Yeovil District Hospital NHS
NHS Foundation Trust

COMPLAINTS AND CONCERNS POLICY

Version Number	7	Version Date	01 December 2017
Policy Owner	Patient Experience & Engagement Manager		
Author	Patient Experience & Engagement Manager		
First approval or date last reviewed	30 November 2017		
Staff/Groups Consulted	Trust Managers PALS and Patient Experience Team Matrons Patient Voice Trust Risk & Patient Safety Manager		
Draft agreed by Policy Owner	30 November 2017		
Discussed by Policy Group	30 November 2017		
Next Review Due	01 December 2020		
Equality Impact Assessment Completed	Yes		

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1 INTRODUCTION

1.1 The Trust welcomes feedback from all patients and their families and carers. Listening and acting upon feedback is an essential part of providing safe, patient-centred care.

1.2 All feedback from patients and carers, including concerns and complaints, provides essential information about the services the Trust provides. Feedback helps to identify areas which are working well and areas which require a change or need for improvements.

1.3 All health organisations must have a procedure in place for the management of complaints and concerns in order to follow the NHS Complaints regulations (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009).

1.4 All formal complaints received by the Trust are properly investigated in accordance with the regulations and the Patients Association Standards. We aim to resolve all complaints locally, wherever possible and reasonable.

Policy statement

1.5 All staff are committed to listening to patients and carers through responding to compliments, concerns and complaints during the course of their work.

1.6 No member of staff will treat a patient, carer, relative or representative unfairly because they have raised a complaint or concern.

1.7 Patients and their families can feedback to all staff members, nursing staff, ward and service managers and the Patient Experience Team.

1.8 We welcome all feedback verbally, face to face, via the telephone, letters, emails and other online media including social media where the Trust has an account.

1.9 We will support all patients and their families to give feedback, taking into account however they might best communicate with us. We will strive to meet the information and communication support needs of patients and carers where those needs relate to a physical or learning disability, impairment or sensory loss, in line with the Accessible Information Standards.

2 PURPOSE AND SCOPE OF THIS POLICY

2.1 The purpose of this policy is to provide a framework for listening and responding to all patient feedback including complaints.

2.2 The aim of this policy is to ensure that we comply with the user-lead vision for raising concerns and complaints described in the ‘My Expectations’ report.

- I felt confident to speak up.
- I felt that making my complaint was simple.
- I felt listened to and understood.

- I felt that my complaint made a difference.
- I would feel confident making a complaint in the future.

3 DUTIES AND RESPONSIBLITIES

3.1 **All staff** have a duty to respond to complaints and concerns in the first instance, requesting advice and help from their line managers as needed. All staff caring for patients should be familiar with the procedures detailed in this document and other related policies and immediately inform their line manager of any complaints they receive.

3.2 All staff are responsible for responding to patient feedback wherever they can, with the support of their line manager, to apologise and put things right when needed, and to record and promote good practice that is highlighted by patient feedback.

3.3 **The Chief Executive** is the responsible officer for complaints and oversees and agrees all final response letters in reply to all formal complaints received by the Trust.

3.4 The **Trust Board** is responsible for reviewing learning from complaints and ensuring that this is heard at every level of the Trust

3.5 The **Governance Assurance Committee** agrees the policy and its content and is made aware of all formal complaints raised.

3.6 The **Director of Nursing & Clinical Governance** is the Executive Lead for this policy and will ensure policy development and review takes place at least every three years, or sooner in line with local and national guidance.

3.7 The **Director of Nursing & Clinical Governance or Head of Governance & Assurance** reviews all new complaints to ensure they are being managed with the appropriate clinical input and risk assessed appropriately.

3.8 The **Patient Experience & Engagement Manager** will be responsible for the co-ordination and administrative functions of the complaints process.

3.9 **Matrons, Business Manager & Clinical Directors** will be responsible for the management of investigation of formal complaints and will assist the Complaints Manager in providing a comprehensive response to the patient or carer from the Chief Executive. In the complaints procedure they are considered the "**Decision Makers**".

3.10 **Ward & Department Managers** are responsible for carrying out investigations as requested by the Decision Maker and ensuring that all comments received by Complaints and PALS are properly considered and responded to. In the complaints procedure they are considered the "**Investigation Leads**". All Heads of Service should ensure that they have copies of PALS and Complaints leaflets available for enquirers and that the Complaints Poster is on display in a public area in all services; Leaflets and posters are available in a range of formats and languages to meet the diverse needs of the communities of Somerset and managers should obtain the appropriate version/s for their service.

3.11 **All Managers** are responsible for ensuring all staff are conversant with this policy and related policies. Line managers should seek advice from the Patient Experience Team about outstanding issues, who can offer support to the team and the enquirer. Where concerns and comments are received at a service or ward level and a response provided, PALS should be provided with a copy to be logged on the Safeguard (Ulysses) system. All formal complaints should be passed to the Complaints Lead. Managers should support staff in their interaction with patient or carers, particularly in cases where some personal animosity is evident.

3.12 **The Patient Advice and Liaison Service (PALS) Staff** are responsible for providing the PALS service and ensuring that it is available:

- To support patients and their families through Trust services by providing timely and appropriate information;
- To actively seek views from the public to ensure effective services;
- To alert senior managers of any trends emerging from patient and carer feedback;
- To provide help for staff to negotiate solutions to problems; and
- To keep a log of all issues raised on the Safeguard (Ulysses) database and provide reports to senior management and the Board about the views of patients and the public obtained through the PALS service.
- To validate PALS enquiries and PALS concerns and manage and record accordingly.

3.13 The **Patient Experience & Engagement Manager** is responsible for:

- monitoring the implementation of the complaints procedure;
- monitoring and oversight of the effectiveness of the PALs and complaints procedures;
- being available and accessible to patients or carers;
- maintaining records of complaints, action taken, and outcome;
- writing assurance reports to the Patient Experience & Engagement Steering Group and the Governance Assurance Committee or as required.
- Providing statistical returns e.g Hospital and Community Health Services Complaints Collection – (KO41a);
- Providing information to the Parliamentary Health Service Ombudsman where requested;
- Ensuring the complaints process takes into account diversity needs including access to translation and interpreting services.
- monitoring compliance with the content of this policy at an operational level. This is undertaken through the production of monthly, quarterly and annual reports.

Governance responsibility:

3.14 The **Trust-wide Learning Forum** is responsible for reviewing trends data in relation to complaints received.

3.15 The **Governance Assurance Committee** receives quarterly performance and risk reports.

3.16 The **Patient Experience & Engagement Steering Group** is responsible for reviewing and monitoring monthly PALS and complaints reports provided by the Complaints Lead, including the implementation of action plans and PHSO action plans as required.

4 CONCERNS

4.1 Some patients or their carers or families may have concerns about the Trust's services that they would like resolved without making a formal complaint.

4.2 All patients and their families must be encouraged to raise concerns in order to resolve any worries or problems with care and improve services

4.3 Concerns may be raised verbally or in writing. Patients should be encouraged where possible to raise concerns directly with the staff members involved in their care. Alternatively, concerns can be raised with the service/ward manager or the PALS service.

4.4 The PALS Service can help patients or carers with concerns by investigating concerns raised or meeting with the patient or carer, with ward/department staff where this is felt appropriate. These meetings may be called 'resolution meetings' and PALS staff can support these meetings by taking notes and facilitating meetings.

4.5 The person raising the concern will be kept informed of all progress made and should be involved in the process

4.6 If staff are not sure whether a concern should be dealt with informally or as a formal complaint, staff should discuss the issue with either the PALS staff, Complaints Lead or their Line Manager. Emphasis should be placed on resolving the issue quickly and sensitively at a ward or service level where possible.

4.7 Some patients will prefer to raise their initial concern with someone who has not been involved in their care. In these circumstances they should be advised, and assisted if necessary, to address their complaint to the Ward/Department Manager, PALS team or Complaints Lead.

4.8 All concerns raised should be reported to PALS by the service manager in order to keep a record of lessons learned and trends arising across the Trust.

4.9 When liaising with recently bereaved families, we will ask if they were satisfied with the care the patient received in the hospital. If they wish to raise concern we will inform them of our complaints and concerns process and work closely with them to ensure they are satisfied with the response they receive. Concerns raised by bereaved relatives will be reported to PALS on the Safeguard (Ulysses) system and the investigation conducted by the Bereavement staff.

5 FORMAL COMPLAINTS

5.1 Formal complaints are dealt with under the NHS Complaints Regulations and according to the Patients Association Complaints Standards.

5.2 A concern should be handled as a formal complaint if:

(i) the patient or carer wants their concern handled as a formal complaint;
(ii) it cannot be resolved quickly by the service or team manager within a short timeframe (less than five working days) or as agreed with the patient or carer;
(iii) there is important learning for other services or for the Trust;
(iv) the concern relates to a significant issue or a breach of fundamental standards of care.

5.3 In such cases, patients should be encouraged and supported to raise a formal complaint.

5.4 A formal complaint may be made in writing, verbally (over the telephone or face to face) or via email to any member of staff.

All formal complaints should be sent to the Complaints Manager or PALS Team for immediate action and recording on the Safeguard (Ulysses) complaints database.

5.5 The Trust recognises the important role provided by advocacy services in assisting patient or carers through the complaints process. The Trust will ensure that individuals are made aware of how to contact the local advocacy services by publicising these services, particularly through the PALS and complaints process.

5.6 The Trust will ensure people are able to complain in a variety of ways to suit their diverse backgrounds including sensory loss support, language support and those who cannot read or write. The Trust will ensure the services of a professional translator or interpreter if required.

5.7 The Trust recognises its responsibilities with regard to Accessible Information Standards. Any concerns raised relating to this will be managed according to the Trust policy.

6 WHO CAN COMPLAIN

6.1 Patient or carers will be existing or former Trust patients or their carers/relatives.

6.2 Carers and relatives can raise concerns on behalf of patients. Carers can also raise concerns about the care and treatment that they, as carers, have received.

6.3 If the person concerned is unable to act for him or herself, or has died, the complaint may be taken forward by a relative or carer.

6.4 Where the issue is raised by a third party and it directly relates to the circumstances surrounding a patient's care, it will be necessary to gain patient authorisation/consent in writing from the patient before any information about their care is shared. See Appendix F.

6.5 Patients or carers can choose to make complaints or raise concerns anonymously; however, these may be difficult to investigate. This will be discussed with the patient or carer if possible.

6.6 All complaints will be investigated but in order to release the full finding to the patient or carer in cases where a patient is unable to make a complaint due to capacity or death, suitable evidence must be presented to show that the representative has authority to act in this capacity (for example, they hold Enduring Power of Attorney).

6.7 All complaints will be investigated but in order to release the full finding where the patient is a child the identity of those with parental responsibility will be sought.

6.8 Complaints may be raised by solicitors on behalf of their clients.

Members of Parliament (MP) Enquiries:

6.9 Complaints may be raised by MPs on behalf of constituents. However, unless an MP enquiry is clearly referred to as a complaint, it will not be dealt with through the complaints service but instead the investigation will be managed by the Patient Experience team and responded to in writing by the Chief Executive Officer.

7 WHO CANNOT COMPLAIN?

7.1 Staff of the Trust and other providers or commissioners can only use the NHS complaints procedure if their complaint relates to their own health care or that of a friend or relative. In both situations they are acting as a patient or member of the public and not a member of staff or their relative in line with the criteria set out in section 6.

7.2 Staff grievances cannot be dealt with through the complaints process. The Trust has local procedures for handling staff concerns about health care issues, and established grievance and openness procedures. Staff should refer to their line manager or HR representative for further guidance.

7.3 Other providers or commissioners may raise concerns about Trust services formally but these will not be investigated through the NHS complaints procedure.

8 TIME LIMITS

8.1 Ideally, a complaint should be made within one year of the incident, or within one year of the patient or carer realising there is something to complain about. This is because of the difficulties in obtaining accurate information about a patient's care after such a period of time. However, we will extend this time limit where it would be unreasonable in the circumstances for the complaint to have been made earlier, and/or where it is still possible to investigate the facts of the case.

9 COMPLAINTS PROCEDURE: LOCAL RESOLUTION

9.1 The NHS complaints procedure is in two stages, local resolution and independent review by the Parliamentary and Health Service Ombudsman.

9.2 The primary objective of Local Resolution is to investigate and resolve the patient or family's complaint and learn from any issues raised.

9.3 The first responsibility of a recipient of a complaint is to ensure, before doing anything else, that the patient's immediate health and social care needs are being met. This may require urgent action before any matters relating to the complaint are investigated. This is likely to involve speaking to the patient or their family at the earliest opportunity.

9.4 Patients or carers should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they say will be treated with the appropriate confidentiality and sensitivity.

When a complaint is received:

9.5 If a complaint is resolved verbally or in person the Safeguard system is updated with details of the resolution.

9.6 The patient or carer's preferred approach should be established at the beginning of the process.

9.7 All formal complaints received (written or verbal) should be passed to the Complaints Lead who will risk assess the content of the complaint using the Risk Assessment Matrix on Safeguard.

9.8 If possible, the Complaints Lead will telephone the patient or carer to agree what will be investigated, agree a summary of the complaint and ask if there is anything in particular that the patient or carer is seeking as an outcome.

9.9 All formal complaints will be acknowledged in writing within three working days.

9.10 The organisational target response time for resolution of complaints is 25 working days from receipt to final written response. Extended timescales may be negotiated with the patient or carer where required, for example if cases are complicated, records are held by another organisation or if it is a complaint about several organisations but we will always seek to complete these investigations within 60 days.

Complaint Investigation:

9.11 The acknowledgement letter and the original complaint are sent to the Matron/Business Manager/Clinical Director (**Decision Maker**) asking them to investigate via the Safeguard system.

9.12 The Decision Maker decides who is to investigate (this is usually the Service Manager) and sends the complaint to them. This person is the **Investigation Lead**.

9.13 The Investigation Lead undertakes the investigation. This may take the form of reviewing the complaint, taking statements where required, reviewing patient records, liaising with other services or HR if needed and preparing a draft response. See Investigation Management Plan – Appendix C.

9.14 The Investigation Lead sends a draft response, in the form of a letter from the Chief Executive and a Complaint Action Plan to the Decision Maker. The Decision Maker signs off the response and sends this, alongside the supporting evidence, to the Complaints Team. The Complaints Lead reviews the response and passes to the Director of Nursing & Clinical Governance to review on behalf of the Board

9.15 The Complaint File is passed to the Chief Executive for review and final sign off.

9.16 The letter is then sent to the patient or carer, with the offer of a meeting or further response if they feel that their concerns have not been fully addressed.

9.17 A meeting with relevant clinical staff may form a valuable tool in the local resolution of a complaint. It provides the complainant with the opportunity to meet face to face with the staff who are best placed to answer their questions or dispel any misconceptions. It also allows the complainant to review the medical records in the presence of those staff who can explain terminology etc. In addition it also allows the clinical staff to better understand the outstanding concerns and their impact on the complainant.

10 COMPLAINTS PROCEDURE: INDEPENDENT REVIEW

Parliamentary and Health Service Ombudsman (PHSO)

10.1 Patients or carers who are dissatisfied with the outcome of local resolution have the right to contact the Parliamentary and Health Service Ombudsman. The patient or carer has one year from the end of local resolution to do this. The PHSO will independently review the complaint and decide what action should be taken next.

10.2 They may decide:

a. the complaint has been answered fully by the Trust and no further action is necessary;

b. the complaint has raised issues the Trust should address. They will then make recommendations to the Trust on how to make improvements for the future and/or appropriate redress.

10.3 This is the last stage of the complaints process and the Ombudsman's decision is final.

10.4 Complaints involving other health or social care providers or commissioners:

a. If a complaint is made about care delivered by more than one organisation, a lead organisation will provide a single point of access for investigating the complaint. The Joint Protocol (Appendix I) will be followed.

b. For complaints relating to SHS and DayCase UK will be managed according to SHS and DayCase UK policies and procedures.

11 SERIOUS INCIDENTS AND SAFEGUARDING CONCERNS

11.1 Where a complaint is considered to be of a serious nature, consideration will be given to the commissioning of an RCA (Root Cause Analysis) Investigation as described within the Incidents Requiring Investigations Policy.

11.2 The Safeguarding Lead for the Trust should be contacted if a complaint or concern received raises an issue relating to safeguarding children or adults.

12 COMPLAINTS AND DISCIPLINARY ACTION

12.1 The complaints procedure will only be concerned with resolving complaints and not with the investigation of disciplinary matters, which are managed separately.

12.2 If a disciplinary investigation is felt to be necessary, the Investigation Lead will seek advice from the Human Resources directorate (HR) and follow the relevant HR policies.

12.3 The patient or carer should be informed and reassured that the appropriate policies have been followed.

12.4 Any complaint which concerns possible allegations of fraud and corruption is passed immediately to the Trust Director of Finance for further investigation. (Please refer to the Trust Counter Fraud Policy).

13 SECURITY OF PATIENT INFORMATION

13.1 The PALS and Complaints staff will only request and access information about patients on a 'need to know' basis, in order to perform their duties and ensure safe patient care.

13.2 Investigation of a complaint does not remove the need to respect a patient's confidentiality and everyone working within the Trust has a legal duty to keep records confidential (with specific exceptions).

13.3 Correspondence relating to formal complaints will not be filed in the patient's notes.

13.4 PALS and Complaints records will be kept for a period of 10 years from the date that the record is created. At the end of this 10 year period all information on that case (paper and electronic) will be reviewed and if no longer required by the Trust will be shredded (paper) and deleted (electronic) from the Trust's systems.

14 UNREASONABLY PERSISTENT COMPLAINANTS

14.1 Patient or carers (and/or anyone acting on their behalf) may be deemed to be 'unreasonably persistent complainants' where they meet two or more of the following criteria:

(i) persistence in pursuing a complaint where the NHS complaints procedure has been fully implemented and exhausted;

(ii) refusal to pursue the next stage in the procedure by not applying to the Parliamentary and Health Service Ombudsman (PHSO) whilst still communicating dissatisfaction with the Trust's response;

(iii) Persistently changing the substance of a complaint or raising new issues during the process of resolution (care must be taken, however, not to overlook new issues which differ significantly from the original complaint. These should be recorded and dealt with as new complaints);

(iv) unwillingness to accept documentary evidence as being factual;

(v) unwillingness to accept that the time elapsed since the situation complained about has been too long to enable verification of facts;

(vi) lack of clarity about the precise issues the patient or carer wishes to be investigated, despite reasonable efforts by Trust staff and, where appropriate, an advocate to help them to achieve this;

(vii) the concerns identified are not within the Trust's remit to investigate or remedy but this is not acknowledged by the patient or carer;

(viii) unreasonable focus on a minor matter which appears out of proportion to their significance (in this situation, it is crucial to realise that decisions about the importance of such matters are subjective, and must be made sensitively, taking into account the patient or carer's personal situation);

(ix) excessive numbers of contacts made by patient or carers in the course of pursuing a complaint. These may be via any communication medium, and/or in person. Judgement based on the specific circumstances of each case will enable an appropriate decision about the point at which contacts are considered to be excessive in number;

(x) recording meetings, face-to-face or telephone conversations without the prior knowledge and consent of the parties involved and/or using these recordings without prior permission;

(xi) refusing to accept a staff member as a single point of contact when this has been requested, and contacting other staff members despite requests not to do so;

(xii) if physical or non-physical violence or aggressive or inappropriate language is threatened or used towards staff or their families/associates.

PROCEDURE FOR DEALING WITH UNREASONABLY PERSISTENT COMPLAINANTS

14.2 If the above criteria are fulfilled, and after agreement with the Chief Executive, the Patient Experience & Engagement Manager or other assigned senior manager should proceed as follows:

(i) inform the patient or carer in writing of the actions already taken and the fact that local resolution has been exhausted;

(ii) identify one person in the organisation to be the point of contact and inform the patient or carer of this;

(iii) inform the patient or carer that no further telephone calls or personal visits will be accepted and letters will be filed but not acknowledged;

(iv) notify the patient or carer that the Trust reserves the right to pass all correspondence to the Trust's solicitors.

14.3 Care should be taken that new issues of concern raised by the patient or carer are not overlooked.

Withdrawing 'unreasonably persistent' status

14.4 Once patient or carers have been determined 'unreasonably persistent' there needs to be a mechanism for withdrawing this status, if, for example, patient or carers subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedures would appear appropriate.

14.5 Staff should use discretion in recommending that unreasonably persistent status should be withdrawn when appropriate. This will be agreed with the Chief Executive; Subject to this approval, normal contact with the patient or carer and the Trust's complaints procedure will then be resumed.

15 TRAINING REQUIREMENTS

15.1 The Patient Experience Team will deliver iCARE training to all new employees at the Trust Induction Course

15.2 Team awareness sessions will be provided on request;

15.3 One to one training sessions will be provided on request.

15.4 Training for Decision Makers and Investigation Leads will be provided.

16 MONITORING LEARNING AND EFFECTIVENES

16.1 Monthly reports are produced by the Patient Experience & Engagement Manager and submitted to the Patient Safety Steering Group and the Patient Experience & Engagement Working Group. Reports include:

- Number of complaints;
- Details of the complaints handling process and the outcome of investigations, including learning;
- Number of PALS enquiries received and by service;
- Any themes identified in complaints and PALS enquiries.

a. In addition to the work undertaken by the Patient Safety Steering Group, the Patient Voice Group considers issues arising from complaints. Quarterly trend analysis reports are provided to the Group to enable consideration of trends in complaints and PALS.

b. Quarterly reports are provided by the Governance Assurance Committee. This includes the escalation of areas of concern or significant areas of risk. It is the responsibility of the Governance Assurance Committee to escalate emerging risks to the Board via quarterly reporting.

c. Monitoring of action plans produced in respect of recommendations raised by the Parliamentary and Health Service Ombudsman (PHSO) is undertaken via the Governance Assurance Committee.

d. The Complaints annual report details the following information:

- Number of concerns raised during the year
- Number of complaints received during the year
- Number of complaints that were well founded, specifying if they were upheld, partially upheld or not upheld.
- The numbers of complaints referred to the Parliamentary Health Service Ombudsman (PHSO).
- Breakdown of complaints received by ward/department;
- Detail of where action has been, or is to be taken to improve services as a consequence of those complaints.
- The annual report is provided for approval by the Trust Board.

17 NATIONAL POLICIES AND LEGISLATION

17.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

17.2 The Equality Act 2010

17.3 NHS England Accessible Information & Communication Policy (November 2016)

18 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

19.1 **References**

Principles of Good Complaints Handling - Parliamentary Health Service Ombudsman – February 2009

'My expectations for raising concerns and complaints' – Local Government Ombudsman, Healthwatch England and Parliamentary Health Service Ombudsman – November 2014

Assurance of Good Complaints Handling for Acute and Community Care - A toolkit for commissioners – NHS England – November 2015

19.2 **Cross reference to other procedural documents**

Being Open and Duty of Candour Policy
Data Protection Policy
Consent to Examination and Treatment Policy
Equality & Inclusion Policy
Grievance Policy
Risk Management Strategy
Safeguarding Adults Policy
Incident Reporting Policy
Trust Guidance is accessible to staff on the Trust Intranet.

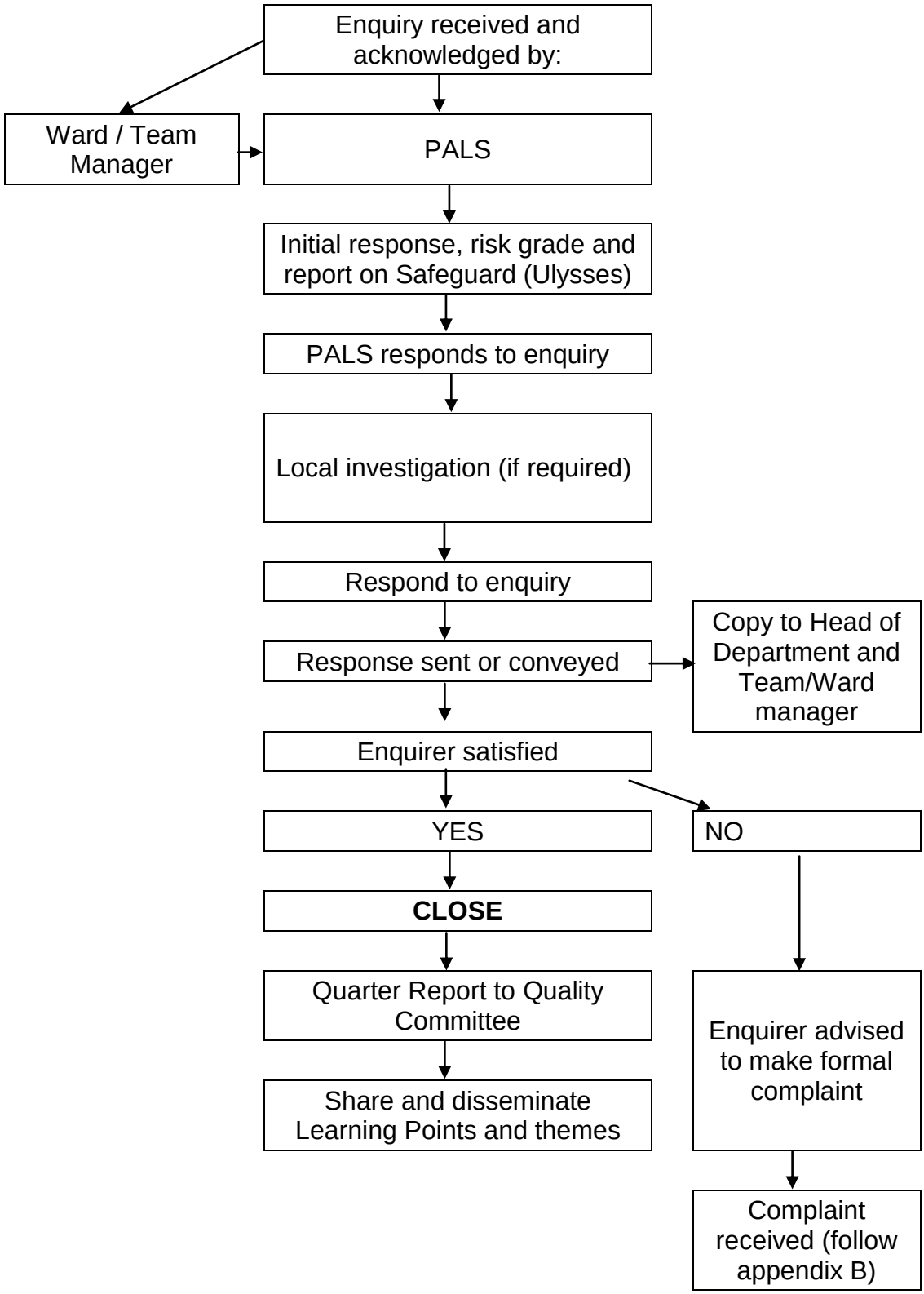
19 APPENDICES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Patient Advice and Liaison Service Enquiry Handling Diagram
Appendix B	Complaints Handling Diagram
Appendix C	Investigation Management Plan
Appendix D	Guidance for Responding to Complaints
Appendix E	Constructing a complaint response letter
Appendix F	Obtaining Consent to investigate a concerns or complaint
Appendix G	Patient Consent Form
Appendix H	Protocol for Patient Conciliation Meetings
Appendix I	Joint Working Protocol for PALS and Complaints Handling

APPENDIX A

PATIENT ADVICE AND LIAISON SERVICE PROCESS DIAGRAM



APPENDIX B

COMPLAINTS PROCESS DIAGRAM

Working Days	Stage	What happens?	Who is responsible ?	What should be on the Complaints file?
0	**Complaint received and triaged**	Complaint received (written or verbal) and passed to Complaints Lead	Complaints Lead	• Original Complaint
		• Complaints Lead telephones patient or carer to offer a meeting and agree what will be investigated and if there are is anything that the patient or carer is seeking (an apology/appointment etc) • Initial risk grade of complaint & register on the Safeguard database	Complaints Lead	• Telephone Note
		Acknowledgement letter sent confirming the above.	Complaints Lead	• Acknowledge-ment Letter
3	**Investigation stage**	Safeguard notification sent to Lead Decision Maker asking them to investigate.	Complaints Lead	• Email
		Decision Maker decides who is to investigate (e.g. manager) and sends complaint to them. This person is the Lead Investigator.	Decision Maker	
		Lead Investigator reviews case, takes statements where required, reviews patient records etc. and prepares draft response and updates Safeguard.	Lead Investigator	• Documentation e.g.: Patient records / statements
	Draft response stage	Lead investigator sends draft response and Action Plan to Decision Maker.	Lead Investigator	
15		Decision Maker signs off response and sends to Complaints Team.	Decision Maker	
		Complaints Lead reviews response (actions/learning, upheld or not upheld) and sends to Director.	Complaints Lead	
		Director signs off letter.	Director of Nursing	
25	**Final response**	Complaint care file taken to Chief Executive for final sign off and sending.	Chief Executive	• Final letter

APPENDIX C

Investigation Management Plan

Name of Lead Investigator:	**Date sent to investigator:**

Concerns investigated by discussion	**Concern No(s) to be covered:**	**Upheld**	**Partly upheld**	**Not upheld**
Concerns investigated by interview/statement	**Concern No(s) to be covered:**	**Upheld**	**Partly upheld**	**Not upheld**
Notes Review	**Concern No(s) to be covered:**	**Upheld**	**Partly upheld**	**Not upheld**
Other relevant investigation information:				

Overall Outcome of Investigation:

Lead Investigator Signature: **Date:**

APPENDIX D

Guidance for Responding to Complaints

Patients and their families have the right to raise a concern or a complaint. They rarely do so lightly and most have done a great deal of soul searching before they do. This could be you or a member of your family. Consider how you might feel if it was.

Before responding, read the complaint thoroughly and try to identify all the points raised which relate to you or a member of the team.

Ask for statements from other members of your team involved in the complaint they may need your guidance in writing these, particularly HCAs. Don't presume that RGNs, however senior, will be able to do this unaided though.

Always use the patient notes to check clinical details, chronology, dates, correct spelling of patient name etc. Do not write responses from memory.

Start your statement with your name, your status, title and involvement on the day/days referred to:

"I am Mary Smith, RGN, Staff Nurse on Ward 6A. I was in charge of the ward on the day of the incident. When commenced my shift at 07.00 I was providing direct care of Mrs Jones with HCA Brown".

Answer each point in order using dates and times where appropriate.

Stick to facts, not feelings, thoughts or presumptions. Only write what you actually know.

Apologise even if you do not agree with their version of events. They are telling you how it felt/was for them. Remember, there can be more than one version of the truth.

Be honest about any failings.

Don't make excuses.

Don't blame the system the complainant doesn't want or need to hear about our internal difficulties.

Identify actions/changes that will be made to prevent recurrence, how these are going to be achieved and by when.

Offer to meet.

Sign and date your statement.

Keep a copy

Get your manager/Matron or member of the PALS team to read through your statement.

Support other staff in statement writing using these guidelines.

APPENDIX E

Constructing a complaint response letter

Open response by referring to the complaint letter and it was received.

- Thank you for your letter received on _____
- I am writing in response to your letter of _____
- If appropriate personalise with following your telephone conversation we agreed to look into as you specifically asked etc

Then refer to the complaint issue in brief detail

- In which you raise concerns/complaint about ____

Provide an expression of regret and an acknowledgement of the impact:

- I was so very sorry to read of your concerns about your mother's care and the apparently uncaring attitude of the nursing staff and the further pain and distress this has caused you and your family at this very sad time.
- I was very sorry to read of your experience of trying to make an appointment in _____ and do understand why this has damaged your confidence in the hospital.

Provide an explanation of what you have done and from where you have gained your information:

- I have asked for a thorough investigation into the points you have raised and have received statement from Mr _____ Consultant, Sister _____ Ward ___ . I will use the information they have provided to respond to you in full.
- I have asked The Outpatient Manager to investigate your cancelled appointment and she has provided the following information.

Provide the information in chronological order wherever possible and where more than one statement is used try to use them in a chronological order.

Avoid too many apologies. Starting each paragraph or point with 'Sister apologises', sounds insincere and tends to annoy people.

One or two sincere apologies should be sufficient, certainly one nearing the end of the letter.

- I would like to apologise_____
- I would like to add my own apologies for your poor experience_____

It will be helpful to provide assurances that this has been taken seriously and that their complaint is justified and is always helpful to identify actions you have taken or plan to take to ensure it does not happen again.

Finally, where appropriate, offer a meeting.

APPENDIX F

Obtaining consent to investigate a concern or a complaint

When is consent needed?

It is very important that consent is obtained, where appropriate, in order to deal with a concern or a complaint. It is sometimes possible to start an investigation ahead of consent being received if there is a good likelihood that this will be forthcoming. This saves time in the process. However a response should never be provided, which relates to specific patient care or experience without the explicit permission of the person affected or ahead of consent being received. There are exclusions to this explained below.

The Local Authority Social Services and NHS Complaint (England) 2009 Regulations state that:

"A complaint may be made by a person (in this regulation referred to as a representative) acting on behalf of a person who:

1. Has died
2. Is a child
3. Is unable to make the complaint themselves because of:
    - Physical incapacity or
    - Lack of capacity within the meaning of the Mental Capacity Act 2005
4. Has requested the representative act on their behalf.

Consent for a child

Under the Regulations, a child means a person under the age of 18 years. The Regulations also state that:

- Where a representative makes a complaint on behalf of a child, the responsible body (hospital) must not consider the complaint unless it is satisfied that there are reasonable grounds for the complaint being made by the representative and not the child.

It also states that:

- If it is not so satisfied, it must notify the representative in writing and state the reason for its decision.

It is therefore appropriate to gain consent from young persons who you believe will have sufficient understanding of the situation in order to provide their consent (Gillick Compentency). This will vary from child to child, but is likely to apply mostly to teenagers.

Consent not received

If, after consent has been requested, it is not received within one month, it is reasonable to write again requesting consent but giving a deadline for receipt after which the case will be closed. This avoids cases remaining open indefinitely.

These Regulations are applicable for both formal complaints and PALS cases i.e concerns.

Formal Complaints

Written consent is preferable in the case of a formal complaint and a form (Appendix G) is used for this purpose.

The Regulations do, however, allow for verbal consent to be received and recorded where the person receiving this consent has a reasonable assumption that they are speaking to the correct person.

Investigation without consent

Public concern

There are cases where it may be possible to investigate a complaint where consent has not been received if it is a matter of public concern but a general response can only be provided. An example of this may be around disabled car parking where the complainant may have witnessed several members of the public having difficulties because of the location of disabled facilities on site. It would be reasonable to thank them for bringing their concern to our attention and confirm that the concern will be highlighted with the relevant department.

Patient Safety

There may be other times when someone raises an issue of such importance that it would not be in the interests of the Trust to ignore it even though we do not have consent. An example of this may be a visitor who witnesses unprofessional behaviour (such as shouting at or rough handling) of one or more patients in a ward who are not known personally to the person complaining.

If they prove sufficient information, such as ward, dates, bay etc, it is in the interests of patient safety and experience to ensure that this is dealt with appropriately. A response in this case would be to thank the person for raising this, assure them it has been taken seriously, and appropriate action taken. An explanation as to why no further information can be provided should be included in the response.

Concerns (PALS)

Much of PALS work is conducted over the telephone and therefore verbal consent is most frequently given.

It is not uncommon for the complainant to be in the same room as the person making the call on their behalf. It is often the case that the complainant can be heard talking in the background and contributing to the detail. We must establish that this is the person raising the concern. It may appropriate to ask to speak with the person in some cases. It is a matter of judgement by the PALS staff or other person dealing with the concern as to whether they are satisfied that they have consent.

NB: Always document on the Safeguard (Ulysses) database how consent was obtained.

No feedback should be given to a person where there is any doubt at all about consent.

PALS AND COMPLAINTS CONSENT FORM

Patient Consent Form

REF: PM/LH/AM

Full name of patient: .....

Address: .....

.....

.....

Date of birth: .....

Connection to person making the complaint: .....

I hereby authorise:

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

Address of person: *(if different from above)* .....

.....

.....

to act on my behalf and to receive any information as may be relevant to the complaint.

I understand that any information given about myself is limited to that which is relevant to the investigation of the complaint, and only disclosed to those people who have a need to know it, in order to investigate the complaint.

Signature of patient: .....

Date: .....

APPENDIX H

Protocol for Patient Conciliation Meetings

This protocol outlines the process for arranging and conducting a meeting between a complainant and relevant clinicians/staff as part of the Trust's local resolution of a complaint.

A meeting with relevant clinical staff may form a valuable tool in the local resolution of a complaint. It provide the complainant with the opportunity to meet face to face with the staff who are best placed to answer their questions or dispel any misconceptions. It also allows the complainant to review the medical records in the presence of those staff who can explain terminology etc. In addition it also allows the clinical staff to better understand the outstanding concerns and their impact on the complainant.

In order to achieve the best possible outcome from such a meeting it should be well planned.

Planning should include:

1. A nominated person to co-ordinate the arrangements.

2. A suitable time and date for all parties.

3. An appropriate room which is quite uninterrupted and has comfortable seating for up to six people. A table will be needed if patient notes are to be reviewed and also to allow the note taker to record the meeting in comfort.

4. A pre-meeting, if appropriate, to allow a briefing for those who may not be familiar with the case i.e a manager or director and to agree conduct of the meeting.

5. Identification of a note taker who has experience in recording such meetings, or agreement that the meeting will be recorded.

6. An agreement with the complainant about the most suitable people to be present at the meeting. Some complainants may be quite clear about who they want to be present and, where this is reasonable every effort should be made to accommodate this. Some complainants may require guidance on who would be best placed to respond to their questions.

   In all cases the fewest number of people should be present in order to answer likely questions. (A roomful of clinicians can be very intimidating and therefore not achieve the desired resolution).

7. Written notification in advance of the meeting to the complainants, the names and job titles of those staff who will be present at the meeting. It is helpful to identify who will chair the meeting.

8. A check with the complainant about any special requirements – mobility, hearing loops, interpreters etc.

9. An agreement with the complainant about the number of family members/friends who will be present.

10. An agreed time limit for the meeting, usually a maximum of 1 hour unless the complexity of the case suggests a longer time may be required.

11. An agreed agenda based on the issues raised in the complaint. Any additional issues should, where possible, be identified in advance to allow clinical staff to be prepared.

On the day:

Meeting Co-ordinator should:

1. Check the room 10 minutes before meeting to ensure it is clean, warm enough and adequate furniture is available.

2. Provide drinking water, glasses and tissues.

3. Ensure clinical case notes are available where this is relevant.

4. Provide pens and paper for those who may not have brought their own. Ensure recorder available and working.

5. Alert reception staff on the arrival of the complainant.

6. Nominate a member of the meeting to greet the complainant and bring them to the meeting room.

At the meeting the Chair/Lead should:

1. Make the introductions, especially if the meeting is being recorded.

2. Identify the purpose of the meeting – referring to the planned/agreed agenda.

3. Remind everyone of the timescale agreed.

4. Keep control of the meeting to ensure all points on the agenda are addressed and all parties have an opportunity to speak.

5. Deal with any issues raised that are not on the agenda decided whether they can be addressed at the time or what other action may be necessary.

6. Summarise what has been said and any agreed further actions.

7. Attempt to ascertain from the complainant whether the meeting has been successful in resolving their issues.

8. Advise complainant that they and all present at the meeting will receive a copy of the notes made/recording –within an agreed timescale.

9. Bring the meeting to a close.

After the meeting, the nominated lead co-ordinating the meeting should:

1. Write up the notes and circulate to all staff present at the meeting for approval/obtain CD of recording.

2. Identify in the notes any agreed actions, who is responsible and any timescale agreed.

3. Once notes/recording have been approved, send a copy to the complainant with covering letter, providing contact telephone number for any further queries.

4. Retain a copy of the notes/CD for the complaints file.

PROTOCOL FOR JOINT WORKING ON PALS/COMPLAINTS

An agreement between:

Taunton and Somerset Hospitals NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Somerset County Council
Somerset Partnership NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Somerset Doctors Urgent Care

Version 2
June 2016

PROTOCOL FOR JOINT WORKING ON PALS/COMPLAINTS

1 INTRODUCTION

1.1 If a complaint is made about care delivered by more than one organisation named in this protocol, it is important to provide a single point of contact and a single response to the enquirer/complainant.

1.2 This document is an agreed protocol for handling such enquiries or complaints. The aim of this protocol is to:

- help to avoid confusion for the enquirer/complainant
- provide clarity about the responsibilities of each organisation
- encourage regular communication
- help to ensure that the relevant organisations learn from the incident, and provide jointly agreed timescales for resolution

1.3 This document includes:

- confirmation of the signatory organisations
- a flow chart showing how joint PALS/complaints will be handled

2 PURPOSE

2.1 Dealing with a wide range of health and social care organisations can be confusing for people. This protocol aims to address this, by bringing together the various organisations to provide a unified, responsive and effective service for enquirers/complainants.

2.2 This protocol provides a framework for collaboration in handling enquiries and complaints, to ensure:

- a single consistent and agreed contact point for all contacts
- regular and effective liaison and communication between PALS/Complaints Managers and contacts, and
- that learning points arising from enquiries/complaints covering more than one body are identified and addressed by each organisation involved in that case

3 THE ROLE OF THE COMPLAINTS MANAGERS

3.1 The designated PALS/Complaints/Customer Experience Manager in each organisation that signs up to this protocol is responsible for:

- co-ordinating whatever actions are required within jointly agreed timescales

- co-operating with other managers and agreeing who will take the lead role in joint cases

- ensuring that there is someone else to whom any requests for collaboration can be addressed when they are absent

4 IDENTIFYING THE LEAD ORGANISATION

4.1 When determining which organisation will take the lead role in a joint enquiry/complaint, the following will be taken into account:

- which organisation manages integrated services
- which organisation is care managing the individual patient / client
- which organisation is responsible for the most significant element of the enquiry/complaint
- which organisation does the larger number of issues in the enquiry/complaint relates to
- which organisation originally received the complaint (if the seriousness and number of complaints are about the same for each one)
- whether the complainant has a clear preference for which organisation takes the lead

4.2 At the outset of the enquiry / complaint, the lead organisation should clarify with the complainant the outcome the complainant is seeking ~~at the outset~~ and re-visit this, during the process, as appropriate.

5 PROCESS

5.1 The enquirer/complainant should receive one single, co-ordinated response by the method agreed by the lead organisation.

5.2 PALS/Complaints managers will need to co-operate closely, with the agreement and involvement of the enquirer/complainant where appropriate.

5.3 The lead organisation should ensure that the draft response is circulated for comment and agreement before it is sent to the enquirer/complainant as part of the quality assurance for the PALS/complaints process.

5.4 Timescales for due process will be agreed between all organisations and the enquirer/complainant.

6 COMPLAINTS ABOUT ONE ORGANISATION THAT ARE ADDRESSED TO ANOTHER ORGANISATION

6.1 On occasions, a complaint that is concerned in its entirety with one provider's services is sent to another provider or Trust. The Complaints Manager of the organisation receiving such a complaint should:

- contact the complainant within three working days

- advise them that the complaint has been addressed to the wrong organisation

- ask if they want it to be forwarded to the other organisation on their behalf

6.2 Provided that the complainant agrees, the complaint should be sent to the other organisation immediately and a written acknowledgement should be sent to the complainant, detailing where/to whom the letter has been sent, including the contact details.

7 ENQUIRER'S/COMPLAINANT'S CONSENT ABOUT SHARING INFORMATION BETWEEN ORGANISATIONS

7.1 By law, all organisations have to ensure that information relating to individual service users and patients is protected, in line with the requirements of the Data Protection Act, Caldicott 2 principles and the confidentiality policies of that organisation.

7.2 The enquirer/complainant must give their consent before information relating to the concern/complaint is passed between organisations. Wherever possible, this should be in written form, but otherwise verbal consent should be recorded and logged. The enquirer/complainant is entitled to a full explanation of why their consent is being sought.

7.3 If the enquirer/complainant does not agree to the concern/complaint being passed to the other organisation, the PALS/complaints manager of the receiving organisation should:

- advise the complainant that elements of their complaint involves other organisation(s) and this is essential if they are seeking resolution of those particular elements

- seek to resolve any issues or concerns with the complainant about remit and responsibility

- offer any liaison that could contribute to resolving the matter

- remind the complainant of their entitlement to contact the other organisation directly

7.4 The Data Protection Act requires informed and explicit consent for the sharing of sensitive personal information such as Medical and Social Care records. However, there are a number of exemptions detailed in the Act. The most likely to be encountered is the need to share in accordance with Safeguarding Children or Protection of Vulnerable Adults procedures or other service user safety issues. In such cases, the organisation should refer to their own individual safeguarding procedures and advice.

7.5 It will be the responsibility of the lead organisation to obtain valid consent from the patient or their representative. If there is any doubt as to the veracity of the consent, then an identity check will be sought.

7.6 It is essential for the effective continuity of care and the successful resolution of the complaint, that information is exchanged where appropriate and both NHS and Social Care should do all they can to facilitate the process for the benefit of patients and clients. Close co-operation between PALS/complaints managers is crucial to ensure that confidential case file information is shared appropriately, and that the necessary safeguards are put in place.

7.7 Information exchanged under this protocol can be used only for the purpose for which it was obtained.

8 LEARNING FROM COMPLAINTS

8.1 It is vital to identify communication, procedural, operational or strategic issues within and across each organisation. It may be necessary to share information with other organisations when serious concerns are raised about a health or social care worker.

8.2 If matters come to attention regarding competency and fitness to practice these must be raised through the employing organisation's HR procedures.

8.3 Enquirers and complainants may be kept updated of learning outcomes following resolution if the complainant has requested this information.

8.4 Learning from individual complaints should be collated by the lead organisation and be included in the joint response letter. It should also be fed back to the other organisations involved in the complaint. There is an expectation that this learning is then taken forward by each individual organisation through their own processes/procedures.

8.5 The protocol will be adopted by each participating organisation by inclusion in their individual complaints policy and approved by each organisation through their usual governance procedures.

8.6 The Duty of Candour will need to be considered. In general, each organisation must discharge their own obligation for Duty of Candour. Where the Duty is shared, or is not clear, then agreement must be reached between relevant organisations about who will take responsibility.

FLOW CHART FOR HANDLING JOINT ORGANISATION COMPLAINTS

Complaint received – the protocol sets out the factors that determine which organisation will take the lead and new timescales for completion are agreed. If this is not clear, the PALS/Complaints Manager contacts the other organisations involved to jointly agree how the complaint is best dealt with.

Once this is decided the lead PALS/Complaints Manager should contact the enquirer/complainant to discuss their concern/complaint, agree how the concern/complaint will be handled, confirm the issues to be addressed and establish the outcome the complainant is seeking. Explain the implications of a joint organisation concern/complaint and who will co-ordinate the response and advise of timescales set by the organisations involved with the investigation.

Further contact with the enquirer/complainant to be made if the timescales look like they will be breached. New timescales negotiated and shared with organisations involved.

Lead PALS/Complaints Manager to circulate draft response for comment and agreement before it is sent to the enquirer/complainant.

Enquirer/complainant provided with joint organisational response and same shared with all organisations involved.

Action plans are prepared by each organisation to demonstrate learning and organisational improvement where appropriate. These should be shared across the organisations concerned.

ANNEX J – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Complaints & Concerns Policy**

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:	no	
	1 Race	no	
	2 Ethnic origins (including gypsies and travellers)	no	
	3 Nationality	no	
	4 Gender	no	
	5 Culture	no	
	6 Religion or belief	no	
	7 Sexual orientation including lesbian, gay and bisexual people	no	
	8 Age	no	
2.	Is there any evidence that some groups are affected differently?	no	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	no	
4.	Is the impact of the policy/guidance likely to be negative?	no	
5.	If so can the impact be avoided?	n/a	
6.	What alternatives are there to achieving the policy/guidance without the impact?	n/a	
7.	Can we reduce the impact by taking different action?	n/a	

For advice or if you have identified a potential discriminatory impact of this procedural document, please refer it to The Equality & Diversity Lead, Yeovil Academy, together with any suggestions as to the action required to avoid/reduce this impact.

Signed: Alison Male
Date: 16th January 2018