Heathgate Medical Practice
Policy and protocol
Complaints, significant and critical events

Background

This policy has been created to formalise Practice procedures on the reporting of significant events, critical events and complaints.

It is available to and for adherence by the whole Practice team.

Complaints

The Practice welcomes comments from patients, both good and bad. Sometimes patients will feel the need to complain – verbally or in writing.

The Practice policy is summarised in our leaflet titled 'comments, complaints and compliments' which is available to patients.

Initially complaints should be handled in house with local resolution, although, depending on the nature of the matter, patients have the ability to contact NHS England and or the Clinical Commissioning Group direct.

Our Complaints Manager is the Managing Partner and formal complaints should be made in writing/E Mail to them, unless the complaint is about them, when the correspondence should be addressed to one of the other Partners.

The Practice may choose to accept a verbal complaint if deemed appropriate.

The Practice will acknowledge the complaint within three working days, providing a time scale by which our full investigation and response will be made.

Complaints must be made within 12 months of an incident occurring or of the complainant becoming aware of the matter.

All complaints will be investigated fully with an independent clinical review if the matter is of a clinical nature.

Complaints will be brought to the attention of all the Partners at the weekly Partners meeting.

On completion of a complaint investigation, we will write to the complainant explaining our review of the matter, any resolve and action that has or will be been taken.

We will remind the complainant that they have the ability to take the matter to the Parliamentary and Health Ombudsman if they are not happy with or acknowledge our response.

Significant and critical events

Significant and critical events should be brought to the attention of the Managing Partner, who with clinical support will investigate the situation.

If from the prima facia review of the situation, the need for urgent clinical intervention is required, advice and support will be taken as necessary from the GP Partners.

If deemed necessary or the situation is deemed as a serious untoward incident (SUI), the Practice will follow the CCG/Area Team policy for a SI and or Quality Reporting.

The incident will be full investigated, learning points identified and policies, protocols or processes amended or introduced to prevent the event happening again. A summary of the review will be prepared using the agreed template for this, which is available on the Practice Intranet.

The patient will be kept informed of any situation that may affect them. If appropriate, we will contact them with details of the outcomes of our investigation/review.

Dispensary significant events

Whilst these are covered in the Practice Dispensing Services Quality Scheme (DSQS) and SOP, with a separate reporting mechanism, the principles are the same as detailed above.

Practice reporting

All complaints, significant and critical events are discussed and minuted at the weekly Partners meeting, whether the matter is resolved or on going.

Significant and critical events are also discussed in greater detail at the performance and governance meetings where learnings and outcomes from the reviews are discussed.

The Managing Partner produces as annual review of all complaints and significant/critical events, which are discussed with the clinical team at a Performance and Governance Meeting, to identify trends and whether further action, learning, or development is needed in Practice.

Learning is often shared between the wider Practice team.

Quality reporting to the CCG

The Practice has access to the quality, intervention report, which is a local web based tool available to Practices which allows them to provide constructive feedback to Commissioners on services that either we use with our patients or report experiences our patients have with services commissioned by the CCG.

Serious incidents

Where an incident is deemed to be a 'serious incident', this should be reported via the National STEIS system.

A serious incident is one that occurred during NHS funded healthcare which resulted in one or more of the following:

- Unexpected or avoidable death or severe harm to patients, staff or members of the public
- A never event – which is a preventable patient safety incident that should not occur if the available preventative measures have been implemented
- A scenario that prevents or threatens to prevent an organisations ability to continue to deliver healthcare services (including data loss and property issues)
- Allegations or incidents of physical abuse, sexual assault or abuse during the delivery of NHS services
- Loss of confidence in the service because of adverse media coverage or public concern about healthcare or an organisation

If such incidents occur then NHS England will provide support on the reporting mechanisms to ensure the process is competed appropriately.

In accordance with the latest communication from NHS England on SI reporting, a telephone call should initially be made to the Primary Care Quality Team at NHS England (East) on 01223 708720.

Summary

The Managing Partner will coordinate the appropriate investigations and compile the necessary reviews and responses to all Practice complaints, significant and critical events.

The Practice is open to receiving constructive complaints / comments from patients and to learn from these.

Complaints and significant events relating to other parts of the NHS will be passed to the appropriate organisation and the complainant advised.

Reviewed and updated by Garry Whiting 20th April 2016
For review no later than 20th April 2017