Managing and Responding to Formal Complaints

### Purpose

To describe the arrangements for the management of complaints so that complainants receive an appropriate and timely response and are assured that action has been taken to improve standards. In addition, that a proactive approach will be taken by staff to minimise the need for patients, families and carers to raise concerns through the formal process.

### Who should read this document?

All staff

### Key Messages

- The Trust has a duty of care to ensure that when things go wrong the patient and their family is given an explanation, an apology and an assurance that action is taken to make improvement.
- Overall ownership for reviewing, responding to and acting on learning from, a complaint sits within the nominated service line.
- Care groups and service lines are responsible for ensuring there is a review and approval process in place prior to submission back to the Complaints team for Executive sign off.
- When a complaint is received the complainant can expect their complaint to be fully investigated and that they will be treated fairly and equitably.
- **Timescales:** The Complaints team will review every complaint and assess the likely timeframe for the investigation taking account of issues including but not limited to:
  - The complexity of the complaint
  - The number of teams/ specialities involved
  - The timespan of the events complained about.
  - Whether the complaint is associated with a Serious Incident investigation.

  Complaint timescales will usually range between 25 and 60 working days but in exceptional circumstances may exceed this. In line with the NHS Complaints Regulations, timescales are agreed in consultation with complainants and there are no specified timeframes for responding to complaints. In accordance with the NHS Complaints Regulations, if a complaint response is not sent within six months from receipt of the complaint, the Complaints team will provide a written explanation of the reasons for the delay and send a complaint response ‘as soon as reasonably practicable’.
- The Trust is committed to the timely resolution of complaints and will take all possible to prevent delays. If it is not possible to meet a timeframe, the investigator or Complaints team will contact the complainant to explain the reasons why and agree a revised timescale.
Core accountabilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner</td>
<td>Complaints and PALS Manager/ Patient Experience &amp; Engagement Manager</td>
</tr>
<tr>
<td>Review</td>
<td>Patient Experience Committee</td>
</tr>
<tr>
<td>Ratification</td>
<td>Chief Nurse and Director of Integrated Clinical Professions</td>
</tr>
<tr>
<td>Dissemination</td>
<td>Complaints and PALS Manager</td>
</tr>
<tr>
<td>(Raising Awareness)</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>Complaints and PALS Manager/ Patient Experience &amp; Engagement Manager</td>
</tr>
</tbody>
</table>

Links to other policies and procedures

- Incident Management Policy
- Incident Management SIRI Procedure
- Supporting Staff Policy
- Patient Experience Strategy
- Handling Enquiries from the Press
- Risk Management Framework
- Information Governance Policy

Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>February 2016</td>
<td>New SOP produced to replace Responding to Formal Complaints SOP (TRW.PAS.POLICY.638.1)</td>
</tr>
<tr>
<td>2</td>
<td>November 2019</td>
<td>Reviewed and Updated</td>
</tr>
</tbody>
</table>

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Purpose, including legal or regulatory background</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Definitions</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>Duties</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Arrangements for the handling and consideration of complaint</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Definition and scope</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Principles of complaints handling</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Duty to co-operate</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Handling and consideration of complaints by the Ombudsman</td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Overall responsibility for the document</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Consultation and ratification</td>
<td>12</td>
</tr>
<tr>
<td>8</td>
<td>Dissemination and implementation</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Monitoring compliance and effectiveness</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>References and associated documentation</td>
<td>13</td>
</tr>
</tbody>
</table>

<p>| Appendix 1 | Dissemination Plan and Review Checklist                                       | 14   |
| Appendix 2 | Equality Impact Assessment                                                     | 15   |
| Appendix 3 | How to manage complaints and concerns                                          | 18   |
| Appendix 4 | Escalation guidance                                                           | 19   |
| Appendix 5 | Identifying the level of seriousness for complaints                            | 21   |
| Appendix 6 | Flow Chart for Managing Complaints                                            | 22   |
| Appendix 7 | Flow chart for acknowledging complaints                                       | 22   |
| Appendix 8 | Contact sheet                                                                | 23   |
| Appendix 9 | Investigation flow chart and tips                                             | 25   |
| Appendix 10| Working process for joint and serious complaints                              | 26   |
| Appendix 11| Complaints involving multiple service lines                                   | 27   |
| Appendix 12| Response flow chart                                                           | 28   |
| Appendix 13| Response options – report template                                             | 29   |
| Appendix 14| Response letter guide                                                         | 31   |</p>
<table>
<thead>
<tr>
<th>Appendix 15</th>
<th>Extending time for responding to complaints</th>
<th>33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 16</td>
<td>Monitoring quality and timeliness of responses</td>
<td>33</td>
</tr>
<tr>
<td>Appendix 17</td>
<td>Advocacy Service</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 18</td>
<td>Parliamentary &amp; Health Service Ombudsman (PHSO)</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 19</td>
<td>Persistent or unreasonable complainants</td>
<td>37</td>
</tr>
</tbody>
</table>
1 Introduction

University Hospitals Plymouth NHS Trust (UHP) welcomes feedback, both positive and negative from patients, relatives and other service users. Formal Complaints are just one of the many ways in which the Trust receives feedback and should be used to inform us about our patients’ experiences, to learn from them and improve our services.

The overall duty for this organisation is to ensure that our patients, families and carers are provided with the means to resolve their concerns efficiently, thoroughly and in a manner that has been agreed with the complainant. Ideally, this should happen at ward and department level, to prevent if possible, the need for a formal complaint investigation. Complainants must also be reassured that they will not be treated adversely as a result of raising concerns or making a complaint.

2 Purpose

The Trust’s overall expectations for the management of complaints are set out within this document. Investigating and learning from all complaints received is based around the principles detailed within the legislation, so that an individualised approach is followed.

This policy is written in accordance with best practice set out within national policies and guidance including the ‘Complaints Matter’ report published by the CQC in December 2014 and the ‘My Expectations when raising concerns and complaints’ published by the Parliamentary and Health Service Ombudsman (PHSO) in February 2013. This includes the Review of the NHS Hospitals Complaint System: Putting Patients Back in the Picture’ by Right Honourable Ann Clwyd and Professor Tricia Hart published in October 2013. This review was commissioned by the Prime Minister and the Secretary for Health following Robert Francis QC’s report on the Public Enquiry into Mid Staffordshire NHS Trust.

Regulatory background

The Trust is required to provide ‘arrangements for dealing with complaints’ in accordance with the National Health Service, England and Social Care, England Statutory Instrument (2009) 309: Local Authority Social Services and National Health Service Complaints (England) Regulations (the 2009 regulations).

In addition:
1. The Health and Social Care Act 2008 (Regulated Activities), Regulations 2014, Regulation 16: Receiving and Acting on Complaints
2. Parliamentary and Health Service Ombudsman – Principles of Good Complaints Handling

As a Trust, we have a legal responsibility to ensure that:

1. Complaints are dealt with efficiently;
2. Complaints are properly investigated;
3. Complainants are treated with respect and courtesy;
4. Complainants receive, so far as is reasonably practical:
   a. Assistance to enable them to understand the procedure in relation to complaints; or
   b. Advice on where they may obtain such assistance;
   c. Complainants receive a timely and appropriate response;
d. Complainants are told the outcome of the investigation of their complaint; and
e. Action is taken if necessary in the light of the outcome of a complaint.

3 | Definitions

- **A complaint** – a communication in writing (letter or email) complaining about any aspect of the service or care provided by the Trust. Correspondence asking for information or seeking clarification should not be treated as a complaint. *(Note - For verbal complaints where specific circumstances prevent the complainant from making their complaint in writing, contact information for the Health Complaints Advocacy Service (seAp) will be provided, who will be able to assist them in producing a written formal complaint. Where possible, the Complaints or PALS teams will record the issues for investigation).*

- **Re-opened complaint** – a further written communication relating to an earlier formal complaint where the issues raised in the original complaint have not been fully answered. All other contacts following a response, such as a request for a meeting, will not be formally re-opened, but managed separately. New concerns will technically require separate registration, unless they relate to the same period of care and the Service Line believes it appropriate to respond as part of the original complaint.

- **Joint Complaint** – a written complaint involving more than one organisation or Trust, which requires a response from all parties.

- **Local Resolution** – the local resolution stage of the NHS Complaints Procedure, which gives the Trust the opportunity to resolve issues of discontent or dissatisfaction no matter how they are raised. This can include a written response, a meeting or both.

- **Independent Review** – if the complainant is not satisfied with the outcome of the Trust’s management of their complaint, they can refer their concerns to the PHSO to carry out an independent investigation of the complaint and how it was handled.

- **Mediation** – independent impartial outsider acting as a go between who seeks to achieve agreement between disputing parties (i.e. The Trust and the complainant). For consideration on a case by case basis, particularly where Appendix 19 is relevant to the case. Arrangements to be discussed between Complaints team and Service Line.

4 | Duties

- **The Chief Executive** is the designated responsible person for ensuring the Trust complies with the arrangements set out in the 2009 regulations and best practice. In this role, the Chief Executive is responsible for ensuring complaint responses detail outcomes of the Trust investigation of the complaint and resulting changes.

- **The Board** will be given high-level information about all concerns and complaints raised by people who use our services (and their representatives) and what we are doing to address any problems. The Board will help create an open culture based on listening, learning and not blaming.

- **The Executive team** bears the organisational responsibility to ensure that the culture of services is one of openness and transparency and that we respond to complaints and concerns raised by people who use our services positively, and that appropriate action is taken to address them.

- **The Chief Nurse and Director of Integrated Clinical Professions** will provide clinical support and guidance in the resolution of complaints and be responsible for signing complaints on behalf of the Chief Executive, together with the Directors and the Deputy
Chief Nurse. The Chief Nurse has board level responsibilities for the Patient Experience agenda, including overall management of the NHS Complaints process, supported by the Deputy Chief Nurse.

- **The Complaints & PALS Manager** is responsible for ensuring the Trust maintains adequate arrangements for delivering the requirements of the 2009 regulations, including the production of an annual report. Duties include overseeing management of the PHSO cases and maintaining strong working relationships with Trust staff and external organisations with the oversight of the Patient Experience and Engagement Manager.

- **The Complaints team** will provide administrative support for the complaints process and provide advice and support to Service Lines when required, and ensure there has been Care Group Management or equivalent approval prior to Executive sign off.

- **Heads of Nursing/Director of Midwifery** are responsible for ensuring all aspects of this policy are applied when responding to complaints. Once the complaint response is prepared, the Heads of Nursing/Midwifery/Service Line Lead will be provided with a draft copy so they have an overview of the issues raised and the quality of responses being provided. The Head of Nursing/Midwifery or nominated clinical person will ensure any lessons learnt are fed back to the clinical teams through robust action plans. Overall responsibility of the management and review of these actions will be delegated to an appropriate lead by the Heads of Nursing/Midwifery or equivalent.

- **Matrons/Allied Health Professionals/other relevant leads e.g. Quality Managers** are responsible for undertaking an investigation into the clinical points identified for investigation, coordinating responses, providing a response and ensuring any actions are identified and completed. This will be returned to the Service Line Leads for a quality check prior to sending to the Complaints team. The Matron/Service Line Manager/Equivalent will ensure the response is completed within the agreed timescales set out in the Managing and Responding to Complaints Policy.

- **Care Group and Service Line (Cluster) Managers** are responsible for ensuring that:
  - They foster and promote an open culture where managers and frontline staff provide regular opportunities for people who use their services to discuss concerns.
  - They are responsible for supporting people who raise concerns or complaints via this policy and for dealing with them in a timely way.
  - They respond positively to any concerns raised and take timely, proportionate and appropriate action to address them.
  - Ensuring accurate and comprehensive records of individual complaints, and recording all complaints on the Datix complaints database.
  - Ensure then investigation office follows the flow chart at Appendix 9.
  - Make own internal arrangements for sign off for the response letter to ensure the complaint response has received appropriate approval and sign off from the Service Line.

- **Clinical Staff** are responsible for providing all information as requested from the area leading on the complaint investigation. Details need to be provided in a patient friendly format and all questions asked need a considered response.

- **All Employees** are required to understand their responsibilities to deal with any concerns or complaints raised by people who use Datix services, including the requirement to cooperate fully with any investigation. Staff are responsible for identifying concerns and complaints, escalating these to their line manager, and trying to resolve them wherever possible.
• The **Patient Experience Committee** will review complaints performance for assurance purposes on a monthly basis which includes performance, trends and areas of concerns.

• The **Quality Governance and Learning Group** will identify themes and trends for action when triangulated with other sources of information such as incidents, patient feedback, inquests and claims. In addition, Service Line performance against quality and timeliness of responses will be monitored and escalated to this committee as identified in appendix 14.

• The **Nursing & Midwifery Operational Committee (NMOC)** will review complaints performance, trends, learning and resulting changes to practice in Matron and Allied Health Professional led areas on a quarterly basis. Overarching action plans and improvement projects set up as a result of complaints and patient feedback will also be monitored and good practice will be shared.

• The **Care Group Governance Committees** will review complaints performance, trends, learning and resulting changes to practice in areas within their service lines on a quarterly basis. Overarching action plans and improvement projects set up as a result of complaints and good practice will be shared.

5 **Arrangements for the handling and consideration of complaint**

5.1 **Definition and scope**

A complaint or concern is an expression of dissatisfaction about an act, omission or decision of the organisation, or about the standard of service provided, which requires a response. Complaints of this nature are distinct from the **Raising Concerns policy**.

**Who can complain?**

A complaint can be made by the person who is affected (usually someone using our services). Alternatively, it may be from a person acting on behalf of the person, where they have given consent for a third party to act on their behalf, the person lacks capacity, or has delegated authority (for example has a Lasting Power of Attorney).

If someone is acting on someone else’s behalf, it may be necessary to obtain written permission to disclose any personal information relevant to the investigation of the complaint, unless the person affected is unable to give consent, or has died.

The Trust will only consider complaints made within twelve months of the event happening or within twelve months of discovering that there is cause to complain, unless there are good reasons for not having made the complaint within this timeframe. In this case, UHP may still decide to consider the complaint, if it remains possible to investigate the complaint fairly and effectively.

The Complaints team will organise and obtain the relevant consent to share the concerns with another provider, or when a representative has made a complaint on behalf of the patient.

The nature of complaints means that this Policy will not cover every eventuality. Where it is unclear whether a concern should be managed in accordance with this Policy, we will seek guidance from the Executive team (the Chief Nurse, Medical Director and/or the...
Chief Executive) and the Parliamentary and Health Service Ombudsman. Any decisions will be taken with reference to the NHS Complaints regulations.

5.2 Principles of complaints handling

5.2.1 The Trust will ensure that complainants:

- Know how to complain and access support during the process.
- Feel confident that the organisation will take their complaint seriously and that it will not affect the support/services they receive.
- Understand their concerns will be investigated and when and how they will be informed about the outcome of that investigation.
- Receive a timely response that addresses and takes account of their concerns transparently and comprehensively.
- Trust that UHP will take appropriate action to learn from complaints and where possible, to prevent issues recurring.
- Ensure each complaint is assessed on its own merits and escalate any issues or concerns on receipt of the complaint (Appendix 4)

5.2.2 All people who use the Trust’s services should be provided with information so that they know how to raise a concern or complaint, as set out in the Trust’s leaflets “Do you have any comments, compliments, concerns or complaints about our services?” or our PALS leaflet.

5.2.3 A person can make a complaint in writing (letter or email) or verbally (by phone or face-to-face). If the person raises their complaint verbally, the staff member will where possible, make a written record, and share this with the complainant for their approval.

5.2.4 Staff dealing with complaints should treat complainants with compassion, sensitivity, dignity and respect at all times. Staff should address any cultural, religious, or other specific needs and make any reasonable adjustments required. Staff should provide information on appropriate advocacy services.

5.2.5 Staff should offer all complainants the opportunity to discuss their concerns, desired outcomes, how their complaint will be investigated, and when they will receive a response.

5.2.6 A thorough investigation should be carried out for all complaints to understand what has happened and if possible, the reasons why.

5.2.7 The person investigating the complaint will agree with the complainant how they would like us to share the findings of the investigation with them. The investigator will inform the complainant of any delay in responding to their complaint, the reasons for this, and the progress of the investigation.

5.2.8 The Trust will provide evidence-based responses which address complaints openly, honestly, and comprehensively, and take account of the complainant’s views. Any written communication should be clear, using language that is easy to understand.

5.2.9 The Trust will acknowledge if mistakes have been made, and offer a full apology. The Trust will explain any action taken to put things right and to try to prevent the same thing from happening again. In the response, we will tell the complainant how they can progress their complaint if they remain dissatisfied.
5.2.10 Managers will monitor and follow up actions arising from complaints, maintaining all relevant information, evidence and documentation, and ensuring that it adequately reflects action taken and outcomes of learning.

5.2.11 Staff who are the subject of a complaint will be offered support, for example, through the Supporting Staff Policy. An individual referenced in a complaint should be notified at the earliest opportunity by the Investigating Officer.

5.3 Duty to Co-operate

Where the Trust receives a complaint involving another Trust or local authority (not including LA Children’s Services), the two bodies must co-operate for the purposes of co-ordinating the handling of the complaint and ensuring the complainant receives a co-ordinated, single response to their complaint.

Each body must agree as to who should take the lead in co-ordinating the complaint and communicating with the complainant.

Each body must provide to the other body information relevant to the consideration of the complaint which is reasonably requested and must attend, or ensure representation at any meeting reasonably required in connection with the consideration of the complaint.

The Trust’s arrangements for managing concerns and complaints can be found at Appendix 3.

5.4 Handling and consideration of complaints by the Parliamentary & Health Service Ombudsman (PHSO)

Where a complainant is not satisfied with the result of an investigation, or for any reason an investigation has not been completed within 6 months of the date on which the complaint was made, or the Complaints & PALS Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, they may request the Health Service Ombudsman to consider the complaint. The Complaints & PALS Manager will ensure that the complainant is made aware of their rights to refer to the Ombudsman where appropriate.

A request to the Health Service Ombudsman may be made in writing (including electronically) and must be made within 12 months of the incident. The Health Service Ombudsman has the discretion to accept referrals outside this time depending on the individual circumstances. The contact details for the Health Service Ombudsman are detailed in the Chief Executive Officer’s letter; the Trust’s complaints leaflet and can also be found on the Health Service Ombudsman’s website – www.ombudsman.org.uk

On receipt of a complaint, the Health Service Ombudsman will assess the nature and substance of the complaint and decide how it should be handled, by taking into account:

- The views of the complainant;
- The views of the Trust;
- Any investigation of the complaint and any action taken as a result of such investigation; and
- Other relevant circumstances.

The Ombudsman will look for any maladministration or a failure to provide a service and whether this resulted in any injustice or hardship.
They will apply a broad test of fairness and reasonableness, taking into account the circumstances of each particular case.

The Ombudsman will need to see evidence of an agreed action plan, agreed timescales and that there has been good complaint handling, where fair and proportionate remedies have been applied where a complaint is upheld.

As soon as reasonably practicable, the Health Service Ombudsman will notify the complainant as to its decision. The notice of the decision will be sent to any person or body that is the subject of the complaint and must contain the Health Service Ombudsman’s reasons for its decision. The Health Service Ombudsman may also send notice of the decision to any other body, which it considers has an interest in the complaint.

Where the Health Service Ombudsman decides to investigate a complaint the Trust Board must take responsibility to ensure that the final report and its recommendations are implemented and monitored. The Complaints & PALS Manager will be responsible for advising the Trust Board of any report received from the Health Service Ombudsman and the actions taken by the relevant Service Line(s) in response to the recommendations made.

The Ombudsman has produced several guidance documents and these are available on their website at www.ombudsman.org.uk:

- Principles of Good Administration;
- Principles of Good Complaint Handling; and
- Principles for remedy.

The UHP arrangements for managing concerns and complaints can be found at Appendix 3.

6 Overall Responsibility for the Document

The Chief Nurse and Director of Integrated Clinical Professions, Patient Experience & Engagement Manager, Complaints & PALS Manager and the Patient Experience Committee have the responsibility for developing, implementing and reviewing this policy.

7 Consultation and Ratification

The design and process of review and revision of this procedural document will comply with the Trust’s document standards.

The review period for this procedural document is set as five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Patient Experience Committee and ratified by the Chief Nurse and Director of Integrated Clinical Professions.

Non-significant amendments to this policy document may be made, under delegated authority from the Chief Nurse and Director of Integrated Clinical Professions, by the nominated author. These must be ratified by the Chief Nurse and Director of Integrated Clinical Professions and should be reported, retrospectively, to the Patient Experience Committee.

Significant reviews and revisions to this document will include a consultation with Clinical Directors, Service Line Managers/equivalent and Matrons across the Trust. For non-
significant amendments, informal consultation will be restricted to Service Line Managers/equivalent and Matrons who are directly affected by the proposed changes.

8 Dissemination and Implementation

Following approval and ratification by the Patient Experience Committee, this policy will be updated across the Trust. Publication of this policy has been publicised in Vital Signs and the Trust’s weekly staff news briefing. All Service Line management teams will have the document sent to them via email.

This procedural document will be published on the Trust’s Online Document Library and all staff will be notified through the Trust’s normal notification and communication processes. The Information Governance team is responsible for holding and maintaining a master file containing a register and a signed copy of the procedure and corresponding Equality Impact Assessment.

The Information Governance team will ensure that old versions of the policy are archived in the archive master file. Access to archived documents will be through the Information Governance team.

The Information Governance team will issue the policy numbers and maintain an index that will include the document’s title, policy number and version, owner, issue date and next review date.

The approvals are indicated by the front sheet of the document as is the version.

9 Monitoring Compliance and Effectiveness

The management of complaints investigations and communications with complainants will be monitored on a monthly basis through the Patient Experience Report to the Patient Experience Committee and bi-monthly to the Trust Board. An update report is also provided to the Safety and Quality Committee on a bi-monthly basis by the Chair of the Patient Experience Committee.

Within this monitoring and reporting, the Complaints & PALS Manager will deliver, as a minimum, the requirements set out in the 2009 regulations, including:

- Maintaining a record of all complaint enquiries received and the outcome of the investigation;
- A record of the response sent to the complainant and or organisations acting on behalf of a complainant, and whether it was sent within the agreed period;
- An Annual Complaints Report summarising all complaint transactions, including:
  - Number of complaints received – recording numbers of new formal complaints and re-opened cases separately;
  - Number of complaints upheld, not upheld and partially upheld;
  - Number of complaints referred to the Parliamentary Health Service Ombudsman where the Trust has been made aware of the referral;
  - A summary of subjects of the complaint, to include complaints/comments made about the complaints management procedure or about complainants being treated differently as a result of raising a complaint; and
  - A summary of improvement actions arising from complaints including an assessment of effective delivery of actions within agreed timescales and effective sharing of lessons with relevant stakeholders.
The report should be produced as soon as is practicable following the end of the reporting year, submitted to the Patient Experience Committee and sent to the Clinical Commissioning Groups.

The Complaints & PALS Manager will develop actions to include within the corporate level Complaints Improvement Action Plan to address any issues arising from the monitoring activities described above. This will be presented to the Patient Experience Committee on a quarterly basis who will monitor completion of the action plan.

## 10 References and Associated Documentation

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Care Quality Commission (CQC) Regulations – Outcome 17
- The NHS Constitution – the NHS belongs to us all, for England 8 March 2010
- National Patient Safety Agency – Guidance on Root Cause Analysis (RCA)
- Parliamentary and Health Service Ombudsman – Principles of good Complaint Handling
- Parliamentary and Health Service Ombudsman - ‘My Expectations when raising concerns and complaints’
- ‘Complaints Matter’ report published by the CQC in December 2014
Dissemination Plan

Document Title
Managing and responding to formal complaints

Date Finalised
September 2019

Previous Documents
Action to retrieve old copies
N/A

Dissemination Plan

<table>
<thead>
<tr>
<th>Recipient(s)</th>
<th>When</th>
<th>How</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Trust staff</td>
<td>Vital Signs</td>
<td>Information Governance team</td>
<td></td>
</tr>
<tr>
<td>Service Line Management teams</td>
<td>Email</td>
<td>Complaints &amp; PALS Manager</td>
<td></td>
</tr>
<tr>
<td>Key individuals</td>
<td>Complaints training</td>
<td>Complaints &amp; PALS Manager</td>
<td></td>
</tr>
</tbody>
</table>

Review Checklist

<table>
<thead>
<tr>
<th>Title</th>
<th>Is the title clear and unambiguous?</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is it clear whether the document is a policy, procedure, protocol, framework, APN or POLICY?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Does the style &amp; format comply?</td>
<td>Y</td>
</tr>
<tr>
<td>Rationale</td>
<td>Are reasons for development of the document stated?</td>
<td>Y</td>
</tr>
<tr>
<td>Development Process</td>
<td>Is the method described in brief?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are people involved in the development identified?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Has a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>Y</td>
</tr>
<tr>
<td>Content</td>
<td>Is the objective of the document clear?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is the target population clear and unambiguous?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are the intended outcomes described?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are the statements clear and unambiguous?</td>
<td>Y</td>
</tr>
<tr>
<td>Evidence Base</td>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are key references cited and in full?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are supporting documents referenced?</td>
<td>Y</td>
</tr>
<tr>
<td>Approval</td>
<td>Does the document identify which committee/group will review it?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Does the document identify which Executive Director will ratify it?</td>
<td>Y</td>
</tr>
<tr>
<td>Dissemination &amp; Implementation</td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Y</td>
</tr>
<tr>
<td>Document Control</td>
<td>Does the document identify where it will be held?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Have archiving arrangements for superseded documents been addressed?</td>
<td>Y</td>
</tr>
<tr>
<td>Monitoring Compliance &amp; Effectiveness</td>
<td>Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is there a plan to review or audit compliance with the document?</td>
<td>Y</td>
</tr>
<tr>
<td>Review Date</td>
<td>Is the review date identified?</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is the frequency of review identified? If so is it acceptable?</td>
<td>Y</td>
</tr>
<tr>
<td>Overall Responsibility</td>
<td>Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?</td>
<td>Y</td>
</tr>
</tbody>
</table>
## Core Information

<table>
<thead>
<tr>
<th>Date</th>
<th>September 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Managing and responding to formal complaints</td>
</tr>
<tr>
<td>What are the aims, objectives &amp; projected outcomes?</td>
<td>To describe the arrangements for the management of complaints so that complainants receive an appropriate and timely response and are assured that action has been taken to improve standards.</td>
</tr>
</tbody>
</table>

## Scope of the assessment

This assessment covers the impact the Complaints process will have on the workforce, patients and carers.

## Collecting data

<table>
<thead>
<tr>
<th>Race</th>
<th>There is no evidence to suggest there is a negative impact on race regarding this policy and it is likely to improve the impact on patients. Interpreting and translation services are in place to support for patients and carers where English is not their first language. Advocacy services are available through seAp to provide additional support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion</td>
<td>There is no evidence to suggest there is a negative impact on religion or belief and non-belief regarding this policy and is likely to improve any impact on patients. Data from the patient surveys, complaints and feedback will be monitored and analysed as required. Datix</td>
</tr>
<tr>
<td>Disability</td>
<td>There is no evidence to suggest there is a negative impact on disability regarding this policy and it is likely to improve the impact on patients. Facilities have been designed for wheelchair access and there is additional support through seAp. BSL interpreting services are available including the use of video link BSL through the Signlive facility. The PALS team is able to help capture concerns for complainants where appropriate. In addition, the consent process is in place to address any circumstances where a patient may lack capacity or require support for any reason. Data from the patient surveys, complaints and feedback will be monitored and analysed as required.</td>
</tr>
<tr>
<td>Sex</td>
<td>There is no evidence to suggest there is a negative impact on gender regarding this policy and is likely to improve any impact on patients. Data from the patient surveys, complaints and feedback will be monitored and analysed as required.</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>There is no evidence to suggest there is a negative impact on gender identity regarding this policy. There is guidance within the Trust to support staff to ensure the patient’s gender presentation is respected and only consider where relevant to the concerns. See page 24. Data from the patient surveys, complaints and feedback will be monitored and analysed as required.</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>There is no evidence to suggest that there is a negative impact on sexual orientation regarding this policy. Data from the patient surveys, complaints and feedback will be monitored and analysed as required.</td>
</tr>
</tbody>
</table>
### Age

There is no evidence to suggest that there is a negative impact on age regarding this policy. The introduction of this policy will improve the impact on patients by providing guidance to support staff to manage any concerns in line with the NHS complaints legislation. Specifically, there is advocacy available through seAp. Support for minors is usually provided by parents/carers or relatives; and where appropriate, a minor is consulted and their consent obtained before investigating concerns raised on their behalf, in line with our consent process.

### Socio-Economic

There is no evidence to suggest that there is a negative impact on socio-economic regarding this policy. Support is available through PALS and advocacy services through seAp.

### Human Rights

The introduction of this policy will improve the impact on complainants by provided guidance to support staff to manage any concerns in line with complaints legislation and the NHS Constitution. Data from the patient surveys, complaints and feedback will be monitored and analysed as required.

### What are the overall trends/patterns in the above data?

Data from complaints, PALS and patient feedback is monitored and analysed as required. Areas of concern will be addressed through appropriate action plans. PHSO feedback, via their final investigation reports will be used to identify any areas for concern. Requests for interpreters is monitored on a monthly basis and analysed as required.

### Involving and consulting stakeholders

<table>
<thead>
<tr>
<th>Internal involvement and consultation</th>
<th>Patient Experience Committee; all Trust staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>External involvement and consultation</td>
<td>Healthwatch; Patient Council</td>
</tr>
</tbody>
</table>

### Impact Assessment

Overall assessment and analysis of the evidence

### Action Plan

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>Risks</th>
<th>Completion Date</th>
<th>Progress update</th>
</tr>
</thead>
</table>

**Specific issues and data gaps that may need to be addressed through consultation or further research**

The Trust aims to review complaints data by protected characteristics when reliable information is available.
1. GENERAL POINTS

- The complainant may want an explanation, apology, acknowledgement of responsibility, remedial action, new appointment, reimbursement or other remedy. This will need to be clarified at the beginning of the investigation and the complainant informed at the beginning of the process if their expectations are not feasible or realistic.

- The investigation should make clear that any failures in service will be rectified for the future.

- The complainant may be seeking information with litigation in mind. This should not delay a full explanation of events as the claims and complaints processes can run concurrently. If appropriate, an apology, as an apology is not an admission of liability.

- When reimbursement is considered necessary following investigation of the complaint, the Service Line Manager/equivalent will sanction this.

- The complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters. The purpose of the complaints procedure is not to apportion blame amongst staff, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff. It also offers an opportunity to improve service delivery.

- Some complaints may identify information about serious matters and the Trust may feel it appropriate to consider disciplinary investigation at any point during the complaints procedure. Consideration as to whether or not disciplinary action is warranted is a separate matter for management. Where the findings of a complaint investigation raise a management concern regarding the conduct or performance of an individual, this should be brought to the attention of the appropriate line manager. The outcome of any such investigation will not be included within the complaint investigation.

- Similarly, some complaints may identify information about serious matters and the Trust may feel it appropriate to consider whether it would be appropriate to conduct an investigation using the Root Cause Analysis principles or involve the Trust’s Safeguarding team. This will be discussed with the Risk Manager and the Safeguarding team respectively.

- Where an incident also involves, or may involve a Police investigation, consideration should be given as to whether or not the complaint investigation should continue. Where there is a Police investigation in progress, the appropriate department will make contact with the Police to establish whether an internal complaints investigation will prejudice their investigation. The complaint will be placed on hold until its conclusion if this is the case.
As a Trust, we have in the past received complaints that relate to ongoing care, especially when the patient is an inpatient and some that relate to treatment that the patient is urgently waiting for.

This type of issue may require an immediate answer or immediate action, as it cannot wait for a full investigation to take place.

The complaints or concerns that fall within this guidance will most likely be assessed by the Complaints team and the Complaints and PALS Manager, but will not preclude the Service Line Management team, the Executive team, or any other manager within the Trust escalating an issue that is raised directly with them.

Equally, if a decision is delayed in relation to identifying the lead Service Line for a particular investigation, this will be raised directly with the Care Group Manager.

In the event a complaint response has not been submitted by the Service Line within the timescale stipulated, any issues in this regard will be escalated as per the chart below.
<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Action Required</th>
<th>Stage for Escalation &amp; Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1-3</td>
<td>Complaint received, logged and acknowledged</td>
<td></td>
</tr>
<tr>
<td>Day 1-3</td>
<td>Template for response and action plan sent to Service Line for review</td>
<td></td>
</tr>
<tr>
<td>Day 3-13</td>
<td>Complaint investigation and first draft response letter to be completed</td>
<td>Throughout check investigation is proceeding to plan, any issues to be escalated for action to Complaints &amp; PALS Manager Consider additional support, extension if in line with criteria, notes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day 3 - 13</td>
</tr>
<tr>
<td>Day 13-18</td>
<td>Final response drafted by investigator and sent to Service Line Manager/equivalent or Matron/Lead for review and completion of action plan.</td>
<td>Delays to be identified through weekly contact with complaints officers and service line leads – escalate to Complaints &amp; PALS Manager initially thereafter to Patient Experience &amp; Engagement Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day 16</td>
</tr>
<tr>
<td>Day 18-22</td>
<td>Final draft letter sent to Complaints Team for review</td>
<td>Day 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Day 20</td>
</tr>
<tr>
<td>Day 22-25</td>
<td>Final letter to be sent for executive sign off</td>
<td>Day 22</td>
</tr>
<tr>
<td>Day 25</td>
<td>Signed letter sent to complainant and shared with service line.</td>
<td>Day 25</td>
</tr>
<tr>
<td>Day 25 – onwards</td>
<td>Service line lead to share final version of the complaint with staff involved in the investigation</td>
<td></td>
</tr>
</tbody>
</table>
### Identifying the level of seriousness for complaints

<table>
<thead>
<tr>
<th>Severity/Seriousness</th>
<th>Description – what was the impact of the issue raised in the complaint?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Insignificant/No harm</strong></td>
<td>Unsatisfactory service or experience not directly related to care. Attitude of staff not directly affecting level of care. No impact or risk to provision of care.</td>
</tr>
<tr>
<td><strong>2. Minor/Low Harm</strong></td>
<td>Unsatisfactory service or experience related to care, usually a single resolvable issue. Attitude of staff impacting on care. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation. Limited multi agency involvement</td>
</tr>
<tr>
<td><strong>3. Moderate</strong></td>
<td>Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation. Systemic service failure. High multi agency involvement.</td>
</tr>
<tr>
<td><strong>4. Major/Severe</strong></td>
<td>Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity.</td>
</tr>
<tr>
<td><strong>5. Catastrophic/Death</strong></td>
<td>Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.</td>
</tr>
</tbody>
</table>

### Categorise the risk/consequence and indicator for level of investigation required

<table>
<thead>
<tr>
<th>Likelihood of recurrence</th>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
<th>Almost certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seriousness 1</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>2</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>3</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>5</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
Flow chart for managing complaints

Acknowledgement

Complaint received
Immediately share with Complaints team

Consider whether complaint can be more appropriately dealt with by ward or department/PALS

Consider contact with complainant to clarify their wishes

PALS

Allocated Datix reference number

Service Line or Department

Register complaint

Appendix 6

Appendix 7

• Communication can be via electronic methods with the complainant’s consent

• Consider the need for co-ordination across other Service Lines, or investigation outside the Service Line

• Consider the need for co-ordination across other Service Lines

Acknowledgement letter within 3 working days of receipt of complaint

Complaint sent to Service Line for investigation

Consider the need for patient consent before discussion with representative
INITIAL CONTACT PROFORMA

The following proforma should be completed during the initial contact with the complainant. Once the issues have been discussed and the plan for addressing those issues agreed an action plan should be completed. This form can be completed electronically and added to throughout the complaints process to provide a clear audit trail. Essentially, this sheet includes the principles of the legislation.

Maintain good communication with the complainant throughout the investigation process. If a complainant is requesting an update or there is going to be a delay it is essential to keep them informed. Following experience, we have found that if this is not done it can often inflame the situation and causes a breakdown in relationship between the complainant and the Trust.

| Reference number: |
| Complainant’s name (include title): |
| On behalf of (where appropriate): |
| Hospital number: |
| Date of birth: |
| Details of any additional needs relative to equality and diversity (E.g. Disabilities, special needs, Interpreter, large print, Braille, etc) |
| (The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.) |
| Contact details: |
| Telephone: |
| Mobile: |
| Email: |
| Preferred method and time of contact: |
| Name of staff member who made contact. |
| Date of contact: |
| Summary of discussion: |
It was agreed that the following issues would be investigated:

1. 
2. 
3. 
4. 

Outcome the client is seeking (i.e. apology, explanation, acknowledgement of responsibility, new appointment, remedial action, reimbursement):

Agreed timescale for response:

Agreed feedback following investigation: Please tick

Meeting

Phone call

Letter (please state who the letter will be sent by)

Client informed about seAp?

Client informed about any other support agencies? If yes please state which:

**Gender Identity: Transgender**

All service users are protected from discrimination because of any of the nine "protected characteristics" as stated in the Equality Act 2010 and Public Sector Duty.

The following principles apply for patients who identify themselves as transgender:

In all circumstances patients who identify themselves as transgender should be placed on a ward that is reflective of the gender with which they identify;
If there is a clinical indication otherwise e.g. female to male transgender with gynaecological conditions, then full discussion must be had with the patient to ensure there is a balance between patient wishes and clinical circumstances;

In the event of any difficulties for example concerns expressed by other patients then initially this should be resolved by the ward nursing team and the service line matron who should give consideration to all patients’ needs;

If this has been unsuccessful then any ongoing issues should be escalated to the chief nurse or their nominated deputy;

If appropriate alternative ward arrangements can be made e.g. use of a side room.

### Investigation

<table>
<thead>
<tr>
<th>Service Line Manager identifies Investigation Officer (IO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IO contacts complainant and agrees issues, timescales, feedback method and desired outcome</td>
</tr>
<tr>
<td>IO to update complainant regarding progress of investigation</td>
</tr>
<tr>
<td>IO to access relevant records, discuss with involved staff and provide support to individuals as required.</td>
</tr>
<tr>
<td>Response to address each of the agreed issues for investigation.</td>
</tr>
<tr>
<td>Response to be approved by Service Line Manager and any clinical content agreed by clinician(s) involved.</td>
</tr>
</tbody>
</table>

Once the person investigating has collated the evidence it is good practice to prepare a chronology or history of the circumstances and events leading to the complaint. If there are gaps in the information, the investigator should identify these and collect further evidence.

The scale of the investigation should be proportionate to the issues raised. The investigator should seek to establish:

1. What should have happened?
2. What did happen?
3. What was the cause of any identified failings?
4. What can be done to rectify any failings?
5. Consider the 5 whys
The conclusion reached must be based on an objective analysis of the evidence and should provide a clear explanation of this analysis. It is essential that the investigator fully considers, and addresses in the organisation's response, all points raised by the complainant and agreed at the start of the investigation. Multiple subjects of the complaint relating to a similar issue can be grouped together or summarised.

The person investigating should aim to resolve the complaint by either meeting the complainant's expectations or, where this is not appropriate, providing a full explanation of UHP's position.

The Service Line/Department investigating the complaint/leading the production of the draft reply will then send the draft response to the Complaints team within the prescribed timescale.

Ensure your investigation is shared with those involved to ensure accuracy of information, particularly if it contains clinical information.

**NB** Once a response letter has been finalised, ensure a quality check is conducted by a separate person who has not been involved in the investigation. This should be carried out prior to submission to the Complaints team for signature.

Ensure you review the wording used, for example, the length of your sentences, check the clarity of your explanations. Check punctuation and spelling and ensure there are no contradictions. Lastly, read the original complaint letter, review the agreed issues for investigation and then read the response letter from the complainant's point of view.

**Financial redress**

In line with good practice recommendations from the PHSO, the Trust will consider requests for financial redress (where investigation into the issues raised by a complainant identifies that the Trust systems were at fault) on an individual basis. This will be in accordance with the PHSO's guidance on financial remedy and Principles for Remedy.

**Working Process for Joint Complaints and Serious Incidents**

Where the Trust receives a complaint involving another Trust or local authority (not including LA Children's Services), the two bodies must co-operate for the purposes of co-ordinating the handling of the complaint and ensuring the complainant receives a co-ordinated, single response to their complaint. See section 5.2 in the main body of the policy.

In some instances, a complaint will be received which relates to a serious incident. In these cases, whether the complaint is received before or after the serious incident investigation has begun, the Complaints team will liaise with the Risk and Incident team (R&IT) to establish how the concerns will be addressed. A joint acknowledgement letter should be considered where appropriate.

In addition, any concerns raised with the R&IT following Duty of Candour will be passed to the Complaints team if they do not relate to the incident or investigation report. In the event the concerns in their totality are addressed by the serious incident investigation, the complaint will be closed and the complainant notified.
For every complaint received, the Complaints team will check the Datix system to identify whether an incident has been reported. If this is the case, the grading will be confirmed and the R&IT will be asked to confirm the scope of the investigation.

Any concerns which do not fall within the scope of the incident investigation will be sent to the Service Line who will be asked to respond to these issues. The response letter addressing these points will be sent and reference to the incident investigation will be made, including timeframes for completion of that investigation.

A specific plan for each of these cases will be agreed at the beginning of the process as it is recognised that the circumstances in each case may widely vary. In all cases the Complaints team will offer support and guidance in relation to consent, local resolution meetings and responses to concerns which relate to a serious incident.

### Complaints involving multiple Service Lines - Responsibilities

A number of complaints often relate to more than one Service Line or department. In these cases, the Complaints team will identify a lead Service Line who will be responsible for coordinating the response to the complainant.

Consideration should be given in conjunction with the Complaints team and the Service Line to the complexity of the complaint in these circumstances and registering the concerns as a complex complaint.

If a written response is to be provided, the lead Service Line is responsible for coordinating the responses from all areas and must ensure these are submitted to them in a timely manner. Contributing Service Lines should provide their element of the response to the lead Service Line at least three working days before the response is due to be submitted to the Complaints team for signature.

When all elements of the response have been received, the lead Service Line will draft the response letter and will need to address any areas of conflicting information with the relevant area prior to submission of the draft response to the Complaints team. If a response is amended or a separate Service Line is mentioned, this should be shared with them for review and approval.

Where a local resolution meeting is being held, the lead Service Line is responsible for confirming who will need to be in attendance in order to answer all the concerns raised, arranging a convenient date and confirming arrangements with complainant, supplying a minute taker/recording device for the meeting and coordinating the response letter and minutes following meeting. All those who attended must be given the opportunity to comment on minutes, actions and response letters which refer to the meeting.

A complaint will only be reassigned to another Service Line, if the lead can demonstrate that they have tried to obtain all the relevant information to ensure the response was submitted within timeframe.
The Complaints team will:

- Quality check the draft reply and supporting document to ensure completeness, accuracy and appropriateness;
- Correct minor errors/return non-compliant drafts to author;
- Once the draft meets quality standards arrange for signing;
- Print and present for executive signature;
- Post/email reply and send copy of final letter to the Service Line who drafted the response; and
- Record documents and outcomes on DATIX

The response

| Service Line to prepare CEO letter (Appendix 11) | And/or Service Line to arrange a local resolution meeting in line with complainant’s wishes | Feedback mechanism to address each of agreed issues for investigation | Include details of the complainant’s right to refer their complaint to the Health Service Ombudsman. |
**Investigation Action Plan Summary and Report**

**Made on behalf of ***********

**Patient Details**
Name:
Address:
Date of Birth:
Hospital Reference:

**Complainant’s Details**
Name:
Relationship:
Address:

Complaint reference:
Date received:
Date acknowledged:

**Issues for investigation: (as discussed with family on ***********)**

<table>
<thead>
<tr>
<th>Issues</th>
<th>Evidence / data / information required/respondent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

**Details of Complaint**
Date of Incident:
Location:

**Brief Summary of concerns:**

Results of Investigation

**Action Plan**

Signature of Investigating Officer

Name:
Position:
Date:
Our Reference:

Date:

Private & Confidential

Ensure these details are accurate and spelt correctly

Dear Mr/Miss/Mrs/Dr etc

Principles covering any complaints response:

- The letter should be personalised and demonstrate sincerity and compassion.
- The tone should match the seriousness of the complaint.
- The writer should ensure that the response is in a style that can be easily understood by the person receiving – plain English, not excessively formal, nor overly casual, avoiding jargon or specialist terminology.
- Avoid defensive statements/wording.

In the opening paragraph – thank the complainant for writing/emailing and refer to the date of the communication and receipt at the Trust if required, especially if there has been a gap between the date on the initial complaint letter and the time we received it. Refer to any communication or meetings that you have had for example, thank you for meeting/speaking with *** on ****; personalise the paragraph to reflect their concerns in a general sense and add in any condolences as appropriate.

In the second paragraph, reassure the complainant how seriously you have taken their concerns, detail how the complaint has been investigated, for example, an account of events by the complainant, who you have spoken to. Include any policies or procedures that you have referred to during your investigation and other parties/witnesses/staff accounts, relevant documentation including clinical notes, applicable law, policy, guidance, etc., and any independent advice.

Acknowledge how their experience has made them feel, and use their wording if appropriate to reassure them that you have fully read their initial complaint letter.

Outline that you will address each of the points raised/agreed for the investigation, so that we can clearly see each issue has been fully addressed.

If your investigation is detailed and is likely to take up multiple pages, then consider an investigation report and a summary CEO cover letter.

Content of a response:

- A summary or statement of the complaint.
- A full and honest account of events – often better to detail these is date order.
- A response to each issue raised by the complainant.
• Conclusions reached, including a thorough explanation of what you think happened, and if different, what you think should have happened.
• Where conclusions could not be reached, this should be stated, with reasons why.
• Any actions you have or will undertake to prevent recurrence, lessons learnt.
• Acknowledgement of responsibility where appropriate.
• Apologise wherever something has gone wrong.
• Opportunity to discuss the outcome if the complainant would like to discuss the matter further. Offer to meet with them and provide your contact details in case they would like to discuss the response in more detail. A large proportion of complaints are resolved via local resolution meetings. Evidence suggests these are more effective in addressing all the issues raised and complainants are more satisfied with the outcomes.
• When conducting the investigation and finalising the response letter, it is important to bear in mind that they can be subject to scrutiny by the Parliamentary and Health Service Ombudsman (PHSO) and other outside agencies. It is vital that we are able to demonstrate within the response letter that a good quality, fair and unbiased investigation has been carried out, actions have been identified if appropriate and we have been open and honest with the complainant. On occasions, the PHSO will undertake an initial review of a complaint by reviewing only the complaint letter and response letter provided by the Trust and the quality of the response can impact their decision about whether to investigate a case further. Please see Appendix 16 for more information about the PHSO process.
• Advise of their right to seek independent review and signpost to the appropriate body, e.g., Parliamentary and Health Service Ombudsman. These details have been included below.

Yours sincerely

Lenny Byrne, Chief Nurse and Director of Integrated Clinical Professions
Signed on behalf of
Ann James, Chief Executive

If you remain dissatisfied about how your complaint has been handled, you are entitled to put your complaint to the Parliamentary and Health Service Ombudsman. The Ombudsman’s team can be contacted by telephone on 0345 015 4033 or via their website: www.ombudsman.org.uk Alternatively, you can write to the Ombudsman at the following address:

The Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP
The Trust standard for responding to a complaint is **25 working days** this is set-out in the acknowledgement letter sent by the Complaints team when the complaint is initially received. The Complaints team will agree a variation in the 25 day timeframe for:

- Arranging a Local Resolution Meeting;
- Additional queries or concerns received from complainant;
- Unavailability of notes if all attempts to obtain information have been made;
- More than one service line is involved and this is identified during the investigation;
- Complaints involving other agencies or providers; (Appendix 8)
- Any other relevant reason to ensure a comprehensive response is provided.

If during the investigation and response drafting phase of the procedure, a compelling/unavoidable reason is identified that will prevent compliance with the dates for supplying a draft reply to the Complaints team and/or the date for sending the reply, the Service Lines will need to inform the complainant of the reason for the delays and when they are likely to receive the response.

**Monitoring of Response Timeframes and Quality**

The Complaints & PALS Manager will share weekly reports with the Service Lines which details each open complaint for their area. The report will include information about when the complaint was received, if it is a reopened case, whether it is overdue to the Complaints team and complainant and how many days it has been open so far. The report will also detail whether a response deadline has been extended or is overdue and reasons why will be identified.

On a monthly basis, the Complaints Manager will share a report detailing all the complaints which have been closed in the previous month. This report will also detail the information listed above and will highlight the response rates within 25/60 working days for each Service Line. The target is to respond to 90% of complaints within 25/60 working days, unless one of the accepted reasons for extension has been agreed during the investigation process. These cases will be considered as within timescales and will be included within the response rate.

The quality of response letters will also be monitored and all complaints that go overdue as a result of a poor quality response needing to be returned by the Complaints team will be highlighted within the monthly closed complaints report.

Service lines that do not achieve the 25/55 working day 90% response target or provide a significant number of poor quality responses will be monitored and continuing areas of concern will be escalated.
The NHS Complaints Procedure has two distinct phases:

- Phase 1 - Local Resolution
- Phase 2 - Referral to the PHSO - see Appendix 16

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 sets out arrangements for managing and resolving complaints. In addition there are two services available to support complainants during the local resolution phase of a complaint.

- Patient Advice and Liaison Service (PALS)
- Health Complaints Advocacy Service (seAp)

**PALS** - This service is provided by the Trust to support patients in resolving issues and concerns at an early stage with the objective of preventing situations escalating into a formal complaint. In the event that the complainant wishes to make a formal complaint the services can provide the information to do so, but will not become involved with any ensuing investigation.

**seAp** - this service works independently of the Trust and provides:

- A confidential facility independent of the NHS
- Support and advice on the NHS Complaints process
- Letter writing support
- Help with meeting preparation and support during meetings
- Support for complainants when they receive a response from the NHS

seAp can also speak to third parties on behalf of complainants.

**When seAp is involved in a formal complaint**

The procedure set out in this document should be followed, with the following additions:

- All necessary authorisations for seAp to advocate must be in place;
- All correspondence to be addressed to the complainant, and copies sent to seAp;
- The complainant may prefer seAp to be the primary point of contact – ensure these communication arrangements are agreed with both the complainant and seAp; and
- All verbal conversations with seAp must be recorded and saved on the DATIX complaints module.

Complainants may choose to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if they are dissatisfied with the response that they received through local resolution with the Trust.

Delays in responding to PHSO’s requests for information and reports are publicised at a national level, any delays will therefore impact on the Trust’s reputation for managing complaints and the care/support given to patients and their families. If delays will occur, the Complaints team will inform the PHSO of these in advance.
PHSO Definitions

- **Enquiries** - Referrals from complainants to the PHSO
- **Requests** (Information/Documents) – On receipt of an enquiry from a complainant the PHSO will assess if the matter meets the necessary PHSO criteria. If the initial referral is accepted the PHSO may request either information or copies of documents from the Trust. Requests can be made verbally or in writing and the release of information or document is subject to appropriate checks of authenticity of source and necessary authorisations. There may be a number of “requests” as the enquiry, review or investigation progresses. (*Note – in instances where adequate documentation is supplied by the complainant the PHSO may not make a “request” to the Trust.*)
- **Reviews** – Assessment of an “enquiry” using information and documents supplied by the Complainant/Tr ust
- **Investigation** – A referral of an “enquiry” by the PHSO to independent experts. This action will result in a report
- **A Report** – This document summarises the outcome of an “investigation” and will contain comments, observations and recommendations. Draft reports are circulated to the complainant and Trust for comment prior to formal publication. Reports and ensuing action are shared with external bodies / regulators

Roles, Responsibilities & Procedure for the management of PHSO contacts

The following procedure sets out the responsibilities and timescales for handling Ombudsman’s cases (requests for information and responding to reports).

Roles and Responsibilities

The Complaints & PALS Manager - is the designated point of contact with the PHSO and is responsible for:

- Ensuring that appropriate levels of authorisation are in place to share information;
- Coordinating the gathering of information within the timescales required by or agreed with the PHSO;
- Assessing data quality and completeness prior to making response (oral and written);
- Maintaining a record of monthly activity, minimum requirement being:
  - Number of document requests;
  - Number of cases under review by PHSO;
  - Initial enquiries and associated reviews rejected by PHSO;
  - Number of cases currently under investigation;
  - Draft reports with trust for comment;
  - Completed investigations and final report received; and
  - Closed out reports.
- Responding formally to the PHSO;
- Overseeing the delivery of action plans emerging from PHSO reviews or investigations;
- Sharing outcomes with complainants, commissioners, CQC and NHSI as necessary;
- Recording all PHSO activity on DATIX complaints module; and
- Reporting PHSO activity and summaries of PHSO investigations within the Patient Experience Report and to the Quality Governance Learning Group.

The Complaints team will provide all necessary administrative support to the Complaints & PALS Manager.

Procedure

The procedure for managing all aspects of PHSO interactions with the Trust will, subject to the appropriate levels of authorisation, be managed in accordance with PHSO principles and requirements.
Receipt & acknowledgement of requests & reports (3 days)

The Complaints and PALS Manager will:

- Acknowledge receipt of the request or report giving the PHSO:
  - Contact details for any further communication
  - Confirm arrangements to reply (date, etc);
- Send copies of correspondence to the Service Line subject to the enquiry, review or investigation, together with due dates for any requested information or action;
- Ensure arrangements are in place to locate and copying documents;
- Record documents and activity using the DATIX module for complaints; and
- Send reminders of due date for draft reply and update DATIX.

Requests for information and documents

All necessary information will be gathered within agreed timescales – where unavoidable delays are identified the Complaints & PALS Manager will:

- Contact the PHSO to explain the reason for delay and agreed a revised timescale;
- Check the information is complete and appropriate for its intended purpose;
- Provide and sign the covering letter or email that must accompany the supply of documents. The covering letter will include all necessary information to enable clear association with the enquiry from the PHSO (dates, names & references);
- Summarise all verbal communications; and
- Record all activities together with copies of covering letters and file notes on the DATIX complaints module.

Reviews not proceeding to an investigation

- Complaints & PALS Manager will provide and sign any necessary response to the PHSO;
- Advise the Service Line(s) who were subject to the enquiry / review of the outcome; and
- Record on DATIX complaints module.

Investigations

- Any additional requests to information and documents will be managed as above
- The PHSO will supply the Trust with a draft report for comment, this will be circulated for assessment, comment and development of any ensuing actions to:
  - Chief Nurse and Director of Integrated Clinical Professions;
  - Deputy Chief Nurse;
  - Manager and Matron for lead Service Line (handling the original complaint);
  - If the original complaint was designated as “Serious” the RCA Investigator; and
  - Other relevant Organisations, Directorates or Investigators involved in the original case as appropriate.
- The Complaints & PALS Manager will respond to the PHSO providing comments on the draft investigation report within the timescales set out by the PHSO; and
- On receipt of the formal outcome the Complaints & PALS Manager will review all earlier correspondence (especially the response to the draft report) and facilitate a reply to the PHSO.

Quality & signing the response

The Complaints team will:

- Quality check the formal final responses to ensure completeness, accuracy;
- Print and present the letter for Chief Nurse and Director of Integrated Clinical Professions/Chief Executive (CEO) signature;
- Post or email via the secure PHSO Egress system, the reply within the timescales set out by the PHSO;
Send a copy of final letter to the group who were asked to comment on the draft report (see above);
Record documents and outcome on DATIX; and
Ensure the documentation/outcome is shared as required by the PHSO with the complainant, commissioners, regulators and external bodies within the timescales set out by the PHSO.

Managing ensuing actions

All outstanding actions/improvements resulting from a PHSO investigation must be reported to the Quality Governance Learning Group.

<table>
<thead>
<tr>
<th>Procedure for managing unreasonable / persistent (vexatious) complainants</th>
<th>Appendix 19</th>
</tr>
</thead>
</table>

**Definition of an unreasonable / persistent complainant**

There may be a point reached where nothing further can reasonably be done to assist the complainant or to solve their problem. This procedure is to enable staff to identify when this point has been reached and clarify the actions to be taken when situations like this arise.

If a member of staff thinks they are dealing with a complainant who is acting unreasonably, they should inform the Governance team immediately. In such circumstances, staff should keep a documented record of all contacts with the complainant to support any decisions made about a complainant acting unreasonably and to demonstrate the ‘excessive’ nature of the contact.

Complainants (and/or anyone acting on behalf of a patient / family) may be deemed to be an unreasonable or persistent complainant, where previous or current contact with them shows that they meet two or more of the following criteria:

<table>
<thead>
<tr>
<th>Definition of an unreasonable / persistent complainant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vexatious Complainant Criteria</strong></td>
</tr>
<tr>
<td>Persists in pursuing a complaint</td>
</tr>
<tr>
<td>Changes the focus of complaint / continually raising further concerns</td>
</tr>
<tr>
<td>Unwilling to accept documented evidence or facts</td>
</tr>
<tr>
<td>No clear issue identified / not within remit of the Trust</td>
</tr>
<tr>
<td>Focus on a trivial matter</td>
</tr>
</tbody>
</table>
An excessive number of contacts / making unreasonable demands

Have in the course of addressing a registered complaint, had an excessive number of contacts (meetings, telephone, email, letter, etc) with the complaint placing unreasonable demands on staff or the Trust.

Have threatened or used actual physical violence towards staff, families or associates at any time

Only written methods of communication will be employed. All incidents (threats, etc) must have been reported.

Have harassed or been personally abusive or verbally aggressive on more than one occasion

Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress & should therefore make reasonable allowance.

All incidents of harassment should be recorded.

Have a history of recording conversations without consent

Only written methods of communication will be employed. All incidents must have been reported.

Display unreasonable demands/expectation

Fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or usual recognised practice).

### Dealing with Unreasonable and/or Persistent Complainants

All complaints should be processed in accordance with the NHS complaints procedure. However, during this process, staff may have contact with a small number of complainants who absorb a disproportionate amount of resources in dealing with their complaints.

In determining how to identify situations where the complaint might be considered to be habitual or vexatious, how to respond to these situations and how to appropriately manage such complaints, the following must be considered:

- That the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint has been overlooked. It must be appreciated that even habitual or vexatious complaints may have aspects that contain some genuine substance.

- That an equitable approach has been followed.

The Complaints & PALS Manager will oversee the management of a complainant who meets any of the above criteria. If two or more criteria are identified the case will be referred to the Chief Nurse and Director of Integrated Clinical Professions or Chief Executive for approval to instigate the procedure for managing unreasonable/persistent (vexatious) complainants. The Complaints & PALS Manager will make a recommendation taking into account the following:

- Wherever possible the first step will always be to establish “ground rules” with the complainant which sets out a code of behaviour for the parties involved so that the complaint can be dealt with satisfactorily. Breaching of these ground rules could lead to the complaint being closed;

- Where there is an ongoing concern that the situation is escalating, steps should be taken to encourage the complainant to seek independent support in resolving their complaint;

TRW.PAS.POL.638.2 Managing and Responding to Formal Complaints SOP Page 37 of 38
• Decline contact with the complainant either in person, by telephone, letter, e-mail or any combination of these, provided that some form of contact is maintained, possibly via a third party, to enable complaint resolution;

• Notify the complainant in writing using appropriate phases, for example, the Chief Executive Officer has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact will not assist. The complainants should also be notified that the correspondence, including e-mail, is at an end and that further letters received will be acknowledged but not answered.

• The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

• Inform the complainants that in extreme circumstances, the Trust reserves the right to refer unreasonable or persistent complainants to the Police or the Trust's solicitors, where appropriate.

Management Arrangements

The operational groups managing the complaint process or who are implicated in the complaint, must be fully briefed, supported and as necessary, involved in the discussions about the arrangements put in place to manage the vexatious complainant(s).

The vexatious complainant MUST be advised of the arrangements in writing. Letters advising the complainant of the arrangements MUST be signed by either the Chief Executive or nominated deputy.

The complaints procedure MUST be restarted if a new or unrelated complaint is received. Following discussions with the Chief Executive arrangements can be reviewed, changed or removed if the complainant(s) makes the necessary adjustments to their behaviour.

Withdrawing 'Habitual or Vexatious' Status

Once complainants have been determined as ‘habitual or persistent’, there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Each complaint must be reviewed objectively and assessed on merit.

Staff should previously have used discretion in recommending ‘habitual or persistent’ 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 Chief Executive Officer and/or the Chairman (or their deputies). Subject to their approval, normal contact with the complainants and application of the Regulations will then be resumed.