
- We will work together to protect and continue the strengths, the ethos and the values on which the NHS was founded.
- We will work with our member practices, external partners and providers and our local communities to reduce the existing health inequalities for our patients.
- We will play an active role in shaping, supporting and providing education both for our members and more widely for the NHS and the health and social care system.
- We will make our decisions and conduct our business in an open and transparent fashion.
- We will work to ensure clinicians and patients are motivated and inspired by what we do, and so will want to get involved and really influence our thinking.
- We will work to ensure that patient choice is not restricted by the way we commission services and that different groups healthcare needs are considered equally and fairly.
- We will ensure sustainability principles are embedded across our commissioned services thus preserving resources for future generations and ensuring public money is spent in the most effective and sustainable way possible.
- We will play an active role in supporting and stimulating research and in ensuring that robust evidence from research and best practice is translated into our clinical practice.

How will we do this?

- By creating a strong and equal partnership between our patients, public and clinicians, working in an open and transparent manner.
- By operating in an open and democratic manner, with GP consortia and other representative groups electing their representatives and involving all interested parties at all stages of our thinking and our decisions.
- By working with our Health and Wellbeing Boards (HWBs) and our patients, clinicians and partners to ensure that we collectively address the unique needs of our communities identified in both the Joint Strategic Needs Assessment (JSNA) and those raised by our patients, clinicians and partners.

- By committing to promoting and celebrating diversity and equality and to combatting racism, homophobia, sexism, discrimination against people with disabilities and similar behaviours and attitudes which undermine social cohesion and social justice.
- By committing to involving the public, patients and our members in our decisions, consulting and testing out our plans and ideas via our website, formal consultation, meetings and other appropriate routes.
- By being receptive to all the feedback and views that we receive and explaining what we have done in response.
- By publishing our Board papers and decisions in minutes on our website and documenting contract decisions in line with the Information Commissioners Office Model Publication Scheme.
- By only commissioning services from providers who can demonstrate a commitment to their social responsibilities and to sustainability principles.
- By working openly, transparently and extensively with our local providers to ensure we can stay in financial balance.
- By debating and declaring conflicts of interest and anything that might be viewed as a conflict openly to ensure that we do not undermine the trust of our patients.
- By being transparent in the decisions we make and how we make them, making as many decisions as possible in public and resisting being bound by conditions of commercial confidentiality.
- By continually challenging our assumptions and initiatives through robust review of data, clinical evidence, best practice, research, clinical audit, patient and clinician views and experiences, patient and clinical outcomes, quality measures and benchmarked performance information.
- By working together with the public, patients, clinicians and local organisations, learning from and challenging each other and sharing ideas and best practice, promoting a culture of constructive challenge.
- By promoting good governance and proper stewardship of public money in pursuing our goals and meeting our statutory responsibilities.

Annexe A – Complaints Policy

1. Introduction

1.1 Purpose and Approach

The purpose of this policy is to enable City and Hackney CCG (CH CCG) to implement the National Health Service Complaints Regulations 2009. This policy is based on the policy developed by NHS East London and the City (NHS ELC) Cluster and is consistent with the policies of the other CCGs from the former ELC Cluster.

The Board is asked to note that this is a work in progress pending

- Further discussion with CSU about the support on Complaints Management
- Any further national guidance
- Discussions with other local partners – e.g. Healthwatch

It is expected that the National Commissioning Board will handle all complaints relating to primary care contractors (GP's as providers, dentists, optometrists, pharmacists) and to its specialist commissioning responsibilities and that the Local Authorities will be responsible for any complaints relating to their commissioning responsibilities.

The audience for this document is NHS staff responsible either for the implementation of or needing to reference the complaints process. Specifically, but not exclusively:

- CH CCG Board
- Investigators
- Complaints Managers and Officers at the CCG, CSU and Acute, Mental Health and Community Health Services Providers

The approach to handling complaints is engagement led, focussed on developing effective relationships, able to support accessible, timely, clear, improvement focussed resolution which embeds learning for patients, providers and commissioners.

CH CCG will expend all reasonable efforts to ensure that all complaints received by us are *resolved locally* to the satisfaction of complainants and contractors or providers in a clear, accessible and timely way. No complainant or the patient they represent will be treated less favourably on the grounds of age, creed, colour, disability, ethnic or national origin, medical condition or marital status, nationality, race, gender (at birth or reassigned), or sexuality nor will a complainant be placed at a disadvantage by the application of conditions or requirements which cannot be shown to be justifiable.

The Complaints function is part of CSU and we have adopted an approach to working with complainants which focuses on engagement and learning to ensure a personalised response and a true impact on improving everyday quality.

1.2 The role of CH CCG

This document applies to all staff employed by CH CCG or CSU. Provider organisations will be expected to comply with this document in situations where people request that CH CCG (or CSU) respond to or lead an investigation and response.

The role of CH CCG is to make the complaints process accessible, timely and clear, focussing on people not processes and ensuring that making a complaint has no adverse consequences for the ongoing care of the complainant.

In addition, CH CCG as the local commissioner has an assurance and scrutiny role of all provider organisations. This is achieved through our monthly provider Clinical Quality Review Meetings (CQRMs) at which we scrutinise Provider Quality and Governance Reports.

We will also review complaints trends in all Provider organisations as part of our wider quality review and assurances processes.

The CCG PPI group plays a key role in receiving feedback from patients and users, through our engagement activities, through reports from Healthwatch, through comments received by our clinicians, through analysis of complaints.

The PPI group will make recommendations to the CCG Board on key messages and learning coming from all these sources and suggest what commissioning actions need to be put in place to address them.

The PPI group will also play a key role in:

- Assuring the Board on how the CCG has responded to complaints and what feedback has occurred.
- Assuring the Board that the operational complaints management service from the CSU deliver the national policy and the KPIs contained in this policy.

2. Responsibilities

2.1 Definition of a complaint

The NHS Executive has defined a complaint as “an expression of dissatisfaction requiring a response.”

TH CCG will seek to distinguish between requests for assistance in resolving a perceived problem which may be dealt with immediately by Patient Advice and Liaison Service (PALS) and a formal complaint. All issues will be dealt with in a flexible manner, which is appropriate to their nature and the latter will be dealt with in accordance with the complaints procedure.

For the avoidance of doubt, whenever there is a specific statement of intent on the part of the caller or correspondent that they wish their concerns to be dealt with as a formal complaint, they will be treated as such.

What sort of complaints do we anticipate:

1. Complaints about commissioning decisions made by the CCG
2. A complainant wants to complain about a provider but don't want the provider to investigate

2.2 Individual and Team Responsibilities

Party	Key responsibilities
The Board	• CCG Boards have a statutory responsibility for complaints

	<p>management, and this is managed through delegation to the Chief Officer and assured through reporting.</p> <ul style="list-style-type: none"> • The Board are committed to having an effective complaints process and see complaints as an important way of assuring itself of the quality of care and the services it commissions. The complaints handling policy is also a key strand of our approach to being a learning organisation
The Chief Officer	<ul style="list-style-type: none"> • Board delegated responsibility for final sign off on formal complaints.
CCG PPI Group	<ul style="list-style-type: none"> • Board delegated responsibility for complaints review. • Assurance to Board that effective systems are in place for the management of complaints in accordance with the Complaints Regulations and ensuring actions are taken in light of the outcome of any investigation. • Monitor delivery of KPIs against deadlines by CSU and report these to Board.
CSU Directorate of Nursing and Quality Clinical Leads	<ul style="list-style-type: none"> • Support the investigating officer in carrying out a risk assessment of the situation or support an investigation as part of Nursing and Quality.
CH CCG Head of Corporate Affairs	<ul style="list-style-type: none"> • Appoint an Investigator with the agreement of the Engagement Manager • Support the Investigator during the investigation process. • On receipt of a written complaint to ensure that a copy is provided to the CSU Complaints Department immediately. • Review the situation to ensure any immediate actions are completed to improve the situation for the patient in the short term if needed working with PALS. • Ensure that the investigation is completed and the investigation report and draft response is received by the CCG within the agreed time limits. • Ensure that the proposed response addresses all of the concerns raised. • Attend meetings with the complainant, where direct involvement will help resolution of the complaint. • Ensure an action plan is drawn up (where appropriate) as a result of the complaint. • Take action or support action following recommendations arising from a Parliamentary and Health Service Ombudsman's report.
CSU Investigating Officer	<ul style="list-style-type: none"> • Carry out a risk assessment of the situation and draw up an action plan. This can be carried out with the Director. • Seek clarity and agreement with the complainant on the areas of concern they wish to have investigated and create a terms of reference together with the Complaints team • Investigate the complaint within the set timescale • Retain copies of relevant records in the complaints file.

	<ul style="list-style-type: none"> • Attend meetings with the complainant, where direct involvement will help resolution of the complaint. • Ensure that should there be a delay in completing the investigation, the CCG Head of Corporate Affairs is notified of the reason for the delay • Agree with CCG who will contact the complainant to ask for an extension of the investigation period. • Prepare an investigation report and draft a response letter, integrating responses from other services where appropriate and send to CCG.
CSU	<ul style="list-style-type: none"> • Maintain a database and acknowledge all formal complaints providing details of ICAS, (Independent Complaints Advisory Service) and other support as needed. An example of how this information is provided is in Appendix 4. • Obtain consent to disclose information if complainant is not the patient. • Distribute complaint letter/details to appropriate staff. • Ensure that the terms of reference are clearly established in agreement with the complainant. • Maintain contact with Investigating Officer to ensure good progress of complaint and on-going support/advice is available • Ensure extended investigating periods are negotiated where appropriate. • Attend meetings where direct involvement will assist resolution. • Organise and/or provide alternative dispute resolution where appropriate • Review the draft response submitted, ensuring that all areas of concern raised by the complainant, have been addressed • Edit the response that is submitted along with the investigation report • Send the final response letter to the CCG Chief Executive for approval and signature. • Arrange for a copy of the signed response to be sent to all relevant parties • Maintain a record of all action plans and changes in practice resulting from complaints. • Liaison with the Health Service Ombudsman for information requests and facilitation of post Ombudsman follow-up actions as required. • Escalate problems in case of delayed responses. • Ensure Investigators are supported and briefed effectively especially where they are not trained in RCA or any other form of investigation management.
CSU Legal Manager	<ul style="list-style-type: none"> • Provide advice on issues which may indicate admission of liability or any other legal issue. • Liaise with the National Health Service Litigation Authority (NHSLA) as required.

CSU Clinical Advisor	<ul style="list-style-type: none"> • Provide advice on the clinical content of complaints and support risk grading based on these assessments • Support the acquisition of independent clinical opinion about complaints if necessary • Attend meetings where clinical expertise is required or will offer reassurance to the complainant
All Staff	<ul style="list-style-type: none"> • All NHS staff must understand how to refer complaints. • In addition all staff involved in complaint management must put the patient at the centre of the process and ensure that bureaucracy does not get in the way of effective complaints handling.

3. Performance

Performance reporting on all national requirements relation to complaints will be met.

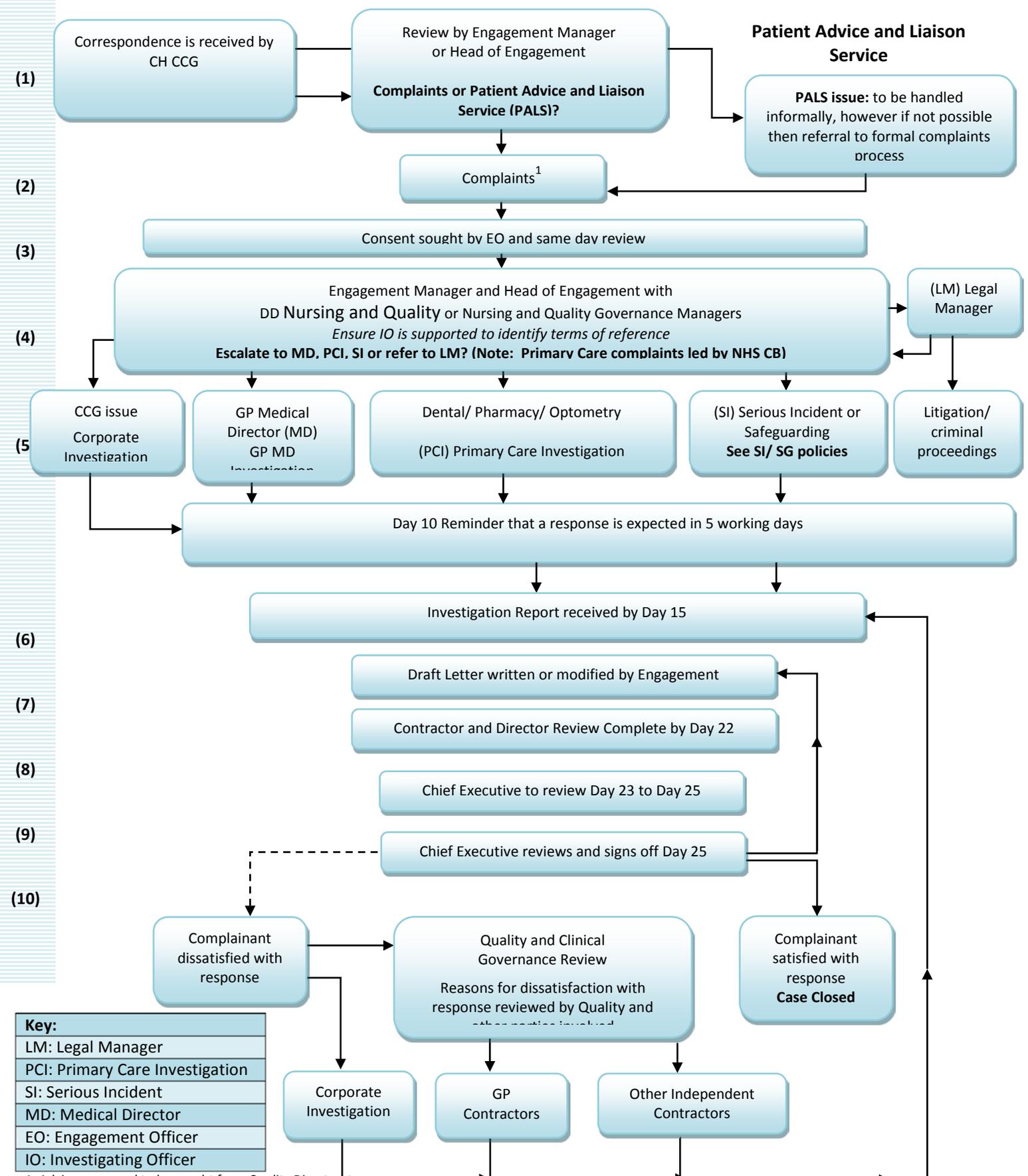
(Current) organisational performance indicators for complaints handling are as follows:

Indicator	Target	Report Detail
Complaints* acknowledged within 3 working days	100%	Number of complaints target met/ unmet
Complaints closed within 25 working days or as agreed with the complainant	100%	Number of complaints target met/ unmet

*These KPIs refer to CH CCG led complaints and not GP led or referred complaints which are managed directly by those providers.

4. Complaints Process

Stage 4.1 Flow Chart for Complaints and referral to PALS, Serious Incidents or Legal



Key:	
LM:	Legal Manager
PCI:	Primary Care Investigation
SI:	Serious Incident
MD:	Medical Director
EO:	Engagement Officer
IO:	Investigating Officer

1. Advice may need to be sought from Quality Directorate leads and investigators to determine categorisation.
 2. Deadline is 25 days or as agreed with complainant.

4.2 Requesting Consent

Staff should not assume that someone complaining on behalf of a patient who lacks capacity to complain themselves has the necessary authority to complain on their behalf. Consent must be acquired which clearly states which organisations patient information will be shared with.

CH CCG must satisfy itself that the representative of the complainant is the appropriate person and staff will make sure they have authority to do so and liaise with the complainant to ensure that consent is obtained. In the case of a patient who lacks mental capacity, it is only the immediate named next of kin who can represent the patient – this need not be a relative but whoever has been the named next of kin documented in the patient's records.

There are specific consent and data handling arrangements in place in respect of patients who have applied for gender recognition or reassignment who make a complaint about any matter including clinical care related to gender reassignment. In these cases the Chief Officer's office or the initial recipient must retain correspondence, acknowledge the complaint, providing details of the Independent Complaints Advocacy Service (ICAS) and obtain consent before redacting information that the complainant is undergoing or has undergone transition before forwarding the complaint to be investigated.

In all cases, if CH CCG is not satisfied that the representative is appropriate, it must not consider the complaint and must give the representative reasons for the decision in writing.

4.3 Timescales for complaints

4.3.1 Making a complaint within 6 months

Formal complaints should normally be received within 6 months of the event concerned or within 6 months of the complainant becoming aware that concerns need to be raised. Complaints managers in NHS organisations may waive the limit at their discretion if there are good reasons why the complainant could not complain earlier.

4.3.2 Routine Responses within 25 Working Days

CH CCG expects complaints to be responded to in accordance with timescales in the flow chart above. The CSU is responsible for ensuring that these deadlines are met which are based on key performance indicators set by the CCG.

The 25 working day deadline is set on the day of receipt of a complaint letter/email/phone call in the Complaints Department. If the consent of the patient is required, the count begins on the day the consent was received.

If by working day 20, no investigation report has been received and it will not be possible to respond to the complainant within the agreed time scale, the complainant will be contacted by the complaints team to agree a new response time. This new deadline should not exceed 20 working days from the date of that conversation or confirmation letter and should normally be less than 10 working days.

4.3.3 Deviation from a 25 working day response

This list is not exhaustive but in more complex cases, it may not be possible to achieve resolution within 25 working days, such as:

- where multiple providers are involved
- where the complainant has made a follow up request
- where staff are absent and need to be interviewed
- where CH CCG has declared a serious incident or
- cases where unforeseen events have caused delay

In cases such as these, a deadline will be agreed with the complainant and they will be kept up to date by the Complaints team. A 48 hour meeting may take place bringing together all Investigating Officers to agree terms of reference and responsibilities and the investigation may be led by individuals or a panel.

4.3.4 Urgent Cases for Immediate Action

Where a patient has a terminal illness or it is otherwise evident the complainant requires a very urgent response; CH CCG will highlight this on the complaint reference and risk grading template and have a one to one discussion with CSU clarifying this in the terms of reference to ensure it is understood that there is a need for immediate action.

Where this is not possible, this will be communicated to the complainant and as much information will be provided as possible in a weekly update from the Investigator – this is to be noted in the terms of reference and risk grading template at the outset.

4.4 Stages of the Complaints Process

4.4.1 Stage 1: Local Resolution

As a result of the 2009 legislation, the NHS complaints process has been simplified to two stages:

- | | |
|----------|---|
| Stage 1. | Local Resolution at CCG level |
| Stage 2. | The Parliamentary and Health Service Ombudsman. |

When patients make a complaint, they will usually expect feedback on actions taken and lessons learned. In order to enable complainants to be satisfied with the response to a complaint, it is advantageous to clarify what outcome they are looking for at the start of the investigation process.

This will usually be the role of the CSU Complaints Team. Although, not exhaustive, the following is a summary of potential remedies:

1. An apology – any patient who has had the misfortune to suffer through an error of whatever nature should receive a full explanation and a genuine apology. The CCG encourages staff to adopt this approach and to clearly express what we are sorry for.
2. An explanation of what happened and why
3. Financial compensation
4. Assurance that the same will not happen to others
5. A face to face conciliation/mediation meeting attended by staff involved
6. A second or independent review of care provided to the patient

If, after CH CCG has expended all possible remedies at the first stage and the complainant remains dissatisfied, or either party believes local resolution can take the complaint any further, the complaint may go to Stage 2.

4.4.2 Stage 2: The Ombudsman

The Ombudsman undertakes independent investigations into complaints where it is believed the NHS has not acted properly, fairly or has provided a poor service. The role of CH CCG is to ensure it is not found to have acted improperly or unfairly and provides a high quality complaints service. When it is established that a complaint has gone to the Ombudsman and no further action may be taken, the complaints process is closed.

4.5 Circumstances where the complaints process is suspended

The complaints process is suspended if the complainant decides:

- to seek legal redress or go to the police
- to apply for judicial review
- the complaint is a Freedom of Information or Subject Access Request

Complaints are suspended until these processes are concluded and the complaint is referred back.

4.6 Serious Incidents

The complaints team will, together with the CSU Clinical and Quality Director, assess all complaints for the potential that they meet the SI criteria. If CH CCG on the advice of CSU categorises the complaint as a Serious Incident (SI), the CSU SI team take the lead on the complaint and will coordinate with Complaints Department to ensure this is communicated to the complainant and the necessary liaison is maintained to keep the complainant informed of the investigation process.

On completion of an SI report or investigation which is required to answer a complaint – the Nursing and Quality team will liaise with the Complaints team on the process for feedback to the family which will usually be led by the person who has had the most significant involvement with the complainant. A formal complaint response will also be prepared to ensure that the original complaint is closed. This will be signed off by the CCG Chief Officer.

4.7 Joint Working between Health and Social Care

Since 2009, statutory sector organisations have been obliged to provide a single point of access to complainants. This includes complaints which involve both health and social care.

In such cases, CSU will liaise with local authority providers or other commissioners to determine lead responsibility for a complaint. CSU will then either provide an investigation report completed to template and terms of reference or agree to coordinate a complaint, including consent. If CH CCG is coordinating a response, CSU will set a deadline for receipt of completed investigations while liaising with the complainant providing details of the actions being taken to resolve the complaint.

Consent will be requested from complainants for each provider or commissioner involved especially in such cases where multiple agencies are involved.

4.8 Habitual or Vexatious Complainants

Use of this categorisation for a complainant should be infrequent and take place only after approval has been sought from CSU in discussion with CCG Head of Corporate Affairs.

This category may be applied where a complainant has become abusive, has called with a frequency which is unreasonable or inhibits the normal functioning of the complaints service

or where all possible avenues for resolution at a local level have been exhausted and the complainant refuses to accept this outcome despite correspondence clarifying the position of the CCG.

There may be cases where this is appropriate and the CCG Chief Officer will write to the complainant clarifying how future correspondence or telephone calls with the complainant will be handled.

To be clear, CH CCG recognises that habitual complaints may mask an underlying systemic or health problem, such as a mental distress or other vulnerability. In all cases, whether someone is categorised as an habitual complainant or otherwise, complainants and their concerns will be treated with dignity and respect, and the complaints team will do all they can to support the complainant to achieve resolution of the problems they experience.

5. Learning from Complaints

5.1 Routine Reporting and Trend Analysis

The CSU will provide a quarterly report and reports will specify the number of complaints received, identify subject trends, summarise handling, outcomes, performance to targets and identify any cases dealt with by the Parliamentary and Health Service Ombudsman.

This will be included in the overall management of the CCGs SLA with CSU and also respond to the CCGs PPI Group.

This group has responsibility for ensuring that the CSU service is robust and in line with our service specification and expectations and that KPIs are being met.

Complaints also form part of the quarterly quality report from CSU which is discussed with the CCG Board.

5.2 Learning from complaints

Complaints should make a difference to how the NHS works and when something goes wrong, the very least patients have a right to expect is that we will do our best to make sure something similar does not happen again in the future, because the service has learned and understands where, how and when things went wrong the last time.

The CCGs PPI Group will receive a quarterly report and the complaints handled in respect of CH residents.

The PPI Group will consider the complaints received and the issues they raised and identify commissioning recommendations.

There will be reported to the Clinical Executive Committee and thereby to the CCG Programme Boards to reflect in commissioning plans.

5.3 Communication with the Public

The PPI Group will disseminate information about improvements and learning from complaints to assure the public that the NHS and the CCG learns from mistakes and takes action. This kind of information can be disseminated using anonymised case studies, details

of specific improvements or describe learning which has been incorporated into policy to avoid repeating past mistakes. For example “you said, we did”

5.4 Risk Analysis

A CSU risk rating matrix will be applied to all complaints and will support learning and improvement by inclusion in trend analysis and day to day reporting for the management of the service. This will link with the SI process.

5.5 Non Routine Reporting

CCG Board members may request ad-hoc reports based on issues which have come to their attention. CSU will be responsible for reporting data back to the Board and Directors as required.

Requests for information may be made by a number of bodies, for scrutiny, governance or trend analysis, these may include:

- The NHS CB
- The NHS Information Centre
- Screening or Performance Panel

Additionally, data may be requested by

- Local Authority Overview and Scrutiny Panels or
- Health Watch

For the purposes of trend analysis and service improvement all such requests will need to be approved by the CSU.

CSU will be asked to prepare any report and get sign off from the CCG before it is submitted.

5.6 Audit

There are a number of different forms of audit which may be expected from a variety of different audiences, this means that data systems must be capable of delivering the expected returns, for example:

The Department of Health monitor CH CCG performance via the annual Korner (KO41) returns submitted by CSU.

NHS CB, the Board and the public monitor and evaluate CH CCG performance via the annual complaints report prepared and submitted by CSU.

5.7 Patient Feedback on Complaints Handling

CSU will carry out surveys on complainants' experience of using the complaints process by sending complainant an evaluation sheet accompanying their final letter. Any other surveys which take place will focus on improving the efficiency, pace and accessibility of the complaints process, including all communication whether written or verbal.

Information on ethnicity and language preferences will be included for equality monitoring purposes and to enable early identification of access problems and data will inform service development and reports to stakeholders.

Appendix 1: Policy Background

A Healthcare Commission review in 2009 found that many NHS complaints relate to the fundamentals of good healthcare:

- effective communication with patients
- the attitude of staff
- record-keeping
- privacy and dignity and
- in 19% of cases, there was also a problem with the way in which the complaint was handled.

The NHS Constitution states that “any individual has the right to:

- have any complaint they make about NHS services dealt with efficiently and have it properly investigated
- know the outcome of any investigation into their complaint
- take their complaint to the independent Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with their complaint
- make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body
- receive compensation where they have been harmed by negligent treatment.

The Parliamentary and Health Service Ombudsman also describes six principles for good complaint handling which tie in with the principles described in this document of an approach which is accessible, swift, clear and improvement focussed.

The six principles are:

1. **Getting it right** meaning compliance with the law and the rights of those concerned who should effectively discharge their duties and any other rules governing the service they provide.
2. **Being customer focussed**, meaning to be accessible, timely and sensitive to clients' needs.
3. **Being open and accountable**, meaning to be honest and up front about what has happened and admitting mistakes where necessary based on a clear policy which clients can understand.
4. **Acting fairly and proportionately**, meaning to respect those we serve, using evidence based approaches while actively shaping the handling process
5. **Putting things right**, meaning to things, if possible to the position they were in before the events took place. If that is not possible, it means compensating complainants and such others appropriately.
6. **Seeking continuous improvement**, meaning we tell clients what lessons have been learned and what we will do to ensure anything similar is avoided in future.

[Source: Principles of Good Complaint Handling, PHSO 2009]

Appendix 2: Detail for flow chart

Day	Activity
D1	<p>Received by Primary Care:</p> <ul style="list-style-type: none"> • Verbal * • NHS Choices Website complaints section * • General enquiry/concern or formal concern, forward to the PALS and Complaints Department* <p>* Clarify if it can be resolved on the spot or informally then use the PALS process, if not then continue to respond to as a formal complaint.</p> <p>Received by PALS and Complaints:</p> <ul style="list-style-type: none"> • General enquiry/concern - clarify if formal complaint or if informal see * • Ask the Complainant about their goals for the process and communicate this throughout to other partners to ensure that the process is patient-centred from start to finish • Scan and date stamp same working day as receipt then risk grade with the Deputy Director (DD) for Nursing and Quality (N&Q) or clinical leads and forward copy of complaint to Director or Responsible Officer with investigation report template. • Director or AD appoints investigator on same day as consent is received
D2	<ul style="list-style-type: none"> • Complaints Department will ensure the investigator understands the remit of the investigation i.e. terms of reference and follows the complaints procedure. If at any point of the investigation the terms of reference need to be updated because of new information received, Complaints Department will communicate this to the investigator. • Investigator commences investigation same day appointed and conducts investigation according to agreed procedure and terms of reference. • The Complaints Department will acknowledge receipt of the complaint within 3 working days by writing back to the complainant and providing details of ICAS, the Independent Complaints Advocacy Service. • Acknowledgement will be made in writing and by phone where possible.
D3	<ul style="list-style-type: none"> • The Complaints Department will continue negotiation process i.e. phone call to complainant to further discuss preferred options for resolution (e.g., meeting/ investigation or conciliation/mediation) and any changes fed back to Investigator.
D3-D12	<ul style="list-style-type: none"> • The investigation takes place using the agreed investigation procedure.
D12	<ul style="list-style-type: none"> • A reminder that the investigation report is due is sent to the Investigating Officer with a copy to their Director or the appropriate Appointing Officer.
After D15	<ul style="list-style-type: none"> • The Investigating Officer will ensure that staff who contributed to the investigation (including a senior representative from the contracting organisation) and the Director or Appointing Officer have the opportunity to review the draft report. • The findings of the investigation will be shared with the contractor concerned in order to ensure contracted services sign off the findings and actions.
D15	<ul style="list-style-type: none"> • Final approved report sent to Complaints Department
D16	<p>If report not sent on Day 15 prompt sent to Investigator and Appointing Officer and 48 hours given for a response. If no response is forthcoming or significant delay is envisaged and this is deemed inappropriate, the case is escalated to Directors.</p>
By D20	<ul style="list-style-type: none"> • Complaints staff write response letter based on the submitted response(s) then forward to a senior representative of the Contractor followed by the DD N&Q or NHS Director of N&Q for final quality check. • If the response makes an admission of liability on behalf of the Commissioner,

	<p>before it is finalised, the Complaints Department will forward the draft response to Legal Manager who will in turn, liaise with the NHS Litigation Authority (NHSLA) to seek their agreement before finalising the draft response letter for dispatch to the complainant.</p> <ul style="list-style-type: none"> • If the response makes an admission of liability on behalf of the Contractor, it is the responsibility of the Contractor to notify their Defence Union or other responsible body. CH CCG encourages contractors to ensure that their Defence Union have agreed any admissions within the timescales of this policy. However if this is not possible CH CCG will liaise with the Contractor to agree how to proceed.
By D22	<ul style="list-style-type: none"> • A senior representative of the Contractor and Directors check that the draft response is in line with investigation report • A Director or DD for N&Q give final approval for the draft response letter.
D23	<ul style="list-style-type: none"> • Sent to (CCG) Chief Officer's Office for final review and sign off
D25	<ul style="list-style-type: none"> • Complaints Department copy in Borough Directors and send the final response letter to the complainant and other relevant parties.

Appendix 3: Reference and Risk Grading Template

Complaint Reference and Risk Grading Template

Name of Complainant:		Name of Person concerned if different:		Ref No:
Tel No:		Mobile No:		Email:
Date Received:		Date of acknowledgement:		Practitioner:
Brief Details of Complaint for trend analysis:				
Service:	Providers Name:	Practice Mgrs Name:		Tel No (Practice Manager):
Date Consent Requested:		D/line Date of Consent (6weeks):		Date Consent Recd (25 days begin)
Date Complaint sent to Provider:		D/line for response (25 days max):		Date Response Recd/Closed:
		F/up in 10 days (date):		
Name of Investigating Officer:		Name of Director of Service:		Weekly Call Back? Yes/No
Tel No:		Tel No:		1 2 3
Email:		Email:		4 5

PASSED TO DEPUTY DIRECTOR FOR RISK ASSESSMENT: YES/NO DATE:

Rating 1 - Insignificant	Rating 2 – Minor	Rating 3 – Moderate	Rating 4 – Major	Rating 5 – Critical/Death
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PASSED TO QUALITY ASSURANCE TEAM FOR SI OR LEGAL ISSUE:

SI	YES/NO	Named Person:	Date:
Legal issues	YES/NO	Named Person:	Date:
Media issues	YES/NO	Named Person:	Date:

DATE LOG SUMMARY:		
Date	Action	Initial

Appendix 4: ICAS and PHSO Information in letters

Examples of standard Information in letters to complainants

In acknowledgement letters, information about referral to ICAS is routinely provided:

If you would like free, independent advice and advocacy you can contact the Independent Complaints Advocacy Service (ICAS), who can be reached on 0300 456 2370. Alternatively, if you wish to write to ICAS, their address is ICAS PohWer, CAN Mezzanine, 32 – 36 Loman Street, Southwark, London SE1 0EH.

In final letters, information about taking a complaint further including contacting the parliamentary and Health Service Ombudsman is routinely provided:

Important Information about your Complaint Response

I hope that you have found our response clear and helpful. Your complaint is important to us and will be used by us to monitor and improve NHS services.

This letter is part of the formal NHS Complaint Procedure. If you have any questions regarding this response, or you would like to discuss anything in this response further, please contact Mr Shahid Sardar, the Engagement Manager, on Tel: 020 7683 5113

Your care should in no way be compromised by raising these issues with us. The Trust has a duty to ensure that service users are treated with dignity and respect, and do not receive less favourable treatment, as a result of them making a complaint. The Trust will take appropriate action, in cases where there is evidence that this has occurred. We are reliant on feedback from our users and would ask that you inform us if you feel that this has been the case. Your concerns will always be discussed confidentially to agree what actions can be taken to address this.

If you are unhappy with the outcome of this complaint, you are entitled to take your complaint to the Health Service Ombudsman (please see enclosed). The Health Service Ombudsman is an independent body established to promote improvements in healthcare. Should you decide to approach the Ombudsman, you will need to do so within twelve months from the date of this letter.

It may be useful to mention that The Ombudsman would normally only consider a complaint if local resolution has been exhausted. I have enclosed a leaflet that you may find helpful. You can contact the Ombudsman at

*The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London SW1P 4QP
Tel: 0345 015 4033
Fax: 0300 061 4000
Email: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk*

Appendix 5

VEXATIOUS OR HABITUAL COMPLAINTS POLICY

1. **Vexatious or habitual complaints are defined by their behaviour.**
The behaviour must be defined over a reasonable period of time. This also includes contact with PALS. Complainants (and/or anyone acting on their behalf) may be deemed to be habitual where previous or current contact with them shows that they meet at least two of the following criteria:
Where complainants:
 - a) Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.
 - b) Seek to prolong contact by changing the substance of a complaint or continually raising new issues and questions whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).
 - c) Are unwilling to accept documented evidence of treatment given as being factual e.g. drug records, GP records, nursing notes.
 - d) Deny receipt of an adequate response despite evidence of correspondence specifically answering their questions.
 - e) Do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.
 - f) Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Primary Care Trust staff and, where appropriate, independent advocacy, to help them specify their concerns, and/or where the concerns identified are not within the remit of the Primary Care Trust to investigate.
 - g) 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).
 - h) Have, in the course of addressing a registered PALS query or complaint, had an excessive number of contacts. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section using judgement with the Primary Care Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, E-mail or fax. This also includes:
 - **Telephoning repeatedly with no clear issues other than the original complaint.**
 - **Turning up at Trust reception points without notice and demanding to be seen**
 - i) Are known to have recorded meetings or face to face/telephone conversations without the prior knowledge and consent of the other parties involved.

- j) Display unreasonable demands or expectations and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).
- k) 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 documented in line with the Zero Tolerance Procedures).
- l) 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.) Staff should document all incidents of harassment in line with the Zero Tolerance Procedures, completing an incident form.
- m) Repeated refusal to attend local resolution/conciliation meetings to explore their concerns.
- n) Do not accept independent investigation and review of their case

2. PROCEDURE FOR DEALING WITH HABITUAL COMPLAINANTS

- a) Check to see if the complainant meets sufficient criteria to be classified as a habitual complainant. Describe the defining behaviour to the Medical Director and the Deputy Director of Nursing and Quality.

Discussions should decide if the complainant should be assigned designated contact point within the complaints team

Where there is an on-going investigation

- b) A Director or the Chair* should write to the complainant setting parameters for a code of behaviour and the lines of communication. If these terms are contravened consideration will then be given to implementing other action.

**** It would be inappropriate for the Chief Executive to set these parameters at stage as s/he will be involved in the ongoing complaints process.***

Where the investigation is complete

- c) At an appropriate stage, the Chief Executive or Chair should write a letter informing the complainant that:
 - The Chief Executive has responded fully to the points raised, and
 - Has tried to resolve the complaint, and
 - There is nothing more that can be added, therefore, the correspondence is now at an end.

The Trust may also wish to state that future letters will be acknowledged but may not be responded to.

- d) In extreme cases the Primary Care Trust should reserve the right to take legal action against the complainant.

Record Keeping:

The Trust should keep an up to date and accurate record of all contacts with the complaints to support action taken.

A notification will also be placed on Datix, showing relevant action and letters issued to the complainant

Record of Contact:

Date of Contact	Method (phone, letter)	Time spent	New or repeat issue