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NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Receiving, investigating, responding to and learning from Complaints, Concerns, Compliments Policy

	POLICY
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Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Patient Experience Team
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1.0 INTRODUCTION

The Trust Complaints and Concerns Policy is based on "The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009".

This policy is issued and maintained by Dr Andy Hayne, Medical Director on behalf of the trust, at the issue defined on the front sheet, which supersedes and replaces all previous versions.

1.1 The NHS Constitution and patients' rights

The NHS Constitution sets out the following rights concerning complaints and redress:

- The right to have a complaint you have made about NHS services to be acknowledged within three working days and to have it properly investigated.
- The right to discuss the manner in which you want the complaint to be handled and to know the period within which the investigation is likely to be completed and the response sent.
- The right to be kept informed of progress and to know the outcome of any investigation into your complaint including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.
- The right to take a complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if not satisfied with the way the complaint has been dealt with by the NHS.
- The right to make a claim for judicial review in the event of being directly affected by an unlawful act or decision of an NHS body or local authority.
- The right to compensation where there has been harm by negligent treatment.

The NHS Constitution also makes the following pledges:

- To ensure treatment with courtesy and to receive appropriate support throughout the handling of a complaint and the fact that a complaint has been made will not adversely affect future treatment.
- To ensure that when mistakes happen or if harm occurs whilst receiving health care there will be an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma experience and to know that lessons have been learned to help avoid a similar incident occurring again.
- To ensure that organisations learn lessons from complaints and claims and use these to improve NHS services.

1.2 CQC Regulation 19 – Outcome 17

CQC regulation states that people who use services or others acting on their behalf should:

- Be sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint and that providers will comply with the regulations and ensure:
- There are systems in place to deal with comments and complaints including providing people who use services with information about that system.
- Support people who use services or others acting on their behalf to make comments and complaints.
- Consider fully, respond appropriately and resolve, where possible, any comments and complaints.

1.3 Legislation governing NHS complaints

The NHS complaints system is designed to provide explanations of what happened and where appropriate apologies and information about actions taken to ensure similar incidents do not happen again. The legislation governing NHS complaints is the Local Authority and National Health Service Complaints (England) Regulations 2008. The 2009 regulations set out various obligations on NHS bodies; for example regulation 14 imposes a duty on NHS bodies to provide a written response to complaints. Advice for patients on the two stages of the standard NHS complaints process (introduced in 2009) is set out on the NHS Choices website:

1. Ask your hospital or Trust for a copy of its complaints procedure which will explain how to proceed. Your first step will normally be to raise the matter (in writing or by speaking to them) with the practitioner, e.g. the nurse or doctor concerned or with the organisation which will have a complaints manager. This is called local resolution and most cases are resolved at this stage.
2. If you are still unhappy you can refer to the matter to the Parliamentary and health service Ombudsman who is independent of the NHS and Government.

1.4 The Parliamentary Health Service Ombudsman

The remit of the Office of the Health Service Ombudsman is set out in the Health Service Commissioners Act 1993 (as amended) which gives the Ombudsman power to investigate in certain circumstances including:

- On a complaint made by or on behalf of a person that he has sustained injustice or hardship in consequence of:

  - A failure in a service provided by a health service body
  - A failure of such a body to provide a service which it was a function of the body to provide
  - Maladministration connected with any other action taken by or on behalf of such a body

- Any failure or maladministration that may have arisen from the health service body, a person employed by that body, a person acting on behalf of that body or a person to whom that body has delegated responsibility.

2.0 POLICY STATEMENT

Sherwood Forest Hospitals NHS Foundation Trust is committed to listening to the views of patients and the public about the care we provide and values feedback on the experiences of our patients.

The Patient Experience team actively seeks the views of patients and public about the quality of our services and feeds back the information to the Trust and staff to ensure appropriate action is taken to improve services. Under the NHS Constitution people have the right to have their complaint dealt with efficiently. Compliments, concerns and complaints are encouraged and welcomed from patients, carers and the public.

It is the right of every patient to bring aspects of treatment and care with which they are dissatisfied to the attention of the Trust management. They are entitled to have their complaint or concern investigated, to receive a full and prompt, open and honest explanation, as well as an apology if it is due. People who complain about a service want to be treated with dignity and they seek assurance that their complaint is taken seriously. Under no circumstances should patients, relatives or carers be treated any differently as a result of making a complaint or raising a concern. In addition, the Trust recognises that it has a duty to act fairly towards staff involved in a complaint investigation.

Strong internal structures for the investigation of complaints, instigating action, monitoring the effectiveness of resultant action, supporting practitioners and maximising complainants' satisfaction are fundamental to effective complaints handling. In addition, the process should inform the clinical governance process by enhancing and improving the quality of care provided to users of the services by ensuring lessons are learned.

The Trust's policy:

- ✓ Regards complaints positively as an aid to improving services
- ✓ Ensures easy accessibility for persons who wish to complain
- ✓ Ensures a clear guidance and consistency
- ✓ Provides fairness for both staff and complainants and ensures communication on all sides
- ✓ Promotes the speedy resolution of complaints at the most appropriate level in the organisation
- ✓ Ensures an approach that open, honest and robust evidenced based explanations with the primary aim of resolving the complaint satisfactorily

- ✓ Embeds reflection and learning as a result of upheld and partially upheld complaints and concerns

3.0 DEFINITIONS/ ABBREVIATIONS

Definitions for specific terms used in the policy or procedure should be clarified e.g

The Trust
means the Sherwood Forest Hospitals NHS Foundation trust.

Staff
means all employees of the trust including those managed by a third party organisation on behalf of the Trust.

Concern
is an issue raised by a patient, their relative or carer can be resolved within the next 3 working days.

Complaint
is an expression of dissatisfaction requiring a response. A formal complaint can be in writing or verbal, and is made within 12 months of the incident/episode of care

Patient Experience
is the department that manages all methods of patient feedback including complaints, concerns and compliments.

Advocacy Services
are provided by PohWer and are free, independent and offer confidential services to people throughout the NHS complaint process.

Parliamentary and Health Service Ombudsman (PHSO)
provide a service to the public by undertaking independent investigations into complaints that government departments, a range of public bodies in the UK, and the NHS in England have not acted properly or fairly, or have provided a poor service.

Care Quality Commission (CQC)
is the independent regulator for all health and social care services in England, whether they are provided by the NHS, local authorities, private companies or voluntary organisations.

Unreasonable complaint conduct
is any behaviour by a current or former complainant which because of its nature or frequency raises substantial health, safety, resource or equity issues for the party to a complaint.

Complaint is Upheld
if: we did not get things right, we were not patient focused, we were not open and accountable, we did not act fairly and proportionately, there is organisational learning to be implemented.

4.0 ROLES AND RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive has overall responsibility for complaints and fulfils the role of the responsible person under the regulations. The Chief Executive is accountable for:

- Demonstrating that there is a robust process for the management of complaints and ensuring that complaint responses are signed by authorised personnel.
- Ensuring compliance with Outcome 17 of the Care Quality Commission Regulations.
- Signing off letters responding to complaints, particularly when they relate to serious care failings.

4.2 Medical Director

The Medical Director will independently review any complaint regarding medical care which requires Serious Investigation scoping. All independent review requests will be reviewed and facilitated by the Medical Director.

4.3 Director of Nursing and Quality/Deputy Director of Nursing and Quality

The Director of Nursing and Quality has executive responsibility within the Trust for complaints, including informing the Trust Board of performance and compliance status.

4.4 The Trust Board

The Board is required to receive assurance that robust systems are in place to enable feedback to be heard, actioned and lessons learned in order to provide the best possible care leading to an improved patient experience or service. The Trust Board receive quarterly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals. Board level scrutiny of complaints should regularly involve lay representatives. The Trust will publicise an annual complaints report, in plain English, which should state what complaints have been made and what changes have been put in place.

4.5 Head of Patient Experience

The Head of Patient Experience is responsible for managing the procedures for handling and considering complaints in accordance with the arrangements made under these Regulations including:

- Head of Patient Experience acts as the Complaints Manager and is responsible for maintaining a central database of complaints, concerns and compliments including the subject matter and outcome of each complaint or concern, and the response times as required by the complainant.
- There will be weekly chases of all open and re-opened complaints, arrangements of meetings and responses to the Ombudsman, and delays will be escalated thorough the Divisional Matrons/Directors.

- The Head of Patient Experience will provide guidance and templates for IOs and provide training sessions related to complaints handling, and provide advice where requested to IOs, and senior Managers of the organisation, on complex cases, and points of policy or regulations.
- The Head of Patient Experience will ensure that where complaints are received which relate to other organisations, joint working protocols are used and managed effectively.
- The Head of Patient Experience will produce an annual report in compliance with section 18 of the Regulations, and reports of complaints, concerns and compliments to relevant committees to include themes, actions as a result of complaints and evidence of actions taken, along with response times and reasons for delays.
- Liaise with Head of Governance and Governance Support Unit to share any concerns/complaints that may require Serious Investigation scoping and maintain progress of Serious Investigations.
- Frequent communication and monthly meetings with the Clinical Governance Co-ordinators and Legal Manager to review complaints linked to Serious Investigations and Coroners, to triangulate the learning for the Trust.

4.6 Divisional Patient Experience Leads

The Team manages all contacts made within the Patient Experience Team to ensure that all concerns are dealt with in the correct way according to the policy, ensuring that the needs of the patient are met where possible and assistance is provided according to the needs of the patient at the time of contact. All written complaints correspondence is read upon receipt and assigned to the correct pathway for investigation.

- The Leads provide assurance to the Patient Experience Manager on the quality and accuracy of all complaint responses leaving the Trust.
- Monitor the stage of the formal complaints process, confirms the integrity of the electronic data stored and used for reporting and produce the regular reports for Trust and divisional meetings.
- Support Patient Experience Officers to establish the relevant aspects of concerns/complaints received for investigation
- Support Patient Experience Manager to triangulate concerns/complaints with Serious Incidents with the Clinical Governance Co-ordinators.
- Co-ordinate action plans and monitors the learning implemented as a complaint outcome, liaising with the Divisional Matrons and Matrons.

4.7 Patient Experience Officers

The Officers action all contacts made with the Patient Experience Team:

- Assisting patients/relatives/carers to ensure that their concerns are managed and responded to in the appropriate way.
- Contact patients/relatives/carers who have made contact to discuss their concerns and advise of the process for responding.

- Assist the Divisional Patient Experience Leads in the management of the complaint process, including updating the complaints database as necessary.
- Contact patients/relatives/carers to discuss on-going complaints as necessary, assist in the meeting process where meetings are the arranged to respond to the complaint.

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- Monitor all informal a concern to enable a response is made to the client within the timeframe that was agreed with the client at the time of the call.

4.8 Divisional Matrons/ Assistant Directors

The Divisional Matrons/Assistant Directors are responsible for ensuring that:

- The Patient Experience team has an up to date record of staff and contact details relating to complaints handling.
- Reading each complaint relating to the division and a member of staff is appointed as the IO and contact for each complaint
- Each complaint is investigated fully within the required timescale.
- All complaints responses are reviewed and signed off at a Divisional level.
- The complaint response fully addresses the concerns raised to avoid the complaint being referred to the Parliamentary and Health Service Ombudsman for investigation.
- Responses apologising where necessary and providing an open and honest explanation.
- The investigation report and any supporting documents are supplied to the Patient Experience team within the required timescale.
- They, or the most appropriate members of staff, are available to meet with complainants to resolve their issues.
- Responsible for ensuring effective and timely responses to complaints, and ensuring that actions as a result of action plans are implemented and followed up.
- Liaise with the Governance Support Unit when complaints are managed parallel to Serious Investigations.
- Escalate serious complaints to the Executive Director of Nursing and Quality and Medical where appropriate.

4.9 Investigating Officers (IO's)

IOs will investigate complaints as requested by Divisional Matrons/Directors as follows:

- They will conduct a full investigation following the process for investigating an incident, where this is a proportional means of responding to the complaint.
- The investigation report will be sent to the Divisional Patient Experience Lead and will be signed off at Divisional Matron.
- The Divisional Patient Experience Lead will identify any actions required as a result of the complaint, draw up and share an action plan with the Divisional Matron.
- All supporting statements will be sent to the Patient Experience Team for the complaints

file.

- Ensure that staff involved in a complaint are included in the investigation process and made aware of the findings and the outcome.

4.10 Consultant Staff

Consultant staff will:

- Should a member of junior medical staff be involved, discuss the complaint with the doctor concerned at the outset and at subsequent stages in the investigation, as necessary.
- As clinical leads for care, consultants should take every opportunity to resolve potential complaints and concerns at an early stage, and are recognised as providing valuable contributions and a key role in resolution meetings.

4.11 All staff

All staff members are responsible for understanding and adhering to the guidance on front line responses to complaints, comments concerns and compliments as follows:
All staff have a responsibility to understand this policy and its impact on their area of work. Specifically staff responsibilities include:

- Listening and responding and where possible resolving any voiced and unvoiced expressions of dissatisfaction by patients and carers.
- Reporting immediately to the person in charge of the ward/ department or consultant in charge of the patient's treatment at the time, when a complaint or concern is made.
- Acting promptly when requested to assist in investigating a complaint, to ensure the complainant receives a response within the agreed timescale.
- Ensuring patients are not discriminated against as a result of making a complaint, i.e., their care does not suffer or attitudes to them become negatively affected.
- Immediately notifying line managers of any instances of discrimination arising from a complaint or concern.
- Ensuring staff receive the appropriate level of training in complaints handling.

5.0 APPROVAL

From October 2018, the previous Complaints and Concerns Policy version 4 was emailed to all senior leaders at the Trust following a complaint process mapping exercise, as part of a review of complaint management at SFH.

The Policy was approved by the Patient Safety and Quality Group (PSQG) on 10 July 2019 prior to final formally endorsement by Trust Management Board. (DATE TBC) Provide details of how and where the document has been approved
Patient Safety Quality Group is the approval committee

6.0 DOCUMENT REQUIREMENTS

A complaint is described as 'an expression of dissatisfaction requiring a response' and can be made verbally or in writing. In the case of a verbal complaint the complainant will be asked to verify the facts of the complaint in a summary statement sent to them with the acknowledgement letter.

- If the complainant is not the patient, written consent from the patient or next of kin is required.
- All complaints must receive a written or telephone acknowledgement within three working days and formal response within 25 working days or in a timescale agreed with the complainant, from the Chief Executive or a nominated responsible person.
- The primary responsibility on receipt of a complaint is to ensure that the patient's immediate health care needs are being met.

6.1 Concerns

Staff have a responsibility to deal with any initial concern rapidly, and in a professional and sensitive manner. This will very often prevent the complainant's concerns from escalating into a formal complaint.

- Whoever receives the concern should demonstrate understanding of the situation and make efforts to resolve the concern there and then.
- Where the recipient is unable to investigate at that time, or feels unable to provide the assurances that the complainant is seeking, the complainant should be referred to their immediate line manager or Matron or the concern escalated to the Patient Experience Team and a decision will be made with the agreement of the complainant whether to escalate to a formal complaint investigation.
- Concerns, which are recorded on Datix, and where they have been escalated to formal complaints, are linked for reporting purposes.
- All Trust staff are able to record concerns directly on Datix and any unresolved concerns will be addressed by the Patient Experience Team following discussion with the relevant staff member/s.
- Divisional/Specialty Datix dashboards have been developed for all divisions/specialties to access Patient Information Feedback.

6.2 Compliments

In order to provide a balanced picture compliments are recorded on Datix and reported to the trust.

- Compliments are recorded on Datix by the Patient Experience Team and reported to the Trust Board via the Patient Safety Quality Group and the Annual Report to the Quality Committee.
- All staff are able to record compliments directly onto Datix which will be included in Patient Experience reporting through to Trust Board.
- Divisional/Specialty Datix dashboards have been developed for all divisions/specialties to access Patient Information Feedback.

6.3 Who can make a complaint?

Complaints and concerns can be made by former or existing patients of the Trust or by a person acting on their behalf with their consent.

- A person can complain if they have been affected by an action or decision of the Trust.
- A complaint can be made by someone acting on behalf of a former or existing patient if that person:

Is a child: If a minor is considered to be 'Gillick' competent, attempts should be made to obtain their consent prior to disclosing sensitive clinical information to the parents or guardian. Advice should be sought from the Legal Services Manager and Specialist Safeguarding Team.

Is unable to make the complaint themselves because of physical incapacity or lack of capacity within the meaning of the Mental Capacity Act 2005. Mental Capacity. If the patient is unable to give consent due to lack of mental capacity, a check needs to be made to determine if the complainant is a significant person in the patient's life who is considering their best interests. Consideration needs to be given to any instructions the patient have made when they had capacity with regard to disclosure of information, or if they have appointed an Attorney with a Health & Welfare - Lasting Power of Attorney. This should be considered in conjunction with the Trust policy for the Mental Capacity Act. If it is considered the complainant is an 'interested party' in a patient's life and care, in order to maintain confidentiality any information disclosed must be focused on the complaint and not involve issues outside of the scope of the complaint raised.

Next of kin' has no definition in law and if the patient is still alive holds no relevance in complaints handling.

Has died: the relationship of the complainant to the deceased patient must be clarified and confirmed as the next of kin or Executor of the Estate.

Has requested the representative to act on their behalf. The Trust has a duty to preserve and uphold patient confidentiality and at the same time have a realistic approach to answering third party complaints. Unless the patient has given consent the only factors that will be included in such responses are those required to enable the Trust to adequately answer the complaint, excluding reference to clinical details. For many reasons it may not always be possible to obtain a patient's explicit authority, however reasonable steps must always be taken to obtain this.
In the event the patient's consent or appropriate authorisation is not available the Trust will need to consider its response in respect of the inclusion of any of the patient's clinical details.

The 25 working days timescale for responding to complaints will only start when consent has been established.

Some complainants instruct solicitors to act as their advocates in respect of their complaint. The appropriate authorisation from the patient should be provided. The correspondence from the solicitors must be explicit that they are acting in respect of a complaint and not with the intention of commencing a claim against the Trust. If there are any doubts advice should be sought from the Legal Services Manager.

If a Member of Parliament (MP) makes a complaint on behalf of a constituent and states, in writing, that they have the patient's consent to access confidential patient information this will be accepted without further resort to the patient. (NHS Confidentiality Code of Practice, 2002).

Independent Advocacy Services are available for anyone who requires support to make a complaint about NHS Services. Details of the Advocacy Services are available from the PRT or in the case of Prisons provided on the individual Healthcare Concern Form. Appendix 5 contains advocacy information.

6.4 Complaints excluded from investigation

Complaints which are not required to be dealt with under the NHS Complaints Regulations 2009 and this policy are:

- A complaint made by a Local Authority, NHS body, Primary Care Provider (Clinical Commissioning Groups) or an independent provider.
- A complaint made by an employee of a local authority or NHS body about any matter relating to employment.
- A complaint made orally and resolved to the complainant's satisfaction not later 3 working days. These are logged as concerns on datix.
- A complaint where the subject matter is the same as that of a complaint previously made by this complainant and previously investigated and resolved.
- A complaint arising out of the alleged failure of the Trust to comply with a request for information under the Freedom of Information Act 2000.

6.5 Confidentiality

- Complaints and concerns will be handled in the strictest confidence. Information will only be disclosed to those who have a demonstrable need to access it.
- Care must be taken in cases where the patient's records contain information provided in confidence by, or about, a third party who is not a health professional.
- Letters, statements and other documentation relating to the complaint will be kept at all times separate from the patient's medical records.

6.6 Record Keeping

Details about all complaints received, formal and concerns will be entered into Datix and given a reference number.

- Complaints will be coded with national codes (KO41a for Department of Health returns) and with locally agreed codes to enable reporting and identification of trends.
- All correspondence received by the Patient Experience Team in relation to any complaint or concern will form part of the electronic complaints file which is potentially discloseable to the Ombudsman, to legal representatives and to the complainant.
- Complaints, Concerns and Compliments will be reported to the relevant Trust governance meetings.

6.7 Duty of Candour (Being Open)

From April 2013 all NHS organisations are required to comply with the Duty of Candour and tell patients if their safety has been compromised.
The Trust will ensure that patients/relatives/carers receive a prompt apology for any incidents when this has occurred, whether or not a complaint has been made or information has been requested and ensure that lessons are learnt to prevent them from being repeated. This will be led and reported by the Deputy Head of Nursing for Quality Governance.

6.8 Collaboration with other organisations

The Trust will work with other organisations to comply with the complaint regulations, and to provide an efficient and effective complaints handling process including:

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require NHS Trusts to work with other NHS trusts and local authority Social Services departments when handling complaints which cross these organisational boundaries, in order to provide the complainant with a single combined response where possible.
- When a complaint is received in one organisation which applies to two or more organisations, the Divisional Patient Experience Lead/Patient Experience Manager will liaise to agree who will lead the response and provide a single letter of response.
- When a complaint is received in one organisation and it relates to another organisation in totality, then the complainants' consent will be requested, and, if given, the complaint will be transferred to the other organisation to deal with in its entirety.

6.9 Stages in Resolving Complaints Local Resolution

The first stage of the Complaints Process is entitled 'Local Resolution'. The intention of Local Resolution is to resolve the complaint to the complainant's satisfaction. In doing so, our approach should be open, honest, fair, flexible and conciliatory. The objective is to provide the fullest possible opportunity for investigation and resolution as quickly and sensibly as circumstances allow, aiming to satisfy the complainant whilst also being fair to staff.
The Trust will endeavour to achieve local resolution through the investigation of the complaint, writing letters and through meeting with complainants.

- The method of resolution is decided in discussion with the complainant when the relevant deputy director contacts the complainant; this may for example be a meeting, phone call or a letter.

- It is important that everything is done to resolve the issue as soon as possible to investigate appropriately and with compassion and respect. A complaint which is delayed in being responding to causes increased anxiety.

- Anonymous complaints will be logged onto Datix and investigated as far as is possible though anonymity can result in challenges to do so thoroughly.

- In instances when a complaint and claim are brought at the same time the complaints process will still apply unless contrary to the Trust's legal advisers or insurers.

- Where a complaint relates to a logged incident the complaint response timescale may be extended pending completion of the internal investigation.

If the relevant Divisional Matron and Head of Patient Experience are satisfied that all reasonable measures have been taken to manage the complaint investigation and response, then this should be stated and the option for them to pursue an independent review by the Parliamentary and Health Service Ombudsman should be highlighted. The Trust should ensure the public are aware of the purpose and what can be achieved through the complaints process from the outset. It may be necessary to signpost members the most appropriate organisation if outside of the scope of the trust.

- **Independent Review by the Parliamentary & Health Service Ombudsman (PHSO)**

The second stage of the process is an independent review carried out by the Parliamentary and Health Service Ombudsman (PHSO). The Ombudsman will not investigate a complaint until the complaints procedure has been invoked and exhausted, unless, in the circumstance of a particular case, he judges that these conditions would be unreasonable. When an Ombudsman decides to investigate a complaint, the HOPE will liaise with the Ombudsman for the complaint. The Ombudsman is appointed by the Crown and is responsible to Parliament. He/she is therefore independent of the NHS and of government. The Ombudsman has jurisdiction to investigate any complaints made by or on behalf of NHS patients and to instruct where changes are required to be made or redress offered.

7.0 Discrimination

Patients and complainants should not feel discriminated against for raising a concern, complaint or making an enquiry. In order to avoid this complaint letters and investigation correspondence must not be stored or held in patients' medical records; however if a patient or family member raises a concern or complaint during a care episode it may be documented that they had done so and it had been reported for investigation or action. Any instances of discrimination arising from a complaint or concern should be immediately notified to the Patient Experience Manager and Deputy Director of Nursing and Quality to take the appropriate steps to remedy this.

7.1 Complaint Management

The investigation process and response will take account of any special needs of the complainant, including those whose first language is not English.

- The process for dealing with formal complaints is time limited and will be managed corporately by the Head of Patient Experience and Team (Appendix 8).

- All formal complaints will be recorded and acknowledged within 3 working days of receipt, which will include the Trust's complaints information leaflet and information relating to PohWer advocacy services
- The Patient Experience Team will request consent where required. Where the complaint is made by a third party, consent from the patient will be obtained in accordance with the requirements of the General Data Protection Regulations 2018, before a response is sent.

- If the patient is still an inpatient at the time the complaint is received the investigator will make direct contact with them or their representative to discuss their concerns. A written response may still be provided.

- In cases where the investigating officer has contacted the complainant and has addressed, and answered, their concerns to their satisfaction, the outcome of that conversation will be recorded and sent to Divisional Patient Experience Lead for the complaints file. A closing letter will be approved at Divisional level and sent from the Chief Executive.

- All complaint investigations will be sent to the designated Investigating Officer (IO) within the Division for investigation with the relevant information and report template(Appendix 3) .

- The Divisional Matron will be copied into all correspondence relating to the complaint, and is responsible for the response, and for ensuring that it is done within the timescales and fully addresses the complaint . The IO will acknowledge receipt of the investigation request to the Divisional Patient Experience Lead.

- The IO will investigate the complaint relating to the relevant division using the Trust"s investigation processes and templates provided.

- Each complaint has one Divisional Patient Experience Lead, even in exceptional circumstances where a complex complaint covers several divisions. The Lead will take responsibility for liaising with the other divisions and will compile the final response for the complainant.

- If another organisation is involved, the Patient Experience team will seek consent to share the complaint with that organisation and, if consent is given, will liaise with the other organisation about which organisation will lead the response, and collaborate with them on a single response to the complainant.

- The IO will be responsible for identifying and contacting the relevant individuals who need to provide statements to answer the complaint.

- The IO is responsible for obtaining the medical records and will make them available to any clinician required to provide a response, including copies of relevant records with the completed investigation report.

- The IO will keep the Divisional Patient Experience Lead informed in the event of a delay in responding to the complaint within the agreed timescale, and the reason for the delay. The Patient Experience team will keep the complainant informed about any delay. If the IO is absent for any reason a dominated Matron must ensure that the investigation is not delayed.

- The IO will receive a reminder, one week before the due date, if no response has been received. The Divisional Patient Experience Lead will escalate delayed responses to the Head of Patient Experience for escalation with the relevant senior manager.

- The IO will forward the completed investigation and action plan where relevant to the Divisional Patient Experience Lead for review and drafting of the response letter. The draft letter will have sign off by the Divisional Matron or a nominated Deputy Divisional sign off of the completed complaints.

- A copy of the final signed response will be copied to the relevant Divisional Matron/Assistant Director, including an action plan when required in upheld or partially upheld complaints.

- The IO will ensure all completed relevant docuemnets are emailed to the Divisional Pateint Experience Lead which will be saved in the complaints file.

- The Patient Experience team will submit the response to the Chief Executive or nominated deputy for sign off and sending to the complainant before 25 working days from the date the complaint was received.

The table below shows each step of the process highlighting responsibilities for each role.

Step	Time frame	Patient Experience Department	PPC/Admin Teams	Divisional Matrons/Assistant Directors/Investigating Officer	Divisional PE Lead/HOPE	Additional comments
Receipt and review	Day 0	• HOPE/D PE Leads to triage whether formal complaint or concern, resolve where possible.			Review Datix systems for incidents/inquests if complaint relates to deceased patient/potential SI/Safeguarding Team.	• If considered a concern, confirm the agreed action with complainant and record as concern. If complaint relates to potential media interest/or regulatory bodies, HOPE to escalate to Executives/communications Team.
Acknowledge	Day 0-3	• Establish need for consent, record onto Datix and create acknowledgement for HOPE Signature.			• Call complainant, (when consent is provided) apologise for concerns, establish context, reassure being addressed, agree complaint response and inform who their main contact will be / case manager.	• If no contact details retrieve from Medway- if not patient and no contact number/email address written acknowledgment requesting contact details.

Agree complaint investigation points and resolve where possible.	Day 0-3	• Scan in complaint documents, complete relevant information to the investigation report template recording onto Datix • Email to relevant Divisional PE Lead • Record on internal PE complaints spread sheet	• Obtain notes, photocopy or scan if notes being used for care to minimise delays; retain notes in site office. • Advise Divisional PE Lead of any delays which may occur if Medic on leave/absence form work or if notes are unavailable.		• Review complaint file and contact relevant divisional Matron if complex • Liaise with GSU if SI scoping necessary. • Liaise with external agencies as required • Email investigation report and	

		• Draft acknowledgement letter to complainant to confirm details, timeframes and contacts for HOPE sign off Manage • consent as indicated. • Create file.			supporting documents to the relevant investigating officer copying to Divisional Matron/Assistant Director	
Investigate	Day 1-15	• Provide admin support to case manager, sending out statement templates etc.	• Provide admin support Investigation officer liaising with the PE team if any possible delays .	• Full investigation commenced including a review of medical/nursing records including interviews with relevant staff • All evidence to be copied and included with the complaints investigation template, ensuring all sections of the report are completed and shared with Divisional Matron for sign off	• Contact complainant r information is required, assistance to resolves any aspects of complaint that can be remedied and advise of any delays in a timely manner	• Investigation Officer to inform Divisional Matron and HOPE if initial investigation findings identify serious risk for the trust
Resolution Meeting (where agreed)	Day 15-25			• All completed investigation reports are provided to the Divisional PE Lead	• Support meeting setups, book room, establish attendees and invitations.	Divisional PE lead or Patient Experience Manger to lead all resolution meetings.

				prior to the resolution meeting to enable thorough review of case for all attendees	• Arrange and support pre-meet. • Accurately record meeting. • Post meeting recording and summary letter drafted for complainant	
	Within 5 working days of meeting *Or* Day 16-20		• Support case manager with draft response and identification of learning points. • Ensure draft sent to DD within timescales. • Log learning points on DATIX and update site learning logs.	• Relevant DD to edit / approve / assure letter ready for exec sign off. • Ensure learning points identified and included in the letter.	• Draft response and identification of learning points. • Ensure draft sent to Divisional Matron within timescales. • Ensure learning points identified and included in the letter. • Confirm complaint outcome • Develop action plan for sharing with Divisional Matron with response letter	
Sign off	Day 20-25	• Scan final signed off response • Complete action tracker and email relevant documents to relevant PE lead	• Action any instructions following exec review. • Send copy of final version of letter to all involved. • Update DATIX.		• Obtain Exec sign off • Action any instructions following exec review. • Send copy of final version of letter to all involved. • Update DATIX.	

7.2 Information / medical records

Only those investigating the issues would access a patient's personal information. A member of staff requested to provide a statement or answer issues raised in the complaint should be given access to the relevant information if necessary to aid the investigation. A complaint should only be made known to those directly involved in responding to or investigating the issues raised. Medical records will remain in the Patient Experience office throughout the investigation unless required for clinical care. Staff needing the information for their contribution to the investigation must either access them in the office or take a photocopy of them. Complaints records must be kept separate from health records and no reference to a complaint made within the health records. All staff must comply with the requirements of the Data Protection Act 1998.

7.3 Answering the issues within the complaint

Staff responding to questions and issues within the complaint will be provided with a copy of the investigation template where the issues are detailed in the first section. These will then be highlighted to indicate where staff are required to respond. They will enter their response into the relevant sections and the corresponding learning or actions to prevent recurrence or share learning. Staff will not be required to write a draft letter or provide a statement – the template will provide the necessary information to the Divisional Patient Experience Lead/|Head of Patient Experience who will edit as and if necessary to make it easily understandable and will then merge the responses into a final investigation template. If indicated any supporting documentation such as charts or clinical reports can be included as part of the response report.

7.4 Investigation Process

- The Patient Experience Team will assist with the administration involved with complaints handling, this may include following up requests for information from professionals who have been asked to provide responses to the complaint, taking a proactive approach.

- The procedures for managing incidents and claims for negligence are dealt with under separate policies. However, if during the course of investigating an incident, a complaint is received, the incident procedure should take precedence in terms of investigation. If the investigation of a complaint reveals the need to take action under the serious untoward incident procedure, the case manager should inform the lead deputy director and again the incident procedure should take preference in terms of investigation.

- It may not always be clear whether a complainant is intending to make a claim for litigation. It may be that an open and sympathetic approach will satisfy the complainant. A hostile or defensive reaction is more likely to encourage the complainant to seek information or remedy through the courts.

  Complaints correspondence and accident/adverse incident reporting information will **not** be regarded by the courts as privileged. This means that all correspondence and papers generated in the course of a complaint investigation, including staff statements etc. will have to be disclosed to a claimant if they later pursue a claim for negligence through the courts. From October 2001, the Data Protection Act classified complaints and untoward incident documentation as personal data. Patients are able to request

copies of complaints and risk management files in the same way as they do for their health records. The Freedom of Information Act 2000 is entirely separate and does not relate to personal information.

- If investigation of a complaint reveals a possibility that there may have been negligence on the part of the Trust, the Investigating Officer should immediately inform the HOPE and Divisional Matron. The existence of negligence does not prevent a full explanation being given and if appropriate, an apology. An apology is not an admission of liability.

- If at any time it becomes clear that the complainant is intending to take formal legal action, a copy of the complaint and response will be sent to the Legal Team for review prior to CEO sign off. . If it is necessary to delay the response while the legal process takes its course, the complainant will be informed of a revised timescale and kept updated with progress.

- During the investigation, those involved must inform their Divisional PE Lead of any delays and the reasons for this, so they can provide appropriate updates to the complainant. It may be appropriate for the PE Lead to contact the complainant to keep them informed of progress and if there are any delays and the reason(s) for this.

- Where a complaint identifies junior members of staff this should be drawn to their attention by their manager/consultant and they should be given the opportunity to reply. Staff involved may need to be interviewed to ascertain the facts.

- Where staff have been specifically identified they will need to respond to the issues raised within the investigation template and report their facts and position. Such information must include the background to the event where relevant, factual detail of the staff member's involvement in the situation, an explanation of what did happen and why it happened, and details of any mitigating circumstances and must address all relevant issues raised by the complainant; the aim of the response is to answer the complainant's questions and issues. The manager/consultant of the junior member of staff should also provide their comments/response.

- Staff involved in a complaint should be given the necessary support during the investigation process, and the process should be a mechanism for learning and improving practice.

- All members of staff directly involved, or contributing to the complaint should be informed of the outcome of the investigation through their line manager and be provided with a copy of the response being sent to the complainant.

7.5 Investigation detail

The Divisional Matron/Assistant Director is responsible for ensuring a full and thorough investigation takes place and the following points should be taken into account:

- A review of the relevant patient documentation, policies and guidance documents must be undertaken.

- The cause of a complaint needs to be established to enable appropriate action to be taken to prevent reoccurrence.

- The investigation template provides a structured approach and it is important that as well as responding to the points raised there are accompanying actions and learning points.

- Ensure that the aim of the investigation which is to identify the true cause of the problem is clearly understood by the staff involved.

- Ensure that the investigation is independent from the staff directly involved but inclusive, i.e., if a Clinical Lead has a complaint about them as an individual, the Medical Director will have oversight of this investigation report and responses provided or a nominated representative made by the Medical Director. This is not about not believing the individual but about providing assurance to the complainant that we have been open and balanced.

- Ensure that all staff involved in the complaint are aware of the complaint and are involved as appropriate. Staff who have been complained about should be made aware of the situation, be given the opportunity to respond and their views taken into account.

- Ensure that all correspondence and documentation are retained by the PE Lead or coordinator.

- All key documentation must be retained electronically on the complaints database. (e.g. complaint letters, response letters, investigation template returns, correspondence with complainant)

- Staff should use the investigation template at Appendix 3.

7.6 Documentation
The complaint templates are included as appendices within this policy.

7.7 Approval Process
The proposed response from division will be provided to the Divisional PE Lead and reviewed by HOPE to ensure the report fully addresses all aspects of the complaint. Any queries in relation to the response will be returned to the IO for further information and clarification/evidence.

The proposed draft response written by the Divisional PE Lead will be sent to the relevant Head of Nursing/general Manager/Clinical Chair as agreed with each division who will complete a final quality assurance before approving the letter for CEO sign off.
This will be checked that:

- All queries have been investigated and answered.
- All relevant staff have had the opportunity to contribute.
- Documentation guidelines have been followed particularly that the investigation template is legible, appropriately edited and that the executive response has been drafted using the template.
- Actions have been identified.
- All grammar and language used is correct and appropriate

The completed letter and investigation template, accompanied by the original complaint letter and any relevant further information will then be sent to the Chief Executive (or identified executive) for final approval and sign off. If any final formatting is required the Patient Experience Team can do this though using the required Trust templates will minimise this requirement.

The signed final copy will be circulated to relevant staff involved in the complaint – **though this must not be placed in any of the patient records, unless mitigating circumstances.**

Complainants will be provided with 10 working days to respond to the Patient Experience Team should they remain dissatisfied with the investigation findings. This advice is included in the final letter of response, along with details for PHSO for independent advice.

7.8 Police / Legal Involvement / Escalation

- **Police Investigations**
  When a complaint is also the subject of a police investigation; wherever possible, copies of the medical records should be obtained to allow the internal Trust investigation to be conducted as usual if permitted by the Police. Discussion on how to proceed will need to be considered on an individual basis together with the Executive Director for Nursing and Quality. Refer to the Guidelines for the NHS in support of the Memorandum of Understanding 2006, regarding police investigations.

- **Coroner Inquests**
  Where it has been identified that the complaint is also the subject of an inquest, discretion will be applied to determine when a response will be provided in relation to the inquest. HOPE to liaise with Trust Solicitor and agree sharing or response/LRM. Any concerns raised by family members with the Bereavement Centre will be escalated to the Patient Experience Team for review and management.

- **Legal Claims**
  Where a clinical negligence claim is being pursued through legal processes, these cases should be discussed with the Legal Services Team and agreement made on the process to be followed, recognising that it may be legal services that will coordinate an investigation.

- **External Reviews**
  Complainants may ask for an external review of their complaint or treatment as part of the process of resolving their complaint. Any external review will be initiated by the Medical Director and Chief Nurse

- **Serious Investigation**
  Some complaints will already have been reported and investigated under the Trust"s incident/serious incident investigation process. The incident investigation may be on-going when the complaint is received the Patient Experience team will be responsible for liaison with the complainant.
  The Patient Experience Team will liaise closely with the Governance Support Unit and where appropriate the scope of the Serious Incident (SI) will include the complaint and coordination of complaint will be managed by the Duty of Candour (DOC) Lead if appropriate. The complainant will be contacted by the Patient Experience Team to confirm the SI will supersede the complaint investigation and subsequent communications will be made by DOC lead.

The signed off report will be shared with the complainant by
DOC lead/GSU and any subsequent meetings will be coordinated by GSU/DOC Lead. The GSU will share the signed off SI report with the Patient Experience Team to include in the complaint file and the complaint will be linked to the incident on the database (Datix) for reporting purposes.
In cases where a DOC lead is not appointed, the Patient Experience Team will continue to liaise with complainant with the agreement of HOPE.

- **Escalation Procedure**
  During a complaint or concern investigation, any concerns identified by the Patient Experience Team or Investigating Officer relating to a serious organisational risk must be escalated immediately to the HOPE and/or Medical Director/Executive Director of Nursing and Quality for further action (Appendix 8)
- **Remedy**
  Remedy of a complaint should be suitable and proportional when there has been injustice or hardship resulting from poor administration or poor service. Non-financial remedies are most common, in the form of apologies or actions to change decisions about care or a service provided to an individual.

  Where a complainant requests financial remedy or reimbursement, the HOPE and Trust Solicitor will assess each case following investigation. They will determine whether to refer the case to the NHS Resolution if negligence is identified, decline to offer the financial reimbursement or remedy, or make an offer based on poor quality care, experience or complaint handling when there is no clear negligence. This in turn will need to be agreed with the relevant operational management team and budget holder responsible for the service that was involved, with authorisation in line with the financial authorisation matrix. Financial remedy will always be a monetary sum paid directly to the relevant party as an ex gratia payment. This will adhere to the Trusts financial standing orders. The giving of gifts is not permitted.

7.9 Habitual or Unreasonably Persistent Complainants

Regardless of the manner in which the complaint is made and pursued, its substance should be considered carefully on its objective merits. Complaints about matters unrelated to previous complaints should be similarly approached objectively and without any assumption that they are bound to be frivolous, vexatious or unjustified.

may have issues of genuine substance, it is

It is accepted that complainants or others coming into contact with the Trust may act out of character. They may show signs of habitual and unreasonable behaviour for several reasons and may be unaware that their attitude/behaviour is causing unnecessary distress to others. Unacceptable behaviour that continues through several contacts however, should be considered against this procedure.

Trust staff should not be faced with verbal aggression or abuse. Staff encountering such abuse by telephone, are encouraged to politely explain the situation to the caller and advise that, if the behaviour continues, they will bring the call to a close. It is inappropriate for any member of staff to tolerate objectionable behaviour in the course of their work, and meetings with aggressive, abusive or excessively confrontational complainants may similarly be terminated or refused.

- One definition of habitual and unreasonable behaviour is to harass, distress, annoy, tease, cause trouble, agitate, disturb or pursue issues excessively.

- Behaviour exhibited by a person (and/or anyone acting on their behalf) may be deemed to be habitually demanding or unreasonable where previous or current contact with them shows that they meet any of the following criteria:

a) persisting in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted, but no appeal has been made to the Parliamentary Health Service Ombudsman.

b) seeking to prolong contact by continually raising further concerns or questions upon receipt of a response. (Care must be taken not to discard new issues, which are significantly different from the original issue. These might need to be addressed as separate issues).

c) unwilling to accept documented evidence as being factual or denying receipt of an adequate response in spite of correspondence specifically answering their questions, or does not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

d) does not clearly identify the precise problem, despite reasonable efforts of the Trust staff and, where appropriate, the Independent Advocacy Service, to help them specify their concerns, and/or where the concerns are not within the remit of the Trust to investigate.

e) focuses on a matter to an extent, which is out of proportion to its significance and continues to focus on this point.

f) has threatened or used actual physical violence towards staff or their families or associates. This will, in itself, cause personal contact with the person and/or their representatives to be discontinued and the issue will, thereafter, only be pursued through written communication. In these cases, consideration will be given to contacting the Police.

g) has harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their issue or their families or associates. However, staff must recognise that people may sometimes act out of character at times of stress, anxiety or illness and should make reasonable allowances for this.

h) has had, in the course of addressing an issue, an **excessive number of contacts with the Trust**, placing unreasonable demands on staff time or resources. (A contact may be in person, or by telephone, letter, fax or e-mail).

i) has electronically recorded meetings or face to face/telephone conversations without the prior knowledge or consent of the other parties involved.

j) displays unreasonable demands or expectations and fails to accept that these may be unreasonable (e.g. insists on responses to enquiries being provided more urgently than is reasonable or normally recognised practice).

This list is not exhaustive and other examples of unreasonable behaviour or conduct may be deemed to be habitually demanding or unreasonable.

- **Options for dealing with habitual or unreasonable behaviour**

Where people have been identified as exhibiting "habitual or unreasonable" behaviour in accordance with the above criteria, the HOPE, Chief Executive and the relevant Director (or their deputy) will decide what action to take. The HOPE will then implement the action and will notify complainants in writing of the action that has been taken and the reasons for it, following the stages below:

Stage 1:
Once it is clear that an individual meets the criteria above, it may be appropriate to inform them, in writing, that their conduct is unacceptable and that, if it continues, they may be classified as "habitual or unreasonable". The letter should state clearly which

elements of their behaviour are causing problems and be accompanied by a copy of the Policy for receiving, investigating, responding to and learning from Complaints, Concerns and Compliments.

Stage 2:
It may be appropriate to try to resolve matters by drawing up a signed agreement with the person, which sets out a code of behaviour for the parties involved, if the Trust is to continue communication or to process a complaint. If these terms are contravened consideration will be given to implementing Stage 3 of the procedure.

A code of behaviour could include the following:

- An agreement relating to appropriate behaviour and conduct. Any such agreement should normally not extend beyond six months.
- Restricting contact to one of two individuals within the Trust.
- Restricting the method of communication (e.g. by letter only, not fax/e-mail).
- Offering a meeting to attempt to resolve outstanding issues.

Stage 3:
Where the Trust has responded fully to the points raised by the person and has tried to resolve the issues, without success, and continuing contact on the matter would serve no useful purpose, the individual will be notified by the Chief Executive that the contact is at an end and that further contact will be acknowledged, filed, but not responded to.

In extreme cases, or where the safety of staff is at risk, the individual will be informed that the Trust reserves the right to pass habitually unreasonable behaviour to the solicitors. All contact with the person and/or investigation of the complaint will be suspended whilst seeking legal advice or other contact with other relevant agencies.

Any further complaints received from a person who has been designated as habitually demanding or unreasonable, under this policy, will be subject to a reasonable investigation as deemed necessary by the HOPE in conjunction with advice received from staff dealing with complaints.

The Chief Executive (or deputy), in conjunction with a nominated Director, may, at their discretion, choose to omit one or two of the above stages.

3. Withdrawing habitual or unreasonable status

When individuals have been classified as habitual or unreasonable, the status will continue to apply for six months, at the end of which period habitual or unreasonable status will automatically be withdrawn. In exceptional circumstances, the Trust will consider withdrawing this status earlier if, for example, the person subsequently demonstrates a more reasonable approach. The status of habitual or unreasonable will only apply to specific issues, not general. If a new issue comes to light, an individual may not be deemed habitual or unreasonable unless their behaviour demonstrated this relating to the new issue. Where it appears to be appropriate to withdraw "habitually or unreasonable" behaviour status, the approval of the Chief Executive and relevant Director (or their deputy) will be required. Subject to this approval, normal contact with the person will be resumed.

7.10 Meetings with Complainants

It can be helpful to offer complainants the opportunity to meet relevant clinicians or a manager to discuss the outcome of the investigation. This also enables the complainant the opportunity to ask additional questions and seek clarification on points and aid local resolution. This meeting is held as the Trust"s response to a complaint.

The arrangements for such meetings should be timely; and aim to be held within the timeframe agreed with the complainant, however it is acknowledged that it can be difficult to arrange a meeting due to the availability of clinicians. Clearly the investigation must continue so that all findings are available for the meeting, and the Patient Experience Team will maintain communications with the complainants during this time.

Meetings can be electronically recorded (unless the complainant/patient/staff participating does not consent to this and written notes will be taken). This will be sent together with details of any relevant action/s to be taken. POhWER independent advocates recommend "that all local resolution meetings be recorded as this avoids any doubt or future discrepancies and allows the patient to listen to the recording and hear what was said, not what they thought was said.

A recording helps the advocate focus the client / patient on the responses actually received rather than an interpretation on written notes. This also helps get across the empathy given by service provider staff during the meeting which helps support any written apology."
All Trust staff must attend a complaints meeting if required. However, it should be noted that attendance by complainants is voluntary and it is their right to decline an invitation to meet. An appropriately trained and experienced member of staff should chair the meeting to ensure issues are addressed and all attendees are supported.

However, when a meeting has been suggested to resolve a complaint when the written response has not achieved this, the Trust must clearly inform the complainant that if a meeting is declined written responses cannot be provided indefinitely. Should a complainant remain dissatisfied following receipt of a written response, any request for a meeting will be reviewed and decided by HOPE. Each complaint case will be reviewed and a decision taken on a case by case basis.

7.11 Possible Claims for Compensation

Where a complainant has expressed a wish to claim for compensation in their letter of complaint, the acknowledgement letter from the Trust will detail the way in which this will be taken forward. If, following investigation, financial remedy is the best option this will be discussed by HOPE and the Trust Solicitor to determine the best course of action. Once agreed the way forward will be discussed with the relevant HON.. If it is agreed that

compensation should be paid, the amount will be determined and agreed by the aforementioned people. The authorisation of payment will need to be agreed with the relevant budget holder and in line with the financial authorisation matrix in place.
If a complainant explicitly indicates an intention to take legal action, the complainant will be advised that their letter will be passed to the Legal Services Team review. Again a decision will be made with the complainant the HOPE and Trust Solicitor.

7.12 Complaints and Disciplinary Procedures

This procedure is concerned with resolving complaints and not with investigating disciplinary matters. The complaints procedure is not designed to apportion blame amongst staff; however, some complaints may identify information about serious matters, which may lead to a disciplinary investigation and in these cases the appropriate manager should inform the Human Resources department to ensure their involvement. There should be no reason to delay responding to the complainant because of disciplinary procedure.

7.13 Concerns Reporting

- Any concern received throughout the trust that cannot be resolved locally by the relevant staff should contact the Patient Experience team for reporting and formal investigation. (Appendix 8)

- The concern will be logged on to Datix and investigated by the Patient Experience Officers.

- The Patient Experience Officers are responsible for keeping the patient/relative/carer informed of the progress/outcome of the concern and feeding back to the relevant ward/department.

- Any concern unresolved in 3 working days will be escalated to a formal complaint with the consent of the patient/relative or carer.

- Datix dashboards providing complaints, concerns and compliments feedback is available for divisions to retrieve real-time data. HOPE will provide data to HON via the Ward Assurance and Nursing and Midwifery Board as requested.

- Provide an identifiable and accessible service to the community served by the Trust.

- Provide assistance in the resolution of issues and concerns raised by service users through negotiation and liaison with Trust staff, other local NHS staff, health and health related organisations and, where appropriate, other Patient Experience Teams in organisations or Trusts.

- Give accurate and appropriate information to individuals wishing to access the NHS complaints procedure.

- Refer where appropriate to independent advice and advocacy services.

- Monitor concerns and trends and highlight information needs, including identifying gaps in services or problems with systems or processes with the relevant manager.

- Support staff at all levels of the Trust to foster a responsive culture through positive support, sharing good practice and providing swift advice to staff when difficulties occur.

7.14 Action Planning and Learning

An action plan will be completed for each complaint when the complaint is upheld/partially upheld. The plan must be designed to address both individual and systemic issues. A copy of the final written response and the proposed action plan will be sent to the IO and the following actions:

- Progress against the Action Plan will be reported to the Patient Experience team within four weeks of the response. This is the responsibility of the Divisional Matron.(Appendix 6)

- The HOPE will provide a quarterly reports to the Patient Safety and Quality Group identifying trends and themes for each division and speciality.

- Good complaint handling is not limited to providing an individual remedy to the complainant. Feedback and lessons learnt from complaints contribute to service improvement.

- Complaints are one way in which the Trust can learn from the experiences of patients. Changes to service and practice will be identified by the Divisional Matrons/Assistant Directors and Managers, and action plans developed to implement and monitor outcomes.

- The Divisions will report on progress against the action plans to the Patient Experience Team, and include the outcomes in their annual governance reports.

- The Trust will publish examples of changes to service and practice in the Annual report.

The investigation template includes a section for actions and learning identified. These entries will be copied and pasted into a running action log spread sheet action tracker) for use within divisional meetings and for monitoring progress, analysis and onward reporting. Actions will also be entered into Datix by the Patient Experience Team.

A bi-annual internal audit of complaint files will include a sample of complaints made across the organisation. An annual external audit led by the commissioners will be completed. The content of the audits will include:

- the management of complaints in respect of acknowledgement and following policy and procedures
- response rates
- the effectiveness of local resolution for reopened cases
- appropriate risk grade
- appropriate identification and action to for serious incidents, safeguarding issues, information requests

The audit report will be presented to Patient Experience Committee.

- **User Satisfaction**

Satisfaction surveys are sent to selection of complainants 2 months after a complaint response is sent and closed. Changes to processes are made as a result of these surveys where necessary and will be communicated through the quarterly Patient Experience Report and the Annual Patient Experience Report which is published on the Trust's website.

External Reporting

- Annual report for the commissioner and for this to be available to any public request and available on the Trust website
- The KO41a return.

8.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
A. duties	HOPE	Timescale performance reported via SOF exception reports.	Monthly	Trust Board/Performance Meetings/PSQG
B. how the organisation listens and responds to concerns and complaints from patients, their relatives and carers	Patient Experience Team PSQG	Audit of complaint files. CLIP report to PSQG Other modes of patient feedback (FFT, national surveys)	Monthly Quarterly Monthly/Annually	HOPE, PSQG & DGM, HON and Clinical Chairs PSQG
C. how joint complaints are handled between organisations	HOPE and Patient Experience Team	Audit of complaint files.	Monthly	HOPE
D. how the organisation makes sure that patients, their relatives and carers are not treated differently as a result of raising a concern or complaint	Patient Experience Team	Audit of complaint files. Complaints satisfaction survey	Monthly Patient Experience Team	
E. how the organisation makes improvements as a result of a concern or complaint	Divisional Teams	Complaint action plans	Monthly	HOPE, PSQG & DGM, HON and Clinical Chairs

8.0 TRAINING AND IMPLEMENTATION

The Trust is committed to training its staff in how to handle complaints. It is the responsibility of the Chief Executive to ensure that all employees of the Trust are conversant with the Trust's Policy for receiving, investigation, responding to and learning from complaint, concerns and compliments.

- The policy will be published on the Trust's intranet and internet sites.
- Staff training on how to deal with complaints will be carried out on a regular basis.
- All new employees will be given a short presentation on the Trust's policy at their induction course.
- Training needs analysis within the Divisions will identify key members of staff who require training related to complaints investigation and management. This training will be incorporated in staff development and on-going management courses.
- The Governance Support Unit providing Root Cause Analysis Training to support the complaints investigation training.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix D
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

There have been significant national developments in relation to complaints handling over the last 18 months particularly in light of the report into failings at Mid Staffordshire Hospitals. The following key documents have been used to provide the framework and principles for sfh complaint and concerns management:

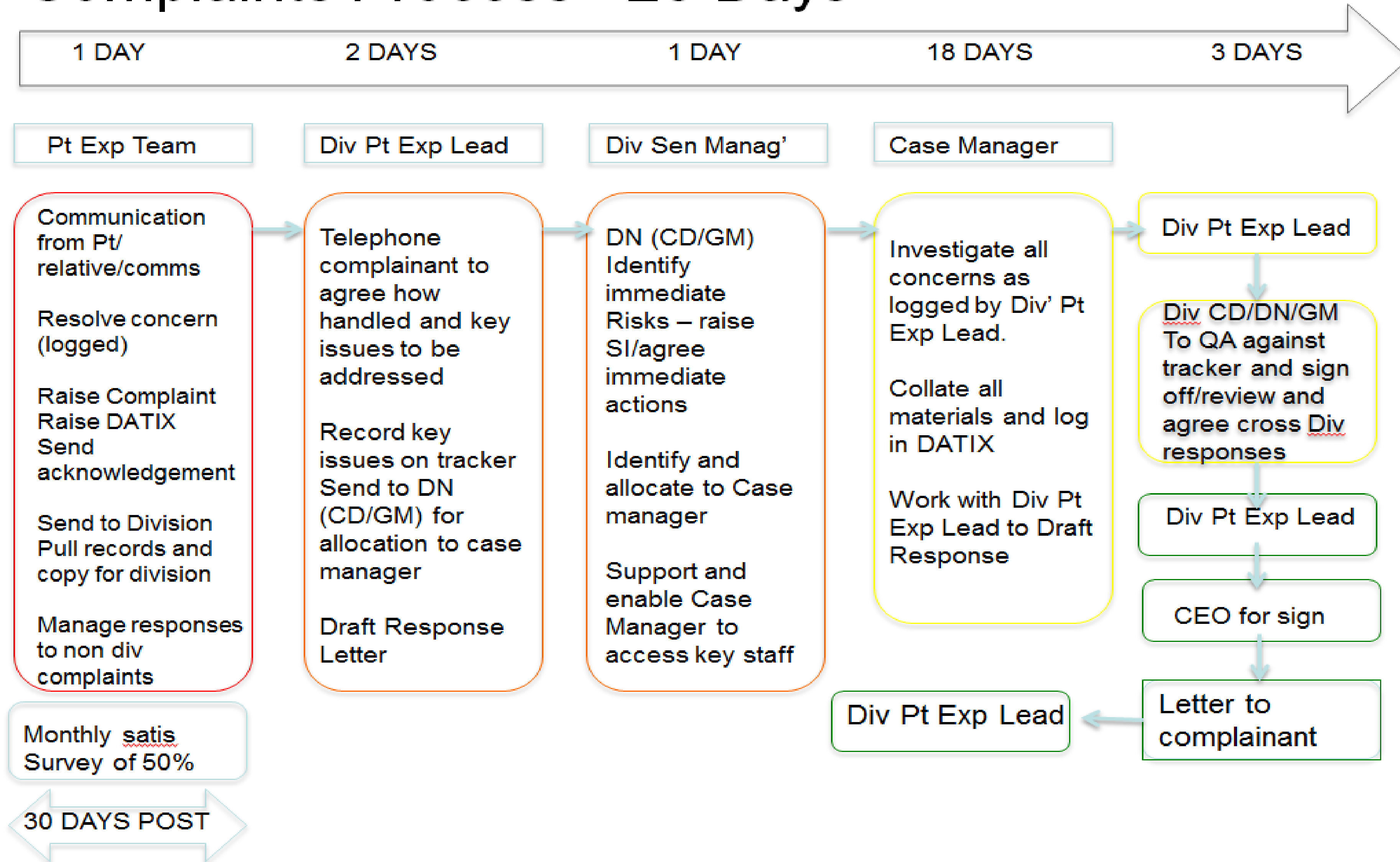
1. Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry – 'The Francis Report'. HM Stationary Office. February 2013.
2. NHS Hospital Complaints System; a case for urgent treatment. Parliamentary and Health Service Ombudsman. April 2013.
3. Designing Good Together; transforming hospital complaint handling. Parliamentary and Health Service Ombudsman. August 2013.
4. Good Practice Standards for NHS Complaints Handling. Patients Association. September 2013.
5. A Review of the NHS Hospitals Complaints System; Putting Patients Back in the Picture. Rt. Hon Ann Clwyd MP and Professor Tricia Hart. October 2013.
6. My Expectation for raising concerns and complaints. PHSO November 2014

Related SFHFT Documents:

- Duty of Candour Policy

11.0 APPENDICES

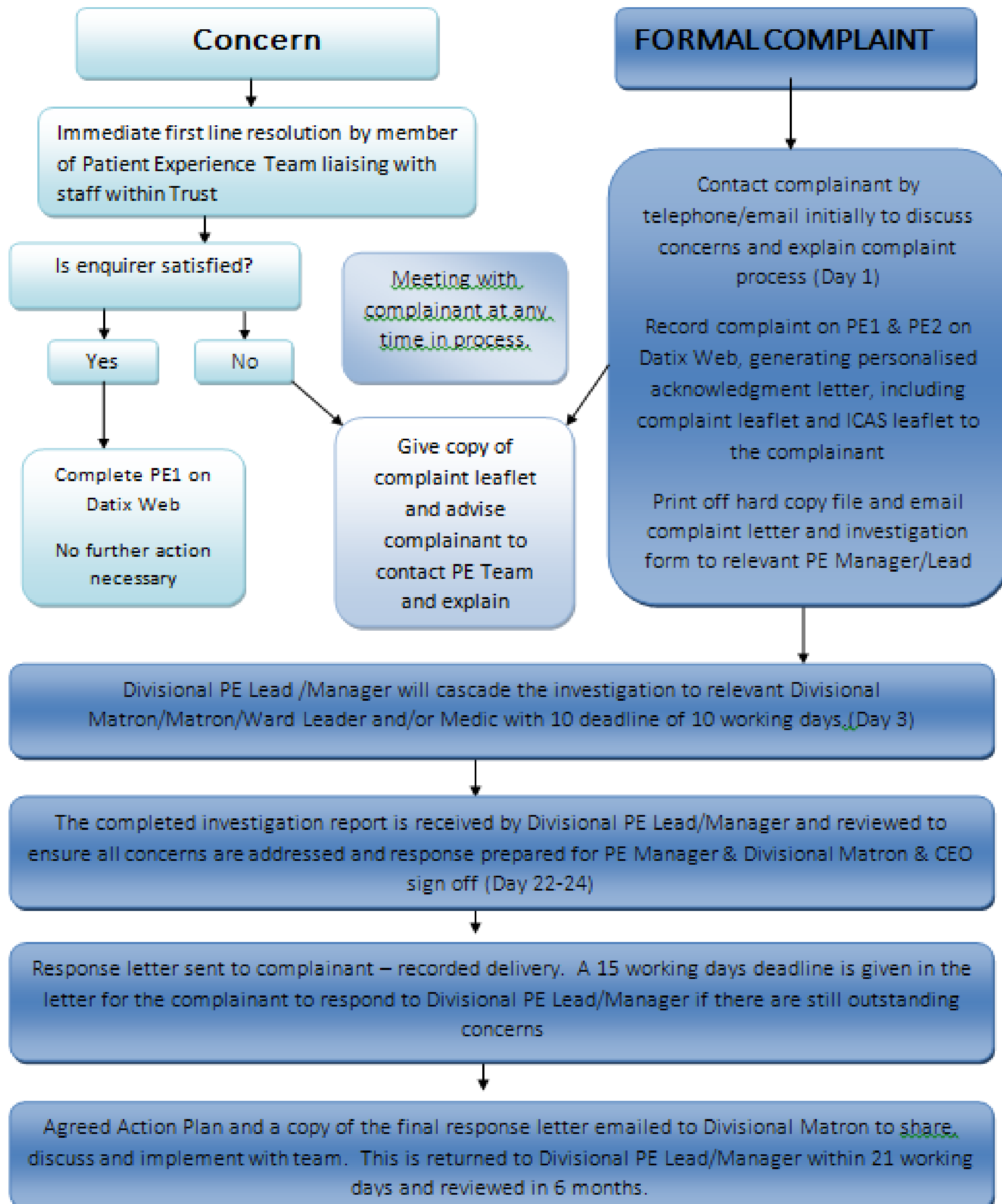
APPENDIX A – Complaints Process flow chart
APPENDIX B - Flow chart for concern and complaint management
APPENDIX C - User Led Vision for raising concerns and complaints – PHSO 2014
APPENDIX D - Equality Impact Assessment


Complaints Process - 25 Days
Sherwood Forest Hospitals NHS Foundation Trust
1 DAY
2 DAYS
1 DAY
18 DAYS
3 DAYS
Pt Exp Team
Div Pt Exp Lead
Div Sen Manag'
Case Manager
Communication from Pt/ relative/comms
Resolve concern (logged)
Raise Complaint
Raise DATIX
Send acknowledgement
Send to Division
Pull records and copy for division
Manage responses to non div complaints
Telephone complainant to agree how handled and key issues to be addressed
Record key issues on tracker
Send to DN (CD/GM) for allocation to case manager
Draft Response Letter
DN (CD/GM)
Identify immediate Risks – raise SI/agree immediate actions
Identify and allocate to Case manager
Support and enable Case Manager to access key staff
Investigate all concerns as logged by Div' Pt Exp Lead.
Collate all materials and log in DATIX
Work with Div Pt Exp Lead to Draft Response
Div Pt Exp Lead
Div CD/DN/GM To QA against tracker and sign off/review and agree cross Div responses
Div Pt Exp Lead
CEO for sign
Letter to complainant
Div Pt Exp Lead
Monthly satis Survey of 50%
30 DAYS POST

PE Team	Divisional PE Lead	IO	DM/AD/WL
Receive/Identify Concern/Complaint Resolve Concern/log on system (PALS) Identify/Negotiate Main Division for Management of complaint Log on DATIX/Send to Division Send out complaints Satisfaction Survey monthly – filter high sensitive e.g death Liaising with relevant staff respond to non clinical divisional complaints Provide Monthly data analyses on complaints, PALS and Surveys	Telephone Complainant and be single point of contact for complainant and maintain dialogue Identify Key concerns to be addressed and how complaint will be handled. Advise of timeline for response. Track progress Ensure all data is logged on DATIX Co-ordinate with Case Manager and Write final response letter and send to CEO Collate/file all related data from complaint to ensure audit trail Analyse Data monthly and prepare Divisional report for Div Gov Committee and Corporate Clinical Gove & Quality Committee (see Governance reporting) Triangulate complaints, PALs, Risks, SI's with Pt Survey results and cross reference to CQC outcomes Work closely with the Trust Governance Team to ensure all relevant data is available and analysed for the Divisional Management Team	Conduct Investigation/RCA Ensure all investigation material is stored on DATIX and statements are signed Liaise closely with Div Pt Exp lead to identify if there is a delay in providing response in given time frame Support the Pt Exp Lead in drafting the response letter and approve final draft letter before sending to the DN/Clead (CD/GM) for QA	Identify any immediate risks and actions to be addressed/ log as SI if required identify and app Case Manager QA and sign off complaints response/ including cross divisional responses Ensure effective Governance and learning is evidenced Identify Gaps and risks, assuring change and continuous improvement Accountable Officers for Governance and Assurance of all aspects of complaints management/Pt Experience and necessary learning and change.

Quality for all

Sherwood Forest Hospitals NHS
NHS Foundation Trust



* Any issue that is a potential safeguarding / possible serious investigation scoping concern must be highlighted immediately to the appropriate child or adult safeguarding lead.
** Timescales are based on a 25 working day response time. Alternative timescales negotiated with the complainant by the Divisional PE Leads/Manager

Patient Experience Team – 01623 672222 Ext. 6101/6683/4061/3004 Email:pet@sfh-tr.nhs.uk

APPENDIX B

My Expectations – Parliamentary Health Service Ombudsman November 2014

APPENDIX D - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Sherwood Forest Hospitals NHS Foundation Trust

Name of service/policy/procedure being reviewed: POLICY FOR REVIEWING, NVESTIGATING, RESPONDING TO AND LEARNING FROM COMPLAINTS, CONCERNS AND COMPLIMENTS			
New or existing service/policy/procedure:			
Date of Assessment:28/06/2019			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Gender	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Age	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Religion	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Disability	None Known	Applies to all patients irrespective of protected characteristic group.	None Known

Sexuality	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Pregnancy and Maternity	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Gender Reassignment	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Marriage and Civil Partnership	None Known	Applies to all patients irrespective of protected characteristic group.	None Known
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None Known	Applies to all patients irrespective of protected characteristic group.	None Known

What consultation with protected characteristic groups including patient groups have you carried out?

None required as the policy and procedures apply to all patients irrespective of protected characteristic group

What data or information did you use in support of this EqIA?

None required as the policy and procedures apply to all patients irrespective of protected characteristic group

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

None

Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: Low Level of Impact
Name of Responsible Person undertaking this assessment: Kim Kirk
Signature:
Date:28/06/2019