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**
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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.

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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.

APPENDIX C

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.

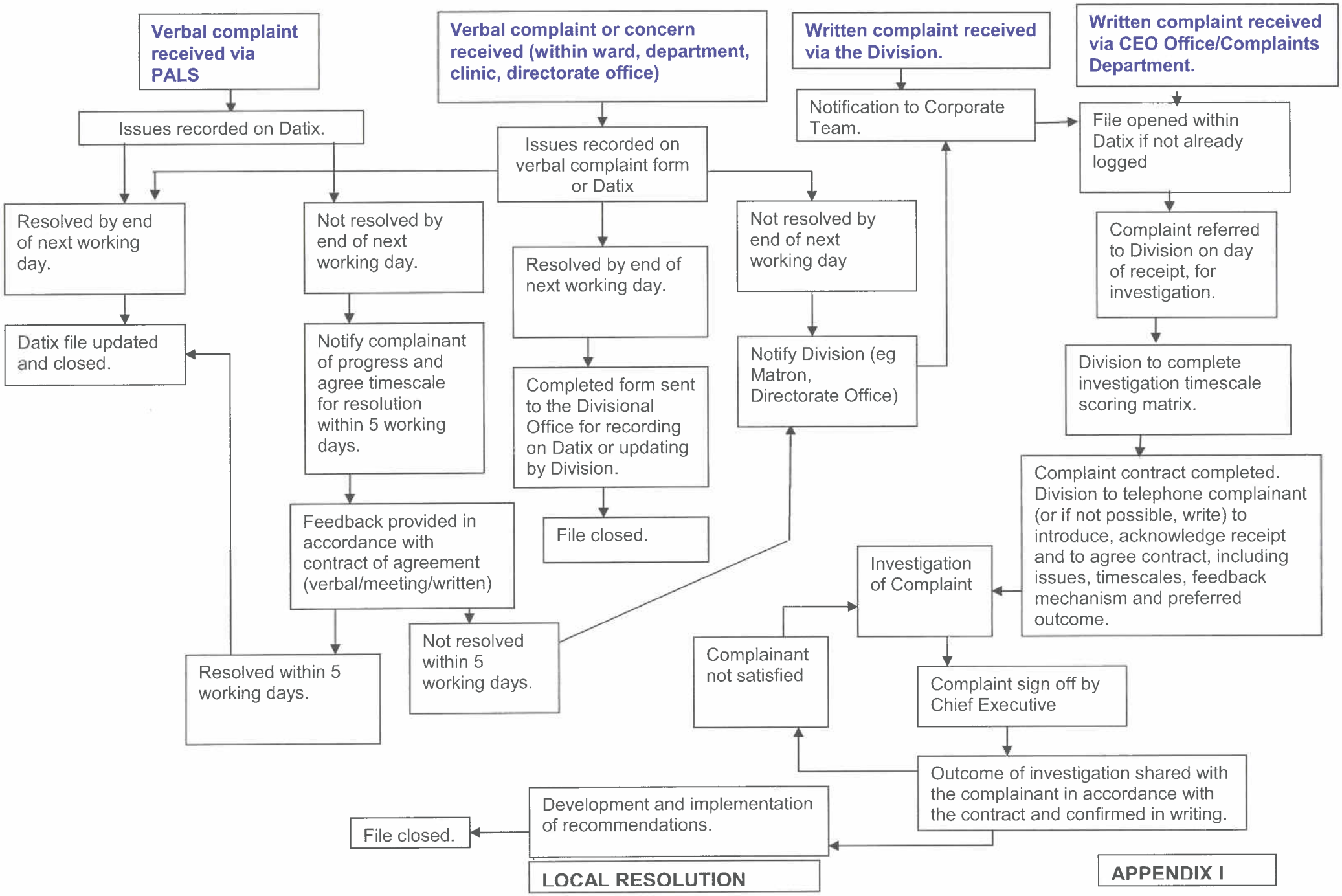
I understand that information will also be obtained from/shared with

.....

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

537 10

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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

APPENDIX K

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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

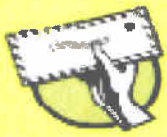
We would like the following information as it will help us to address any concerns you have raised in this form. However please do not feel you have to provide this if you would prefer to remain anonymous.

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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