Public Document Pack

Date of meeting	**Tuesday, 3rd April, 2012**
Time	**7.00 pm**
Venue	**Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffs ST5 2AG**
Contact	Peter Whalan

Health Scrutiny Committee

AGENDA

PART 1– OPEN AGENDA

1 Apologies

2 Minutes of Previous Meeting **(Pages 1 - 4)**

3 Update regarding District Council representation on the Health and Wellbeing Board

4 Infant Mortality in Newcastle under Lyme **(Pages 5 - 12)**

5 UPDATE ON CARDIAC REHABILITATION

To receive a presentation from the Head of Leisure and Cultural Services

6 HEALTH AND WELLBEING STRATEGY **(Pages 13 - 18)**

To receive a presentation from the Head of Leisure and Cultural Services

7 Update on Jubilee 2 (Report to Cabinet on 14th March 2012) **(Pages 19 - 24)**

8 Phlebotomy Services and Publicity **(Pages 25 - 26)**

9 North Staffordshire Combined Healthcare Trust Consultation on the Mental Health and Wellbeing of Local Communities **(Pages 27 - 54)**

10 NHS COMPLAINTS PROCEDURE **(Pages 55 - 104)**

A copy of the procedure is attached for information.

11 Workplan **(Pages 105 - 108)**

12 INVITATION TO ATTEND NEXT CLEANER GREENER SCRUTINY COMMITTEE ON 18TH APRIL 2012

The Chair of the Cleaner Greener Overview and Scrutiny Committee would like to invite Members of the Health Scrutiny Committee to attend its next meeting on Wednesday 18th April, when Officers from Staffordshire Trading Standards will be in attendance to discuss issues relating to the enforcement of alcohol and tobacco legislation.

13 Declarations of Interest

14 URGENT BUSINESS

To consider any business which is urgent within the meaning of Section 100 B(4) of the Local Government Act 1972.

Members: Councillors D Becket (Chairman), J M Cooper, S Hambleton, H Johnson, D Loades and J Taylor

'Members of the Council: If you identify any personal training / development requirements from the items included in this agenda or through issues raised during the meeting, please bring them to the attention of the Committee Clerk at the close of the meeting'

Officers will be in attendance prior to the meeting for informal discussions on agenda items.

HEALTH SCRUTINY COMMITTEE

Wednesday, 11th January, 2012

Present:- D Becket – in the Chair

Councillors J M Cooper, Loades and Taylor

1. **APOLOGIES**

Apologies were received from Councillors Mrs Hambleton and Mrs Johnson

2. **MINUTES OF PREVIOUS MEETING HELD ON 7TH NOVEMBER 2011**

Resolved:- That the minutes of this Committee held on 7 November 2011 be approved as a correct record.

3. **DECLARATIONS OF INTEREST**

There were none.

4. **UPDATE FROM THE CHAIR OF THE COMMITTEE**

The following matters were discussed:-

(i) **Jubilee 2 - Health and Wellbeing Centre**

It was indicated that a report was to be considered by Cabinet in March following which a report would be brought to this committee for consideration.

Resolved:- That the information be received.

(ii) **Health and Wellbeing Board**

The Council's Executive Director-Operational Services indicated that he had recently attended a meeting at Tamworth during which membership of the Board was discussed. Of particular concern to the Chairman was the proposal that District Councils across Staffordshire would be represented by one elected member.

The committee considered that one member would find it very difficult to represent the diverse and complex health issues that existed across the county feeling that that council's would be better served by the appointment of at least two representatives onto the Board.

Resolved:- That a case for increased local authority representation on the Board be prepared in consultation with the Chair and forwarded to the County Council's Cabinet Member for Adult Services for consideration.

(iii) **Phlebotomy Service**

The Chairman expressed the view that provision of phlebotomy services across the Borough had improved following a publicity campaign by the PCT. However, further

publicity was required to raise awareness of the availability of the service at Bradwell Hospital.

Resolved:- (a) That the information be received and that the PCT be requested to raise awareness of the phlebotomy service offered at Bradwell Hospital.

(b) That the situation be kept under review and a further report on this matter be submitted to a subsequent meeting.

(iv) **Fit for the Future**

The committee was advised that the phased transfer of services to the new hospital was proceeding to plan.

Some concern was again expressed at the implications of the reduction in beds at the new site and it was these concerns should be raised with UHNS. However, it was appreciated that this was a matter that may be being pursued by the County Council and that if this was the case then they be left to deal with it and requested to advise that committee accordingly.

Resolved:- That the information be received and that the issue about the effects of a reduction in beds at the new hospital be dealt with in the way described above.

(v) **UHNS – Complaints Procedures**

Concern was expressed that UHNS appeared to be operating a number of patient complaints procedures.

Resolved:- That UHNS be requested to provide details of its complaints procedures and that any response be reported back to this committee for consideration.

5. **INFANT MORTALITY IN NEWCASTLE UNDER LYME**

The committee was asked to approve a scrutiny brief for an investigation into infant mortality in the Borough as had been requested by the County Council's Health Scrutiny Committee.

To assist the process it was agreed that written answers should be sought from the PCT to questions 1 to 4 in the scrutiny brief. The answers received would then be considered at the February meeting of this committee at which a Panel to carry out the scrutiny exercise would also be appointed.

Resolved:- That the Scrutiny Brief be approved and that responses received from the PCT to questions 1 to 4 in the Brief be reported back to the next meeting of this committee at which the Panel referred to above was to be appointed.

6. **PHASE II CONSULTATION ON MENTAL HEALTH SERVICES**

Consideration was given to an update issued by the North Staffordshire Combined Healthcare NHS Trust outlining progress made on the public consultation for

proposed changes to adult and older people's mental health services (phase I) and preparation for further changes to mental health services (phase II).

The committee was not entirely satisfied with the update considering that the proposals did not appear to have been properly thought out and that concerns previously raised by members had not been satisfactorily addressed.

It was considered that a clear pathway for the implementation of the proposed changes in a structured way was required.

Resolved:- That the update be received but that the above comments be forwarded to the County Council Health Scrutiny Committee for consideration.

7. **CARDIAC REHABILITATION UPDATE AND WALK FOR LIFE**

Reference was made to the committee's previous consideration of this matter in connection with which the Executive Director-Operational Services provided an update on the proposals to support cardiac rehabilitation in the Borough from Jubilee 2 and later from facilities at Kidsgrove Sports Centre subject to its refurbishment.

Discussions, that were proving to be very positive, were ongoing with health professionals at UHNS about the delivery of Phase III of the rehabilitation process in a community setting and it was stated that rehabilitation services could be provided through the combined input of medical staff from the hospital and the Council's BACR qualified staff.

Initial discussions had focused on the provision of a 12 or 20 week programme for up to 8 patients using Jubilee 2 swimming, gym, aqua gym, fitness and physiotherapy facilities.

In conclusion, reference was made to the Walk4Life, an annual event that promoted a healthy lifestyle through regular exercise for those who were recovering from a range of medical conditions.

Resolved:- (a) That the update be received.

(b) That the possibility of publicity being given to the Walk4Life on the Council's website and Local Area Partnerships be investigated.

8. **BUS ROUTES TO BRADWELL HOSPITAL**

In accordance with a request made at the last meeting consideration was given to a report providing details of the frequency of bus services to and from Bradwell Hospital.

The committee was also provided with information about the bus routes serving UHNS.

Resolved:- That the attention of the County Council be drawn to this committees concern that Bradwell Hospital is poorly served by our local bus companies, and that the existing stops at which passengers need to alight from buses when visiting the hospital are too far away from the entrance to it.

9. **DISCLOSURE OF EXEMPT INFORMATION**

Resolved:- That the public be excluded from the meeting during consideration of the following item because there is likely to be disclosure of exempt information as defined in Paragraph 1 of Schedule 12A of the Local Government Act 1972.

10. **RESPONSE TO QUESTIONS REGARDING INTERVENTIONAL NEURORADIOLOGY RAISED AT THE ACCOUNTABILITY SESSION**

The Committee considered responses from UHNS to questions raised by the Chairman prior to the Accountability Session held on 10 November 2011.

Resolved:- That the concerns raised by the Chairman about the adequacy of some of the answers provided by UHNS be pursued with its Chief Executive and that a further report on this matter be submitted to a subsequent meeting.

D BECKET
Chair

NEWCASTLE-UNDER-LYME BOROUGH COUNCIL
REPORT TO THE
HEALTH SCRUTINY COMMITTEE

3rd April 2012

1. Infant Mortality in Newcastle under Lyme

Submitted by: **Democratic Services Manager**

Portfolio: **Safer and Stronger Communities**

Ward(s) affected: **All**

Purpose

To update the Committee regarding Infant Mortality In Newcastle under Lyme and the responses received from the Director of Public Health regarding the Scrutiny Brief.

Recommendations

a) That the responses from the Director of Public Health be noted.
b) That a Panel be appointed to carry out the scrutiny exercise

1. **Background**

2.

The Staffordshire County Council Health Scrutiny have requested that this Committee carry out a project regarding the high rates of infant mortality in Newcastle under Lyme.

At your previous meeting, Members approved a scrutiny brief (Appendix A) for the project and to assist the process it was agreed that written answers should be sought from the PCT to questions 1 to 4 in the scrutiny brief. The responses from the Director of Public Health are attached to this report at Appendix B.

2. **List of Appendices**

Appendix A: Scrutiny Brief.

Appendix B: Responses from the Director of Public Health

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Brief for Scrutiny – Infant Mortality

Topic to be scrutinised

The incidences of infant mortality in the Borough, including the data produced on the subject; the causes behind infant mortality and the work being done to tackle the issue and bring the number of incidences down.

Questions to be addressed

1. What is the latest position in terms of the level of infant mortality in the Borough? What are the trends in terms of levels of infant mortality in Newcastle Borough?
2. What are the identified causes behind infant mortality, and what is the situation in Newcastle in terms of the reasons for the levels of infant mortality at the present time?
3. What work is being done by different agencies to combat infant mortality?
4. What barriers are there to this work? Are any opportunities being missed?
5. What are the long-term goals of agencies? Are there any targets in place for reducing levels of infant mortality?
6. Can agencies work together more effectively in tackling this issue?
7. What support is offered to families who have suffered infant deaths? Can more be done?
8. What work is being done elsewhere and what benchmarking work can be done to understand this work and apply lessons from elsewhere in Newcastle

Outcomes

1. A clear picture of the issue in terms of levels of infant mortality and also those geographical areas most affected.
2. An understanding of the issue, including its causes and also its effects
3. An understanding of the work being done to deal with it by agencies in the public sector and elsewhere
4. An analysis of service provision and any gaps which exist in terms of education/prevention and support for families
5. Construction of an action plan – in conjunction with key partners – aimed at dealing with the issue and its aftermath
6. Consideration of the implementation issues connected to the development of an action plan, including the main issues of resources and prioritisation
7. Consideration of work done elsewhere and how lessons learnt could be applied to Newcastle in dealing with this issue
8. Establishment of a clear vision for the way forward and a set of clear targets for reducing the levels of infant mortality in the Borough over a specified time period.

Background materials

1. NHS Data/Area Profiles (monthly)
2. Reducing Health Inequalities in Infant Mortality: A Good Practice Guide (2007)
3. ONS Child Mortality Statistics
4. *Our Future Health Secured?* (King's Fund, 2007)

Evidence and witnesses

1. Portfolio Holder for Safer & Stronger Communities
2. Executive Director (Operational Services)
3. Head of Service Business Partnerships & Improvement
4. Director of Public Health
5. Representatives from National Health Service/Staffs County Council (public health teams)
6. Business Improvement & Partnerships – Research/Partnerships Manager

Method of scrutiny

1 Task & Finish Group – to oversee any review and change process and consisting of Chair of Health Scrutiny Committee, as well as Chair of Cleaner, Greener, Safer Scrutiny Committee (plus Vice-Chairs)
2 Consideration of partner evidence and views
3 Consideration of LAPs/community views
4 Consideration of elected Member views and evidence

Timetable

Start date January 2012
Dates of meetings TBA
Draft report TBA
Final report TBA
Report to Council TBA

Constraints

- Partner buy-in to the processes and capacity of all bodies to take part in the scrutiny process
- Availability of relevant data

Members to undertake the scrutiny

Cllr Becket
Cllr Cooper
Cllr Loades
Cllr Johnson
Cllr Taylor
Cllr S. Hambleton
Others as identified

Support

Executive Director (Operational Services)
Head of Business Improvement & Partnerships
Partnerships Manager
Business Improvement Officer (Research & Equalities)
Elections & Licensing Manager

Newcastle Borough Council Corporate Plan Priority area (s)

- Creating a cleaner, safer and sustainable Borough
- Creating a Borough of opportunity
- Creating a healthy and active community
- Transforming our Council to achieve excellence

CfPS Objectives:

- Provides and critical friend challenge to executive policy makers and decision makers
- Enables the voice and concerns of the public to be heard

• Is carried out by independent governors who lead and own the scrutiny role • Drives improvement in public services
Brief approved by Overview and Scrutiny Co-ordinating Committee Signed Date

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NHS North Staffordshire
South Staffordshire PCT

Report to Newcastle under Lyme

Infant Mortality in the Borough

1. What is the latest position in terms of the level of infant mortality in the Borough?

   The rate for Newcastle in 2010 was 7.7/1000 - infant deaths per 1000 live births. This is a downward trend after a peak of 11.4/1000 in 2012.

2. What are the trends in terms of levels of infant mortality in Newcastle Borough?

   This is a downward trend after a peak of 11.4/1000 in 2007.

3. What are the identified causes behind infant mortality, and what is the situation in Newcastle in terms of the reasons for the levels of infant mortality at the present time?

   Infant mortality, and particularly the early neo-natal component, may be associated with the quality of care (antenatal, intrapartum and neonatal) but the main variations are associated with the characteristics of the population (the mothers). This includes ethnicity, place and age. There is a known association between infant mortality and deprivation. In addition in Newcastle obesity and smoking are important factors.

4. What work is being done by different agencies to combat infant mortality?

A joint committee is being reconvened with to cover Stoke and North Staffordshire with this (draft) remit:

i. To examine trends in perinatal and infant mortality and provide an analysis of key issues, with particular reference to geographical variations.
ii. To examine the evidence for effective interventions in all relevant stages of the life course, and of the care pathways, including lessons from investigations and reviews of maternity services by the Healthcare Commission.
iii. To advise the CCGs commissioning maternity care and other commissioners on all aspects of maternity and early years services provided for its residents, including:
    - Strategy for service development
    - Progress on implementing quality standards
    - Service specifications for maternity service contracts
    - Configuration of services

Clinical governance, audit and guidelines for clinical care

iv. To ensure that maternity and child health services commissioners and the provider units take account of the views of women and families using the service.

Membership will include Local Authority and CCG commissioners, Public Health and key providers

5. What barriers are there to this work?

The main barrier is timely data, in order to understand the current factors influencing outcomes.

6. Are any opportunities being missed?

It will be important to be able to commission any prioritised new interventions in-year, so that option should be available despite committed budgets and commission plans for 2012/3.

March 2012
Staffordshire Public Health Team

The new Local Public Health agenda.

Local Government has a long history of promoting and protecting the publics health dating back to Victorian times. (It was only in 1974 that the NHS took over most public health functions.)

The Government is now returning responsibility for improving public health to local government for several reasons, namely their:

Population focus – recognising the importance of 'place' and local democratic accountability.

Ability to shape services – local government holds many of the levers for promoting and shaping services to meet local demand.

Ability to influence wider social determinants of health – these include the conditions in which people are born, live, work and age (and are important factors in health inequalities.)

Ability to tackle health inequalities – housing, economic, environmental, planning and community safety strategies can positively impact on local inequalities.

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Progress to date.

- **County Shadow Health and Well Being Board** meeting regularly.
- ToR's include **District Council representation**.
- **Director of Public Health**, Dr Aliko Ahmed, appointed and heading up the transition process.
- Public Health **staff will be co-located** with the district teams within the Civic Offices.
- County wide **Health and Well Being Strategy** (being reviewed with refreshed JSNA information)
- **Public Health Support** Officer role established for Borough Council.
- **Public Health accountability** at both District and County Health Scrutiny arrangements.
- North Staffs **Clinical Commissioning Group** established under leadership of Dr David Hughes.

NEWCASTLE UNDER LYME
BOROUGH COUNCIL

Key Local Health Challenges

- **Infant mortality** (around double county and national level)
- **Smoking** (a quarter of the pop smoke 2nd worst in Staffs)
- Substance mis-use (particularly **alcohol** as it has wider effects on health, social and crime and disorder problems.)
- **Teenage pregnancy** (3rd worst in County – prevalent in deprived areas and lower socio-economic groups.)
- **Life expectancy** (overall close to national ave. but wide local inequalities – 10yrs!)
- **Healthy eating** and **physical activity**. (both need improvement)
- Understanding the availability of funding for **preventative funding programmes** (commissioning opportunities)
- Public Health **Outcomes Framework** (66 Statutory indicators?)

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Working with Partners

To deliver the local strategy we aim to:

- Develop sustainable community based services that address **health inequalities** and improve the physical and mental wellbeing of people.
- Support efforts to improve the **long-term health** of our communities.
- Help and encourage vulnerable people to **lead independent lives** and enjoy continued social contact.
- Encourage people to **adopt healthy behaviours** enabling them to be healthy and improve their wellbeing.
- Identify and tackle the **social, environmental and economic factors** that can affect the health and well being of individuals. (wider determinates of poor health)
- Empower **residents to take responsibility** for improving their own health and wellbeing. (‘hand up’ support not ‘hand out’)

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Immediate Priorities

- **Support and engage** with work of Health and Well Being Board.
- Build **sound understanding** of local population needs and priorities.
- **Engage local partners** in the process.
- Position the Council and local partners to respond to outcome based priorities to attract **commissioning opportunities.**
- Develop Borough **Health and Well Being Strategy**.
- Ensure **polices and decisions impact positively** on health and well being.
- Ensure **health inequalities** are recognised as a priority for the Health and Well Being Board and that resources are available to address these.
- Continue to develop **local democratic accountability** for health improvement.

NEWCASTLE UNDER LYME BOROUGH COUNCIL

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JUBILEE 2 UPDATE

Submitted by: **Executive Director - Regeneration & Development**

Portfolio: **Regeneration and Planning/Culture and Active Communities**

Ward(s) affected: **All (particularly Town)**

Purpose of the Report

To provide Members with information about progress relating to the capital build of the Jubilee 2 centre since you considered a report at your December meeting.

Recommendations

(a)_ That Cabinet receive the information contained within this report.

(b) That Cabinet conveys its thanks to all partners involved in delivering this project, particularly those who contributed funding.

Reasons:

(i) To facilitate the decision-making and delivery processes regarding the provision of the Jubilee 2 health and wellbeing centre for the residents of the Borough.
(ii) To ensure that the good practices adopted throughout the delivery of Jubilee 2 and the lessons learned are taken into account for the future projects that the Council may wish to undertake.

1. **Background**

1.1 In the spring/summer of 2008 Cabinet authorised officers to develop the brief for a new Health and Wellbeing Centre (now known as Jubilee 2) to meet the healthy and active lifestyle needs of the Borough's residents. At that stage the "preferred facility mix" included a 25m eight lane swimming pool, a training pool, eighty station fitness suite, two dance studios, health suite (including sauna and steam room), cafeteria, and other ancillary space including changing rooms, plant rooms; no specific requirement was made for sustainable energy solutions in the building.

1.2 Your officers sought specialist advice to determine the likely footprint of the building and the broad cost envelope for the project which was determined to be 4,000sqm and £14 million respectively. It should be noted that Cabinet acknowledged the potential requirement for additional "desirable facilities" including a moveable floor in the competition pool & training pool, an additional 20 stations in the fitness suite, and a climbing wall. None of the latter facilities were factored into either the original footprint for the building or the broad cost envelope for the project.

1.3 The brief for Jubilee 2 was developed throughout 2009 in consultation with key stakeholders including NHS North Staffordshire, Sport England, and the Amateur Swimming Association, the Carbon Trust, the users of Jubilee Pool & Knutton Recreation Centre and the wider community. As a result of this ongoing consultation Officers worked closely with the design team and professional advisors to incorporate the above-mentioned desirable facilities into the design for Jubilee 2, resulting in an increase in the footprint of the building to 4,300sqm.

1.4 Given the Council's strategic responsibility to reduce its carbon footprint a robust options appraisal of the available sustainable energy solutions was undertaken by the Council's professional advisors. This resulted in the following items being incorporated into the design for Jubilee 2: a combined heat a power unit; L.E.D lighting; photovoltaic cells; waterless urinals; heat recovery systems and; automated (PIR) lighting systems.

1.5 Throughout the design phase the cost plan for Jubilee 2 was continually refreshed to take account of the fluctuating market conditions, the availability of external funding and the design requirements of the building. This resulted in a revised broad cost envelope being established for the Jubilee 2 of £12.2million prior to freezing the main elements of the building design in the autumn of 2009 and submitting a Planning Application for the Council's consideration.

1.6 Following numerous detailed adjustments and refinements in the internal elements of the building design and the completion of a robust contractor procurement process (with Cabinet agreeing, in July 2010, to appoint Morgan Sindall to build the scheme) the anticipated total cost was envisaged to be about £10.5m. The contractor agreed to commence work with a target date for "practical completion" of 31 December 2011. Officers are pleased to report that Jubilee2 was formally handed over to the Council on 9 December 2011 and opened to the public on 12 December 2011.

2. Issues/Progress Update

2.1 Since the formal handover of the Jubilee 2 building your officers and professional advisors have been working towards establishing the final account for the construction element of the project. Given the large number of parties involved in this process (particularly the large number of sub-contractors) it is envisaged that this exercise will be completed within the next few months, however your officers and advisors are confident that the financial outturn costs of the overall project will be in the region of £10.2 - £10.3million.

2.2 On 7 January 2012 Jubilee 2 was formally opened in a public "come and try" event, by former Olympian Nick Gillingham and former Commonwealth medallist, David Moorcroft. The event was very well attended by key stakeholders, members past and present who have had a direct involvement in the project, members of the community who had received grants from the Newcastle Sports Council along with residents of the Borough. Members are advised that the centre will be the subject of a visit by the Princess Royal too, in April 2012, as part of the Queen's diamond Jubilee year celebrations.

2.3 Since Jubilee 2 opened, your Officers have undertaken an initial review of the performance and are pleased to report the following key outcomes:

(a) There have been in excess of new 1,000 customers taking up a fitness membership by direct debit (in addition to the 1500 existing customers).

(b) The operational hours of Jubilee 2 has increased by 11.5 hours a week when compared to the operational hours of the former Jubilee Pool.

(c) A robust exercise class programme of in excess of forty classes per week has been established at Jubilee 2, compared to a previous weekly class programme being delivered at Jubilee Pool and Knutton Recreation Centre of between 5 and ten classes.

(d) The availability of public swimming has increased from about 57% at Jubilee Pool to 96% of the operational hours at Jubilee 2.

(e) The performance of the combined heat and power unit and photovoltaic cells since the opening of Jubilee 2 has meant that the Council has managed to reduce its carbon footprint by 30,308kgC when compared to operating without them in situ; this increased efficiency will have saved money too.

2.4 Since your meeting in December 2010 Officers have been evaluating the effectiveness of the project management arrangements for delivery of Jubilee 2, so that lessons can be learned for any future projects being undertaken by the Council. The key messages in relation to the delivery of Jubilee 2 that have been identified to date are as follows:

(a) The importance of strong governance arrangements (including a member-led Project Board and a broadly-based officer steering group chaired by the key Portfolio Holder) and the realisation that such large-scale capital projects will typically require support from a variety of disciplines throughout the Council, as well as multiple Portfolio Holders. During the delivery of the Jubilee 2 project it required an input from officers representing in excess 20 separate disciplines within the Council, as well as all six Cabinet members, to ensure that Jubilee 2 was delivered on time and within budget. It is noteworthy that the main contractor found the Council a good client to work for because of both the knowledge available and the approach adopted at the monthly client/contractor project meetings.

(b) The value of developing a detailed building specification upfront and allowing sufficient time to do this. The construction element of Jubilee 2 was tendered at RIBA stage F-G, where it is typical to go to tender at the earlier stage C-D when entering into a design and build contract. This allowed officers and the Council's professional advisors (representing key disciplines that we don't employ such as architectural services, M&E specialists, etc) to ensure that there would be greater cost certainty by affording limited scope for the contractor to change the specification and or make claims for additional costs.

(c) Where projects require input from a number of external disciplines, where possible seek to appoint each discipline on an individual basis as opposed to appointing a consortium where others may work collaboratively to bring a team together. The key benefit of appointing each discipline on an individual basis meant the officers found that each discipline challenged the ideas of others, brought a greater wealth of experience to the project, ensuring a greater degree of cost control, whilst ensuring the final outcome met the Council's expectations.

(d) The preparation and delivery of a robust communications plan. A separate working group was established within the governance arrangements for Jubilee 2 to undertake this role. This meant that relevant communications were issued to the wider community at an appropriate point of time and queries from the public and media were dealt with in a timely manner. As a result of this robust proccess officers are pleased to report that throughout the delivery of Jubilee 2 the Council did not receive any negative media coverage.

(e) Broadly speaking the delivery of Jubilee 2 as a construction project was free of significant or unforeseen complications (largely for the reasons cited above). However officers felt that an improvement to the project could have been made though the earlier engagement of the Highway Authority when considering the requirements in relation to the S.278 works. This would have avoided complex negotiations with the main contractor and other statutory services concerning the dovetailing of various elements of the project in the later stages of the construction programme.

3. **Proposal**

3.1 That Cabinet receive the information contained within this report.

3.2 That Cabinet conveys its thanks to all partners involved in delivering this project, particularly those who contributed funding.

4. **Reasons for the Preferred Solution**

4.1 To acknowledge the key lessons learned form the project management arrangements and to ensure similar arrangement are put in place for any future projects undertaken by the Council.

4.2 To acknowledge the contribution of key partners who contributed to the successful delivery of the project.

5. **Financial and Resource Implications**

5.1 It should be noted that the projected financial outturn for the project is anticipated to be £10.2-10.3 million against a revised cost envelope of £10.5million (compared to the original cost envelope of £14m).

5.2 Additionally the operating costs are forecast to be around £350,000 p.a. less than the joint running costs of the former Jubilee Baths and the Knutton Recreation Centre. compared to 2011/12 where a further £100,000 saving has already been delivered through a management restructuring in readiness for the hand over of Jubilee 2 in December 2011.

5.3 Members will recall that your Officers managed to secure external funding totalling £900,000 towards the capital cost for Jubilee 2, namely, NHS North Staffordshire £500,000, and Sport England £400,000. This means that the total cost to the Council will be around £9.4m. Additionally the operating costs are forecast to be around £350,000 p.a. less than the joint running costs of the former Jubilee Baths and the Knutton Recreation Centre.

6. **Outcomes Linked to Sustainable Community Strategy and Corporate Priorities**

6.1 The provision of accessible leisure facilities contributes to the delivery of the Council's Strategic Priorities as set out in the Corporate Plan. There will be a positive impact on those relating to health improvement, quality of life, and support for disadvantaged communities, community safety and broader regeneration objectives for the town centre. In particular it is anticipated that Jubilee 2 will assist the Council/Partners in achieving positive health outcomes thereby reducing health inequalities.

7. **Legal and Statutory Implications**

7.1 The Council has powers, under the Local Government Act 2000, to improve the social, economic and environmental well-being of the Borough's residents. The Council has general powers to provide adequate resources are allocated for sport and recreation through the statutory framework of the core planning strategy and development plan documents. On a more specific note clearly it is vitally important that the Council procures appropriate and specialist legal advice to prepare the necessary contracts.

8. **Equality Impact Assessment (EIA)**

8.1 Jubilee 2 has been designed to be as an inclusive facility that will seek to optimise access from all sections of the community. The inclusion of a "Changing Places" toilet has received

positive feed back form members of the community as it has will enhanced their experience of using the facilities at Jubilee 2. Officers are now in the process of registering the facility with MENCAP.

9. **Major Risks**

9.1 A full risk assessment/log for the project has been completed in conjunction with the Council's Corporate Risk Manager and continues to be subjected to regular review. The latest version of this document is available upon request

10. **Previous Cabinet Decisions**

Cabinet 18 June 2008
Cabinet 10 September 2008
Cabinet 22 October 2008
Cabinet 26 March 2009
Cabinet 13 May 2009
Cabinet 29 July 2009
Cabinet 9 September 2009
Cabinet 21 October 2009
Cabinet 14 December 2009
Cabinet 13 January 2010
Cabinet 17 February 2010
Cabinet 24 March 2010
Cabinet 2 June 2010
Cabinet 28 July 2010
Cabinet 15 September 2010
Cabinet 2 November 2010
Cabinet 15 December 2010.
Cabinet 9 February 2011
Cabinet 17 March 2011
Cabinet 8 June 2011
Cabinet 20 July 2011
Cabinet 7 September 2011
Cabinet 11 October 2011
Cabinet 5 December 2011

12. **List of Appendices**

Risk Register – available on request

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NEWCASTLE-UNDER-LYME BOROUGH COUNCIL
REPORT TO THE
HEALTH SCRUTINY COMMITTEE

3rd April 2012

1. Phlebotomy Services and Publicity

Submitted by: **Democratic Services Manager**

Portfolio: **Safer and Stronger Communities**

Ward(s) affected: **All**

Purpose

To update the Committee on publicity regarding phlebotomy services in Newcastle under Lyme.

Recommendations

That the response from Tamsin Carr be noted.

That the situation continues to be kept under review.

At the previous meeting of this Committee the Chairman expressed the view that provision of phlebotomy services across the Borough had improved following a publicity campaign by the PCT. However, further publicity was required to raise awareness of the availability of the service at Bradwell Hospital. The situation has been kept under review and an update on the current publicity campaign is detailed below:

'We have got a communications campaign on the relocation of phlebotomy services which includes the following:

- Regular updates to all our GPs and Practice Managers in their weekly newsletter.
- An article in Our City with a photograph taken at Bradwell to be included – distributed in mid March.
- A leaflet which will include details of where the services will be available with maps and opening times is being produced which will be available at the path lab, the community settings and all GP practices.
- A poster is being produced which again will be displayed in the path labs and all GP practices
- A press release will be issued to all media in Stoke on Trent and North Staffordshire and we will be pushing get coverage on Radio Stoke, in Signal's news bulletins and the Sentinel.
- A two week campaign is planned to run on Signal One and Signal Two in the build up the closure of the path lab.'

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North Staffordshire Combined Healthcare NHS
NHS Trust

HAVE YOUR SAY

FOUNDATION TRUST CONSULTATION DOCUMENT
JANUARY - MARCH 2012

Working together, developing together.

CONTENTS

Mr Ken Jarrold C.B.E.
Chair

Fiona Myers
Chief Executive

A Welcome
from our Chair and Chief Executive

We are pleased to welcome you to our consultation document, which sets out an exciting new future for our Trust. Thank you for taking the time to read about our plans on how we will operate as a NHS Foundation Trust.

We need to evolve in response to the changing needs and expectations of our service users, carers, staff and partners. Becoming an NHS Foundation Trust will help us to do this.

One of the greatest and exciting differences of becoming an NHS Foundation Trust is that we have members. This provides us with the ideal opportunity to engage with our local communities to respond to local need.

Members will be elected to sit on our new Council of Governors, which will be responsible for representing the interests of our local communities, service users, carers, staff and partner organisations; bringing together a forum representing their interests.

I hope that when you have read this document you will feel encouraged to share your views on our proposals by completing and returning the reply form. I would also welcome you to join our Trust as a member, so that you have the opportunity to engage and work with us in the future.

Our consultation runs from **Monday January 9, 2012** to **Friday March 30, 2012**. Please complete the questions set out in this document and return your responses to us by 5pm on Friday March 30, 2012.

You can also comment on our proposals by visiting us at www.combined.nhs.uk, by phoning us on 0300 123 1535 ext 2025, by writing to the address on the back page of this document or by email to membershipoffice@northstaffs.nhs.uk

About our Trust

North Staffordshire Combined Healthcare NHS Trust was established in 1994. We provide mental health and learning disability care to people predominately living in the city of Stoke-on-Trent and in North Staffordshire.

We currently work from both hospital and community based premises and provide services to people of all ages with a wide range of mental health and learning disability needs. We also provide specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS), substance misuse services and psychological therapies.

We serve a population of approximately 457,000 people from a variety of diverse communities and the area ranges from prosperous suburban communities to areas of severe deprivation in the city of Stoke-on-Trent and North Staffordshire.

We operate from over 30 sites with a workforce of approximately 1,500 full time staff and have a turnover of approximately £86 million.

Our Partners

Our main partners are the two local primary care trusts (PCTs) – NHS Stoke-on-Trent and NHS North Staffordshire within the NHS Staffordshire Cluster. The PCTs are to be replaced by two clinical commissioning groups in the near future, with whom we are already working.

In addition, we work very closely with the local authorities and the University Hospital of North Staffordshire NHS Trust, as well as with agencies which support people with mental health needs such as the North Staffs Users Group (NSUG).

We have also forged closer links with the two local universities; Staffordshire University and Keele University.

Our Vision, Values and Strategic Goals

Our purpose: Working to improve the mental health and wellbeing of local communities

Our vision

- To provide patient-centred mental health, specialist learning disability and related services for people of all ages.
- To be the best in all that we do.
- To work in partnership to deliver services that promote recovery, wellbeing and independent living.

Our values

- Valuing people as individuals.
- Providing high quality innovative care.
- Working together for better lives.
- Openness and honesty.
- Exceeding expectations.

Our strategic goals

- Deliver high quality, person-centred models of care.
- Be at the centre of an integrated network of partnerships to provide a holistic approach to care.
- Engage with our communities to ensure we deliver the services they require.
- Be a dynamic organisation driven by innovation.
- Be one of the most efficient providers.

Clinical Strategy

- Financial Strategy
- Workforce Strategy
- Estate Strategy
- Customer Focus Strategy
- IM&T Strategy
- Governance Strategy
- Innovation Strategy

Q1. Do you agree with our vision and goals?


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MUMMY

What is an NHS Foundation Trust?

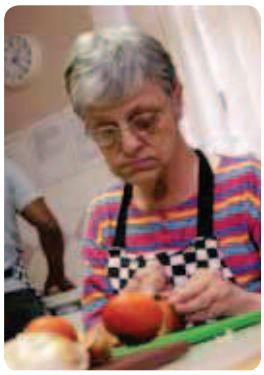
An NHS foundation trust is a new form of NHS organisation with a different legal entity to a NHS trust. It is a 'Public Benefit Corporation' which means that it has members, governors and directors with roles described in the NHS Act 2006.

NHS foundation trusts are regulated by Monitor, which is the independent regulator of foundation trusts.

Foundation trusts are not directed by the Secretary of State; therefore enabling them to have the autonomy to develop services in partnership with their local community, members and governors.

NHS foundation trusts remain firmly part of the NHS, subject to NHS standards, providing free care at the point of delivery.

Why do we want to become an NHS Foundation Trust?



What are the benefits of becoming an NHS Foundation Trust?

- New financial freedoms will allow us to retain and re-invest any extra money we earn in new services, based on service need;
- An enabler for long term planning;
- Local people will be at the heart of service development; our new Council of Governors will be responsible for representing the interests of our local communities, service users, carers, staff and partner organisations via a forum representing these people;
- Membership provides the opportunity for local people to get involved in developing plans for the future. The Council of Governors will have an important role in monitoring our performance, ensuring our compliance to external standards and frameworks as well as bringing innovation and efficiency into service delivery;

Are there risks associated with becoming an NHS Foundation Trust?

As a Foundation Trust, we will no longer be accountable to our regional Strategic Health Authority (SHA), which also means that we will no longer be financially supported by them.

Historically if a trust experiences financial difficulties, it has received additional funds from the SHA.

As an NHS Foundation Trust, we will not have access to that kind of financial support and we will be held to account for decisions taken.

What stays the same and what will be different when the Trust becomes an NHS Foundation Trust?

Same

- We will remain a high quality provider of services;
- We will remain part of the NHS;
- We will continue to provide the same range of services.

Different

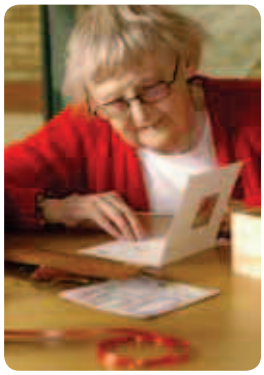
- We will have a Council of Governors;
- We will have more financial flexibility;
- We will be more locally accountable;
- We will have a greater impact and influence in the local health economy as achieving NHS Foundation Trust status demonstrates we are a high quality provider of services;
- We will be regulated by Monitor (independent regulator of foundation trusts) rather than centrally directed by the Department of Health.

Our future plans

Over the next five years we will:

- Implement new models of care, caring for people in the community and closer to home;
- Inform and support people to make healthier and more responsive choices;
- Ensure that people who use our services receive a holistic package of care to meet their needs;
- Continue to build relationships with partners to ensure that people receive expert help as quickly as possible;
- Ensure staff are trained and have access to learning and development opportunities to enable them to perform in their role as effectively and efficiently as possible;
- Maintain and strive to improve our high standards of quality service delivery.

How we will operate as an NHS Foundation Trust



Membership

Membership is free and members can choose how much or how little they want to get involved with the Trust. Members can:

- Elect governors;
- Be eligible to stand for election to the Council of Governors;
- Receive information about the Trust;
- Help shape future plans by engaging in surveys, workshops, seminars, etc;

As a thank you for becoming a member, members will benefit from discounts from major retailers through NHS Discounts.

Members will not receive any special healthcare treatment as NHS patients; they will receive the same level of service as anyone who chooses not to become a member.

We are proposing that to become a member of our Trust, you must be at least 11 years of age. We believe that by recruiting members from 11 years of age enables representation from our younger service users and gives them the opportunity to influence the way they receive their services.

There is no upper age limit on membership or upper limit on the number of people who may register as members as long as they are eligible.

11 year olds will have voting rights but cannot stand for election to the Council of Governors until they are 16 years of age.

We are proposing to group membership into two categories, known as constituencies:

1. Public
2. Staff

Q2. Do you agree with our minimum age to become a member should be 11 years of age?

Public Membership

We propose that there will be four constituencies for members of the public:

- To be a member of the North Staffordshire public constituency you must live within the county of Staffordshire marked 'A' on the map below.
- To be a member of the Stoke-on-Trent public constituency you must live within the city of Stoke-on-Trent marked 'B' on the map.
- To be a member of the South Staffordshire public constituency you must live within the county of Staffordshire marked 'C' on the map below.
- To be a member of the out of area public constituency you must live in England or Wales.

We are keen to hear from anyone who would like to be a member. Please contact our membership office or fill in and return the membership form in this booklet if you are interested in becoming a member.

Q3. Do you agree with our proposed public constituencies?

A = North Staffordshire including Newcastle under Lyme and Staffordshire Moorlands

B = Stoke on Trent

C = South Staffordshire including Stafford, East Staffordshire, South Staffordshire, Cannock Chase, Lichfield and Tamworth

Service User and Carer Membership

We could have a separate service user and carer constituency. There are pros and cons to this:

For

- Representation - it will make sure that service users and carers sit as governors on the Council of Governors.
- Commitment - creating a service user and user constituency would be a symbol of the commitment to involving service users and their carers in everything we do.

Against

- Representation - most of our patients live within Stoke-on-Trent or Staffordshire and will therefore be eligible to join one of the public constituencies and nominate themselves for governor.
- Having a separate service user and carer constituency could reinforce stigma; it divides service users and carers from other members of the public thus weakening the 'knowledge' base of the public constituency.

If we have a service user constituency, we are proposing that there are a maximum of four governors.

This ensures that the Council of Governors remains manageable and operates effectively. The constituency would be open to anyone who has used our services at any time or anyone who has been a carer at any time.

Your views on this topic are really important so please share them with us.

Q4. Do you think we should have a separate service user and carer constituency?
Please give reasons for your answers

Staff Membership

We are confident that most staff will want to be involved in the Foundation Trust. We automatically make all current and future staff part of the membership. Staff are eligible to join as long as they:

- Have a contract with a fixed term of at least 12 months; or
- Have been continually employed by our trust for 12 months; or
- Have exercised functions for the purposes of the Trust for at least a year (this includes those who help or provide services to on a voluntary basis).

There is a process for staff to opt-out if they don't want to be a member.

Staff who opt-out will not be eligible to vote in elections for staff governors, but otherwise will be treated no differently than staff who stay as members. If staff do opt-out, they can opt-in again later, if they want. Staff can choose to opt-out at any time.

Volunteers are also eligible to become members of the staff constituency as they exercise functions for the purpose of the Trust, although not employed by the Trust itself.

We are proposing to include volunteers in the staff constituency as we value the role of volunteers and we are keen to recognise the contribution of volunteers to our organisation. Volunteers are eligible to become a member if they have exercised functions for the purposes of the Trust for at least one year.

We can divide the staff constituency into separate groups known as classes and we are proposing to have five staff classes based on professional groups:

1. Medical
2. Nursing
3. Allied Health Professional and Social Workers
4. Clinical support
5. Non-clinical support

Q5. Do you agree with our proposals for staff membership?

Q6. Do you agree with our intended staff classes?

Council of Governors

We are proposing that there should be 33 governors, that make up our Council of Governors, made up of:

- 23 elected governors (18 public and five staff);
- 10 appointed (four statutory and six partner organisations)

Members of the public and staff constituencies hold elections to select their governors to represent them. They are joined by four statutory partner governors and six other partner organisations.

Governors will work with the Board of Directors to ensure that the views of the local community and staff play a key role in the delivery of future services.

Governors are responsible for:

- Appointment or removal of the Chair and our other non-executives
- Approve the appointment of the Chief Executive;
- Appoint or remove the auditors;
- Be presented with the accounts each year and the annual report;
- Prepare and review the membership strategy;
- Gather the views of members and the wider community about the services we provide and about our plans for developing services;
- Provide their views to the Board of Directors when the Board of Directors is preparing our forward plan; and
- Take part in service user, public and patient-involvement activities and developing strategy in a range of areas.

The Council of Governors will be made up of public, service users/ patients, their carers and staff members, together with people appointed to represent local organisations (commissioners, local authorities, universities and other partnership organisations).

All governors will be eligible to serve up to three years and to stand for re-election or re-appointment for up to nine years in total. We propose that the Council of Governors will meet at least four times a year and that meetings will be open to the public. Meetings of the Council of Governors will be chaired by the Trust Chair or Vice-Chair.

The Trust is free to decide the total number of governors on the Council but, by law, the elected public governors must be in the majority by at least one seat. We are proposing that governors must be at least 16 years of age.

Option 1 - 33 governors

(no separate service user and carer constituency)

Staff Governors (elected)	5
Medical	1
Nursing	1
Allied Health Professionals and Social Workers	1
Clinical support staff	1
Non clinical support staff	1
Appointed Governors	**10**
Primary Care Trust (statutory)	2
Local Authority (statutory)	2
Voluntary organisations	2
Keele University	1
Staffordshire University	1
Police	1
Housing	1
Public Governors (elected)	**18**
Stoke-on-Trent	9
North Staffordshire	7
South Staffordshire	1
Out of area	1

Option 2 - 37 governors

(with a separate service user and carer constituency)

Staff Governors (elected)	5
Medical	1
Nursing	1
Allied Health Professional and Social Workers	1
Clinical support staff	1
Non clinical support staff	1
Service Users and Carers Governors (elected)	**4**
Service users and carers	4
Appointed Governors	**10**
Primary Care Trust (statutory)	2
Local Authority (statutory)	2
Voluntary organisations	2
Keele University	1
Staffordshire University	1
Police	1
Housing	1
Public Governors (elected)	**18**
Stoke-on-Trent	9
North Staffordshire	7
South Staffordshire	1
Out of area	1

Q7. Do you agree with our proposals for public governors?

Q8. Do you agree with our suggested appointed governors?

Q9. If you believe we should have a separate service user and carer constituency, do you agree there should be a maximum of four governors?
Please provide reasons for your answer.

Q10. Do you think our number and balance of proposed governors will enable the Council of Governors to properly represent the public, our staff, service users and carers and other organisations?

Q11. Do you agree that the minimum age of a governor should be 16 years of age?

Board of Directors

The Board of Directors will be made up of executive directors and non-executive directors who will be responsible for managing the Trust. The Board of Directors is responsible for both the strategic and operational management of the Trust.

It is the Board of Directors that exercises the powers of the Trust and is accountable for its performance across the full spectrum of its activities.

The Board of Directors will be made up of a Chair, a maximum of six executive directors and a maximum of six non-executive directors.

The Chair will work closely with the Senior Independent Director (SID) and the Lead Governor. The SID (a non-executive director) will be appointed by the Board of Directors in consultation with the Board of Governors. The SID should act as the point of contact if governors have concerns which contact through normal channels has failed to resolve or for which such normal contact is inappropriate.

The Lead Governor is appointed to lead the Board of Governors in situations where it is not considered appropriate for the Chair or another one of the non-executive directors to do so. These occasions are likely to be infrequent but one example may be a meeting discussing the appointment of the Chair.

The regular meetings of the Chair, SID and Lead Governor will ensure that the Council of Governors and the Board of Directors carry out their roles effectively and efficiently in the best interests of the NHS Foundation Trust.

Q12. Do you agree with our proposals for the Board Directors?

Proposed Name Change

Once we achieve authorisation, we have to include the words 'NHS Foundation Trust' in our name. We understand how important it is to ensure we choose a name that identifies us and therefore we welcome your comments on which of our proposed names you prefer:

A new name:

A) North Staffordshire and Stoke-on-Trent NHS Foundation Trust
B) North Staffordshire NHS Foundation Trust
C) North Staffordshire Healthcare NHS Foundation Trust
D) North Staffordshire Combined Healthcare NHS Foundation Trust

Q13. Which name do you prefer?
Please give your reasons for your choice.

Getting Involved

How you can have your say

We are seeking the views of a wide range of people and organisations during the consultation process and we welcome your views and comments on our proposals to become an NHS Foundation Trust.

Our 12 week consultation runs for three months, from Monday January 9, 2012 to Friday March 30, 2012. There are several different ways in which you can comment on our proposals:

Email

membershipoffice@northstaffs.nhs.uk

By post

Fill out the form at the end of the document and return it to our freepost address:

North Staffordshire Combined Healthcare NHS Trust
Membership Office,
Bucknall Hospital, Eaves Lane
Freepost MID25483
Stoke on Trent
ST4 6BR

By telephone

0300 123 1535 ext 2025

or visit www.combined.nhs.uk

Public meetings

We are holding a number of public meetings in our local areas to give people the opportunity to listen to our proposals and feedback their comments. If you would like to come along to one of our meetings, we would be grateful if you could please confirm your attendance by ringing the Foundation Trust team on 0300 123 1535 ext 2025.

Date	Venue	Time
Tuesday March 6, 2012	Academic Rooms 1 and 2 Harplands Hospital Hilton Road, Harpfields ST4 6TH	6pm - 7pm
Thursday March 8, 2012	The Oak Room in The Learning Centre Bucknall Hospital Eaves Lane, Bucknall ST2 8LD	6pm - 7pm
Wednesday March 14, 2012	Multi Purpose Room Ashcombe Centre 25/26 Wall Lane, Cheddleton ST13 7ED	10.30am - 11.30am
Thursday March 15, 2012	Group Room 2, Lymebrook Resource Centre Bradwell Hospital Site Talke Road, Chesterton, N-U-L ST5 7TL	12pm - 1pm

Next steps

All feedback will be recorded and we will publish a summary of the feedback shortly after the consultation ends. The feedback received will be used to inform how we proceed to become an NHS Foundation Trust and the governance arrangements.

All responses will be confidential and feedback will be considered at the Trust Board meeting in April 2012.

Any changes made in light of the consultation, influenced by responses received during the 12 weeks, will be published on our website.

If you are not a member of our Trust, and would like to join or find out more about what membership means, please go to

http://www.combined.nhs.uk/joinus/Pages/Membership.aspx

or complete the membership leaflet enclosed in this document.

Frequency Asked Questions

1. Are Foundation Trusts a way of privatising the NHS?

No. Foundation Trusts remain firmly part of the NHS. We will still be subject to the same targets, regulation and policies that govern all NHS organisations.

2. What difference will it make to the public when the Trust becomes a NHS Foundation Trust?

The public will be able to become members of our Trust which means that they have the opportunity to work with us to influence future service delivery. We will be more accountable to our local community.

3. How will governors make a difference?

Governors will meet regularly with members and listen to the views of their constituencies. Governors will be able to influence the Board of Directors by bringing forward the views of their local community.

4. As a member of staff, will becoming a NHS Foundation Trust mean that my pay, terms and conditions will change?

The only way the Trust could move away from existing pay, terms and conditions is in full consultation with staff and unions. If a proposal was put forward, it would have to be agreed by the Trust Board and Council of Governors. Of the 141 authorised Foundation Trusts, only one has moved away from Agenda for Change and this was supported by 95% of staff.

5. Should the Trust be pursuing a NHS Foundation Trust application in light of the economic climate?

Yes. As part of the application process, the Trust must demonstrate that it is financially viable and can remain so for the next five years as a minimum. This means that we have already planned to get through the forthcoming tough times that we are facing.

6. Why have some NHS Foundation Trusts experienced problems?

All Foundation Trusts must have robust governance and management structures in place. We will ensure that our systems and structures remain strong and fit for purpose.

www.combined.nhs.uk

North Staffordshire Combined Healthcare NHS Trust
Harplands Hospital, Hilton Road, Stoke-on-Trent ST4 6TH

The Trust is committed to providing communication support for service users and carers whose first language is not English. This includes British Sign Language (BSL).

This document can be made available in different languages and formats, including easy read, on request.

যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদের

Si vous souhaitez des informations dans une autre langue ou sous veuillez nous le demander.

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If you would like to receive the document in a different format please telephone freephone 08000 328728 or write to our FREEPOST address:

North Staffordshire Combined Healthcare NHS Trust
Membership Office
Bucknall Hospital,
Eaves Lane
Freepost MID25483
Stoke on Trent
ST4 6BR

University Hospital of North Staffordshire NHS
NHS Trust

Policy No. RM02
Policy and Procedures for Handling Complaints

The following personnel have direct roles and responsibilities in the implementation of this policy:

- All Trust Staff

Version:	6
Ratified By:	Executive Committee
Date Ratified:	March 2010
Date of Issue via Intranet:	April 2010
Date of Review:	March 2012
Trust Contact:	Deputy Chief Nurse
Executive Lead:	Chief Nurse

Statement on Trust Policies

Staff Side and Trade Unions
The University Hospital of North Staffordshire NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospital of North Staffordshire aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

The Trust aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.'

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Act 1998 and the NHS Confidentiality Code of Practice
The Data Protection Act (DPA) provides a framework which governs the processing of information that identifies living individuals. Processing includes holding, obtaining, recording, using and disclosing of information and the Act applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personnel records. The DPA provides a legal gateway and timetable for the disclosure of personal information to the data subject (e.g. Health Record to a patient, personal file to an employee).

Whilst the DPA applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of the DPA and other relevant legislation together with the recommendations of the Caldicott report and medical ethical considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections

The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights

The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development

University Hospital North Staffordshire NHS Trust recognises the impact that its operations have on the environment as well as the strong link between sustainability, climate change and health. The trust is committed to continual improvement in minimising the impact of activities on the environment and expects all members of staff to play their part in achieving this goal and in particular to work towards a 10% carbon reduction by 2015. The Green Aware Campaign is designed to support you to do this. All trust policy should embed sustainability and refer to our Sustainable Development Management Plan where relevant. Further information and guidance can be obtained from the Trust Sustainability Manager.

Contents	Page

1 INTRODUCTION

Comments on services provided, suggestions for their improvement, and complaints when services fail to satisfy the user, are actively solicited by the Trust. They are seen as a means of identifying and rectifying errors or faults and enhancing the quality of the service. Complaints should therefore, be seen in a positive light, as an opportunity for improvement. This Policy has been formulated in order that all Trust staff may be aware of what constitutes a complaint, and the actions which should be taken in case of complaint.

Prior to 1st April 2009 there were two different processes for handling complaints related to health and social care services. These processes differed in stages and timescales; investigations were also carried out in different ways. Many people use services which cross health and social care boundaries. If problems arose, it was hard for people to know who to go to and difficult for different services to respond jointly.

The Government wished to make it simpler for people to complain about their experiences of using health and social care services. In the White Paper, Our health, our care, our say (January 2006), the Department of Health set out its commitment to develop a single system across health and social care by 2009 that would 'focus on resolving complaints locally with a more personal and comprehensive approach to handling complaints' (Page 160).

In September 2006, the National Health (Complaints) Amendment Regulations 2006 came into force which imposed a reciprocal duty on NHS organisations and local authorities to co-operate and to provide a co-ordinated response to the complaint.

In June 2007 the Department of Health launched a public consultation, 'Making Experiences Count' (MEC) and new regulations were passed by Parliament in February 2009 (Statutory Instrument No 309) to take effect on 1st April 2009.

This Policy and Procedures for the handling of complaints is **entirely separate from the Trust's Disciplinary Procedures**. Its purpose is not to apportion blame amongst staff but to investigate complaints to the complainant's satisfaction while being scrupulously fair to staff. Any matter referred for disciplinary proceedings ceases to be covered by this Policy.

In December 2009 the Care Quality Commission published their essential standards of Quality and Safety, setting out what Providers should do to comply with section 20 regulations of the Health and Social Care Act 2008. This policy takes into account the requirements set out within Outcome 17 of the Act.

The policy also takes into account the minimum standards set out within the NHSLA Risk Management Standards 2010/11.

In reviewing this policy the Trust has taken into account lessons learnt following the inquiry into the care provided by Mid Staffordshire NHS Foundation Trust. The inquiry found that the poor experiences of patients and their families were not taken into account in the delivery of safe and effective services. The University Hospital of North Staffordshire is committed to ensuring that feedback from patients, service users and staff are an integral component in the planning, delivery and continuous improvement of its services.

An "Equality Impact Assessment" has been undertaken and no actual or potential discriminatory impact has been identified relating to this document.

2 POLICY STATEMENT

As referenced in the NHS Constitution patients and/or their representatives have the right to :

- have any complaint made about NHS services dealt with efficiently and to 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 their complaint has been dealt with by the NHS,

- make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body,.

The NHS commits to:

- ensure the patient/representative is treated with courtesy and receive appropriate support throughout the handling of a complaint; and the fact that a complaint has been made will not adversely affect the future treatment of the patient,

- when complaints happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively,

- ensure that the organisation learns lessons from complaints and uses these to improve NHS services.

The Policy of the Trust is to ensure :

- that responses to complaints are outcome-based and focus on achieving the best possible results for complainants, by providing the answers and explanations that complainants need to help them understand when and how something went wrong or why something happened that they perceived to be wrong,

- that complaints are responded to promptly, avoiding unnecessary delays, keeping the complainant regularly informed about progress,

- that the barriers which could prevent or inhibit service users from expressing dissatisfaction with the service are removed,

- that complainants are aware of their right to refer their complaint to the Health Service Commissioner (Ombudsman) if they are not satisfied with the Trust's response to their complaint,

- that all staff are aware of the Trust's Policy and Procedures for the handling of complaints and that these are followed uniformly across the Trust,

- that feedback and lessons learned from complaints are used to improve service design and delivery all across the Trust.

3 SCOPE

This policy applies to all disciplines of staff across the Trust but the degree of responsibility will vary throughout the organisation.

4 DEFINITIONS

Complaints

A complaint can be defined as an expression of discontent which requires a response. It is a generic term for any sort of complaint, raised either orally or in writing by people using health/social care services.

First contact resolution of a complaint
This is defined as a complaint which is made orally and is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made. These complaints are not reportable under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 but should be recorded electronically on DATIX for monitoring purposes.

DATIX
DATIX is the organisation's risk management software which is used for the recording and reporting of Adverse Incidents, Complaints, Claims, PALS, FOI requests, Inquests and organisational risks.

Patient Advice and Liaison Service (PALS)
PALS provides support to patients, carers and relatives, representing their view and resolving local difficulties on-the-spot by working in partnership with Trust staff. In addition to helping resolve patients' concerns quickly and efficiently, and improving the outcome of care in the process, PALS provide information to patients to help make contact with the NHS as easy as possible. Information leaflets regarding the PALS service are available in clinical and non clinical areas throughout the Trust.

Independent Complaints Advocacy Service (ICAS)
ICAS help individuals to pursue complaints about the NHS, ensuring that complainants have access to the support they need to articulate their concerns and navigate the complaints system, thereby maximising the chances of their complaint being resolved more quickly and effectively at a local level. ICAS will determine the level of service required according to complainants' needs. As well as providing advice the service provides advocacy in terms of writing letters and attending meetings to speak on the complainant's behalf.

5 ROLES AND RESPONSIBILITIES

5.1 Chief Executive/Associate Directors/Divisional Senior Management Teams

The Chief Executive has overall responsibility for the management of complaints and, together with the Trust Board, Associate Directors and Divisional Senior Management Teams, is responsible for ensuring that lessons are learnt and the standard of care and treatment afforded to patients, carers and relatives is improved following the investigation of a complaint. They are also responsible for ensuring that this policy is implemented in an effective and timely manner across the organisation.

5.2 Complaints Manager

The role of the Trust's Complaints Manager is fulfilled by the Chief Nurse who reports directly to the Chief Executive in all matters relating to the implementation of the Trust's Policy and Procedures for handling complaints.

5.3 Divisional Nurse/Professional Head of Clinical Service

The Divisional Nurse/Professional Head of Clinical Service is responsible for ensuring:

a. effective complaints management within their Division and for providing clinical support to investigations,

b. that all nursing/midwifery staff receive training in complaints management,

c. that a process is in place which encourages patients to provide feedback prior to discharge from hospital.

5.4 Directorate Managers

Directorate Managers are responsible for overseeing and monitoring the management of complaints within their Directorate, nominating investigating officers and providing support and assistance throughout investigations.

5.5 Investigating Officers

Investigating Officers are responsible for investigating complaints in line with Trust policy, ensuring that all appropriate actions are taken to achieve local resolution.

5.6 Complaints Administrator

The Complaints Administrator reports to the Deputy Chief Nurse and administers the complaints system, in accordance with Trust policy.

5.7 Patient Advice & Liaison Service (PALS) staff

The PALS Manager reports to the Deputy Chief Nurse and is responsible for the management of the PALS team and service, ensuring fast and effective resolution of patient concerns.

5.8 Front Line Staff

Front line staff have a responsibility to manage, and where possible resolve, verbal complaints, in line with Trust policy and to distinguish those serious issues that, even if raised verbally, need to be brought to the attention of senior managers within the organisation, for example where they raise patient safety issues.

5.9 Independent Reviewers (Internal & External)

Independent Reviewers (internal) have the responsibility of considering a complaint outside their area where the initial investigation has failed to resolve the complaint to the complainant's satisfaction. Independent review may be undertaken outside the Trust (external), if it is felt that an internal review would not offer a true independent opinion or if the complainant rejects an internal independent review.

5.10 Senior Clinicians

Senior clinicians have a responsibility to co-operate in the investigation of a complaint relating to treatment provided by them or one of their team, including meeting with complainants, if requested. They also have a responsibility to provide their opinion on treatment provided by a clinician outside their team, if necessary.

5.11 All Employees

All employees have a responsibility to abide by this policy and any decisions arising from the implementation of it.

6 TRAINING

In accordance with the Trust's Training Needs and Analysis, training on the management of

complaints is delivered, dependent on the needs of the individual (See Policy HR053).

7 MONITORING AND REVIEW ARRANGEMENTS

The process for monitoring compliance with this policy is as follows:

- Duties, including process for listening and responding to concerns/complaints. The Corporate Complaints Team will monitor compliance with the standards on an ongoing basis. Where concerns with the handling of a complaint are identified, these will be flagged up to the Divisional Nurse/Professional Head of Clinical Service and, where appropriate, the Chief Nurse.

- Where joint investigations are undertaken, the process will be monitored by the Complaints Administrator at UHNS, alongside the appropriate Complaints Manager in the other organisation(s).

- In addition completed complaint Feedback Questionnaires will be used to monitor these standards, including ensuring that patients are not treated differently as a result of their complaint. The findings will be included in the quarterly and annual Patient Experience Reports. These reports will also monitor the process by which improvements are made as a result of concerns/complaints being made.

- In accordance with Care Quality Commission regulations, an annual report will be submitted to the Care Quality Commission.

- The Performance Report will also be used to monitor the time frames for responding to complaints.

- Where the monitoring identifies deficiencies, divisions are responsible for ensuring that this is included in their local risk register with an action plan to address any shortfalls.

Additional means by which this policy is monitored include the following:

- There must be a record of all complaints made to the Trust. All complaints must be entered onto DATIX which should be maintained both centrally and within each division.

- There should be regular monitoring of the incidence and the handling of complaints both centrally and within the divisions.

- The Chief Executive and/or the Chief Nurse may, at any time, initiate a formal review of the overall investigation, management and outcome of a complaint.

- Divisional Senior Management should ensure that all actions identified from a complaint are implemented and monitored.

- As a minimum, the Divisional Clinical Governance Team should produce a quantitative and qualitative report on a quarterly basis relating to all patient complaints and patient feedback (complaints and plaudits) which highlights action taken to address any shortfalls in service identified through the complaints process.

- The PALS Team will provide the divisions with a Quarterly report on all contacts.

- The Deputy Chief Nurse will review all complaints regarding UHNS with the PCT's on a monthly basis. The Deputy Chief Nurse will feedback to the Clinical Quality Review

meeting.

Information contained in the reports should be anonymised to ensure patient/complainant confidentiality.

RM02 Policy and Procedure for Handling Complaints Monitoring Table					
Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or department responsible for the monitoring	Frequency of the monitoring activity	Group/committee/ forum which will receive the findings/monitoring report	Committee/ individual responsible for ensuring that the actions are completed
duties	Datix	Line Manager	As exception	Divisional Governance Group	Divisional Governance Group
process for listening and responding to concerns/complaints of patients, their relatives and carers	Quality Report Patient Experience Report	Complaints/Nursing	Monthly Quarterly	Execs. Trust Board P.A.G.	Divisional Governance Group
process for the handling of joint complaints between organisations	Quality Report Patient Experience Report	Complaints/Nursing	Monthly Quarterly	Execs. Trust Board P.A.G.	Divisional Governance Group
process for ensuring that patients, their relatives and carers are not treated differently as a result of raising a concern/complaint	Complaints Questionnaire	Complaints/Nursing	Quarterly	Execs. Trust Board P.A.G.	P.A.G.
process by which the organisation aims to improve as a result of concerns/ complaints being raised	Patient Satisfaction Surveys	All Departments	Continual	Trust Board	Nursing Directorate P.A.G.

8 REFERENCES

Department of Health 'Our health, our care our say: making it happen' (October 2006)
National Health (Complaints) Amendment Regulations 2006
Department of Health 'Making Experiences Count' (February 2008)
Statutory Instrument 2009 No. 309, the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009.
NHS Core Standard C14
NHS Confidentiality Code of Practice (gateway reference 1656)
Freedom of Information Act
The NHS Constitution (21 January 2009)

APPENDX A

Procedural Guidance When Managing a Complaint

Time limit on initiating complaints

A complaint should be made as soon as possible after the action giving rise to it. The time limit for making a complaint will be within 12 months from the date the matter occurred or the matter came to the notice of the complainant. There is discretion to investigate beyond this, if there are good reasons for a complaint not having been raised sooner, e.g. bereavement, and it is still possible for the Trust to investigate the complaint effectively and fairly.

Principles on which the policy is based

- It is the right of every health service user to bring to the attention of Trust management aspects of their care and treatment about which they are unhappy. All staff must be aware of an individual's right to comment on the standards of service provided by the Trust and must therefore be familiar with the Trust's policy for dealing with complaints.

Any complaints system should be simple, easy to understand and as devoid of bureaucracy as possible, while ensuring that it is effective in responding to the satisfaction of complainants.

- Service users, regardless of their position in society, age, race, language, literacy level or physical or mental ability should be able to register a complaint.

At all times NHS staff should treat patients, carers and visitors politely and with respect. However, violence, racial, sexual or verbal harassment of staff will not be tolerated. Neither will NHS staff be expected to tolerate language that is of a personal, abusive or threatening nature. (See Trust Policy to Support the Safe and Therapeutic Management of Aggression & Violence HS06)

- All complaints should be taken seriously regardless of how trivial they may appear to the recipient of the complaint.

- Responses to complaints must address the substance of the complaint with the aim of satisfying the complainant.

- In the case of verbal complaints, front-line staff should be empowered to resolve complaints at source.

- Complainants should be involved from the outset and Investigating Officers should seek to determine what complainants are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and should be kept informed

- Both complainant and anyone complained against must feel that any investigation carried out has been impartial and that all points of view have been listened to and judged fairly.

- Respondents should be willing to accept the validity of the complainant's point of view, even if they do not share it; to give an explanation of events and apologise if appropriate.

- Complainants must be assured that the fact that they have made a complaint will not jeopardise their care or treatment in the future. Concerns regarding discrimination in relation to treatment as a result of raising a concern or complaint will be highlighted to the Trust through the questionnaire which is issued to all complainants following completion of a complaint.

- Complaints should be viewed as opening up opportunities for quality enhancement and, therefore, should be responded to positively rather than reacted against negatively.

General guidelines

All complaints, whether they are received within divisions or centrally, must be checked on receipt:

- against the criteria for referral to the Chief Executive (See Section 4). If referral is required, immediate action must be taken,

- to ensure that the complaint does not indicate that a service user, patient or member of staff is at immediate risk. If the service user, patient or member of staff is at risk, action must be taken without delay to ensure their safety,

- as to whether it is from a solicitor, or made via a solicitor, or makes mention of litigation. If a complaint is a potential legal claim, it should be referred to the Complaints Administrator without delay. The Complaints Administrator should check whether a legal claim has been lodged against the Trust. If a legal claim has not been lodged the complaint should be investigated as described in section 6.3. If a legal claim has been lodged the Claims & Medico Legal Risk Manager, Chief Nurse and Medical Director will decide whether responding to the complaint may be seen as prejudicial to the outcome of the legal case,

- as to whether the complaint has been made within the timescale for making complaints (See Section 4).

- as to whether the complaint concerns matters for which the directorates or Trust have responsibility or jurisdiction. If this is not the case, the complaint should be sent to the Complaints Administrator for appropriate re-direction,

- to see whether the complaint has been sent by a third party. The actions set out in Section 6.10 must be taken in the case of third party complaints.

The principle of confidentiality must be respected throughout (see Section 6.9).

The complained against, as well as the complainant, should be kept informed of the progress of complaint investigations and be made aware of the outcome. The final draft response to complainants must be shared with the complained against (relevant sections).

Complete and accurate records must be kept throughout the investigation of complaints. A complaint file has the same status as any other created by a healthcare organisation. It is a public record, its contents are confidential and should be maintained to an appropriate standard. All records/correspondence must be dated and kept on file electronically, using the Complaints Module of the Trust's Risk Management System (DATIX). Electronic and paper records should be kept separate from the patient's health records, for 8 years after the resolution of the complaint (HC(89) 20, Appendix C.9).

If investigation of a complaint reveals a possible need for disciplinary action against staff at any point in the investigation, the matter must be referred at once by the appropriate manager to the

Chief Nurse who, if appropriate, will liaise with Human Resources and any other relevant professional lead. If disciplinary proceedings are to be initiated, then the complaints process and the matter should be taken forward under the Trust's Disciplinary Procedures. The complainant and complained against should be advised accordingly. Relevant information gathered in investigating the complaint may be handed over for the purpose of the disciplinary investigation. However, if any part of the complaint is not the subject of the disciplinary proceedings, proceedings under this Policy may continue for that part of the complaint.

The Complaints Administrator will ensure that a check takes place to establish if there has been a previous Adverse Incident Report or Request for Disclosure, related to the complaint. This information will be taken to the Corporate Clinical Governance and Risk Portal, and where appropriate the complaint investigation will be linked to existing RCA/investigation processes and documentation via Datix.

If investigation of a complaint reveals an unreported adverse incident, the matter must be referred at once by the appropriate manager to the Clinical Governance, Audit and Risk Department.

For complainants who have difficulty communicating, or for whom English may not be their first language, the Trust has access to a range of services to facilitate understanding. These can be accessed by contacting the Complaints Administrator or PALS service.

The fact that a death has been referred to the Coroner's Office does not mean that the Trust cannot carry out a complaint investigation. Any investigations involving the Coroner must be signed off by the Chief Executive. The Complaints Administrator should liaise with the Coroner's Office and forward a copy of the report to the Coroner on completion of the investigation and advise the complainant of this.

The NHS complaints procedure does not cover complaints about private medical treatment, provided in an NHS setting but it does cover any complaint made about an NHS body's staff or facilities relating to care in their private pay beds.

The Trust is committed to providing safe and effective care for patients and individual employees have a right and duty to raise any concerns. This policy should be read in conjunction with the Trust's Whistleblowing Policy (HR30) which has been drawn up to provide an avenue for staff to raise issues of concern and to protect patients from harm.

The Chief Nurse should be notified immediately of any concerns arising from a complaint which require referral to professional regulatory bodies, the police, the coroner, or protection agencies (vulnerable adults and children).

IF YOU ARE UNSURE HOW TO DEAL WITH A COMPLAINT, INVOLVE YOUR LINE MANAGER/DIRECTORATE MANAGER.

Stages of Complaint

Stage One (Local Resolution)

When those providing the service are able to resolve the complaint to the complainant's satisfaction within the Trust's complaints procedures.

Stage Two (Health Service Ombudsman)

When the complaint is not resolved at Stage 1 and the complainant takes up the option to refer the case for review by the Health Service Ombudsman. The Ombudsman is independent of

the NHS and the Government and derives her powers from the Health Service Commissioners Act 1993.

1 Stage One – Local Resolution

A complaint may be made verbally or in writing (including electronically).

1.1 Verbal Complaints

Verbal complaints can be made face to face or by telephone. If a telephone complaint is received out of hours this should be referred to the relevant Senior Manager. In the absence of such a manager the complaint should be referred to the Site Manager on duty or on call manager.

The member of staff receiving the complaint should listen courteously to what the complainant has to say and should identify the issues of concern and the outcomes expected by the complainant. These should be recorded on a verbal complaint form (Appendix B) in the case of front line staff or on DATIX if the complaint is received within the Directorate office. If the complainant does not wish to discuss their concerns over the telephone they should be offered the opportunity of a face to face meeting. The member of staff should apologise if appropriate, and seek to resolve the complaint immediately if at all possible. If the complaint is resolved at first contact (by the end of the next working day), the member of staff should update the verbal complaint form and forward this to the Divisional Office for recording on DATIX. The file can then be closed.

In the case of a clinical complaint, the relevant consultant, senior nurse, midwife or allied health professional must be contacted without delay. The offer of a meeting with a clinician at this stage may resolve the complaint.

If the complaint is not resolved at first contact the member of staff should escalate this to the Division who will open a file within DATIX, using the information contained on the verbal complaint form. The Division should notify the Corporate Complaints Team by email, through DATIX. The divisional office will proceed to investigate the complaint (See section 2 below).

If the verbal complaint is received by a member of the PALS team, the same process applies, however the PALS officer will record the information directly onto DATIX and if resolved at first contact will update and close the DATIX file.

If it is not possible for the PALS officer to feedback to the complainant by the end of the next working day, for example because the member of staff has to obtain information from another source which cannot be provided immediately, the PALS officer will agree a timescale and respond as agreed. This should be no longer than 5 working days. The PALS officer will update the DATIX file and close the complaint. Follow up on implementation of any recommended actions will be undertaken by the Division in which the complaint occurred.

If the PALS officer is unable to resolve the complaint within the maximum agreed 5 working days timescale she should update DATIX and refer the complaint to the relevant divisional manager who will continue to investigate the complaint (see section 2 below) The PALS Officer should also notify the Corporate Complaints Team by email through DATIX.

If the complainant is verbally or physically abusive the matter should be escalated up to the Divisional Nurse/Professional Head of Clinical Service, Associate Director, Chief Nurse, as necessary, for discussion re the management of the case in

accordance with the Trust Policy to Support the Safe and Therapeutic Management of Aggression & Violence (HS06).

1.2 Written complaints

Written complaints can be received by letter, fax or electronically. All written complaints should be forwarded to the Corporate Complaints Team who will acknowledge receipt of the complaint and open a file within DATIX.

The Corporate Complaints Team will refer the complaint to the Directorate Manager or Deputy on the day of receipt copied to the Divisional Nurse/Professional Head of Clinical Service and the Associate Director. The Directorate Manager will review the complaint and allocate an Investigating Officer who will proceed to investigate the complaint in conjunction with the Senior clinical Nurse (See section 6.3).

If the issues raised in the complaint involve more than one division, the Complaints Administrator will consider the complaint and decide which Division should lead the investigation. The complaint will be referred to each individual Directorate Manager or Deputy who will allocate the complaint to relevant Investigating Officers in the divisions.

2 The Investigation

The Investigating Officer should assess the seriousness of the complaint using the Risk Matrix (Appendix C). The complaint should be categorised using the information contained in the written complaint or the information provided as part of the verbal complaint.

The investigating officer should also complete an investigation timescale scoring matrix (Appendix D) using the information contained in the written complaint or the information provided as part of the verbal complaint.

Within 3 working days of receipt, the Investigating Officer should contact the complainant by telephone to acknowledge receipt of the complaint and introduce themselves as the Investigating Officer. The Investigating Officer should confirm with the complainant the issues of concern and the outcomes expected by them and agree a timescale and preferred format for response. This information will be recorded on DATIX on a Complaints Plan/Contract (Appendix E). In the case of a complaint involving more than one division the Investigating Officers should liaise with one another prior to the lead Investigating Officer contacting the complainant. Investigating Officer should inform the complainant of the services provided by the Independent Complaints Advocacy Service (ICAS). On completion of the Complaints Plan, the Investigating Officer should notify the Complaints Administrator who will send a copy of the Complaints Plan to the complainant together with a copy of the Trust's complaints leaflet and consent form, if appropriate.

If the complainant does not wish to discuss their concerns over the telephone they should be offered the opportunity of a face to face meeting. If the Investigating Officer is unable to contact the complainant by telephone or the complainant does not wish to discuss the complaint with the Investigating Officer either over the telephone or in a face to face meeting, the Investigating Officer will determine the response period. The Investigating Officer should notify the Complaints Administrator who will send the Complaints Plan to the complainant as above.

Any communication by e mail must be with the consent of the complainant. Consent should not be implied if the complainant's first contact is by email, consent should be confirmed with the complainant. Caution must be exercised regarding the sensitivity around e mailing of reports and confidential information.

The investigation should be managed discreetly and confidentially in a manner appropriate to resolve it speedily and efficiently. Any meetings with staff should be in private, written notes of the discussion should be taken, agreed by all parties and a copy retained in the electronic complaint file. Telephone conversations should not take place in public places, and records concerning complaints should be stored in such a way that only those with a need to know have access. Correspondence should be conveyed electronically, where possible. In cases where this is not possible correspondence should be in sealed envelopes marked "Private and Confidential".

The Investigating Officer should write to the ward/department manager and to any other relevant parties enclosing a copy of the complaint or extract, as appropriate, asking for the individual's comments. The Investigating Officer may consider it more appropriate to meet with the staff concerned to obtain a statement or to clarify events. It is also useful to make it clear to those members of staff being asked to make a statement, exactly which elements of the complaint they need to answer.

The Investigating Officer should ensure that staff understand the procedure to be followed and offer support and guidance, if necessary. Staff should also be made aware that they can request professional support from their line manager or staff side representative if necessary.

If the Investigating Officer encounters difficulties obtaining a statement from a member of staff this should be escalated up to the Divisional Nurse/Professional Head of Clinical Service/Clinical Director/Head of Department as appropriate.

If the complaint surrounds clinical issues, the Investigating Officer should involve the Divisional Nurse/Professional Head of Clinical Service/Clinical Director/Head of Department or other professional lead, as appropriate, in the investigation.

As part of the investigation the Investigating Officer should review relevant Trust and national policies/guidance etc to ascertain whether the care/service complained about was in line with established standards.

The Investigating Officer should telephone/write to relevant members of staff who have left the Trust, if contact details are available, and ask for their comments. The member of staff is not legally obliged to respond although they should be encouraged to do so under their duty of continuing care.

Any response which refers to matters of clinical judgement must be agreed by the clinician (not only doctors) concerned and, in the case of medical care, by the patient's consultant prior to being fed back to the complainant.

The Investigating Officer, in liaison with the Divisional Nurse/Professional Head of Clinical Service/Department Manager, and Chief Nurse may seek advice, where appropriate, from independent experts (clinical and otherwise) from both within and outside the Trust.

The Investigating Officer should keep the complainant informed of the progress of the investigation. Divisions should establish a bring forward system whereby they automatically monitor the time taken to investigate the complaint. The Complaints Administrator will email the Investigating Officer (through DATX) alerting them to the fact that they are nearing their deadline and if it is clear that the deadline cannot be met the Investigating Officer should contact the complainant, apologise for/explain the reason for the delay and agree an extension which should be documented with the rationale for any delay. The Investigating Officer should then notify the Complaints Administrator of the extension and update DATIX

When the investigation is complete this should be signed off prior to feedback being given to the complainant. All responses should be signed off by the Chief Executive. Feedback should be given to the complainant as agreed in the Complaints Plan/Contract. Verbal feedback (telephone or meeting) should be followed up in writing, unless the complainant indicates that they do not wish to receive a written record. The complainant should be invited to contact the Investigating Officer should they be dissatisfied with the response or require clarification.

The Chief Nurse will intervene if the submission of a final response for the Chief Executive's signature is unreasonably delayed. She may involve the Associate Director/Clinical Director in reviewing the cause of delay.

If a response is not sent to the complainant within a reasonable timescale, a letter must be sent from the relevant Directorate Manager explaining the reasons for the delay and the response should be sent as soon as is reasonably practicable thereafter.

The Complaints Administrator will send a Complaint Feedback Questionnaire to each complainant on completion of the investigation. The purpose of this contact is to ascertain whether the response has resolved the complaint to the complainant's satisfaction and to elicit suggestions for improvement. Information from completed forms will be used to monitor the Trust's management of complaints and will be included in the quarterly Patient Experience Report.

At the end of each investigation, if shortfalls have been highlighted recommendations will be developed and an individual action plan generated. The action plan incorporated as part of the DATIX complaints module should be updated as and when the actions are completed. Divisional Senior Management should share any issues that have Trust wide implications with the Corporate Clinical Governance Team.

A summary of lessons learnt arising from complaints investigations will be included in the quarterly Quality & Safety and Patient Experience reports. These are reported at a corporate level to the Clinical Governance Committee and locally within divisional Clinical Governance Groups to ensure that lessons are shared as widely as possible.
The Investigating Officer should feedback the outcome of the investigation to the staff involved.

The Investigating Officer should review the Risk Assessment (Appendix B) made on receipt of the complaint, based on the results of the investigation and re-categorise as necessary.

3 Complaints involving more than one organisation

A protocol has been developed by members of the local health and social care organisations which should be followed for complaints involving more than one organisation. A copy of the protocol is attached at Appendix F. The Complaints Administrator will be responsible for co-ordinating this process.

4 Action to be taken when the complainant is not satisfied

In those situations when complainants are not satisfied with the response made by the Trust to their complaint, the Investigating Officer should contact the complainant to identify why the complainant is dissatisfied, what issues have been resolved, what issues remain outstanding and the expected outcomes. The Complaints Administrator, in liaison with the Investigating Officer and the Deputy Director of Nursing will then review the outstanding issues and the action taken so far to resolve the complaint and identify an appropriate course of action. The Investigating Officer should then contact the complainant again to agree the proposed course of action, and timescale. A new Complaint Plan/Contract (Appendix E) should be drawn up and sent to the complainant, as in Section 6.3.3.

The following actions may be explored in order to effect resolution:

- Further investigation by the Investigating Officer.

- Meeting with Trust representatives
  Any meeting with complainants should be in line with Trust protocol
  Appendix H)

- Mediation/Conciliation
  Mediation/Conciliation is a method of facilitating a dialogue to resolve an issue. It is an intervention whereby a third party helps the parties to reach a common understanding. It gives space to resolve issues, preserve on-going relationships and time to defuse or calm heightened situations. The Chief Nurse may consider the use of mediation/conciliation in the resolution of a complaint.

- Independent review by internal/external reviewer

The Investigating Officer should make every effort to resolve the complaint locally.

On completion of the further work a written response should be sent to the Complainant, signed off by the Chief Executive, which should again invite the complainant to refer back to the Investigating Officer should they require further clarification or remain dissatisfied.

If the complainant does not wish the Trust to investigate the complaint further, or if the Division believe that all avenues for local resolution have been exhausted, the complainant should be reminded of their right to ask the Health Service Commissioner (Ombudsman) to review their case and information should be provided concerning this process. The final decision as to whether the Division have exhausted local resolution will be made by the Chief Nurse, in liaison with the Directorate Manager.

5 Complaints referred to the Chief Executive

Complaints requiring referral to the Chief Executive

Complaints requiring referral to the Chief Executive include those which:

- involve allegations of serious misconduct;
- involve the police in the investigation of possible criminal activity;*
- could attract media attention;
- indicate a serious breakdown in clinical management;
- are detrimental to the image of the Trust;
- include serious criticism of the implementation of the Trust's policies and procedures, particularly those regarding suspected abuse of children or vulnerable adults;*
- relate to a serious adverse incident.

* Where allegations of theft or misuse and abuse of assets are involved, the matter should also be reported to the Director of Finance in accordance with Standing Financial Instructions.

If the Chief Executive decides that he/she wishes to handle a complaint personally, he/she will, in collaboration with the relevant senior managers, identify the course of action required and will seek legal and professional advice as is appropriate in each individual case.

6 Stage Two – Health Service Ombudsman

If the complainant remains dissatisfied with the Trust's attempt(s) at Local Resolution, they can

ask the Health Service Ombudsman to review their case. The complainant should be advised in the Trust's final response of their right to refer their case to the Health Service Commissioner (Ombudsman) if they are not satisfied. Any correspondence received from the Health Service Commissioner relating to such requests should be forwarded to the Complaints Administrator for action.

7 Prolific Complainants

We are committed to dealing with all complainants fairly and impartially. However, people who bring prolific complaints can be difficult to deal with. Whether they are right to persist with their complaint or not, they need your support to resolve the issue. It is important to remember that if a person contacts you with what they believe is a complaint, then it is to them. If the complainant raises the same or similar issues repeatedly, despite receiving a full response, there may be underlying reasons for this persistence.

A prolific complainant is someone who raises the same issue despite having been given a full response. They are likely to display certain types of behaviour such as:

- Complains about every part of the health system regardless of the issue.
- Seeks attention by contacting several agencies and individuals.
- Always repeats full complaint.
- Automatically responds to any letter from the Trust.
- Insists that they have not received an adequate response.
- Focuses on trivial matter.
- Is abusive or aggressive.

Regardless of the manner in which the complaint is made and pursued, its substance should be considered carefully and 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.

Particularly if a complainant is abusive or threatening, it is reasonable to require him or her to communicate only in a particular way – say, in writing and not by telephone – or solely with one or more designated members of staff; but it is not reasonable to refuse to accept or respond to communications about a complaint until it is clear that all practical possibilities for resolution have been exhausted.

If you are faced with a prolific complainant you should refer the matter to the Divisional Nurse/Professional Head of Clinical Service (in the case of the Central Functions and Support Services Divisions, the relevant Directorate/Department Manager) who should liaise with the Chief Nurse in order to consider whether the complainant is unreasonably persistent or vexatious.

8 Identifying a vexatious or unreasonably persistent complainant

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

- Persist in pursuing a complaint where the NHS Complaints procedure has been fully and properly implemented and exhausted.

- Change the substance of a complaint or seek to prolong contact by continually raising further concerns or questions upon receipt of a response or whilst the

complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These may need to be addressed as separate complaints).

- Are unwilling to accept documented evidence of treatment given as being factual, e.g. medical or nursing records, deny receipt of an adequate response in spite of correspondence specifically addressing their concerns or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Trust staff and/or others, e.g. Independent Complaints Advocacy Service (ICAS), to help them specify their concerns.

- Focus on 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 is a trivial matter can be subjective and careful judgement must be used in applying this criterion).

- 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 such be documented).

- Have, in the course of pursuing a complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, email or fax). Staff should be instructed to keep a clear record detailing the number, type and nature of contacts. Discretion must be used in determining the precise number of excessive contacts applicable under this section, using judgement based on the specific circumstances of each individual case.

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

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

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

Once it is clear that complainants meet any of the criteria above, it may be appropriate to inform them in writing that they may be classified as unreasonably persistent or vexatious complainants, make them aware of the criteria and advise them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate at this point to suggest that complainants seek advice in processing their complaint, e.g. through ICAS.

Judgement and discretion must be used in applying the criteria to identify potential vexatious or unreasonably persistent complainants and in deciding action to be taken. This should only be used as a last resort and after all reasonable measures have been taken to assist the complainant.

9 Options for dealing with vexatious or unreasonably persistent complainants

Where a complainant has been identified as vexatious or unreasonably persistent in accordance with the above criteria, the Chief Nurse should liaise with the Chief Executive to determine what action to take. The Chief Nurse/Chief Executive will implement such action and will notify the complainant in writing of the reasons why they have been classified as vexatious or unreasonably persistent and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. Trust staff, conciliator, ICAS, MP. A record must be kept for future reference.

The Chief Nurse/Chief Executive may decide to deal with the complaint in one or more of the following ways:

- Try to resolve matters by drawing up a signed 'agreement' with the complainant (and if appropriate involving the relevant practitioner in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.

- Decline contact with the complainant either in person, by telephone, fax, letter, email or any combination of these provided that one form of contact is maintained or alternatively restrict contact to liaison through a third party.

- Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant should also be notified that correspondence is at an end and that further letters received will be acknowledged but not answered. The complainant should also be reminded of their right to refer their case to the Health Service Ombudsman, if appropriate.

- Inform the complainant that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to its legal advisors.

- Temporarily suspend all contact with the complainants or investigations of a complaint whilst seeking legal advice or guidance from the NHS West Midlands, Health Service Ombudsman or other relevant agencies.

10 Withdrawing unreasonably persistent or vexatious status

Once a complainant has been identified as being unreasonably persistent or vexatious there needs to be a mechanism for withdrawing this status at a later date if, for example, the complainant subsequently demonstrates a more reasonable approach or if they submit a further complaint for which normal procedures would appear appropriate.

Staff should previously have used discretion in recommending unreasonably persistent or vexatious status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, discussion will be held with the Divisional Nurse/Professional Head of Clinical Service (in the case of the Central Functions and Support Services Divisions, the relevant Directorate/Department Manager), Chief Nurse and Chief Executive. Subject to their agreement, normal contact with the complainant and application of the NHS Complaints Procedure will then be resumed.

11 GMC/NMC Complaints

Complaints referred directly from the General Medical Council or Nursing & Midwifery Council should be forwarded to the Medical Director or Chief Nurse, as appropriate. If the Medical Director or Chief Nurse are aware of further issues that suggest that the GMC/NMC should undertake a full investigation into the doctor's/nurse's fitness to practice they should notify the GMC/NMC accordingly. If this is not the case, the complaint should be investigated as described above.

12 Confidentiality

Refer to Trust Policy G10 Patient Confidentiality and Patient Information Protection Policy and the NHS Confidentiality Code of Practice (gateway reference 1656)

Patients entrust the UHNS with, or allow the gathering of sensitive information relating to their health and other matters as part of their treatment. They do so in confidence and they have the legitimate expectation that staff will respect their privacy and act appropriately. In some circumstances patients may lack competence or may be unconscious, but this does not diminish the duty of confidence. It is essential, if the legal requirements are to be met and the confidence of patients is to be retained, that this Trust provides a confidential service. For full guidance on the disclosure of patient identifiable information refer to the NHS Confidentiality Code of Practice or contact the Information Governance Manager.

13 Third party complaints

If a third party submits a complaint on behalf of another, a thorough check must be undertaken to ensure that the complaint is being made with the knowledge and consent of the person concerned. ".....patient-identifiable information must not be used or disclosed, for purposes other than direct healthcare, without the individual's explicit consent, some other legal basis, or where there is a robust public interest or legal justification to do so"." (NHS Confidentiality Code of Practice).

A complaint may be made by a representative acting on behalf of the patient who :

- has died
- is a child
- is unable to make the complaint themselves due to :
  - (i) physical incapacity
  - (ii) lack of capacity within the meaning of the Mental Capacity Act 2005(a)
- has requested the representative to act on their behalf

If there is any doubt that a person complaining on behalf of another may
be making a complaint without the knowledge of the person concerned, the person on whose behalf the complaint is supposedly being made should be contacted to ensure that they are content for personal information concerning themselves to be released to the complainant. They should be asked to sign a form authorising release of information to the third party (Appendix F); this should then form part of the electronic complaint file.

It may be appropriate, when a number of complaints raising similar issues are made on the same person's behalf, to contact the person concerned and agree that one composite response will be sent to him or her personally, rather than multiple responses being sent to each complainant.

If the Chief Nurse is of the opinion that the person making a complaint on behalf of another is not a suitable person to pursue the complaint, a letter should be sent to the complainant stating

the reasons for this decision.

14 Health records

Documentation relating to complaints and PALS issues, must not be stored in health records and no reference to the complaint/PALS issue or that the person has raised an issue should be made in a health record.

15 Reports

Extreme caution must be exerted when writing letters or reports as part of the complaints procedures that third party confidence is not breached. Any person mentioned by name in a letter or report must be made aware of what is written and agree to its inclusion.

16 Freedom of Information Act

Many complaints contain requests for corporate information. The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway for the disclosure, to the public, of corporate information held by this Trust. If the Trust does not wish to disclose requested information, complainants should be informed of their right to complain directly to the Information Commissioner and should be given the Information Commissioner's contact details. If they wish to pursue their complaint through the Trust's Complaints Procedure this should be processed as described in Section 5. The Information Governance Manager will be responsible for the investigation of all FOIA complaints. Complainants who remain dissatisfied at the end of Local Resolution should be advised to progress their complaint via the Information Commissioner.

There is a legal requirement to provide any information requested under the FOIA within 20 days and for a record to be kept of all such requests. If corporate information is requested as part of a complaint **this must sent to the complainant within 20 days,** irrespective of whether the complaint investigation/response have been completed. In such cases the relevant information should be forwarded to the Complaints Administrator who will send this to the complainant together with a holding letter explaining/apologising for the delay in the investigation.

APPENDIX B

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST
VERBAL COMPLAINTS FORM

Division.....Ward/Dept.....

Nature of complaint

.....

.....

.....

Date and Time Complaint Received.....

Method of Communicating eg Face-to-face, Telephone Call (Letters/Statements to be Attached if Available):-

.....

Name and Address of Complainant.....

.....

Telephone Number of Complainant .....

Name of Patient (if not complainant) and Unit No.....

Relationship of Complainant to Patient.....

Name/Grade of Staff Receiving complaint.....

Immediate Action Taken .....

Date .....Signature.....

Complaint Resolved/Referred (delete as appropriate)

Management Action.....

Date Received/Informed..... .....

Advice to Ward/Dept Staff.....

Complaint Recorded on DATIX? YES ☐ NO ☐ Ref. No. .....

Signature of Senior Divisional Manager/Head of Service .....

Top sheet to be passed to directorate/service office as appropriate without delay. (Each division will identify the appropriate referral route). Second sheet to be retained by the ward/department.

Risk Assessment

Complaints Risk Scoring Matrix (pre and post investigation)

SECTION 1 – CONSEQUENCE	
1. Insignificant	• Local to a specific location/service and organisation • Outcome for the patient is minor and temporary • Reduced quality of patient experience not directly related to the delivery of clinical care (logistics/transport/waiting)
2. Minor	• Local to one organisation • Involving <3 Specialties/Services/Directorates • Suboptimal treatment with minor implications for patient outcome or safety • Unsatisfactory patient experience directly related to clinical care/readily resolvable
3. Moderate	• More than one organisation involved • Involving <4 Specialties/Services/Directorates involved • Significant impact on timeliness or effectiveness of treatment/intervention • Mismanagement of patient care – short term effects less than one week
4. Major	• Multiple organisations involved • Impact across many services/specialities/directorates • Mismanagement of patient care which fails to meet national requirements for timeliness or intervention • Mismanagement of patient care, long term effects (more than a week)
5. Catastrophic	• Totally unacceptable level of treatment or quality of service • Gross failure of patient safety • Gross failure to meet national standards • Totally unsatisfactory patient outcome or experience • Irreversible consequence/outcome on patient care

SECTION 2 – LIKELHOOD OF OCCURENCE		
Risk Score		**Probability**
1.	**RARE**	The event may only occur in exceptional circumstances.
2.	**UNLIKELY**	Unlikely to occur.
3.	**POSSIBLE**	Reasonable chance of occurring.
4.	**LIKELY**	The event will occur in most circumstances.
5.	**ALMOST CERTAIN**	Most likely to occur than not.

SECTION 3 – RISK SCORING MATRIX						
		Consequence/Impact Score				
		1	**2**	**3**	**4**	**5**
Likelihood	**1**	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

APPENDIX D

Complaints Investigation Scoring Matrix

Name of complainant:	
Complaint number:	
Date matrix completed:	

Scoring Indicators:					**Enter Scores**
Number of Organisations Involved	**1**	**2**	**3**	**4**	
Number of Divisions Involved	**1**	**2**	**3**	**4**	
Number of Specialities Involved *e.g. imaging, medicine, surgery*	**1**	**2**	**3**	**4**	
Size of Complaint *i.e number of issues identified*	**2**	**4**	**6**	**8**	
	1 to 5	6 to 10	11 to15	16 to 20	

Total score: 0 / 20

Using the total score, use the table below as a **guide** to agreeing the number of days at which you will provide a response to the complainant. You should still apply your own knowledge/judgement depending upon the issues raised.

Anything over 30 days or allocated a timescale oustide of this matrix must be discussed with and agreed by the AD/DAD/PHON.

Score:	**5 to 7**	**8 to 11**	**12 to 15**	**16 to 20**
Days:	**5 to 15**	**16 to 25**	**26 to 30**	**31 to 60**
Number of days allocated:				
Discussed with AD/DAD/PHON: *Please circle*	**Yes**	**No**	**N/A**	
Person discussed with and date:				
Reasons for extended timescale:				
Date response due:				
Deadline date to forward to complaints if applicable: *(Response date - 7days)*				

APPENDIX E

Complaints Plan

Complaint/PALS no:	Datix no:
Name of complainant & contact details (include telephone)	Patient name and unit number:
Happy to have contact by e mail: yes/no	E mail address:
Relationship to patient if applicable:	
Consent required: yes/no	Type:
Investigating Officer/PALS staff:	Division/Directorate:
Date/time received:	Date acknowledged:
Method: (verbal/written/e mail etc)	
Date complainant contacted:	Timescale agreed:
Other Organisations/Divisions/Specialities providing input:	
Issues to be addressed: (continue in additional information if necessary) Preferred outcome:	
Agreed format of feedback: Telephone: □ Meeting: □ Written response only: □	
Review date: (if applicable following discussion with complainant or change in timescale)	
Verbally agreed with complainant : Print name: Date:	

APPENDIX E

Complaints Plan

Additional Information:		
Verbally agreed with complainant :	Print name:	Date:

APPENDIX F

SHROPSHIRE AND STAFFORDSHIRE VIAN

PROTOCOL FOR THE HANDLING OF MULTI-AGENCY FORMAL ORGANISATIONAL COMPLAINTS

between

Shropshire County Council
Staffordshire County Council
Telford & Wrekin Council
Stoke on Trent City Council
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Telford and Wrekin Primary Care Trust
Shrewsbury and Telford Hospitals NHS Trust
South Staffordshire Primary Care Trust
University Hospital of North Staffordshire NHS Trust
North Staffordshire Combined Healthcare NHS Trust
Burton Hospitals NHS Trust
North Staffordshire Primary Care Trust
Stoke-on-Trent Primary Care Trust
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust
Mid Staffordshire General Hospitals NHS FoundationTrust
Shropshire County Primary Care Trust
West Midlands Ambulance NHS Trust

- Health and Social Care Act 2008
- The Local Authority Social Service and National Health Service Complaints (England) Regulations 2009
- Supporting Staff, Improving Services (Department of Health 2006)
- Data Protection Act 1998
- Human Rights Act 1998

1 Introduction

1.1 A commitment to high standards in the management of complaints is fundamental to ensuring that service users and patients who complain either to social services or to NHS bodies are provided with prompt, comprehensive and consistent responses.

1.2 Given the potential for confusion arising from the range of health and social care agencies with which people might be in contact, a complaints management protocol is seen as an effective means of bringing together the agencies in the interest of providing a responsive and effective service for complainants.

1.3 In a complicated service environment, the more general benefits of a protocol will be measured in terms of:

- reduction of confusion for service users and patients about how complaints will be dealt with, and by whom;
- clarity about the respective roles and responsibilities of agencies; and
- enhancement of inter-agency co-operation, in advance of the anticipated new regulatory framework.

2 Why is a protocol necessary?

2.1 One of the intentions of the complaint reforms which were implemented from April 2009 was to facilitate and to promote collaboration between health and social care organisations. This was to be assisted by the introduction of a common framework for the handling of complaints, and single regulatory base.

2.2 In an environment where there is increasing collaboration between Social Services and parts of the NHS, as seen in jointly commissioned services, operational teams in which there are both NHS and local authority employees and the development of pooled budgets, it can sometimes be difficult to identify which agency is the most appropriate to respond to a given complaint.

2.3 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 strengthen the existing duty shared by social services and NHS organisations to co-operate with each other in the management of those complaints, which cut across organisational and service boundaries. Organisations on either side are under an obligation to work together to provide complainants with reliable information and clear responses, and to meet agreed deadlines.

2.4 This protocol is intended to clarify responsibilities across the agencies and to set out a framework for interagency collaboration in the handling of complaints and to ensure:

- the provision of prompt responses to complainants whose concerns may need to be addressed by more than one organisation
- comprehensive and co-ordinated responses to complaints;
- a single consistent and agreed contact point for complainants;
- regular and effective liaison and communication between Complaints Managers

- that learning points arising from complaints, covering more than one body, are identified and addressed both by each agency and collectively as appropriate (see Section 7).

3 The Role of the Complaints Manager

3.1 For each signatory agency, the designated Complaints Manager is responsible for co-ordinating whatever actions are required or implied by this protocol.

3.2 Foremost among these is to co-operate with other Complaints Managers, to agree who will take the lead role in cross-boundary complaints and in cases where complaints require a response from another signatory agency, than that which received it.

3.3 Complaints Managers should also liaise closely with their counterparts on action-planning the implementation of learning points arising from cross-boundary complaints. (*see below)

3.4 Each Complaints Manager should clarify to whom in their agency any requests for collaboration under this protocol should be addressed when s/he is absent (through leave, illness etc).

3.5 In the unlikely event that Complaints Managers are unable to reach agreement about any matter covered by this protocol, they should each refer the matter promptly to the relevant Directors/ Senior Managers in their respective agencies, for resolution.

4 Complaints which apply to both Social Services and to an NHS body, and to which both need to contribute part of the response

4.1 Within the new regulatory framework, there is an emphasis on the co-ordinated handling of complaints. However it will generally remain the case that each individual organisation will manage the complaints which relate to the services it provides. Exceptions may arise in the case of organisations where services are jointly provided, or those with pooled budgets, under S31 Health Act 1999.

4.2 As soon as a complaint which appears to relate to both Social Services and the NHS is made, the Complaints Manager of the agency which received it should write to the complainant, within three working days, to acknowledge the complaint, to notify him/her of the cross-boundary issue and to seek agreement for details of the complaint to be passed on to the other agency.

4.3 If the complainant agrees, the Complaints Manager of the agency which received the complaint should pass the details on to the Complaints Manager in the other agency and engage in a strategy discussion about how the two agencies will work together to co-ordinate their response, and how this will be provided to the complainant.

4.4 It is desirable, wherever possible, for a single composite response to be provided to the complainant, by the organisations involved in the complaint

4.5 In each case which arises, the two Complaints Managers will need to co-operate closely with the complainant as well as with each other to negotiate an agreement with regard to:

- The way in which the complaint will be handled, and which organisation is most appropriate to take the lead
- The timescale within which a response to the complaint will be delivered
- The implementation of any alternative means to resolve the matter

- How the parties will communicate with each other and with the complainant

4.6 The lead organisation's Complaints Manager must ensure that a comprehensive risk assessment is undertaken, they grade the complaint and communicate with colleagues in all affected organisations.

4.7 In circumstances where legal action is being taken or where the police are involved with the matters which are also the subject of a complaint involving more than one organisation, it will be vital for the two complaints managers to agree what further contacts need to be made and advice sought, especially if the suspension of the complaint is under consideration.

4.8 Similarly, the two complaints managers need to agree formally, following due consultation at which point the suspension will end.

5 Complaints about one agency which are addressed to another agency

5.1 On occasions a complaint which is concerned in its entirety with Social Services is sent to an NHS body, or vice versa. This may be due to lack of understanding about which body is responsible for which service, or because the complainant chooses to entrust the information to a professional person with whom s/he has a good relationship.

5.2 The Complaints Manager of the agency receiving such a complaint should contact the complainant within *3* working days and advise that the complaint has been addressed to the wrong agency and ask if s/he wants it to be sent to the other agency. Providing the complainant consents, the complaint should be sent to the other agency at once, and a written acknowledgement should be sent to the complainant.

6 Complainants' consent to the sharing of information between agencies

6.1 Nothing in this protocol removes the obligation to ensure that information relating to individual service users and patients is protected in line with the requirements of the Data Protection Act, Caldicott principles and the confidentiality policies of each signatory agency. It is for this reason that the complainant's consent must always be sought before information relating to the complaint is passed between agencies. Moreover, the complainant is entitled to a full explanation of why his/her consent is being sought.

6.2 Consent to the passing on or sharing of information under this protocol should be obtained, in writing, wherever possible. Where this is not possible, the complainant's verbal consent should be recorded and logged, and written confirmation sent promptly to him/her.

6.3 If the complainant withholds consent to the complaint being passed to the other agency, the Complaints Manager of the agency receiving the complaint will seek to engage with him/her to resolve any issues or concerns about remit and responsibility and offer any liaison which could contribute to the resolution of the matter of concern. The complainant should be reminded of his/her entitlement to contact the other agency direct. It should be stressed that the agency to which s/he sent the complaint has no legal remit to respond to it.

6.4 The only circumstances in which a complainant's lack of consent could be overridden would arise if the complaint included information which needed to be passed on in

accordance, for example, with safeguarding procedures. In such cases, the complainant would be entitled to a full written explanation as to the agency's Duty of Care and its obligation to pass on the information.

6.5 If a complaint is received about services provided by more than one organisation to a patient/service user who lacks capacity, it will be for the Complaints Managers together to establish that the person making the complaint has sufficient interest in the welfare of the patient/service user, and that s/he is an appropriate person to act on their behalf.

6.6 Where one agency undertakes a formal investigation of a complaint arising from a service which is provided jointly or in collaboration with another, the complainant's written consent must be obtained before the investigation is given access to case records held by the other agency. Providing that consent has been obtained, the agency holding the records should make them available to the investigation.

6.7 A form is attached to this protocol as Appendix 2, which records the consent of complainants for their case records to be disclosed for the purpose of complaints investigations.

6.8 Close co-operation between Complaints Managers will be crucial in ensuring that confidential case-file information is shared appropriately, and that the necessary safeguards are put in place. Information exchanged under this protocol must be used solely for the purpose for which it was obtained.

7. Learning Outcomes

7.1 At the point at which the complaint affecting more than one organisation is concluded to the complainant's satisfaction, or at which all procedural steps have been exhausted, the two complaints managers should collaborate in identifying the learning points which arise, both for the respective agencies individually and with regard to their future collaboration.

7.2 Joint action plans, with responsibilities ascribed and timescales set, should be recorded, along with details of how they should be monitored and of how the complainant will be kept informed of developments

7.3 In many cases, the action plan will be based on the recommendations of the person who investigated the complaint, especially where there has been a formal investigative process.

8. The future of the protocol

8.1 This protocol will be kept under review and will evolve by means of agreed amendments, in reflection of any future changes in the statutory or regulatory framework

8.2 In the meantime, it is intended that the implementation of the protocol will contribute to amalgamating the present diversity of perspectives, in the interest of providing an effective complaints service for patients and service users.

Appendix 1

Complaints Managers and other Contacts in Signatory Agencies*

Agency	Complaints Manager	Other contact in complaints manager's absence
Telford & Wrekin Council	Dave Robson 01952 381101 dave.robson@telford.gov.uk	Jo Chambers 01952 381104 jo.chambers@telford.gov.uk
Shropshire County Council	Jo Hill 01743 253991 jo.hill@shropshire.gov.uk	Vacant pending re-organisation
Staffordshire County Council	Kate Bullivant 01785 277407 Kate.bullivant@staffordshire.gov.uk	Polly James 01785 277406 polly.james@staffordshire.gov.uk
Stoke-on-Trent City Council	Jacqui Jones 01782 235921 jacqui.jones@civic1.stoke.gov.uk	Aleta Steele 01782 232013 Aleta.steele@stoke.gov.uk
Telford and Wrekin Primary Care Trust	Mark Crisp 01952 265163 Mark.crisp@telfordpct.nhs.uk	Karen Ball 01952 265188 Karen.ball@telfordpct.nhs.uk
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Paula Johnson 01785 221432 paula.johnson@sssft.nhs.uk	Amelia Murray 01785 221404 amelia.murray@sssft.nhs.uk
Shrewsbury and Telford Hospital NHS Trust	Maggie Hulme 01743 261652 Maggie.hulme@rsh.nhs.uk	Beverley Cheadle 01743 261000 x2600 Beverley.cheadle@rsh.nhs.uk
South Staffordshire Primary Care Trust	Gill Cotterill 01889 571826 gill.cotterill@southstaffspct.nhs.uk	Gareth Durber 01889 571810 gareth.durber@southstaffspct.nhs.uk
University Hospital of North Staffordshire NHS Trust	Ruth Findler 01782 555481 Ruth.findler@uhns.nhs.uk	Ann Brian 01782555481 Ann.brian@uhns.nhs.uk
North Staffordshire Combined Healthcare NHS Trust	Sandra Storey 01782 275031 SandraJ.Storey@northstaffs.nhs.uk	Karen Marsh 01782 275031 karenJ.marsh@northstaffs.nhs.uk
Burton Hospitals NHS Trust	Janet Cort 01283 511511 Ext 5472 janet.cort@burtonh-tr.wmids.nhs.uk	Di Crump 01283 511511 Ext 3112 di.crump@burtonh-tr.wmids.nhs.uk
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust	Vicky Morris 01691 404394 vicky.morris@rjah.nhs.uk	Julia Palmer 01691 404127 julia.palmer@rjah.nhs.uk
North Staffordshire Primary Care Trust	Cathy Haigh 01782 427414 cathy.Haigh@northstaffs.nhs.uk	Di Chadwick 01782 427416 diane.Chadwick@northstaffs.nhs.uk
Shropshire County Primary Care Trust	Bharti Patel-Smith 01743 261300 x3125 bharti.patel-smith@shropshirepct.nhs.uk	Nina Dunmore 01743 261300 nina.dunmore@shropshirepct.nhs.uk
Stoke-on-Trent Primary Care Trust	Sue Daykin 01782 227807 Sue.daykin@northstaffs.nhs.uk	Barbara Cadman 01782 227732 Barbara.cadman@northstaffs.nhs.uk
Mid Staffordshire General Hospitals NHS Trust	Sharon Llewellyn 0870 1706104 Sharon.llewellyn@msgh-tr.westmids.nhs.uk	PALS office 01785 230811
West Midlands Ambulance Service	Marie Tideswell 01384 246366 marie.tideswell@wmas.nhs.uk	Karen Longhurst 01785 273321 karen.longhurst@wmas.nhs.uk

*Agency representatives are asked to notify any changes or additions in this information with the amended contact details, to Dave Robson (Telford & Wrekin Council), who will then issue an updated list.

Appendix 2

Statement of consent for the disclosure of personal records

Complainant's name: .....

Complainant's address: .....

.....

.....

.....

Telephone number: .....

I hereby give my consent for the organisations listed below to share any relevant information in order to complete the investigation into my complaint. I understand that this is likely to include disclosure of my personal health and social care records.

..... (Lead Organisation)

..... (Organisation)

..... (Organisation)

This will assist the investigation of my joint organisation complaint, which is being co-ordinated by:

..... (Name of Complaints Manager)

of

..... (Organisation)

The reason for, and the implications of, this have been explained to me by the above-named complaints manager. I understand that information exchanged as agreed by me must be used solely for the purpose it was obtained.

Signed .....

Date .....

Once completed, please return this consent form in the envelope provided.

27.04.09

APPENDIX G

PROTOCOL FOR ARRANGING MEETINGS BETWEEN UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE REPRESENTATIVES AND COMPLAINANTS, ARRANGED AS PART OF THE LOCAL RESOLUTION STAGE OF THE NHS COMPLAINTS PROCEDURE.

1. **Introduction**

This protocol has been developed to ensure that meetings between University Hospital of North Staffordshire representatives and complainants are as effective and comprehensive as possible.

2. **Process**

There are three distinct stages which should be considered .

2.1 **Pre-meeting**

Trust Investigating Officer and complainant should have initial discussion to ascertain/agree the following :

- Issues to be addressed.
- What sort of resolution the complainant is looking for.
- Who should attend.
- Number of people attending to support the complainant (relatives/friends).
- Any special requirements (Wheelchair access, Venue, Holiday commitments of complainant/advocate).
- Duration of meeting.

In cases where complainant is to be supported by advocate (e.g. ICAS, ASIST), then the initial discussion may be with the advocate, rather than the complainant.

Investigating Officer should then :

- Liaise with the nominated Trust representatives to brief/prepare them and identify suitable dates/times for the meeting. This should be within a reasonable timescale.
- Arrange suitable accommodation, taking into account the complainant's circumstances/specific requirements. (Accommodation should also be arranged, if possible, for advocate to debrief complaint after the meeting). **N.B. The room should be inspected prior to the meeting to ensure that it is tidy and fit for purpose.**
- Decide who will chair the meeting.
- Nominate a note taker (this should not be the chairperson or anyone participating in the meeting.
- Consider refreshments, if appropriate.
- Telephone complainant (or advocate) to agree mutually convenient date and time and advise of venue.
- Confirm arrangements in writing, i.e. Date, Time, Venue, Attendees, Duration, Enclose map/directions and contact details for cancellation/further information etc.
- Request medical records.

- Complainant (or advocate) should confirm issues to be addressed in writing prior to the meeting. This should allow sufficient time for the Trust to undertake any preparatory work.
- Investigating Officer to notify complainant (or advocate) as soon as possible if any Trust representative is subsequently unable to attend so that decision can be made as to whether or not to cancel/reschedule the meeting.
- Complainant (or advocate) to notify Investigating Officer as soon as possible if complainant unable to attend so that meeting can be cancelled/rescheduled.

2.2 **During Meeting**

- Note taker in attendance.
- Medical records available.
- Chairperson to introduce attendees, state aim and duration of meeting.
- Advocate (if relevant) to ensure that complainant focuses on agreed issues to be discussed.
- Chairperson to ensure that Trust representatives focus on agreed issues to be discussed.
- Chairperson to close meeting detailing next step with timescales, as necessary.

2.3 **Post Meeting**

- Separate room to be made available for advocate to debrief complainant(s).
- Investigating Officer to write to complainant (or advocate) with a summary of meeting for approval by complainant. **N.B. This should be in a timely fashion and to timescales agreed during meeting.**
- Advocate (if relevant) to advise Trust of outcome of meeting.

APPENDIX H

Consent Form

Full Name of Complainant: .....

Address: .....

.....

Full Name of Next of Kin: .....

Address: .....

.....

Relationship to patient:.....

Patient's name: .....

Address:.....

.....

Date of Birth: .....

Date of Death: .....

I confirm that the information set out above is true and accurate.

I give my permission for the University Hospital of North Staffordshire NHS Trust to investigate this complaint and, where necessary, obtain disclosure of relevant personal and confidential information relating to ..... (patient's name), including any clinical notes.

I understand that the University Hospital of North Staffordshire NHS Trust will use any information gathered to assist in the investigation of this complaint.

I understand that information will also be obtained from/shared with

.....

. to enable the co-ordination of a joint response.

Signature of Next of Kin: .....

Date:.....

Consent Form

Full Name of Patient: ....

Address: .....

.....

Date of Birth: .....

I hereby authorise

Name of person making the complaint: .....

Relationship to patient:.....

Address: .....

.....

To act on my behalf and to receive any and all information, including personal and confidential information, that may be relevant to my complaint.

I give my permission for the University Hospital of North Staffordshire NHS Trust to investigate this complaint and, where necessary obtain disclosure of relevant personal and confidential information relating to me, including my clinical notes.

I understand that the University Hospital of North Staffordshire NHS Trust will use any information gathered to assist in the investigation of this complaint.

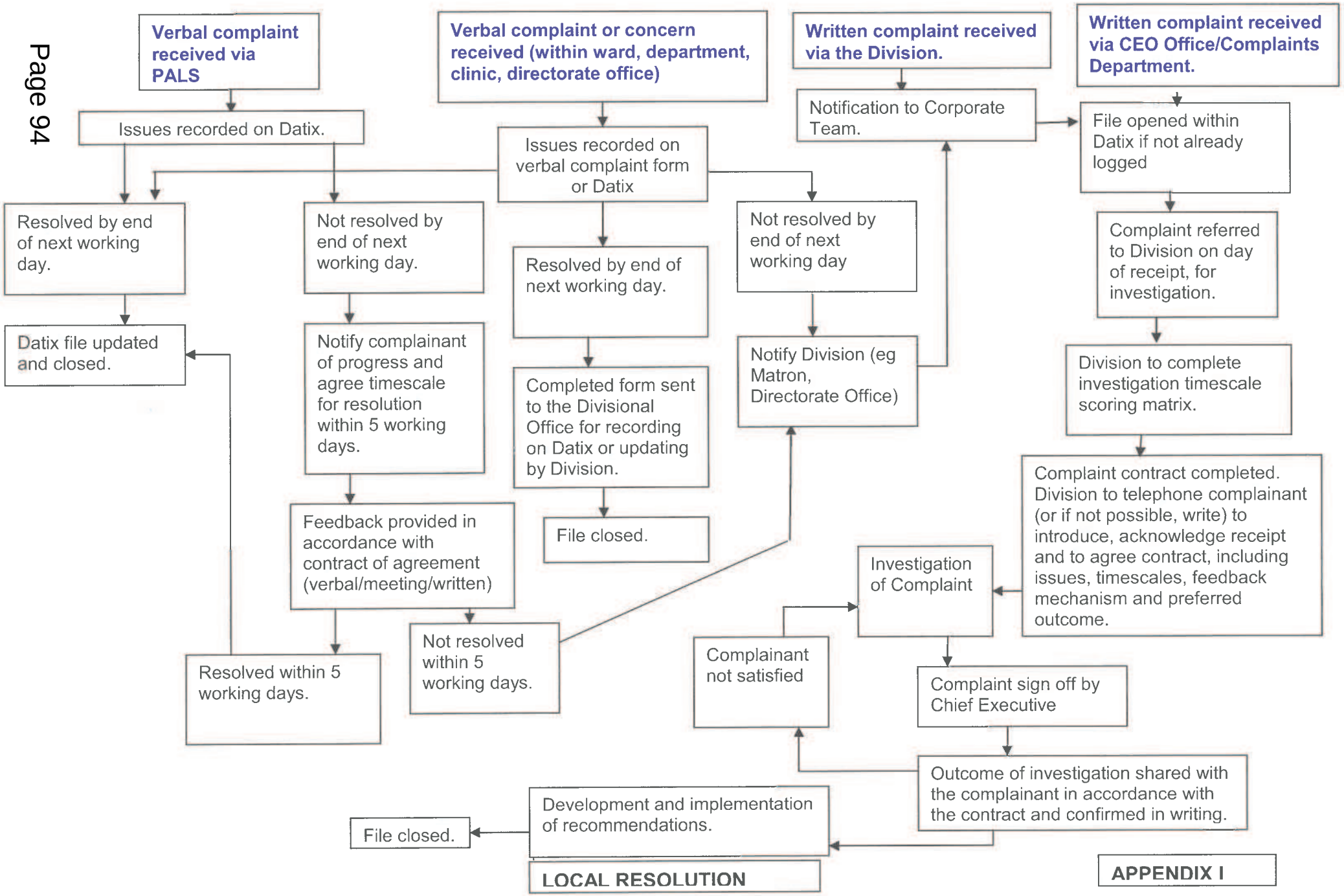
I understand that information will also be obtained from/shared with

.....

to enable the co-ordination of a joint response.

Signature of patient:.....

Date:.....


Verbal complaint received via PALS
Verbal complaint or concern received (within ward, department, clinic, directorate office)
Written complaint received via the Division.
Written complaint received via CEO Office/Complaints Department.
Issues recorded on Datix.
Issues recorded on verbal complaint form or Datix
Notification to Corporate Team.
File opened within Datix if not already logged
Resolved by end of next working day.
Not resolved by end of next working day.
Resolved by end of next working day.
Not resolved by end of next working day
Complaint referred to Division on day of receipt, for investigation.
Datix file updated and closed.
Notify complainant of progress and agree timescale for resolution within 5 working days.
Completed form sent to the Divisional Office for recording on Datix or updating by Division.
Notify Division (eg Matron, Directorate Office)
Division to complete investigation timescale scoring matrix.
Feedback provided in accordance with contract of agreement (verbal/meeting/written)
File closed.
Complaint contract completed. Division to telephone complainant (or if not possible, write) to introduce, acknowledge receipt and to agree contract, including issues, timescales, feedback mechanism and preferred outcome.
Investigation of Complaint
Resolved within 5 working days.
Not resolved within 5 working days.
Complainant not satisfied
Complaint sign off by Chief Executive
Outcome of investigation shared with the complainant in accordance with the contract and confirmed in writing.
Development and implementation of recommendations.
File closed.
LOCAL RESOLUTION
APPENDIX I

APPENDIX J

Aggregated Risk Management Process, Learning and Reporting

1. Duties

The Clinical Governance, Audit and Risk Management Department Senior Team (as described in the Terms of Reference and Membership of the Corporate Clinical Governance and Risk Portal Group) have responsibility for ensuring a co-ordinated learning approach to the aggregation of incidents complaints and claims through the development of a corporate quarterly quality and safety report and an Annual Report to the Clinical Governance Committee

As a minimum the report will include both qualitative and quantitative analysis of

- the type and number of events (complaints, claims, adverse incidents)
- by specialty/directorate
- trend analysis
- lessons learned
- information on plaudits

2. Communication

This information will be communicated to divisional groups (via divisional reports) and the Clinical Governance Committee (via divisional and corporate reports). A summary of the information will also be communicated to the Governance and Risk Committee and also the Trust Board via the Monthly Clinical Governance and Risk Report.

The information will be communicated to more widely to staff by including the corporate report on the Trust intranet site.

3. Learning lessons

3.1 Local Learning – Informal Complaints and Incidents Scoring <8

Incidents with a risk rating of less than 8 and informal complaints are likely to be resolved through local action at the time and are unlikely to require the development of an action plan. Information on Informal complaints and trend analysis of incidents will be included in the Divisional Quality and Safety Report.

Recommendations are developed as a result of lessons learned following investigations into incidents scoring 8 or above and formal complaints.

The Adverse Incident Trust Root Cause Analysis Tool has a specific requirement to ensure local feedback on lesson learned as a result of the investigation.

3.2 Organisational – Formal Complaints and Incidents Scoring 8>

Incidents with a risk score of 8 or above, and formal complaints will result in the development of an action plan where appropriate. Learning from these will be reported via the Divisional Quality and Safety Reports and the Corporate Quality and Safety Report to the Clinical Governance Committee.

The Risk Management Panel has specific responsibility, as set out in their terms of reference, to

ensure that it considers lessons should which be learned from information it receives and scrutinises.

The Risk Management Panel also has responsibility continuous review of investigation outcomes until it is satisfied that recommendations, which will result in changes in organisational culture and practice, are being fully implemented. Where the Panel considers that issues should be further escalated, it will make representation/referral to the Clinical Governance Committee.

The Trust also has a process of Internal Safety Alert development and distributed whereby lessons learned which have trustwide implications are issued via the Clinical Governance, Audit and Risk Department.

The Clinical Governance Intranet site is populated with a range of learning material including the quarterly quality and safety report.

In addition to this, the Complaints Administrator will bi-annual audits on progress with completion of action plans which will be reported in the Corporate Quality and Safety Report.

3.3 Local Health Economy

A process has been put in place whereby quality and safety information is shared with primary care partners via the Clinical Quality Review meeting.

On a case by case basis, the outcome of investigations will be share with local health economy partners as appropriate.

4. Monitoring

The Clinical Governance Committee will monitor compliance through receipt of reports.

The Clinical Governance Committee will monitor the impact of the above process by reviewing trends through receipt of both Divisional and Corporate Quality and Safety Reports (incorporating the Patient Experience Report).

APPENDIX K

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1. General details

Are you ☐ The patient ☐ A relative ☐ A carer ☐ A friend

When the reason for your complaint first arose did you attempt to resolve it with staff from the ward / department? ☐ Yes ☐ No

If yes, who with, (staff group)?

☐ Medical ☐ Domestic ☐ Management

☐ Nursing ☐ Car Parking ☐ Catering

☐ Administration ☐ Portering ☐ Unsure

☐ Other (Please specify) _____

2. Making a Complaint

How did you find out how to make a complaint?

☐ Patient Advisory Liaison Service (PALS) ☐ Poster

☐ Asked a member of staff ☐ Leaflet

☐ Hospital Website ☐ Can't remember

☐ Other _____

How easy / difficult was it to make a complaint?

☐ Very easy ☐ Easy ☐ Difficult ☐ Very difficult

☐ Can't remember

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3. Making a Complaint

Do you feel the process of finding out how to make a complaint could be improved?

☐ Yes ☐ No ☐ Unsure

If yes, how do you feel the process could be improved?

☐ More leaflets available across the Trust

☐ Extended access to Patient Advice and Liaison Service (PALS)

☐ Improve staffs' knowledge of complaints procedure

☐ Unsure

☐ Other (Please specify) _____

_____

4. Acknowledgement of Complaint

Did we send a letter acknowledging the receipt of your complaint?

☐ Yes ☐ No ☐ Can't remember

Did we provide a copy of our complaint leaflet called *'How to make comments suggestions and complaints'*?

☐ Yes ☐ No ☐ Can't remember

How easy / difficult was the leaflet to understand?

☐ Very easy ☐ Easy ☐ Difficult ☐ Very difficult

☐ Can't remember

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What do you think of

The layout of the leaflet?

☐ Very good ☐ Good ☐ Bad ☐ Very bad ☐ Can't remember

The content of the leaflet?

☐ Very good ☐ Good ☐ Bad ☐ Very bad ☐ Can't remember

Other comments on the leaflet _____

_____

_____

5. Discussion prior to the complaint investigation

Was your complaint discussed with you before the investigation began?

☐ Yes ☐ No ☐ Can't remember *If no, please go to section 6*

If yes, was this:

☐ On the telephone ☐ Face to face ☐ Can't remember

☐ Other _____

Did we confirm the reason for your complaint?

☐ Yes ☐ No ☐ Can't remember

Did we agree how we would tell you the outcome of your complaint?

☐ Yes ☐ No ☐ Can't remember

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Did we agree a timescale for responding to the complaint?

☐ Yes ☐ No ☐ Can't remember

What is your opinion of the people who discussed the complaint with you?

☐ Friendly ☐ Understanding ☐ Sympathetic ☐ Polite

☐ Not interested ☐ Difficult to talk to ☐ Unsympathetic ☐ Rude

☐ Other _____

When we discussed the complaint with you before our investigation began, how did you find the discussion?

☐ Very helpful ☐ Quite helpful ☐ Neither helpful nor unhelpful

☐ Unhelpful ☐ Very unhelpful ☐ Can't remember

6. Answer to Complaint

Did we answer your complaint within the agreed time?

☐ Yes ☐ No ☐ Can't remember

If no, did we contact you to explain the reason for our delay in answering your complaint?

☐ Yes ☐ No ☐ Can't remember

☐ Not applicable I did not agree a timescale for answering my complaint

If we contacted you to explain the reason for our delay, did we agree to extend the investigation time?

☐ Yes ☐ No ☐ Can't remember

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7. Outcome of Complaint

Please indicate which of the following outcomes you were hoping to achieve from your complaint?

a) An apology? ☐ Yes ☐ No

If yes, did you receive an apology? ☐ Yes ☐ Partly ☐ No

b) An explanation ☐ Yes ☐ No

If yes, did you receive an explanation? ☐ Yes ☐ Partly ☐ No

c) To be listened to ☐ Yes ☐ No

If yes, do you feel you were listened to? ☐ Yes ☐ Partly ☐ No

d) A change or improvement in practice ☐ Yes ☐ No

Do you feel a change or improvement in practice has happened? ☐ Yes ☐ Partly ☐ No ☐ Unsure

Were you told about any recommendations made as a result of your complaint?

☐ Yes ☐ No ☐ Can't remember

How satisfied / dissatisfied were you with our final response to your complaint?

☐ Very satisfied ☐ Satisfied ☐ Neither satisfied nor disatisfied

☐ Disatisfied ☐ Very disatisfied ☐ Unsure

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7. Outcome of Complaint

If you were dissatisfied with our final response, please tell us why.

- ☐ Did not address all of the issues raised
- ☐ Difficult to understand
- ☐ Unhappy with content
- ☐ Not applicable
- ☐ Other (Please specify) _____

_____

Do you think your treatment / the patient's treatment was adversely affected as a result of your complaint? ☐ Yes ☐ No

If yes, in what way?

- ☐ Care / treatment worsened
- ☐ Avoided / ignored by staff
- ☐ Staff were unfriendly towards you
- ☐ Not applicable still to be treated
- ☐ Not applicable complained after treatment
- ☐ Other (Please specify) _____

8. Whole Complaint Process

How do you rate your overall experience of the complaint process?

☐ Very good ☐ Good ☐ Poor ☐ Very poor ☐ Unsure

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Please write below if you wish to make any other comments.

Would you be willing for the Trust to use your complaint (anonymised) to share your experience with our staff in order that lessons can be learned? ☐ Yes ☐ No

Would you be willing to come into the Trust to discuss your experience? ☐ Yes ☐ No

We would like the following information as it will help us to address any concerns you have raised in this form. However please do not feel you have to provide this if you would prefer to remain anonymous.

Your name:

Name of patient if not you.

Your address:

Thank you for taking the time to complete this questionnaire.

Please could you return the questionnaire in the prepaid envelope provided.

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HEALTH SCRUTINY

Title	Action	Method of Scrutiny and Way Forward
Consultation on Mental Health Services	**Response submitted to Staffordshire County Council Health Scrutiny Committee – Still concerns that clear pathways were not in place and that proposals had not been though through adequately.** **Update to Committee on 3rd April 2012**	The Committee considered an update issued by the North Staffordshire combined Health Care Trust outlining progress made on the public consultation for
Fit For the Future and move of the Accident and Emergency Centre	**Visit to new A & E now taken place** **Phased transfer to the new hospital was proceeding to plan.** **There was still concern regarding the reduction in beds which would need to be monitored by the Committee – Now thought that not all the beds in the old hospital would close immediately.** **There was still concern regarding the bus routes to Bradwell Hospital and it was agreed to write to the County Council regarding these concerns.** **Updates required regarding progress of the New A&E**	The Chair requested that should any risks or problems materialise then the Committee be informed at an early stage and that this would remove the requirement for regular updates regarding the move. The Committee discussed that best time to visit the new site of the A&E department and decided to aim for January when the building had been handed over, the visit would also be open to colleagues from the County Council Health Scrutiny Committee.
Review of Major Trauma Services	**Recommendation accepted and Trauma Service to remain at North Staffs** **FINISHED**	Recommendation submitted to the County Council.

SCC Health Scrutiny Committee to seek involvement in work on excess seasonal winter mortality in their area and Newcastle Borough Council Health Scrutiny Committee to seek scrutiny involvement in work on infant mortality in their area. Report to be provided to the next meeting of the Committee and project brief. Project brief to be completed. **PRIORITY** **A set of questions had been sent to the Director of Public Health for consideration at the next meeting prior to the setting up of a possible working group. Awaiting Responses.** The Committee had been requested by the County Council Health Scrutiny Committee to look into infant mortality rates in ewcastle under Lyme.		
Cardiac Rehabilitation Response to County Council Health Scrutiny Report regarding phase IV Cardiac Rehabilitation	Work being undertaken by the Executive Director for Operational Services regarding Phase 3 and 4 Cardiac rehab being carried out at the new J2. Publicity would be circulated regarding the walk for life programme.	
Closure of High Street Practice Newcastle under Lyme	The Committee received a presentation from representatives of the PCT at its meeting on 7th November 2011. **FINISHED**	That the PCT be asked to provide regular updates on the progress made on the dispersal of patients from the High Street Practice. That the PCT be asked to keep the Committee advised of any proposals to run clinical services from the High Street premises.+
Services Provided by GPs and Publicity	At its meeting on 7th November 2011 the Committee questioned representatives from the PCT regarding concerns expressed at a previous meeting relating to arrangements that were in place to enable patients to access phlebotomy services other than at the University Hospital of North Staffordshire. **FINISHED**	That the PCT be asked to look at updating current information on the availability of services in the community and providing improved information on how to contact NHS Direct.

Neuroradiology Review Final Report	Question regarding this were referred to the accountability session which was held at the Civic Offices on 10th November 2011. **The Committee discussed the responses received from the UHNS and it was agreed that further clarification be sought regarding some of the answers and a further report on this matter be brought to a subsequent meeting.**	The Committee would continue to monitor the situation.
Health and Wellbeing Strategy **PRIORITY**	During consideration of this matter the Chairman expressed the view that the Borough Council should have two representatives on the County Council's Health and Wellbeing Board and that through the development of our own Strategy document demonstrate that we were making positive steps regarding this issue. **Priority**	It was hoped that a first draft of the Strategy would be available in the New Year.
Health and wellbeing Board	A case for increased local authority representation on the Board would be prepared in consultation with the Chair and forwarded to the County Council's Cabinet Member for Adult Services.	
Phlebotomy Services	Appeared to have improved following a publicity campaign by the PCT but further publicity was required regarding services at Bradwell Hospital. **Update to Committee on 3rd April 2012**	
UHNS Complaints procedure	UHNS would be requested to provide details of its complains procedures to the committee. **Documentation presented to Committee on 3rd April 2012**.	

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