UNIQUE IDENTIFIER NO: G-106-2015
EQUIP-2017-046
Review Date: July 2019
Review Lead: Director of Nursing

Calderdale and Huddersfield
NHS Foundation Trust

Procedure for Handling Concerns and Complaints

Version 2

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Version Control	
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1	This policy used to form part of the Learning From Experience policy and has been extract to form a standalone policy. This policy has been updated to reflect our current processes and national guidance.
2	Updated to reflect current practice and 3 gradings for complaints. Addition of information on handling habitual and persistent complainants, cross divisional complaints.

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1. Introduction

1.1 This Policy describes the requirements and Trust procedures for the investigation and management of Concerns and Complaints, received across Calderdale and Huddersfield NHS Foundation Trust (CHFT).

CHFT views complaints positively and is committed to having an effective procedure in place to handle all concerns and complaints. The Trust will take an active approach to seeking people's views, dealing with complaints and using the information received to learn and improve both the experience of our patients and the quality of the service we provide.

Where it is not possible to rectify a problem we will provide an open, accountable and effective complaints service. Concerns and Complaints will be dealt with on an individual manner, and will be investigated fully, transparently and honestly in a timely manner and where required in partnership with other agencies.

CHFT recognises that service users and their representatives have a fundamental right to raise concerns about the services they receive. Accordingly it is expected that staff will not treat service users and their representatives, unfairly as a result of any complaint or concern raised by them. Any complaints, by service users or their representative, of unfair treatment as a result of having made a complaint will be investigated as a separate complaint and appropriate action will be taken.

1.2 Who this policy applies to:

This policy applies to all permanent, locum, agency, bank and voluntary staff of CHFT and any person or persons working in a contractor role acting for or on behalf of CHFT. CHFT employees work very hard to get the job right first time; however, sometimes mistakes can occur. As a CHFT employee you need to follow this policy this policy so that CHFT can ensure compliance to best practice and legal obligations to demonstrate that:

- any service users of CHFT, their family, or members of the public are given the opportunity to seek advice, raise concerns, and/or make a complaint about any of the services it provides
- that a person who raises a complaint, receives a high quality response in a timely manner
- lessons learned from complaints are acted upon and shared throughout the organisation to improve standards of care and prevent avoidable harm/experience
- complaints are investigated and managed in line with:

- the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- www.opsi.gov.uk/si/si2009/uksi_20090309_en_1
- the Parliamentary and Health Service Ombudsman's (PHSO): My expectations for raising complaints and concerns 2014 http://www.ombudsman.org.uk/myexpectations

1.3 What is covered by this Policy:

This Policy covers concerns and complaints made by service users and their representatives.

1.4 Complaints dealt with under this policy:

A complaint can be made to CHFT about any matter reasonably connected with the exercise of its functions including in particular:

- care or treatment provided
- anything to do with the hospital or healthcare environment
- any member of staff in relation to the care and service they provide
- how services are organised if this has affected treatment or care
- complaints about the CHFT's staff or facilities relating to the care provided to any patient in a private pay bed (but not to the private medical care provided by the Consultant outside their NHS Contract)
- care, treatment or an establishment that has been commissioned by the Trust to provide care on behalf of the NHS

1.5 Complaints that cannot be dealt with under this policy are those:

- Made by a local authority, NHS body or independent provider (service – Service)
- Relating to services not provided by CHFT
- From any current or former NHS employee about any matter relating to their employment
- Requests which are made under a subject access request under the Data Protection Act or a request for information under the Freedom of Information Act
- Which are, or have been, investigated by the Health Service Commissioner under the 1993 Act

NOTE: Where complaints are received from general practitioners regarding a patient, and the general practitioner has the consent of the patient to make the complaint on their behalf; then the complaint will be dealt with under this policy. Where the general practitioner does not have the consent of the patient or wishes to raise concerns about a service then the Patient Advice and Complaints Service/Divisional Team will deal with this outside of NHS Complaints Regulations.

1.6 Who can complain under this policy

The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 specify that complaints may be made by:

- a person who receives or has received services from CHFT; or
- any person who is affected or likely to be affected by any action, omission or decision of CHFT
- a person who is acting as a representative of:
  - a person who has died
  - a child
  - a person who is unable to make the complaint themselves because of lack of physical incapacity or lack of mental capacity
  - any individual who has otherwise asked the representative to act on their behalf

1.7 Time limit for making a complaint under this Policy

1.7.1 The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 require that a complaint must be made within twelve months of:

- the date on which the matter which is the subject of the complaint occurred; or
- the date on which the complainant became aware of the matter which is the subject of the complaint.

1.7.2 Where a complaint is made outside this time limit the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manger may exercise discretion to waive the time limit where it can be demonstrated, and satisfied that:

- the complainant had good reasons for not making the complaint within the time limit; and
- providing it is still possible to investigate the complaint effectively and fairly.

NOTE: Complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

1.7.3 If it is not possible to waive the time limit and the complaint is not accepted into the Complaints Procedure, an explanation of this will be provided to the complainant.

2. Purpose

2.1 The purpose of the policy is to make sure CHFT procedures are fully compliant with the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 meets NHS Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts (RMST) and Care Quality Commission (CQC) Outcome 17 and supports Sections 2a and 3b of the NHS Constitution.

Our approach is to consider issues thoroughly and objectively and share our findings openly, honestly and in a timely manner. This policy and procedure is based on the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 and Principles of Good Complaint Handling from the Parliamentary and Health Service Ombudsman (PHSO).

2.2 Policy Aims

The aim of this policy is to provide all those involved in the complaints process with a clear understanding of CHFT's expectations and requirements. The Trust approach to managing concerns and complaints will be to listen and respond to concerns raised by service users and/or their representatives, to learn from their experiences and improve services accordingly. CHFT's arrangements for the handling of complaints will ensure that:

- Complaints are dealt with efficiently
- Complaints are properly investigated
- Complainants are treated with respect and courtesy
- Complainants will be involved in decisions about how their complaints are handled and considered as far as reasonably possible
- Complainants will be kept updated on the progress of the investigations and if the response is delayed, complainants will be notified and advised when to expect the response will be completed by
- Complainants receive a timely and appropriate response, with an acknowledgement and apology where appropriate for any upset or distress caused
- Complainants are told the outcome of the investigation of their complaint; and
- Following completion of the complaint, action is taken if necessary to ensure lessons are learned and to improve the quality of service provided.

2.3 Key Principles

This policy sets out the following key principles in handling complaints and concerns:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties
- High standards of conduct are expected from all staff at all times to ensure that service users and their representatives will be treated respectfully, courteously and sympathetically
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise); All service users and their families and carers will be advised how they can raise a concern or make a formal complaint via information leaflets and posters available on all wards and clinical service units and the internet
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint
- As far as reasonably possible, people who make complaints will be involved in decisions about how their complaints are handled and considered
- CHFT will aim to resolve complaints within CHFT as part of local resolution (first stage of the national complaints procedure), wherever possible
- Complainants receive a meaningful apology when appropriate
- CHFT will co-operate with other organisations when a complaint involves other outside organisations
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint
- Violence, racial, sexual, verbal or any other forms of harassment are unacceptable and will not be tolerated on the part of staff or people who make complaints

2.4 Support

2.4.1 The needs of those affected are a primary concern for CHFT as part of its processes for the investigation of complaints. It is important that affected patients, staff, families and carers are involved and supported throughout the investigation.

2.4.2 It is important to recognise that complaints investigations can have a significant impact on staff who were involved.

2.4.3 Staff involved in the complaints investigation process must be given support, which may include some or all of the following: Support from their line manager or professional lead, the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

2.4.4 CHFT recognises that individual members of staff may experience higher levels of stress if they become the subject of a complaint. CHFT is committed to supporting staff through the complaints process by offering guidance and by recognising the opportunities for personal development that may arise from the outcome of complaints. Line managers have the primary responsibility for providing this support to staff and can draw on further advice and guidance from the Patient Advice and Complaints Department. Where necessary, additional support including counselling, can be arranged through the occupational health service. Staff also have access to support from their professional or trade union organisations.

2.4.5 CHFT is clear that the investigation itself is separate to any other legal and/or disciplinary process. CHFT will advocate justifiable accountability when required but will operate a policy of zero tolerance for inappropriate blame and those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process.

2.4.6 Staff who are unhappy with the way they have been dealt with under the complaints procedure may raise the matter through the CHFT's Grievance Procedure

3. Definitions

3.1 **Concern:** Issues raised which require assistance to reach a swift and satisfactory resolution, usually within 72 hours, but do not require formal investigation.

3.2 **Complaint:** According to the Department of Health a 'complaint' is an expression of dissatisfaction about the service which CHFT provides, for which a response must be provided.

4. Open and Honest

4.1 The core professional standards are set out in *Good medical practice* for doctors and in *The Code: Standards of conduct*, *performance and ethics for nurses and midwives* for nurses and midwives. Both *Good medical practice* and the *Code* say that doctors, nurses and midwives must:

- Be open and honest with patients if something goes wrong with their care

- Act immediately to put matters right if that is possible; and

- Promptly explain to patients what has gone wrong and the likely long-term and short-term effects

NOTE: The NMC and the General Medical Council (GMC) ran a consultation on new joint guidance to help doctors; nurses and midwives comply with their professional duty to be open and honest with patients about their care. The consultation is entitled 'Openness and Honesty when things go wrong: the professional duty of candour.

4.2 Statutory Duty of Candour

On 1st October 2014, new requirements for a statutory duty of candour came into force for NHS bodies as part of wider regulations developed by the CQC in line with their strategy for 2013-2016, '*Raising standards, putting people first.'* The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The CQC can prosecute for a breach of parts 20(2) (a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action.

Further information can be found in CHFT Duty of Candour Policy.

4.3 Failure to adhere to the values and principles set out by CHFT, in relation to complaints handling, may be subject to an internal investigation under HR processes.

5. Accessibility of Patient Advice and Complaints Service

5.1 Clear information on how to make a complaint must be made available to the public through leaflets throughout Trust premises and information on the Trust web-site.

5.2 All staff dealing with complaints must consider the needs of vulnerable people such as adults with learning difficulties, children, some older people or people with particular disabilities, (such as visual impairment or hearing impairment), and will offer support from relevant agencies to such individuals.

5.3 All staff dealing with complaints will consider the need for language or sensory support in order to make sure that the complaints procedure is accessible to all.

6. Receiving a Concern or Complaint

6.1 A flowchart setting out the actions to be taken when an issue is raised can be found at Appendix 1.

7. Consent

7.1 Where a complaint is made by a representative then they must demonstrate that they have the appropriate authority or consent to act.

7.2 Consent is not required from MPs when they act directly on behalf of a constituent as CHFT may assume that the MP has obtained sufficient consent to release relevant confidential information (see section 17 S1 2002 (2905)); however, consent is required when acting on behalf of a third party (e.g. complaint by a daughter on behalf of her mother being represented by the MP).

7.3 Where a complaint is made on behalf of a person who has died, The Patient Advice and Complaints Department will check that the person making the complaint is the deceased patient's next of kin or is acting with their authority. Where this is not the case, The Patient Advice and Complaints Department will obtain the consent of the next of kin in writing. In doing so, the Trust will offer the next of kin the opportunity to review the complaint that has been made

7.4 Where a representative makes a complaint on behalf of a child or a person who lacks capacity, prior to investigating the complaint CHFT staff will satisfy themselves that there are reasonable grounds for the complaint to be made by the representative rather than by the child or the person who lacks capacity. CHFT staff will also satisfy themselves that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is being made. If not satisfied, the representative will be notified in writing of the reasons for refusing to investigate the complaint.

7.5 **Young people aged 16 and 19** – unless there is clear medical evidence that they lack mental capacity, then their express authority should be obtained before responding to the complaint if it will involve disclosing confidential patient information.

7.6 **Children under the age of 16** – if a complaint is made by a child who is 'Gillick competent' (i.e. of sufficient intelligence and maturity to consent to treatment), then their agreement should be obtained before responding to the complaint if doing so will involve disclosing confidential patient information.

NOTE: Where a complaint is made on behalf of a child under the age of 16 who is not Gillick competent then no authority from the child will be needed to responding to those with parental responsibility.

8. Data Protection

8.1 Staff must always be mindful of the Data Protection Act and their NHS responsibilities in terms of patient confidentiality, particularly where a complaint is made by a representative on behalf of another individual. Staff must also be aware that all documents generated in the course of a complaints investigation (including internal memoranda/comments etc) are generally liable to be disclosed under the Data Protection Act or in any subsequent legal claim.

8.2 Complaint investigations will be conducted in a confidential manner and only those members of staff who need to be involved in the investigation will be, in order to protect patient and staff confidentiality.

8.3 On acknowledgment of the complaint, complainants will be informed that it may be necessary to access their health record and to disclose information within it to those staff conducting the investigation and involved in preparing the response.

9. Independent Complaints Advocacy Service

9.1 The NHS Complaints Advocacy Service provides external support to patients to pursue a complaint about their NHS treatment or care.

9.2 When receiving a complaint via the Complaints Advocacy Service, the Patient Advice and Complaints Department will ensure that written consent has been received, from the patient, to release information to a Complaints Advocacy Service representative.

9.3 CHFT will respect the complainant's wish to be represented and supported by the Complaints Advocacy Service by sending all correspondence to the Complaints Advocacy Service, unless the complainant specifically instructs otherwise.

9.4 CHFT will accommodate Complaints Advocacy Service, and other recognised advocacy agencies or support groups when arranging meetings if the person making the complaint feels they require support.

9.5 CHFT will promote the services offer by Complaints Advocacy Service, and advise complaints of these services.

10. Learning from Complaints

10.1 CHFT will learn from complaints by identifying trends at a local and strategic level, which will assist in the prevention and recurrence or more serious incidents or other similar complaints occurring in the future.

10.2 Trend analysis of complaints as well as benchmarking with other Trusts is fundamental to service improvement.

10.3 Divisional Directors, Associate Directors of Nursing, Directors of Operation, General Managers and Matrons are responsible for preparing action plans arising from individual complaints and for ensuring that these are implemented. Action plans should cross reference to actions of other providers (e.g. other NHS Trusts or social services departments) where appropriate.

10.4 Learning from complaints is a critical part of complaints management. Lead Investigators will be responsible for providing feedback, in respect of complaint outcomes, to appropriate individuals who can take action and ensure lessons are learned. Lessons are also required to be shared across relevant meetings at ward/department, Directorate, Divisional and Trust level.

10.5 Internally, this will be through the provision of reports to Trust Board on a quarterly basis, through the quarterly Complaints Report and by specifically highlighting reports from the Parliamentary and Health Service Ombudsman in these reports.

10.6 Each Division within CHFT will devise a structure framework for learning from complaints to ensure that all learning is shared across the Division.

11. Claims for Compensation

11.1 Requests for compensation should be processed in accordance with the CHFT's Claim's Policy in line with CNST/NHSLA procedures rather than through the Complaints Procedure.

12. Duties (Roles and Responsibilities)

Ultimately, all staff members within the Trust have responsibilities in relation to complaints management, with certain members of the Trust having specialist functions.

12.1 Board of Directors

The Board of Directors is accountable for ensuring that effective controls are in place to support effective complaints management and organisational learning.

12.2 Chief Executive

12.2.1 The Chief Executive is the responsible person as detailed in the NHS Complaints (England) Regulations 2009. S/he is responsible for ensuring compliance with the arrangements made under these Regulations, and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint. This responsibility may be delegated as appropriate.

12.2.2 The Chief Executive will delegate responsibility for the signing of complaint responses to the following staff in the following order:

i. Executive Director of Nursing
ii. Medical Director
iii. Nominated Executive Director

12.3 Executive Director of Nursing and Medical Director

The Executive Director of Nursing is responsible for complaints management within the Trust. S/he will report regularly to the Trust Board, through the Patient Experience Group, in relation to complaints activity and performance, and will liaise with other senior members of the Trust as required.

12.4 Head of Clinical Governance and Risk

12.4.1 The Head of Clinical Governance and Risk is the senior manager with responsibility for complaints policy development and for managing the procedures for handling complaints in accordance with the regulations.

12.4.2 The Head of Clinical Governance and Risk will ensure that:

- CHFT's complaints handling policy reflects national regulations and guidance
- Systems and processes are sufficient to provide the Chief Executive with assurance that robust arrangements are in place
- CHFT meets all performance standards in respect of complaints management
- Systems are in place to ensure that the Trust Board, Chief Executive and managers throughout CHFT receive regular reports on key performance indicators and are made aware of trends in complaints so that they can take action through the relevant clinical governance and risk management processes

- An annual report on complaints is provided to the Trust Board and published, to provide an assurance to the Trust Board of compliance with Care Quality Commission outcome 17 and NHSLA Risk Management Standards

12.5 Patient Advice and Complaints Manager

12.5.1 The Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager, supported by the Patient Advice and Complaints administrative staff, are responsible for implementing this policy.

12.5.2 The Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will ensure that:

- all complaints that are received are triaged (Appendix 2)
- all allegations of abuse or negligence are reviewed in line with CHFT's Safeguarding Adults and Safeguarding Children Policies
- all complaints received are processed in line with this policy
- staff are supported through the complaints process
- appropriate responses to the required standard are prepared in conjunction with Divisional and Directorate staff, within the relevant timescales
- trends in complaints are identified and drawn to the attention of senior managers and regular key performance indicator and trend analysis reports are provided
- they provide support to front line staff in dealing with immediate situations and provide advice to all staff with regard to formal and informal resolution of complaints
- queries or concerns about draft responses are raised with the relevant Division so that an appropriate response is provided to the complainant
- A programme of staff training in complaints handling is developed and implemented across the Trust

12.5.3 The Patient Advice and Complaints Manager and Assistant Patient Advice and Complaints Manager will review and approve all complaint responses, with the assistance of the Clinical Governance Manager, prior to the response being prepare for signature.

12.6 Divisional Directors

12.6.1 Divisional Directors are responsible for ensuring that the standards referred to in this policy are followed for their Division. They will ensure that investigations are undertaken appropriately and in a timely manner. They ensure that the Trust does not suffer reputational or financial penalty due to maladministration of complaints.

12.6.2 Under the direction of the Executive Director of Nursing, Divisional Directors will ensure that their Directorates comply with this Complaints Policy and undertake appropriate investigation, using Root Cause Analysis as necessary.

12.6.3 The Divisional Director will ensure that there is an adequate process within the Division for an appropriate investigator to be appointed.

12.6.4 The Divisional Director will:

- Quality assure all complaint responses to ensure that they answer all issues raised as honestly and as comprehensively as possible.
- Ensure an action plan is developed to complete any actions identified in the investigation
- Ensure compliance with action plans to improve service provision

12.6.5 The Divisional Director may nominate a colleague with the Divisional Triumvirate to undertake these duties.

12.7 Divisional Lead for Complaints

The Division will identify a lead for complaints to manage and assist with the investigation of patient complaints in line with this policy, instigating any immediate action required for reasons of health, safety and security. The Divisonal Lead will be responsible for ensuring complaints are dealt with in a timely manner.

12.8 Lead Investigator

12.8.1 The Division will appoint a lead investigator for each complaint.

12.8.2 The Lead Investigator may delegate all or part of the investigation to a suitably qualified and/or experienced colleague, but will retain overall responsibility for the quality and content of the investigation and complaint response.

12.8.3 The Lead Investigator will contact the Complainant within 7 calendar days from the date of the acknowledgement of the complaint. The purpose of this contact is for the investigators to:

- Introduce themselves to the Complainant
- Clarify and agree the issues to be investigated as part of the complaint

- Explain how the investigation will be conducted
- Advise of the expected timescale for investigation and response, in line with the timescales set out in section 14 of this policy
- Establish with the complainant the method in which they would like to receive the response to their complaint

A file note of this contact should be upload onto the complaint file.

NOTE: The purpose of this contact is NOT to respond to the complaint but to clarify the scope of the investigation with the Complainant.

12.8.4 As far as reasonably possible the Lead Investigator will involve the Complainant in the investigation of the complaint.

12.8.5 The Lead Investigator will ensure timely communication is maintained with anyone raising a complaint or concern

12.8.6 The investigation will be overseen by the Lead Investigator, and may involve collecting verbal or written statements from current or former staff, and examination of the relevant documentation and other sources of evidence. It is important that data is collected systematically, recorded at an appropriate professional standard, and filed according to a logical system. **The data used in the investigation of a complaint is always requested when the Ombudsman undertakes a second stage independent review.**

NOTE: Where verbal statements are taken a file note summarising the conversation should be made and uploaded.

12.8.7 Should the complainant wish to attend a Local Resolution Meeting (LRM), the Lead Investigator must complete a Resolution Report (Appendix 4) detailing the investigation into the complainant's concerns and outcome of the investigation prior to the LRM.

12.8.8 Once the complaint response is completed, the Lead Investigator will ensure that any action and learning is progressed and developed and shared with the relevant staff.

12.9 Patient Advice and Complaints Department

12.9.1 The Trust's Patient Advice and Complaints Department will deal with enquiries and concerns from members of the public and will be the point of contact for anyone wishing to raise a concern orally away from the ward or department.

12.9.2 If the Patient Advice Team is able to provide a mutually agreeable solution to issues within 72 hours, or with the agreement of the individuals this will be recorded as a concern.

12.9.3 The Patient Advice and Complaints Department will also:

- Administer the CHFT's Patient Advice and Complaints Inbox
- Advise members of the public on the complaint procedure if contacted directly
- Register concerns and complaints received centrally on the CHFT's Information System
- Provide reports to CHFT on compliance with quality indicators associated with complaints
- Offer advice, guidance and training to groups where required
- Facilitate the process with regard to multi-agency complaints
- When required obtain consent from the patient or next of kin, when required.

12.10 All staff

12.10.1 Frontline staff are usually best placed to address issues and complaints raised by those who use CHFT's services. By taking prompt and effective action many issues can be addressed without the need for recourse to the formal complaints procedure. This approach is better for the complainant and for staff. It reduces tension and conflict, demonstrates understanding and empathy and builds confidence in CHFT staff and services.

12.10.2 All staff have a responsibility to ensure that:

- They observe and comply with this policy and associated procedures;
- They proactively address issues raised by those who use CHFT's services in order to minimise the number of complaints.
- Where faced with a verbal concern they make every effort to rectify the problem immediately by:
- Investigating the issues and providing a response;
- Contacting the most appropriate person to find out the information required, if necessary seeking advice from their line manager;
- Passing the issue on to a named person and informing the complainant why they have done so, who this is and when they can expect a

response.

- They co-operate fully with complaint investigation and resolution;
- They support the implementation of action plans arising from complaints.
- They protect the interests of adults at risk, young people, and children. Reference to the CHFT's Safeguarding Team is advised if staff are unsure about this aspect.

13. Severity Rating

All complaints will be allocated a severity rating of Green, Amber or Red using the likelihood and consequence matrix see Appendix 3.

13.1 Red complaints

13.1.1 Complaints identified as potential red severity will be shared with the Division for a lead investigator to be appointed to make contact with the person making the complaint.

13.1.2 Preliminary investigations will be completed and brought to an initial Red Complaint Investigation Panel.

13.1.3 The Patient Advice and Complaints Department will ensure the Initial Investigation Panel meeting will be arranged to take place at the earliest opportunity, as close to two weeks after receipt of the complaint as possible. Attendance at this meeting will depend on the circumstances of the complaint but, as a minimum, will include:

- A Chair; the Head of Clinical Governance and Risk, and in the absence of the Head of Clinical Governance and Risk the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager
- The Divisional lead with responsibility for coordinating the subsequent investigation.
- Relevant Divisional members of staff
- Senior member of the Patient Advice and Complaints Department
- Any relevant specialist who can provide expert guidance e.g. pharmacist

13.3.4 The Red Complaint Investigation Panel will review the initial findings and include decisions on the following:

- The grading of the complaint
- If there is a need to report as a Serious Incident
- The Lead for completion of the response
- Any additional action required prior to completion of the response; including the need for the involvement of Workforce and Organisational Development and whether an external view or review is required.
- Whether there is a requirement for contacting external agencies/professional bodies
- Any further support for staff, in accordance with CHFT policy

13.3.3 A member of the Patient Advice and Complaints Department will complete the Initial Investigation Panel checklist to ensure all issues above have been addressed and file the checklist centrally.

14. Timescale for Responding to Complaints

14.1 CHFT aims to respond to complaints in the following target timeframe:

- Complaints triaged as Green will be responded to within 25 working days from the date of receipt
- Complaints triaged Amber and Red will be responded to within 40 working days from the date of receipt

14.2 Should a complainant request a LRM the lead investigator should make all reasonable attempts to arrange the meeting with the target timeframe set out in 14.1.

14.3 CHFT will a amend the target timeframe set out in 14.1 for the following reason:

- Delays caused by an external organisation, whose response is required to complete our investigation and respond to the complainant;
- A LRM has been requested by the complainant and the date agreed is outside of the target timeframe.

14.4 Should 10% of a Division's complaints exceed the target timeframe set out in 14.1 the Associate Nurse Director of that Division, with the aid and assistance of the Patient Advice and Complaints Manager, will present a robust action plan to the Executive Director of Nursing detailing the plans for the Division to get back on track.

14.5 The action plan required in 14.4 must include :

- the lead investigator for each overdue complaint
- reasons for the delay
- sets taken to move the investigation forward
- expected date of completion

14.6 The Lead Investigator must keep the complainant updated regarding timescales throughout the complaint investigation.

15. Process for Complaints Management

15.1 Receipt of a complaint will be acknowledged by the Patient Advice and Complaints Department within two working days from the date of receipt. Complaints received on or after 14:00 hours will be considered as being received on the next working day.

15.2 The Patient Advice and Complaints Department will register the details of the complaint on the Complaints Management System and emailed to the Division involved within two working from the date of receipt of the Complaint. Following which the Patient Advice and Complaints Department will create a file for the complaint and send this to the Divisional lead.

15.3 The Division will identify a lead investigator for the complaint within 1 working day from receipt of the complaint from the Patient Advice and Complaints Department. Complaints emailed to the Division on or after 14:00 hours will be considered as being received on the next working day of the date of receipt.

15.5 The Lead Investigator will make initial contact, as detailed in 12.8.3, with the complainant within 7 calendar days from the date of the acknowledgement of the complaint.

15.6 The issues will be investigated and a formal written response prepared which will include:

- how the complaint was considered;
- the conclusions reached;
- details of remedial action taken or planned;
- confirmation that the action will address the issues raised;
- an apology where appropriate.

15.7 All formal written responses to a complaint must be signed off by a person detailed in 12.2.2.

15.8 If the person making the complaint does not wish to receive a formal written response to their complaint the Lead Investigator must complete a Resolution Report Appendix 4. This will be required prior to any agreed LRM.

15.9 The Resolution Report must include:

- concerns clarified with the complainant
- details of how the complaint was considered/investigated
- outcome of the investigation
- details of remedial action taken or planned
- confirmation that the action will address the issue

16. Investigation

16.1 Complaints should be investigated by someone not directly involved in the complaint.

16.2 It is important that during the initial contact, that the person making the complaint understands where the Lead Investigator sits in the organisation in relation to the issues being investigated. If the complainant is not satisfied that there is sufficient impartiality, this will be reviewed by the Divisional Lead and an acceptable alternative identified.

16.3 The investigation will be proportionate to the issues raised. Developing a plan of what information is needed to establish the facts will be essential in complex cases. For example, reviewing records and logs of telephone calls; speaking to staff; checking local and national policies, guidelines and good practice; and seeking advice from professionals or clinicians as relevant.

16.4 It important to remember that information obtained from the complainant is just as important as information obtained from staff when investigating a complaint.

16.5 During the course of a complaint investigation CHFT may need to source advice and assistance. This may take the form of obtaining independent clinical advice to comment on a case during investigation to establish best practice, the Police if a criminal act is suspected, or Social Services if the complaint crosses boundaries of care, HM Coroner or other organisations such as the Equal Rights Commission.

17. Cross-Division Investigations

17.1 Should a complaint involve two or more Divisions within CHFT the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will decide which Division should lead the investigation of complaint.

17.2 Should it become apparent through the course of the investigation the Division selected to lead the investigation is not the most appropriate Division, the Division will inform the Patient Advice and Complaints Department of the following:

- the division who is best placed to lead the investigation
- the investigation which has taken place within the Division
- names of staff involved in the complaint and the Divisions in which they are part of
- reason why selected Division is best placed to lead on the investigation
- what information, if any, will be required from the Division wishing to transfer the complaint
- confirmation that the complainant has been contacted, and issues have been clarified

17.3 The transferring of a complaint to another Division **should not** prevent the complainant from being contacted to clarify issues for investigation. The complainant must be contacted by the Division before the complaint will be transferred.

17.4 The Division who has been selected to lead the investigation will appoint a Lead Investigator for the investigation.

17.5 Divisions who are involved in the complaint but have not been selected to lead on the investigation will identify the members of their staff, who have been involved in the complaint, within 1 working day from receipt of the complaint from the Patient Advice and Complaints Department. Divisions must ensure that identified staff to provide statements/information to the Lead Investigator for the complaint within a reasonable time ensuring that target timeframes, as detailed in section 14, are met.

17.6 The Lead Investigator in a cross-division complaint investigation is responsible for ensuring that the complaint is responded to within the target timeframes, as detailed in section 14.

17.7 The Lead Investigator will be required to collate all information required to investigate the complaint, consider this information, make a fair decision on the outcome of the complaint, and draft the response to the complaint.

17.8 Upon conclusion of the investigation should the Lead Investigator identify failing or learning for another Division involved in the complaint they will present these to the Patient Advice and Complaints Manager / Assistant Patient Advice Complaints Manager, who in turn will forward these on to the Divisional Lead for that Division and request an action plan and confirmation of how these will be resolved. This will be forwarded to the Lead Investigator for inclusion in the Complaints response.

17.9 During the course of the investigation of a cross-division complaint, should the Lead Investigator have difficulties in obtaining information from the staff of another Division, the Lead Investigator will escalate this to the Patient Advice and Complaints Department. The Patient Advice and Complaints Department will escalate this to the Divisional Lead of the Division involved and request that urgent action be taken. The Divisional Lead will provide reasons for the delay and assurances that the information will be provided to the Lead Investigator.

17.10 Should the Complainant request an LRM for a cross-division complaint the Lead Investigator will be responsible for ensuring that all Divisions involved in the complaint are represented at the LRM.

NOTE: In the event that an LRM has taken place without a representative from another Division, the Lead Investigator will be responsible for arranging a further LRM with the staff from that Division. The Lead Investigator must attend the further LRM for completeness of their investigation.

18. Cross-Organisation Complaint Investigations

18.1 If the complaint involves another organisation the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manger will review the complaint and decide which organisation is best placed to lead on the investigation of the complaint. This will usually be the organisation to which the majority of the issues pertain and/or if the organisation is considered to be the main cause of the complaint for the complainant.

18.2 The Patient Advice and Complaints Department will advise the Complainant of their right to a joint response and obtain consent from the complainant to share the complaint with the other organisation involved should the complainant agree to a joint investigation.

18.3 The Patient Advice and Complaints Department will be responsible for obtaining a response from the other organisations involved and passing this response to the Lead Investigator for inclusion in the complaints response.

18.4 Should the Complainant request an LRM for a cross-organisation complaint, the Patient Advice and Complaints Department will be responsible for advising the other organisations involved of this request. The Patient Advice and Complaints Department will also be responsible for advising the other organisations involved of the dates for an LRM and arranging their attendance.

18.5 Should another organisation involved in the complaint not be able to attend the LRM or not wish to attend the LRM, the Patient Advice and Complaints Department will be responsible for trying to obtain a written response from the organisation to be read by the Lead Investigator during the LRM.

18.6 Should delays be occurred due to another organisation involved in the complaint, the Lead Investigator will be responsible for advising the Complainant of these delays and the new timescale for providing a response.

18.7 Where an undertaking has been made to seek comments from another organisation, then a complaint will remain open until such time that the response has been received and provided to the complainant. It will be the responsibility of the Lead Investigator to share the other organisation's response with the complainant.

19. Complaints linked to Incidents

19.1 During the Triage of the complaint the Patient Advice and Complaints Department will check CHFT's computerised incidents database for any linked incidents relating to the complaint.

19.2 Upon triage or during the investigation of a complaint should it become apparent that the incident has occurred and the statutory Duty of Candour is required, the Patient Advice and Complaints Department will advise the complainant that their concerns raised in the formal complaint will be answered as part of the incident investigation and Root Cause Analysis.

19.3 Upon conclusion of an incident investigation, where the statutory Duty of Candour has been required, should the patient and/or family of the patient remain unhappy with the outcome of the investigation, the complainant will be re-opened to capture the Complainant's additional concerns and these will be responded to through the complaints process. In the event that a complaint has never been received, a new complaint file will be opened to capture the additional concerns. The Patient Advice and Complainant Department will advise the Complainant of this.

19.4 Should the Complainant wish to pursue their concerns with the Parliamentary and Health Service Ombudsman (PHSO) the Incident and Complaint files will both be provided to the PHSO.

19.5 All complaints relating to an incident will be linked on CHFT's computerised complaints and incidents database.

20. Complaints Records

20.1 The Complainant is entitled to see all records made during the investigation of a complaint, and may make a Subject Access Request for the file. It is important that the records are factual and avoid jargon. The Lead Investigator should be honest about noting any discrepancies, disputes or gaps and consider whether further action could rectify these.

20.2 The Lead Investigator should make a note of any errors or shortcomings the investigation has exposed, along with the action required to deal with these.

20.3 All notes and records made during a complaints investigation should be uploaded onto CHFT's computerised complaints database.

20.4 The PHSO receives many complaints that expose inadequate record-keeping, making it difficult to establish facts and impossible to reconcile conflicting accounts of a consultation. Remember that if something is not recorded, the PHSO will assume that it did not take place.

20.5 The PHSO may ask CHFT to make financial redress to complainants based on a finding of maladministration and it is therefore vital that file notes detail the actions taken when dealing with a complaint. This **must** include all contact made with the complainant to discuss the complaint issues and the timescale for reply.

20.6 A complaint file will consist of the following information:

- The complaint
- Consent (where the complaint is being made by a person who is not the patient)
- Correspondence (final copies of letters and any emails, telephone/file notes, generated as a result of the complaint)
- Statements (any statements obtained for the purpose of investigating the complaint)
- Copies of relevant clinical records
- Copies of relevant policies and procedures
- Action Plan for any outstanding actions
- Capturing the Learning sheet (to be completed for every complaint)
- Complaints Quality Assessment Checklist (completed)

21. Make a Fair Decision

21.1 The Lead Investigator should make a decision about the complaint that is fair and is supported by the available evidence. The Lead Investigator should take into account any discrepancies or omissions that cannot be reconciled and be honest about these in their response.

21.2 Complaints will sometimes be made that cannot be substantiated. If the Lead Investigator is satisfied that this is the case, then the Lead Investigator must explain the reason why and be confident and clear in their response.

DO	AVOID
• act proportionately; whilst a document review may be sufficient for straightforward complaints, for more serious or complex complaints consider more extensive action such as involving the complainant (if applicable), holding case conferences or taking fuller notes of interviews with staff. (See Investigation Standards) • be sensitive as well as objective; complainants may be writing at a time of grief and shock but that does not make their concerns invalid or unfair as a result. • challenge your colleagues' responses if they are weak, inconsistent, or do not make sense.	• getting key facts wrong or making assumptions • responding by answering long lists of questions from complainants; try to agree a summary of all the key issues to be addressed first. • fudging the matter, or skating over missing information. The complainant should **not** have to ask further questions to be satisfied that the response is as comprehensive as it can be. • being defensive. • apologising indirectly. Try and avoid phrases like "we are sorry that you *felt* the organisation or an individual did something wrong". Apologise directly for what has not gone right instead. e.g I am sorry this was a poor experience for you.

21.3 The complaints procedure is separate from the disciplinary procedure. During the course of a complaint investigation it may become apparent that there are grounds for a disciplinary investigation. Consideration as to whether disciplinary action is warranted is a separate matter, outside of the complaints procedure, and is subject to a separate process of investigation. Similarly, during the course of a complaint investigation, it may become apparent that the matter needs to be referred to another agency (Police, Coroner, Professional body etc). Again, consideration as to whether disciplinary action is warranted is a separate matter, outside of the complaints procedure. These decisions will be taken by line managers. Lead Investigators have a responsibility to draw to the attention of line managers and more senior management any specific issues, concerns or trends where they are of the view that further action separate to the complaints investigation is required.

22. Unresolved Complaints

22.1 Where the Complainant is not satisfied with the response to a complaint, the Patient Advice and Complaints Manger / Assistant Patient Advice and Complaints Manager will review the Complainant's additional concerns and

decide what action, if any, will be undertaken to resolve the complaint.

22.2 Where the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager has concluded that CHFT has made all reasonable efforts to resolve the concerns of the Complainant, the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will advise the Complainant that they should raise the complaint with the PHSO.

23. Responding to the Parliamentary and Health Service Ombudsman (PHSO)

23.1 The remit of the PHSO is to assess complaint cases where the local resolution has been unsuccessful. Once CHFT has forwarded contact details for the PHSO onto the complainant it is up to the complainant to pursue their case with the PHSO.

23.2 In circumstances whereby the PHSO contacts CHFT for information relating to a complaint that they have been asked to review, the following actions will need to be taken:

- The Complaints Department should contact the relevant service to advise;
- The service should provide all requested documentation and information to the complaints team within a timely fashion;
- The Complaints Department should provide the PHSO with the information requested within the timescale where practicable.

24. Training

24.1 The Patient Advice and Complaints Department will ensure provision of guidance and support for relevant managers, supervisors, and staff to enable them to carry out their duties and responsibilities relating to complaint resolution and management.

24.2 Awareness of the role of all staff in complaints management forms a part of the Trust's mandatory training programme and all staff are informed of their responsibilities through the CHFT's Corporate Induction process.

24.3 The Patient Advice and Complaints Department will provide guidance and training to promote the effective handling of concerns and complaints.

25. Health Records

25.1 The keeping of sufficiently detailed, clear and legible notes and records (whether clinical or non-clinical) is of paramount importance when dealing with complaints. Good note/record keeping can avoid complaints or reduce the potential consequences of them.

25.2 Complaint records must be kept separate from health records, subject to the need to record any information that is strictly relevant to a patient's health in the patient's records. This applies to all reports and medical reports produced during a complaint investigation.

26. Habitual and Persistent Complainants

26.1 There are a small number of occasions when there is nothing further which can be done to assist a complainant to rectify a real or perceived problem. These complaints take up a disproportionate amount of staff time and resources and dealing with the complainants can cause undue stress to staff.

26.2 Such complaints are considered to be habitual or persistent, by virtue of being unreasonably demanding. Where a complaint meets two or more of the following criteria it may be defined as being a habital and persistent complainant.

- Persistence by the individual in pursing an issue or complaint after the NHS complaints procedure has been fully and properly implemented and exhausted;
- Changing the substance of the issue or complaint, continually raising new issues or continually raising further concerns / questions whilst the complaint is being addressed or upon receipt of a response in order to prolong contact (new issues which are significantly different from the original complaint will not be included within this category and may need to be addressed as separate complaints);
- Unwillingness to accept documented factual evidence or to accept that facts can be difficult to verify if a long period of time has elapsed;
- Will not identify the precise subject matter of the complaint;
- Harassing any member of staff or being personally abusive or verbally aggressive or racially abusive (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;
- Threatening or using actual physical violence (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;
- Meetings or face-to-face / telephone conversations tape recorded by the complainant without the prior knowledge or consent of other parties involved;
- Unreasonable demands / expectations made and failure to accept these may be unreasonable;

- Repeated refusal to follow alternative avenues open to the complainant (e.g. refusal to refer the complaint to the PHSO).

26.3 CHFT reserves the right to restrict and ultimately end communication on complaints that are classed as habitual and persistent. This approach will only be used after all reasonable measures have been taken to try to resolve the complaint through the NHS complaints procedure with, where appropriate, the involvement of independent advice, support or conciliation services.

26.4 It is accepted that in the initial contact a person making a complaint to the Trust may act out of character, for example aggressively, and allowances will normally be made for this. However, unacceptable behaviour that continues through several contacts will be considered against the background of this policy.

26.5 When the complaint has been identified as being habitual and persistent the complainant will be advised in writing that their actions are prejudicing the continued investigation of their complaint or that there is nothing further that the Trust can do to assist. The letter from the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will clearly identify why the complaint is unreasonably demanding and will list the circumstances in which the individual may legitimately continue to raise their concerns. This might include:

- explaining the complaints procedure and help that is available;
- imposing a time limit on further discussions;
- meetings or on drawing the complaint to a conclusion;
- declining contact with the complainant unless clearly pre-arranged;
- declining contact with the complainant either in person, by telephone, fax, letter or email, providing one form of contact remains open, or
- alternatively restrict contact to a third party.

26.6 Where these actions do not bring about a change in behaviour and the complainant's behaviour continues, then a report will be prepared for the Chief Executive. The Chief Executive (or nominated deputy) will determine what further action may be taken and will advise the complainant in writing. These actions may include:

- an agreement and code of behaviour for both parties to sign which sets out the circumstances in which the Trust will continue to investigate the complaint
- declining all further contact regarding the complaint

- Where appropriate pursuing a legal remedy

26.7 Even after the above steps have been implemented it is important to recognise that further contact from the complainant on different matters is not to be automatically considered unreasonably demanding, unless such contact is of a nature designed to consume staff time to such an extent that it prevents ongoing work and the provision of service to other individuals.

26.8 Withdrawal of habitual and persistent status may be achieved if the complainant demonstrates a more reasonable approach. The Chief Executive (or nominated deputy) will determine whether habitual and persistent status may be withdrawn. If this is the case the complainant will be notified in writing and normal contact will be resumed.

27. Trust Equality Statement

27.1 CHFT 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. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

28. Monitoring Performance, Compliance and Effectiveness

28.1 Compliance with this policy will be monitored as outlined in the table below:

Criteria	Monitoring Mechanism	Responsible	Frequency	Monitoring Committee
Listening and responding to complaints	Compile reports using Datix information to include: Number of complaints received and compliance with the agreed deadline for complaint response; and analysis of themes	Patient Advice & Complaints Manager	Monthly	Board Performance Report Patient Experience and Caring Group
	Summary of open complaints to Divisional Directors	Patient Advice & Complaints Manager	Weekly	

	Compile a report using Datix information to include referrals to monitoring bodies	Patient Advice & Complaints Manager	Monthly	Patient Experience and Caring Group
Complainants are not to be treated differently as a result of raising a complaint	Compile reports using patient survey tools to inform: Patient experience as an inpatient and feedback generally	Patient Experience Lead	Quarterly Quality Report	Patient Experience and Caring Group and Quality Report
Improvements made as a result of concerns/complaints being made	Compile report of changes in practice as a result concerns/complaints	Patient Advice & Complaints Manager	Quarterly Complaints Report	Patient Experience and Caring Group Quality Committee

28.2 Annual Complaints Report

28.2.1 As detailed in section 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 CHFT is required to produce an annual complaints report that:

(a) specifies the number of complaints which the responsible body received;
(b) specifies the number of complaints which the responsible body decided were well-founded;
(c) specifies the number of complaints which the responsible body has been informed have been referred to:

(i) the Health Service Commissioner to consider under the 1993 Act; or
(ii) the Local Commissioner to consider under the Local Government Act 1974; and

(d) summarise:

(i) the subject matter of complaints that the responsible body received;
(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

28.2.2 The Trust has a duty to send a copy of the report to the Clinical Commissioning Group who commissions services from the Trust and also to ensure that this report is available to any person on request.

28.3 Aggregated analysis

28.3.1 In order that the Trust is able to identify emerging safety and quality themes, an aggregated quality report that includes data from incidents, complaints and claims will be produced on a quarterly basis. The Risk Management Team will be responsible for producing the report and disseminating it to the following committees:

- Quality Committee (sub-committee or the Board, who will review themes and request further action as required)
- Quality Board (Commissioners and Trust Committee for information and assurance)

28.3.2 The minimum requirements for reporting aggregated data will consist of the following:

- Top 3 category themes for incidents, complaints and claims for the quarter being reported.
- Top 3 SI themes for a 6 month period.
- Trust actions in response to identified themes.
- Quantitative analysis of incidents, complaints and claims by Division for the preceding 12 months.

28.3.3 The contents and frequency of aggregated reports provided to Groups and Committees will be subject to an annual review by the Quality Committee, to ensure the minimum reporting requirements are met.

28.3.4 Data in relation to safety lessons and improvements will be disseminated to staff through the Trust newsletter.

29. References

29.1 Supporting References and Bibliography

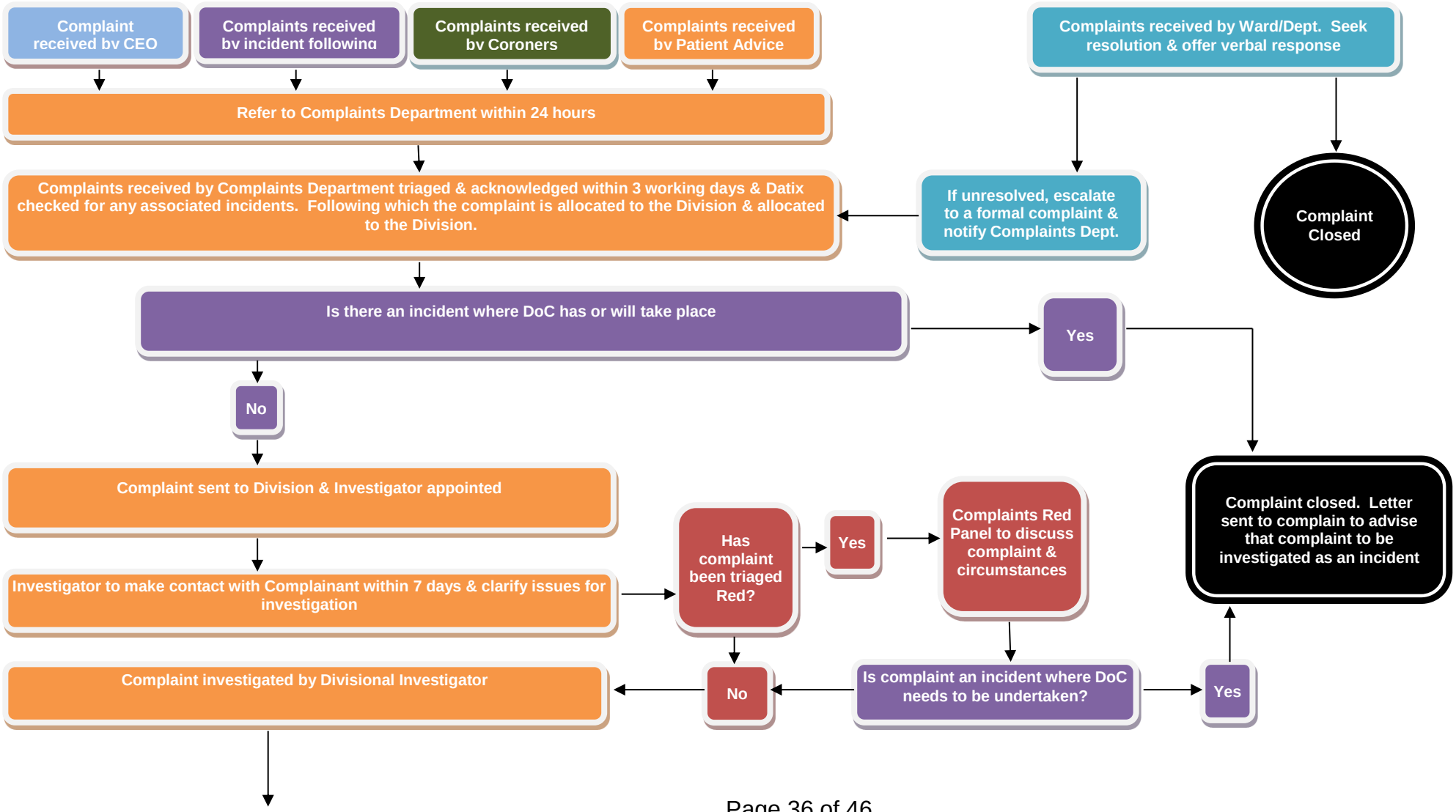
- Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Data Protection Act
- Freedom of Information Act

- NHS Constitution (DH, 2009)
- The Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman, 2008)
- Department of Health (2009) Listening, improving, responding: a guide to better customer care
- NHSLA Litigation Authority guidance about complaints
- My Expectations for Raising Complaints and Concerns (Parliamentary & Health Service Ombudsman, 2014)
- National Health Service Litigation Authority (2002). Litigation Circular No: 02/02: Apologies and Explanations, February 2002.
- NHSLA (2012) NHSLA Risk Management Standards 2013-14 for NHS Trusts.
- Care Quality Commission Core Standards

UNIQUE IDENTIFIER NO: G-106-2015
EQUIP-2017-046
Review Date: July 2019
Review Lead: Director of Nursing

APPENDIX 1

Complaint Process Flow Chart



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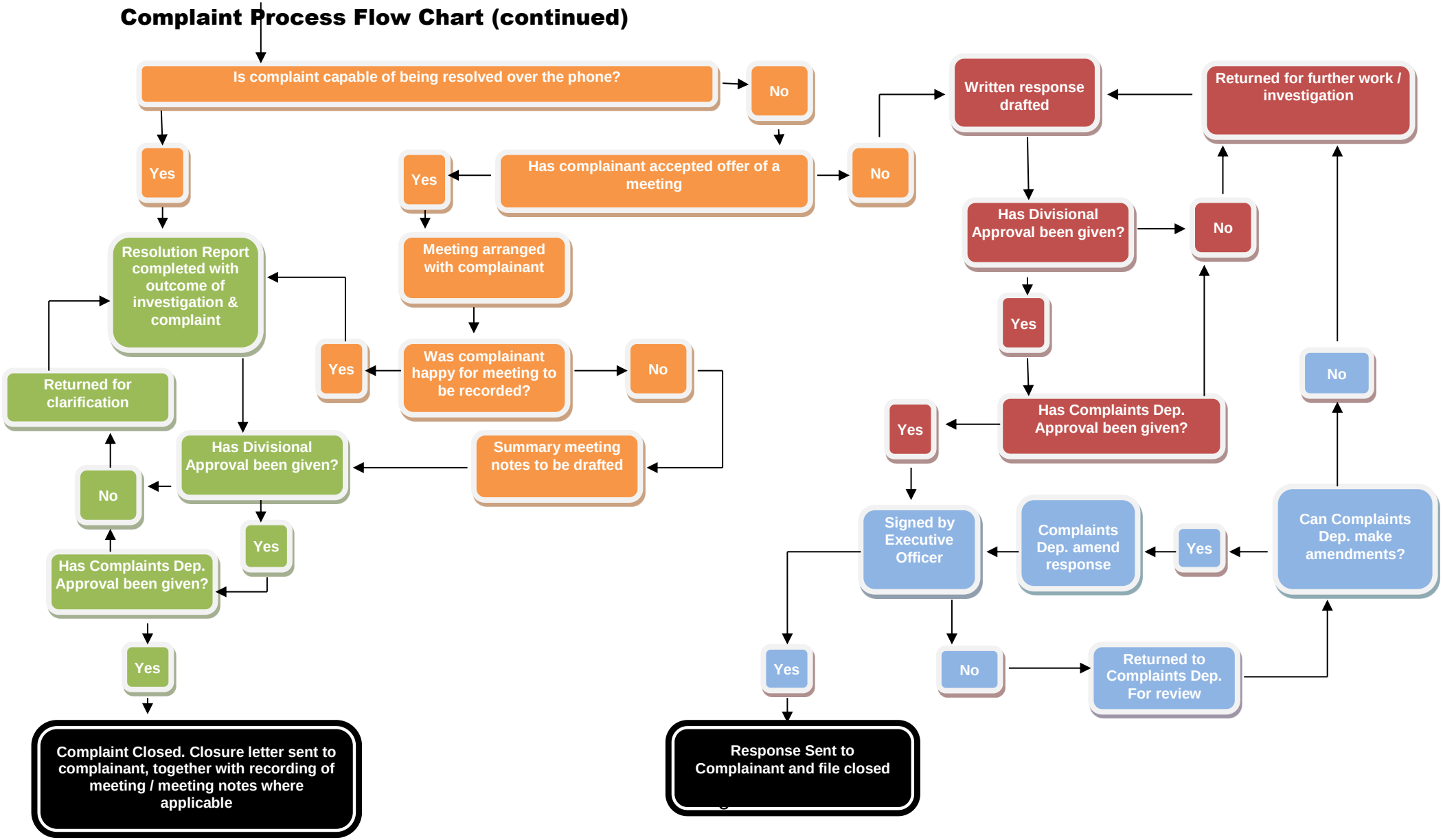
Complaint Process Flow Chart (continued)



APPENDIX 2

Complaint Triage Form

BASIC DETAILS				**DATIX ID:**	
Date Received by PACS:		**Assessed by:**			
Date Reviewed:					
Complainant:		**Patient:**			
How was complaint received:	Letter / E-mail / Phone call / website / other				

INITIAL REVIEW		**Comment**	
Is consent required?	Y / N		
Are there safeguarding concerns?	Y / N	Category 1 Concerns? (Low Level)	Category 2 Concerns? (Refer to Karen Hemsworth)
Are there equality & diversity issues?	Y / N	*(Copy all to Ruth Mason, Equality and Diversity lead and Lead for characteristic)*	
Does this relate to End of life?	Y / N	Copy to Mary Kiely and Gillian Sykes for awareness	
Does this relate to cancer care?	Y / N	Copy to Julie Hoole for awareness	
Is a Mortality review required? *Patients who have died in our care or within 3 months of leaving hospital*	Y / N	Advise Carole Hallam and Andrea McCourt	
Is this linked to an incident &/or a PALS? *Link records on Datix)*	Y / N	Incident No: PALS No:	

SEVERITY (see separate guidance for completion)					
CONSEQUENCE	**LIKELIHOOD OF RECURRENCE**				
	Frequent	**Probable**	**Occasional**	**Uncommon**	**Remote**
Serious	**HIGH**	**HIGH**	**HIGH**	**MEDIUM**	**MEDIUM**
Major	**HIGH**	**HIGH**	**MEDIUM**	**MEDIUM**	**MEDIUM**
Moderate	**HIGH**	**MEDIUM**	**MEDIUM**	**MEDIUM**	**LOW**
Minor	**MEDIUM**	**MEDIUM**	**LOW**	**LOW**	**LOW**
Minimum	**LOW**	**LOW**	**LOW**	**LOW**	**LOW**

If HIGH (Red) confirmed by:			**Date**:	
Is Complaint Panel Required:	YES		NO	

Instructions to Complaints Team / Advice to investigator

Lead Division:	COMM / CORP / ESTATES / FSS / MED / SAS
Other Divisions:	COMM / CORP / ESTATES / FSS / MED / SAS
Does the complaint involve other Organisations?	List all organisations required to comment on the complaint:

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SUMMARY OF COMPLAINT

COMPLAINANTS STATED AIMS / DESIRED OUTCOME							
Apologies		Compensation		Disciplinary action		Explanation	
Investigation		Learning		Other:			

Subject of Complaint

Subject KO41A	**Sub-Subject / Issue**	**Directorate**	**Division**	**Staff type**
Clinical Treatment				
Access to treatment or drugs (including decisions made by Commissioners)				
Admissions, discharge and transfers (excluding delayed discharge due to absence of care package)				
Appointments (including delays and cancellations)				
Commissioning Services				
Communications				
Consent to treatment				
End of Life Care				
Facilities Services				
Integrated Care				
Mortuary and post-mortem arrangements				
Patient Care (including Nutrition /				

Hydration)				
Prescribing errors				
Privacy, dignity and wellbeing				
Restraint				
Staffing numbers				
Staff – Values and Behaviours				
Transport (Ambulances only)				
Trust Administration				
Waiting Times				
Other				

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APPENDIX 3

RISK ASSESSMENT TOOL

The risk assessment tool adopts a 3 step process which first **categorises the consequences** of a complaint then **assesses the likelihood of recurrence** of the incidents or events giving rise to the complaint. Finally a **risk level is assigned** to the complaint.

Consequence Categorisation Table

The following table assists in determining how to categorise the consequence of a complaint or the subject matter of a complaint.

Category	Description
Serious	Issues regarding serious adverse events, long-term damage, grossly substandard care, professional misconduct or death that require investigation. Serious safety issues. Probability of litigation high.
Major	Significant issues of standards, quality of care, or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Possibility of litigation.
Moderate	Potential to impact on service provision/delivery. Legitimate consumer concern but not causing lasting detriment. Slight potential for litigation.
Minor	Minimum impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Minimum	No impact or risk to provision of care

Likelihood Categorisation Table

Likelihood	Description
Frequent	Recurring – found or experienced often
Probable	Will probably occur several times a year
Occasional	Happening from time to time – not constant, regular
Uncommon	Rare – unusual but may have happened before
Remote	Isolated or “one off” – slight/vague connection to service provision

Risk Assessment Matrix

Having assessed the consequence and likelihood categories using the tables above, the risk assessment matrix below can be used to determine the level of risk that should be assigned to the complaint.

RISK GRADING					
Consequence	**Likelihood of recurrence**				
	Frequent	**Probable**	**Occasional**	**Uncommon**	**Remote**
Serious	**HIGH**				
Major					
Moderate			**MEDIUM**		
Minor					
Minimum					**LOW**

Resolution Report (to be completed when the complainant does not want a written response)		
Datix number		
Investigating Officer		
Complainant Name		
Patient Name (if different to the above)		
Date of first contact with complainant		
Date of informal resolution with complainant		
Complainant satisfied with resolution and closure	YES	NO
Has Learning Action Plan been completed	YES	NO

Key issues of complaint (as agreed with complainant):

Evidence used to investigate Complaint:

Patient Records:
(Please all records and imagines review to investigate complete. These should include the dates of the records)

-

Staff Statements
(Please list all staff members including their job titles, who have provided comments. Dates when comments were provided should be included)

-

Policies and Guidelines
(Please list all policies and guidelines that are relevant to the treatment being complained about)

-

Response to Key Issues of Complaint:	
Overall Outcome of the Complaint Outcome of the complaint: (delete as appropriate) Upheld Partially Upheld Not upheld Summary reason for Outcome decision:	
Divisional sign off and verified by:	

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APPENDIX 5

Captured Learning

ACTION PLAN DEVELOPED BY _____ ***DATE*** _____

ACTION PLAN SIGNED OFF BY _____ ***DATE*** _____

Issue Identified and the Root Cause/ Contributing Factor	**Agreed Action**	**Level of Recommended action** **I**ndividual **T**eam **D**irectorate **O**rganisation	**By Whom**	**Planned Action Start Date**	**Planned Action End Date**	**Resources Required**	**Expected Outcome**	**How will completion be Evidenced and date provided to Complaints Department**

UNIQUE IDENTIFIER NO:
Review Date:
Review Lead:

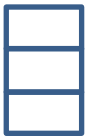
APPENDIX 6

COMPLAINT QUALITY ASSESSMENT CHECKLIST
Divisional Sign Off

DATIX ID		**SEVERITY**	**G O R**
Author of draft response			
Date response due			
Date draft received			
Communication with Complainant			
Meeting offered	**Y N**	**If NO why?**	
Response Date Agreed	**Y N**		
Extension Requested	**Y N**	**Draft received in target**	**Y N**
Involvement and Support for Staff			√
All staff involved aware of issues and had opportunity to respond			
Any staff named in the response aware of response being made			
Where appropriate chronology has been established			
Action Plan completed			
How learning will be shared			
Date learning will be shared			
Response Letter			√
In line with Duty of Candour		**All acronyms explained**	
Shows empathy and compassion		**No medical/technical jargon**	
Includes appropriate apology		**Evidence of learning**	
Personalised		**Spellings and grammar correct**	

Reviewed By…….. Date……..

ACTION **Approved to send to Complaints Team**
Return to Investigator
Complainant updated if response will be delayed



WRITING A 'FIT FOR PURPOSE' RESPONSE

A 'fit for purpose' response means:

- Writing in plain English. In particular, do not forget to explain any medical or technical terms and make sure you do not use acronyms without explaining what they mean. Consider whether other formats could be made available if requested. Avoid unnecessary adjectives e.g. *It was **clearly** documented - It was documented*.

- Ensure that you address all the key issues you agreed to address at the outset. If some points are not addressed, explain why.

- Explaining the steps taken to investigate the complaint and stating what evidence you have taken into account, including

    - The complainant's account of events;
    - The account of events by the person(s) complained about (if relevant);
    - Relevant documentation, including medical records;
    - Relevant law, policy, guidance and procedures (quote when appropriate); and
    - Any independent clinical or professional advice taken.

- Giving a thorough explanation of what you think happened and, if different, what you think should have happened. State your conclusions based on the evidence. Address any conflicting evidence or lack of evidence. Make sure that you decision is clear.

- Apologising if something has gone wrong. Remember than an apology is not an admission of liability. In many cases a genuine apology and a thorough explanation can resolve a complaint.

- Informing the complainant of any actions you will take as a result of the complaint and of the lessons learnt, and how you will keep the complainant updated if applicable (such as when a policy is updated, training has taken place, or anew patient information has been produced).

- Providing any other remedy, including financial redress, as necessary.

- Ensuring that the final response is signed by the responsible person or person authorised to act on his or her behalf, and includes clear signposting to the Health Service Ombudsman (with contact details) in the event that the complainant remains unsatisfied.