Management of Complaints, Concerns, Comments and Compliments Policy

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Controlled document
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1.0	26/07/2007	Patient Liaison Services Manager	First policy for handling complaints and PALS
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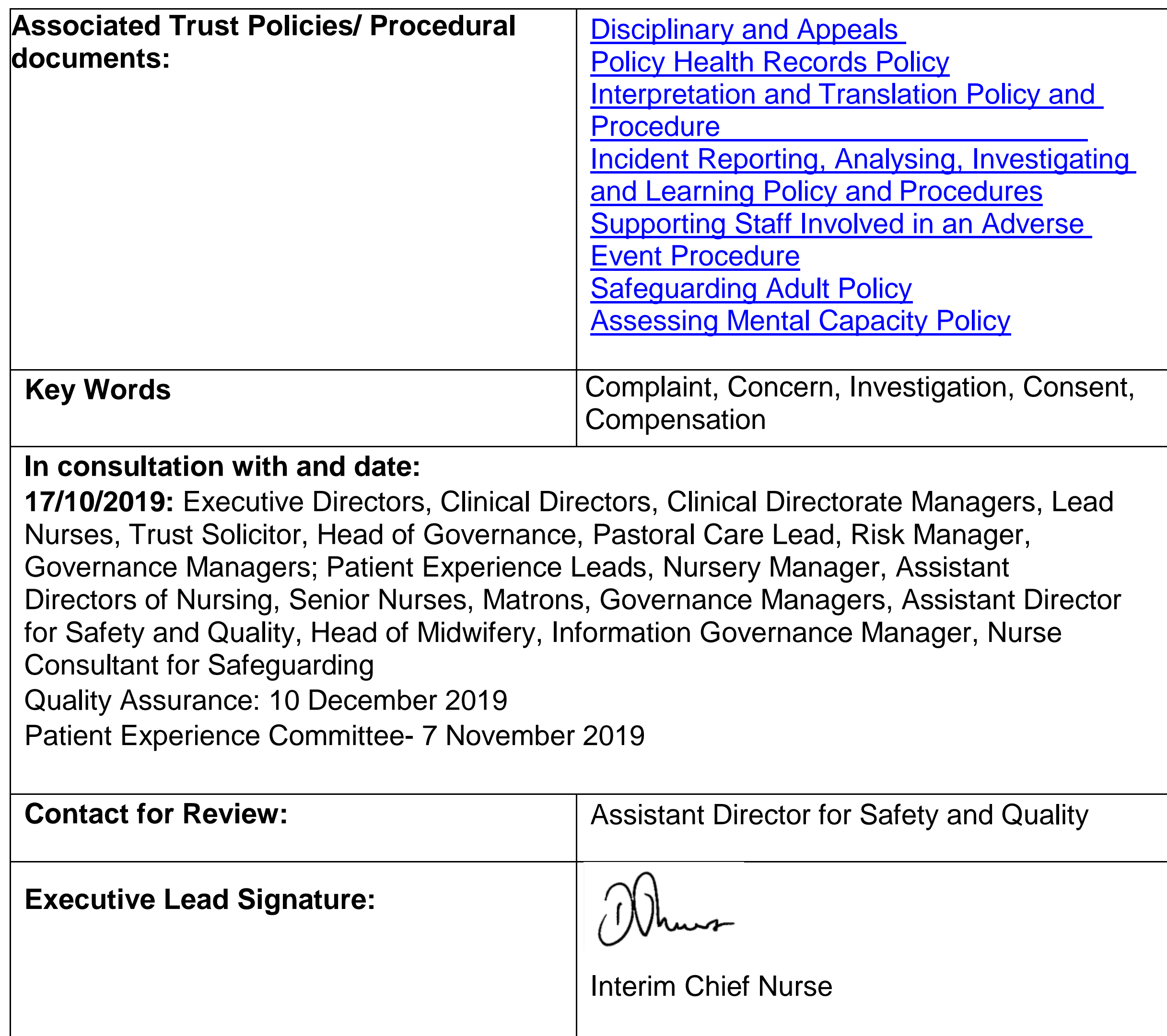

Associated Trust Policies/ Procedural documents:	Disciplinary and Appeals Policy Health Records Policy Interpretation and Translation Policy and Procedure Incident Reporting, Analysing, Investigating and Learning Policy and Procedures Supporting Staff Involved in an Adverse Event Procedure Safeguarding Adult Policy Assessing Mental Capacity Policy
Key Words	Complaint, Concern, Investigation, Consent, Compensation
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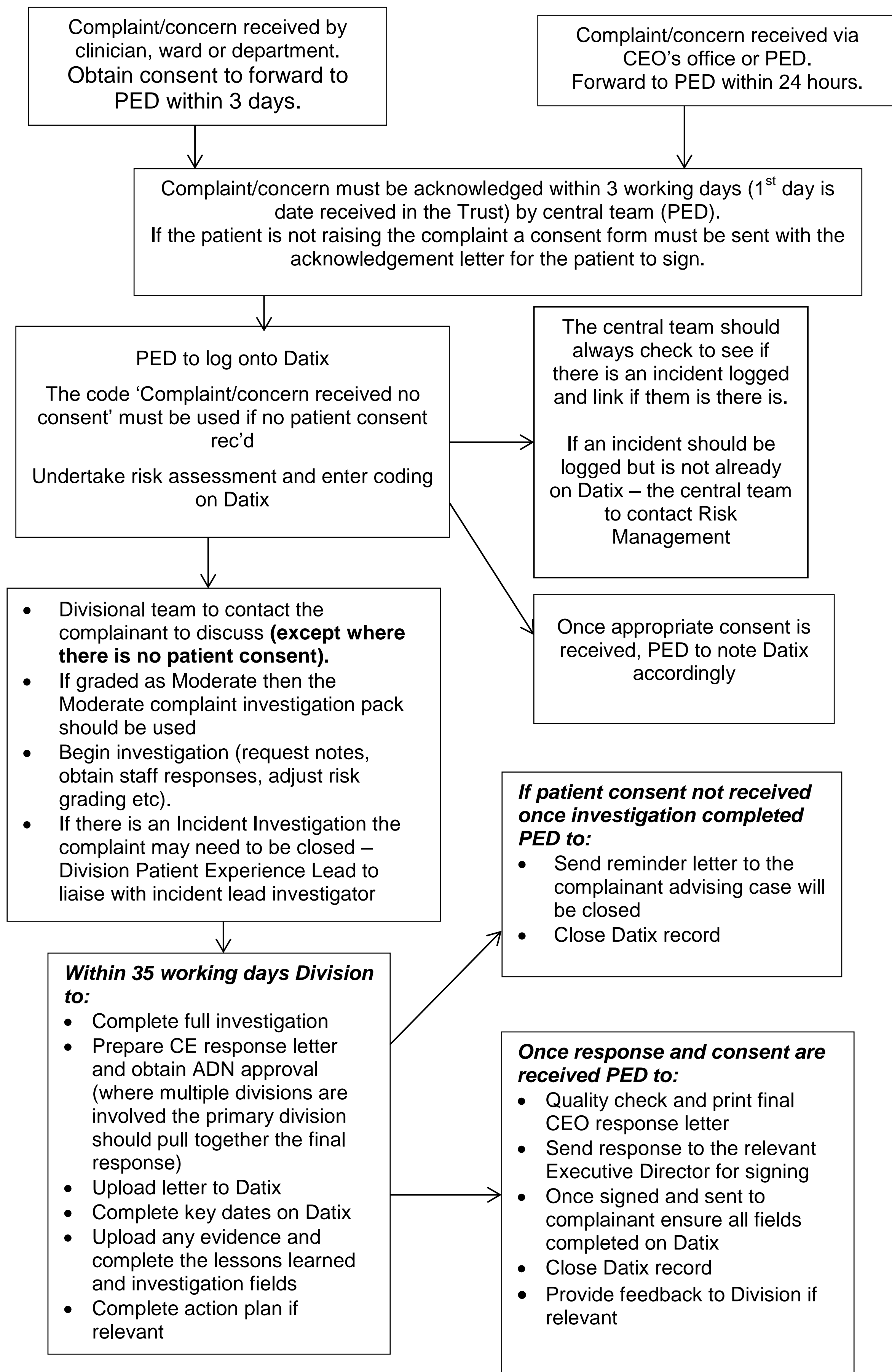
CONTENTS

KEY POINTS OF THIS POLICY: 5
1. INTRODUCTION 7
2. PURPOSE AND KEY PRIORITIES 7
3. DEFINITIONS 8
4. DUTIES AND RESPONSIBILITIES OF STAFF 9
5. WHO CAN MAKE A COMPLAINT? 10
6. TIMESCALES FOR DEALING WITH COMPLAINTS 11
7. INDEPENDENT HEALTH COMPLAINTS ADVOCACY (IHCA) 12
8. JOINT WORKING ACROSS OTHER STATUTORY ORGANISATIONS 12
9. HANDLING UNREASONABLE COMPLAINANTS 12
10. REMEDY 13
11. CLAIMS FOR COMPENSATION WHERE CARE HAS BEEN NEGLIGENT 13
12. LEGAL PROCEEDINGS AND DISCIPLINARY PROCESSES 13
13. PHSO/OFSTED INVESTIGATIONS 14
14. LEARNING AND MONITORING COMPLAINTS, CONCERNS, COMMENTS AND COMPLIMENTS 14
15. GOVERNANCE ARRANGEMENTS 16
16. IMPORTANT FACTORS TO CONSIDER 16
17. EQUALITY MONITORING 19
18. SUPPORT FOR COMPLAINANTS 19
19. SUPPORT FOR STAFF 19
20. TRAINING 20
21. NHS PRIVATE PAY BEDS 20
22. PROCEDURE FOR STAFF TO FOLLOW WHEN DEALING WITH COMPLAINTS AND CONCERNS 20
23. ARCHIVING ARRANGEMENTS 20
24. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY 20
25. REFERENCES 21
APPENDIX 1: PROCEDURE FOR HANDLING UNREASONABLE COMPLAINANTS 22
APPENDIX 2: THE PROCEDURE FOR HANDLING COMPLAINTS, CONCERNS AND COMMENTS 25
APPENDIX 3: COMMUNICATION PLAN 34
APPENDIX 4: EQUALITY IMPACT ASSESSMENT 36

KEY POINTS OF THIS POLICY:

Complaints/concerns - Flowchart



The Trust recognises the importance of having a process for dealing efficiently and effectively with concerns and complaints from any area of service. Our response should demonstrate the values and behaviors which are the foundation of everything we do at the Trust.

- **Fairness**
  People have a right to be listened to when raising complaints and concerns. Our response should treat people with compassion, courtesy and respect. People raise concerns when their experience of our services has not met their expectations and therefore we should listen without prejudice.

- **Honesty, Openness and Integrity**
  We all have a responsibility to contribute to a climate where the truth can be heard, and learning from complaints or concerns is encouraged. We should never be afraid to say we are sorry.

- **Respect and Dignity**
  We are here to provide a service to our patients and their families. This is never more important than when responding to complaints of concerns. We should ensure that we value the person who is raising issues as an individual, and seek to understand the issue they have raised from their perspective. People have a right to expect respect when they are engaging with our services, and this includes when raising a complaint.

- **Inclusion and Collaboration**
  We should involve the person making a complaint as fully as possible throughout the process, supporting them to develop the terms of reference and maintaining regular contact throughout the investigation of the complaint. The more we treat people raising complaints as partners the more likely it is that they will have a positive outcome, regardless of if their complaint is upheld or not.

The Trust is committed to using feedback from complaints and concerns in a positive way by listening to our users and learning lessons from their experiences to improve the quality of services offered.

A thorough, honest and balanced investigation will be conducted and a full and understandable response provided to the complainant.

1. INTRODUCTION

1.1 The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) recognises the importance of having a Trust-wide, systematic, accessible and impartial process for dealing efficiently and effectively with complaints from any area of service. The culture is underpinned by the existence of the Patient Experience Department (PED). The Trust is committed to using feedback from complaints and concerns in a positive way by listening to our users and learning lessons from their experiences to improve the quality of services offered.

1.2 The Trust is committed to ensuring that those who use its services are readily able to access information about how to make a complaint and that the issues raised are dealt with promptly and fairly. The policy advocates adherence to the principles of good complaint handling as defined by the Parliamentary and Health Service Ombudsman (PHSO):

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

1.3 This Policy takes into account "The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009", which came into effect on 1 April 2009. These Regulations are supported by Department of Health (DH) guidance entitled, "Listening, Responding, Improving – a guide to better customer care". In addition, the Parliamentary and Health Service Ombudsman (the Ombudsman), who is now responsible for investigating NHS complaints that cannot be resolved locally, has published "Principles of Good Complaints Handling". The PHSO have also published other reports which can be found on their website Parliamentary and Health Service Ombudsman | Health.

1.4 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE AND KEY PRIORITIES

2.1 The purpose of this policy is to provide clear guidance to patients, members of the public and staff as to how the Trust will manage complaints, which is in line with the Local Authority Social Services and NHS Complaints (England) Regulations 2009, No. 309.

2.2 The policy applies to all Trust staff, including the Community Division.

2.3 The Trust upholds the view that everyone has the right to expect a good service and to have things put right where something may have gone wrong. A good complaints procedure ensures patients, their relatives and carers can provide feedback to the Trust if they do not receive the service they are entitled to expect. It must focus on outcomes that are fair, proportionate and sensitive to complainants' needs. The process should be clear, straightforward and readily accessible.

2.4 Complaints are a valuable source of feedback for the Trust. They provide an audit trail and can be an early warning of failures in service delivery. They provide an opportunity for the Trust to improve its services and reputation.

2.5 A complaint can arise from an incident which is already being investigated and when

this happens the Patient Experience Lead should liaise with the Incident Investigator Lead to establish whether the complaint issues will be covered as part of the incident investigation. See paragraph 3.3 of Appendix 2 for further details of the process.

2.6 If there are concerns of abuse or neglect a Safeguarding Adult referral (see Safeguarding Adult Policy) should be considered or seek advice from Trust safeguarding team.

2.7 The Trust's key priorities in handling complaints are to:

i) Create a culture which encourages and welcomes patient and service user feedback, with a clear commitment not to discriminate against complainants, or the patients on whose behalf they are acting. This is demonstrated by staff responding appropriately;
ii) Provide complainants with sufficient support to enable them to participate fully in the complaints process;
iii) Provide clear and widely available information about how complaints are handled in language and formats that are appropriate to the complainant's needs;
iv) Promote a prompt, open, flexible dialogue with the complainant throughout the duration of the investigation and response, and beyond;
v) Conduct a thorough, honest and balanced investigation and provide a full and understandable response;
vi) Act on feedback to improve services;
vii) Provide robust evidence of learning and follow up action, where necessary.

2.8 These priorities support the Trust's own values and its strategic priority of improving the patient experience.

2.9 Ongoing training and development, continual assessment of performance and the active involvement of all staff are prerequisites of a complaints procedure which delivers real improvements and sees complainants as equal partners.

2.10 The Trust Board of Directors will ensure these priorities are met.

3. DEFINITIONS

3.1 The following definitions apply for terms used in this policy:

3.2 **Patient:** the person whose care and treatment is the subject of the complaint, concern or comment.

3.3 **Complainant**: the person who is raising the complaint, concern or comment.

3.4 **Patient Advice and Liaison Service (PALS)**:
PALS provides an identifiable person for a patient or member of the public when they have a problem or need information while they are using hospital (including community hospitals) and other NHS services. PALS can also be accessed directly by staff on behalf of patients.

3.5 **Compliment:** a positive way of informing the Trust when services are working well. Compliments are often received at ward, specialty or Divisional level.

3.6 **Comment:** comments are made anonymously by any user of the Trust about any aspect of service provided. Comments can be negative or positive and do not require a response. The Trust has a patient and visitor comment card.

3.7 A **Concern** or **Complaint** is 'any expression of dissatisfaction that requires a response'. It is how the person raising a concern/complaint would like it addressed that helps define whether the expression of dissatisfaction requires an 'informal' or Formal' response.

3.8 It is therefore not always the complexity or severity of a concern/complaint that defines its formality or informality as described below:

- **Concern:** issues of concern that are of a minor nature which are raised, often with front line members of staff, or PALS, at the time they occur, and can be resolved within 24 hours.

- **Complaint:** any concern or issue, either verbal or in writing (including email correspondence) about any aspect of service provided by the Trust which the patient or representative (with the patient's consent) or any person has specifically asked to be addressed formally.

3.9 A **Concern or Complaint** can be made anonymously by any user of the Trust about any aspect of service provided. However it must be considered that non-disclosure of relevant information may prevent a complete investigation being carried out

3.10 A **Patient Safety Incident** is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

3.11 **Litigant in Person**: A **litigant in person** is an individual, company or organization that is not represented in court by a solicitor or barrister, but nevertheless has rights of audience (this is, the right to address the court in person).

3.12 **Local Action Resolution Action Plan**: Form used to document the details of the complaint/concern, contact details of the person raising the concerns together with expectations for resolution.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The **Chief Executive** is responsible for ensuring the Trust complies with the complaints regulations. The Chief Executive will delegate the responsibility for the effective delivery of the Trust's Complaints Policy and Procedure to the Chief Nurse.

4.2 The **Chief Nurse** will, in turn, delegate to the **Deputy Chief Nurse** the responsibility for the operational management of the Trust's complaints handling in line with this Policy.

4.3 Under the operational management of the **Assistant Director for Safety and Quality**, the **Senior Nurse for Safety and Patient Experience** and the **Patient Experience Department** (**PED)** will facilitate the complaints handling process.

4.4 At a Divisional level, the **Divisional Director, Associate Medical Director** and **Assistant Director of Nursing** will be responsible for ensuring complaints and concerns are investigated and responded to in line with this Policy and for ensuring, where appropriate, lessons are learnt and remedial action is implemented and evaluated.

4.5 The **Patient Experience Lead** (or person nominated to act as point of contact for complaints and concerns within the divisions) has a responsibility for adhering to this Policy and the Procedure (Appendix 2). **All staff**, regardless of their role and seniority,

are responsible for supporting complainants with help and information about the procedure and for trying to resolve complaints quickly and appropriately as they arise. This will be done in line with the Trust's own values and with particular emphasis on treating complainants with respect and dignity and ensuring complainants, or the patients on whose behalf they are acting, are not discriminated against. All staff must co-operate fully in complaint investigations and provide accurate statements when requested within the stated timescales.

4.6 Please see section 14.2 which gives information on the duties/reports of each group associated with the policy.

5. WHO CAN MAKE A COMPLAINT?

5.1 A person who receives or has received services from the Trust or who is affected, or likely to be affected, by the action, omission or decision of the Trust.

5.2 A representative acting on behalf of a person who:

a) is deceased
b) is a child
c) is unable to make the complaint themselves due to physical incapacity or lack of capacity within the meaning of the Mental Capacity Act 2005(a)

Where a patient or person affected has died or they lack capacity the representative must be either a relative or other person who, in the opinion of the Senior Nurse for Safety and Patient Experience, had or has a sufficient interest in their welfare and is a suitable person to act as a representative.

Where there is a registered Health and Wellbeing Power of Attorney document the named attorney/s are able to raise issues on behalf of the patient if they do not have capacity and it is in the patient's best interests.

In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by that authority or organisation.

5.3 A representative who has been asked to act on behalf of a patient.
Where the complaint is made by a representative on behalf of the service user, the service user's consent should be obtained, unless the service user does not have capacity to give consent to making a complaint, after assessment (see Assessing Mental Capacity Policy) and in accordance with the Mental Capacity Act 2005. In that case, a representative who makes a complaint can be accepted as the service user's representative by the Trust, provided that the Trust is satisfied that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made. The representative can be, for example, a family member, friend, solicitor or advocate or member of the Care Quality Commission (CQC).

5.4 The Trust has the authority not to consider a complaint made by a representative on behalf of a child or a person who lacks capacity. However, the Trust may only do this where it is satisfied that the representative is not conducting the complaint in the best interests of the person on whose behalf the complaint is made. This power is given to the Trust under the Local Authority Social Services and NHS Complaints (England) Regulations 2009. The Trust will notify the representative in writing and state the reasons for its decision not to consider the complaint.

5.5 Advocacy organisations also provide a useful service in assisting service users, relatives and carers to make a complaint, especially where a complainant is unable to make, or is disadvantaged in being able to make a complaint personally.

5.6 The Independent Health Complaints Advocacy (IHCA) and the Independent Mental Health Advocacy (IMHA) have a statutory role in advising complainants and, where appropriate, assisting them in making complaints.

5.7 The patient information leaflet entitled "The Patient Advice & Liaison Service - We're here to help' explains the process by which someone may raise any concerns they may have. All wards and departments stock supplies of these leaflets which are readily available for patients and the public if required.

5.8 The Trust has a statutory obligation to inform the complainant of their right to information about other sources of support in making their complaint, including the Independent Health Complaints Advocacy (IHCA. This is a free, independent service providing information to anyone who wants to make a complaint. The IHCA has a statutory role in advising complainants and, where appropriate, assisting them in making complaints. They will, if required, deal with the complaint on behalf of the complainant and/or offer impartial information on how to make a complaint.

5.9 In addition to the offer of assistance from the IHCA, other support, for example, provision of a registered interpreter and/or translator for patients whose first language is not English may need to be considered. The support required will depend on the individual requirements of the complainant. For further information refer to the Interpretation and Translation Policy and Procedure (and supporting information) on the Trust's Intranet: A-Z – Interpretation Services, or contact the Patient Advice and Liaison Service (PALS) on 01392 402093 for advice.

5.10 Complaints made by children will be dealt with as appropriate for their age and development, in a way that is relevant to them i.e. face to face or in writing, directly or via parents/carers and taking into account their capacity to make decisions about their care and treatment and their level of understanding about their care and treatment. Should a child require someone independent from the services to speak with regarding a complaint the Matron or nurse in charge will liaise with the Senior Nurse for Safety and Patient Experience or designated person covering to arrange this.

6. TIMESCALES FOR DEALING WITH COMPLAINTS

6.1 The recommended maximum timeframe for resolving a written complaint is six months. Investigations that exceed this timeframe must be undertaken with the complainant's agreement.

6.2 To ensure that issues are dealt with promptly, the Trust has established an internal timeframe for all issues (raised as a complaint or concern) to be responded to within 45 working days unless there is a valid reason for extending this timeframe, as agreed with the Assistant Director for Safety and Quality. An exception to this would be complaints made about the Trust First steps Nursery service which must be responded to within 28 days of receipt, in accordance with OFSTED regulations.

6.3 All written complaints must be acknowledged within 3 working days. If a department receives a formal letter of complaint or complaint requiring a written response, they must forward the complaint to the PED on the day of receipt, where it will be acknowledged in writing and the details of the complaint entered onto the Datix risk management software programme. All formal complaints must have a written response from the Chief Executive or a deputy.

6.4 The time limit for making a complaint is normally within 12 months of the incident, or when the subject of the complaint came to the notice of the complainant. However, the Trust does have discretion to extend this if the circumstances warrant it. The Assistant Director for Safety and Quality will discuss this with the Deputy Chief Nurse, Deputy Chief Executive / Chief Nurse, on an individual basis.

6.5 The Local Authority Social Services and NHS Complaints (England) Regulations 2009 require complaint investigations, responses and resolution to be undertaken within 6 months of the complaint being received. They expect complaints to be responded to in a period that is proportionate to the issue raised.

7. INDEPENDENT HEALTH COMPLAINTS ADVOCACY (IHCA)

7.1 On occasion complaints will be made to the Trust via the IHCA or another recognised advocacy service. When receiving a complaint via the IHCA, the PED will ensure that it has received written permission, from the patient to release information to an IHCA representative. The PED will also ascertain whether the complainant wishes for the Trust to respond to the IHCA or themselves. This information must be received in writing and kept on file.

7.2 When organising meetings with complainants, Trust staff will advise the complainant of their right to have a representative, whether from the IHCA or otherwise to support them. This will also be reiterated in any final written response from the Trust where the complainant is advised of their right to proceed to a review by the Parliamentary Health Service Ombudsman.

7.3 If a person with special needs (e.g. learning difficulties, mental health problems, particularly young or elderly) raises a complaint the PED will make every effort to recommend the complainant seek advice and assistance from the IHCA or another appropriate advocacy agency. Where English is not the complainant's first language, interpreting services will be considered.

8. JOINT WORKING ACROSS OTHER STATUTORY ORGANISATIONS

8.1 If a complaint is made about care delivered by more than one organisation, it is important to provide a single point of contact and a single response to the complainant, if that is what they would like to happen.

8.2 The PED will agree with the other statutory organisations who will lead the complaint investigation and be the single point of contact and lead for pulling together the single response. The organisation with the majority of issues raised will usually be the lead for the complaint.

8.3 If a complaint involves care and treatment received from the adult community services provided by Devon County Council, contact must be made with the PED to discuss the complaint and decide upon which Trust/Service will lead the complaint investigation, dependent on the nature of the issues raised.

8.4 The outcome of these discussions should be shared with the complainant and they should agree to the proposed way forward.

9. HANDLING UNREASONABLE COMPLAINANTS

9.1 On rare occasions, despite our best efforts to resolve a complaint, a complainant can behave unreasonably. The Department of Health has issued guidance on handling

unreasonable complainants and the Trust has adopted this as best practice. See Appendix 1 for details of the Trust's procedure for handling unreasonable complainants.

10. REMEDY

10.1 If the investigation into the complaint has established that the Trust has failed to deliver a satisfactory standard of care, it must try to put things right. However, if the investigation reveals that an error has been made but this is an incidental finding, this should only be acted upon if it is clear that such action can be beneficial to the patient.

10.2 A full explanation of what went wrong plus details of what action has or will be taken to change and improve practices are essential. These will be outlined in the final response and be accompanied by a full and sincere apology.

10.3 Over and above this the Trust may give financial compensation for loss of earnings or travel costs or for the loss of personal property. The final decision on whether to pay any such financial compensation will rest with the Assistant Director for Safety and Quality or Deputy Chief Executive / Chief Financial Officer (dependent upon amount claimed).

10.4 The issue of financial compensation for inconvenience and distress is complex and the existing guidance focuses on principles. When the issue of financial compensation for inconvenience and distress is raised it should be discussed with senior Divisional staff and the Assistant Director for Safety and Quality. Decisions reached must be done so after full reference to the Ombudsman's "Principles for Remedy".

11. CLAIMS FOR COMPENSATION WHERE CARE HAS BEEN NEGLIGENT

11.1 Where the complainant has suffered harm through negligent care compensation cannot be provided under this Policy and the case must be forwarded to the Legal Department by the PED for review and consideration by the National Health Service Litigation Authority (NHSR).

11.2 If the complainant wishes to take legal action the complaints process can be run in conjunction with the claim and the complainant will be advised to either take legal representation, or proceed as a litigant in person, and contact the Trust Solicitor.

12. LEGAL PROCEEDINGS AND DISCIPLINARY PROCESSES

12.1 The complaints procedure is a separate and distinct process from both legal and disciplinary proceedings. The complaints process cannot provide compensation for clinical negligence or be used in staff disciplinary matters. If concerns are raised via the complaints procedure about a particular member of staff, action may be required under the Trust's Disciplinary and Appeals Policy. Further advice should be sought from the Senior Nurse for Safety and Patient Experience.

12.2 Disciplinary action may take place as a result of the investigation findings, however details of such action cannot be provided to the complainant due to confidentiality to the person involved. The Trust would be able to confirm that appropriate human resources policies have been instigated and followed.

12.3 The PED will establish at the outset the person's suggestions for remedy. Should

this be compensation or disciplinary action, the PED will discuss the options available.

12.4 The Parliamentary Health Service Ombudsman (PHSO) will not investigate any matters being considered or already determined via a legal process.

13. PHSO/OFSTED INVESTIGATIONS

13.1 If, after everything possible has been done to resolve a complaint, the complainant is still not satisfied, they can ask the PHSO, or OFSTED in the case of complaints about the Trust's First Steps Nursery, to review the matter.

13.2 The Trust's information leaflet and final response letters will explain this right to the complainant.

13.3 All dealings with the PHSO will be handled through the PED.

13.4 When investigating a complaint, the PHSO will seek access to all relevant records and documentation kept by both the PED and/or the Divisions. All such records and documentation must be made available to the Assistant Director for Safety and Quality within the PHSO's requested timescale.

13.5 More information about the work of the PHSO can be obtained through the Assistant Director for Safety and Quality or the PHSO's website.

14. LEARNING AND MONITORING COMPLAINTS, CONCERNS, COMMENTS AND COMPLIMENTS

14.1 To ensure learning from complaints and concerns the Trust takes a positive attitude and uses the findings from investigations to highlight areas where changes can be made to improve services and ensure people receive a more positive experience when they visit the Trust.

14.2 To ensure the Trust is able to identify changes resulting from feedback and to monitor emerging trends and themes, a variety of reports are produced within the Trust as detailed below:

14.2.1 Board of Directors

- A quarterly report, as part of the Integrated Performance Review, outlining the total number of complaints and concerns received Trust-wide, top themes and number of cases referred to the PHSO will be submitted to the Board of Directors. This report enables the Board to monitor the effectiveness of the complaints procedure. It will also identify trends and service changes that have been made in response to complaints.
- The Board of Directors will receive an annual report on the Trust's complaint activity for the financial year, including any matters of general importance arising out of the complaints or the way they were handled, cases referred to the PHSO, lessons learned and resultant improvements in care. This report includes data to allow the Trust to benchmark the effectiveness of its procedures against other organisations.

14.2.2 Divisional Performance Assurance Framework

- Complaints activity will be monitored monthly with each Division as part of the Trust's
- Performance Assurance Framework.

14.2.2 Governance Committee

- The Trust's Governance Committee will receive a report following each meeting of the Patient Experience Committee to provide assurance and provide an action plan to cover any gaps in assurance.

14.2.3 **Patient Experience Committee**

- The Patient Experience Committee (PEC) will review a copy of the Patient Experience quarterly report of all complaints and concerns and their trends.

- PEC will analyse sources of patient feedback, identify emergent themes, triangulate with intelligence about and from Members and the wider community and prepare reports for the Governance Committee.

- PEC will set up Task and Finish groups when required to look at specific themes arising from patient experience feedback.

14.2.4 **Incident Review Group**

The Incident Review Group will:

- Ensure a systematic approach to the cross-referencing and aggregation of incidents, complaints and claims and that learning is shared and action plans completed.
- Undertake spot audits on historic investigations, complaints and claims to evaluate the learning and changes in practice.
- Ensure the organisation actively investigates, analyses root causes and learns from adverse events, including Serious Incidents Requiring Investigation [SIRI], complaints and claims via investigation reports.
- Triangulate for emergent themes against incidents, complaints and claims.
- Disseminate lessons learned to the wider organisation and community where indicated.

14.3 **Performance Monitoring**

14.3.1 The Assistant Director for Safety and Quality will be responsible for the conduct of on-going data quality validation of entries on Datix. Any inaccuracies or quality issues identified will be raised with the responsible member of staff and Assistant Director of Nursing for that area. This will include lead times and quality of investigations. Monitoring of completion of specific fields within Datix will also be included in the Performance Assurance Framework for Divisions as required.

14.3.2 The Assistant Director for Safety and Quality will be responsible for providing regular performance monitoring reports to the Divisional Directors and Assistant Directors of Nursing demonstrating performance on complaint activity within the Division. A copy will be sent to the Deputy Chief Nurse for information. It will be the responsibility of the Assistant Director of Nursing for each Division to provide an update to the PED on progress on performance with each outstanding case identified.

14.3.3 The Assistant Director for Safety and Quality will be responsible for the reviewing of complaint investigations on Datix to identify remedial actions and when appropriate, challenge with the Assistant Director of Nursing, any lack of action or recommend actions. This will be done as part of the quality check of the final response to the complainant.

14.3.4 The Assistant Director for Safety and Quality will be responsible for the provision of an

annual audit report to the PEC on a random sample of ten cases per division/, using a standardised audit tool, to ensure that this Policy has been adhered to. This will include a check on whether information in relation to the concern or complaint has been filed within the patient's medical notes or on the Trust's Clinical Document Management System (CDM).

14.3.5 The Trust will make available to Service Commissioners, on an agreed basis, information regarding the number of complaints, and effectiveness of response, the Trust has received. The Trust will also ensure that Service Commissioners receive a copy of the annual patient experience report as required within the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

15. GOVERNANCE ARRANGEMENTS

15.1 The Trust is committed to continually improving the standard of clinical care for patients/clients. The Trust is required to have systems in place to ensure that lessons have been learned and that appropriate action has been taken as a direct result of a complaint. This responsibility is delegated to Divisional Governance Groups which are responsible for implementing and monitoring any relevant actions.

15.2 Care Quality Commission regulations deal specifically with the management of complaints. The Assistant Director for Safety and Quality is responsible for the collation of evidence for this regulation.

16. IMPORTANT FACTORS TO CONSIDER

16.1 Patient confidentiality and consent

16.1.1 If those raising complaints, concerns or comments are acting on behalf of a patient, personal health information must not be disclosed to the complainants without consent from the patient. The PED will obtain consent from the patient prior to the release of any clinical and personally identifiable information. The investigation however must start on receipt of the original letter of complaint, concern or comment and not when the letter is returned providing consent. There are rare occasions when the Chief Executive will seek consent before the formal investigation begins and this decision will be based on the content and nature of the complaint received.

16.1.2 When submitting a complaint, comment etc., the complainant needs to be aware that their information will be shared with the relevant department or service area. If the person wishes to remain anonymous they should state this in their initial contact with the Trust. However it must be considered that non-disclosure of relevant information may prevent a complete investigation being carried out. Each issue is looked at on a case by case basis and in certain cases, such as safeguarding, anonymity would always be considered. Advice can be sought from the Safeguarding Team.

16.1.3 On receiving a complaint, a decision should first be made as to whether the complainant is a suitable person to pursue the complaint. This does not apply if the complainant is the patient. However, where the complaint is brought on behalf of the patient, consideration needs to be given to all relevant factors such as the closeness of the complainant's involvement with the patient over the time they had known them, the nature and frequency of their contact and their beliefs about what the patient would have felt about the complainant making the complaint on their behalf. If the patient is alive and competent to give consent then this should be sought but obviously the difficulty arises where the patient has died or lacks capacity.

16.1.4 It should first be noted in such situations that the term 'next of kin' has no specific

definition in law and therefore has no relevance. Individual trusts or healthcare providers may have policies on which they define and accept as next of kin for their record keeping/notification purposes but this does not confer on the individuals concerned any authority to control access to records or complaints investigations. Any objection by the next of kin to the complainant bringing the complaint might be a relevant factor to consider but this would not be conclusive. The next of kin would not have a right of veto over whether the complainant is accepted as a suitable person to pursue the complaint.

16.1.5 If the next of kin or the respondent to the complaint identifies any reason why it would be inappropriate for the complainant to have information about the patient that would be a factor in considering whether they are a suitable person to complain. On this point, consideration should also be given to whether there are any reasons not to release information to the complainant. This is particularly relevant if the complaint concerns events that the complainant personally witnessed. In such a case, it would not, on the face of it, appear that the information concerned would be of a particularly confidential nature.

16.1.6 When a patient has died, the provisions of the Data Protection Act 2018 (which relates only to living persons) do not apply to any information about their care or treatment, although the Act would protect any information contained about the living next of kin contained on the patient's medical file. As the complainant is making a complaint and not a request for access to the patient's health records, the Access to Health Records Act 1990 (which applies to deceased persons) would also not apply.

16.1.7 With a complaint relating to the treatment and care of a deceased patient, information can be shared with the patient's next of kin or representative of the deceased. If there is any doubt or discrepancy, PED staff will access the patient's medical record and act in accordance with whom the recorded next of kin was at the time of death.

16.1.8 If the NHS Trust accepts the person as a suitable complainant, they will be entitled to receive such information from the patient's file (including personal information) as is necessary to explain the reasons for the conclusions reached by the respondent. This would be releasing information for the purposes of carrying out the statutory function of an NHS complaint investigation, not as a request for access to records.

16.1.9 If a complaint is received on behalf of a patient because they believe they lack capacity, reasonable steps should be taken to confirm the presence of a condition which may impair capacity. This would include conditions such as dementia, brain injury or learning disability. Confirmation of this condition must be sought from:

- The GP, if the patient is not an inpatient.
- The consultant responsible for the patient's care whilst an inpatient.
- The Learning Disability Liaison Nurse
- The presence of a condidtion does not indicate a lack of capacity. Reference must be made to the Mental Capacity Act 2005.

16.1.11 Where a complaint is made by a step-parent/carer or foster-carer on behalf of a child in their care, it must be determined with the complainant who has parental responsibility for the child. The case must never be discussed or any information released to a person who does not have parental responsibility.

16.2 A Duty of Candour to Complainants

16.2.1 It is now a statutory requirement to observe a duty of candour:

16.2.2 On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient, to inform that patient, or other duly authorised person as soon as it is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request.

16.2.3 On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by, or on behalf of any healthcare provider by which they are employed, has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.

16.2.4 Where death or serious harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, even if the information has not been requested.

16.3 Complaints received from Members of Parliament

16.3.1 When complaints are made by Members of Parliament (MP) on behalf of their constituents, if a patient has visited an MP in their surgery, written to them requesting their representation on their behalf in making a complaint, or contacted them by telephone, consent is not required under the current complaints regulations. In most cases the MP encloses a copy of the constituent's letter.

16.3.2 If the MP states that they have received their constituent's permission, the Trust will assume this to be the case and therefore there is no requirement to seek permission. Information is only disclosed on a need to know basis. Nothing more than the relevant information pertaining to the complaint is given in the final response.
The Trust will endeavour to ensure a speedy response and clarify the situation with the MP.

16.3.3 If an MP is representing a constituent who is acting on behalf of a patient, then consent must be obtained from the patient. Information must never be disclosed without the permission of the patient. If the MP has obtained this permission then they must provide us with the written document.

16.3.4 In all of the above situations, under the Local Authority Social Services and National Health Services Complaints Regulations 2009, the final decision about how to proceed rests with the Assistant Director for Safety and Quality, who will, if appropriate, seek guidance and assistance from the Trust's Caldicott Guardian with regard to the Data Protection Act 2018 and patient confidentiality. The Trust must be satisfied that the complainant is acting in the patient's best interest. In certain cases, it may be necessary to seek advice from the Trust Solicitor.

16.4 Complaints received from Legal Representatives

16.4.1 Rarely, complaints will be raised via a complainant's legal representative. This should not in itself be taken as an intention to proceed to legal action although the PED will seek clarification from the legal representative whether the complainant intends to take legal action in respect of the complaint or wishes for an investigation as a formal complaint.

16.4.2 If the complainant wishes to take legal action the complaints process will run in conjunction with the claim and the complainant will be advised to take legal representation, or proceed as a litigant in person, and contact the Trust Solicitor.

16.4.3 When receiving a complaint via a legal representative, the PED will ensure that it has received written permission from the patient to release clinical information to the legal representative. The PED will also ascertain whether the complainant wishes for the Trust to respond to the legal representative or themselves.

16.5 HM Coroner's Office

16.5.1 Occasionally a complaint may be made after a patient's death has been referred to the Coroner's Office or during the course of a Coroner's Inquest. This should not prevent the Trust's investigation continuing but the Trust Solicitor should be informed that a complaint has been made. Information obtained during the investigation of the complaint must not be released to the complainant without knowledge of the Trust Solicitor as certain information could impact upon the outcome of the Inquest.

16.6 Complaints received from Transgender Patients

16.6.1 Under Section 22 of the Gender Recognition Act 2004, we risk legal action if we disclose, without the patient's consent, the past gender history of a patient who is living in a gender other than their birth gender. The risk applies whether or not the patient has a Gender Recognition Certificate, which is the official recognition of a gender transition. Such disclosure could occur if we forward case notes, which include previous gender history, for investigation of a complaint.

17. EQUALITY MONITORING

17.1 It is Trust policy that no person, whether patient/client, relative, carer or any other member of the public, shall be discriminated against on grounds of race, gender, language, colour, religion or any type of disability when making a complaint. Interpreting services can be provided if required.

17.2 Staff who are involved in investigating a complaint should consider whether there may have been less favourable treatment of the complainant, arising from any of the protected characteristics listed above. Where there are issues, these should be reflected in the summary reporting of the complaint.

18. SUPPORT FOR COMPLAINANTS

18.1 Some individuals may not use English as their first language, or may have other communication or learning difficulties. In these circumstances, the Trust will ensure that such complainants have access to adequate support to enable them to fully participate in the complaints process. The PED will make the necessary arrangements on an individual case-by-case basis, after discussion with the complainant or their advocate or representative.

18.2 Where the patient has a known disability or "specific need", they will be offered reasonable adjustments, as necessary, to enable full participation in the investigation and resolution of the complaint. This will include ensuring that facilities used for any meetings with the patient are "disability-friendly".

19. SUPPORT FOR STAFF

19.1 All staff have a responsibility to work towards resolving a complaint to the satisfaction of the complainant. To enable staff to contribute appropriately, the PED will provide a variety of training and awareness sessions.

19.2 When required, PED staff will provide guidance, help and direct support to staff who are responding to complaints. Further information is also available on the Intranet.

19.3 The Trust's Supporting Staff Involved in an Adverse Event Procedure provides further details of the support available to staff.

20. TRAINING

20.1 The Trust understands the importance of staff training and development to ensure it delivers effective complaints handling and this is included within the Corporate Induction. The department will also provide whatever support and training it can to individual departments and staff groups.

21. NHS PRIVATE PAY BEDS

21.1 This Policy covers any complaint made about the Trust's staff relating to care in the Trust's private pay beds/service areas, but not to the private medical care provided by the consultant outside his/her NHS contract. Complaints relating to medical care provided under private arrangements must be pursued with the practitioner concerned.

22. PROCEDURE FOR STAFF TO FOLLOW WHEN DEALING WITH COMPLAINTS AND CONCERNS

22.1 Detailed procedures for staff to follow when investigating and responding to complaints and concerns are available in Appendix 2.

23. ARCHIVING ARRANGEMENTS

The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

24. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

24.1 The Senior Nurse for Safety and Patient Experience will be responsible for the performance of an annual audit on a random sample of ten cases per Division, using a standardised audit tool, to ensure that this Policy has been adhered to. The audit will consist of measuring the effectiveness of this policy but will include as a minimum an examination of the following items:

- the process for raising concerns
- the process by which the organisation aims to make changes as a result of formal complaints or concerns being raised
- the complaints management process, which includes internal and external communication, and collaboration with other organisations when necessary
- acknowledgement times of complaints
- whether information in relation to the concern or complaint has been filed within the patient's medical notes or on the Trust's Clinical Document Management System (CDM)Compliance with specific timeframes
- that a complainant with any form of disability was able to raise their issue and receive a response in a format which met their specific communication needs

24.2 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

What areas need to be monitored	How will this be evidenced?	Where will this be reported and by whom?
Listening and responding to complaints and concerns from patients, their relatives/carers	Annual audit of ten randomly selected cases per Division	Patient Experience Committee
Joint complaint handling between organisations	Included in annual audit as above	Patient Experience Committee
Ensuring that patients, their relatives/carers are not treated differently as a result of raising a complaint/concern	All complainants to receive a user satisfaction survey and an annual report produced.	Patient Experience Committee
Making improvements as a result of a complaint or concern	Changes in practice/service made and details included in the monthly Board report and quarterly Patient Experience Report	Trust Board and Patient Experience Committee
Compliance with complaint response times	Regular monitoring of response times and results included in monthly and quarterly reports	Performance Assurance Framework (PAF) Patient Experience Committee

25. REFERENCES

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

Access to Health Records Act 1990

Data Protection Act 2018

Gender Recognition Act 2004

Mental Capacity Act 2005

Department of Health (DH) guidance entitled, “Listening, Responding, Improving – a guide to better customer care”, February 2009.

Parliamentary and Health Service Ombudsman (the Ombudsman)“Principles of Good Complaints Handling”, November 2008.

APPENDIX 1: PROCEDURE FOR HANDLING UNREASONABLE COMPLAINANTS

1. INTRODUCTION

1.1 Persistent and/or vexatious complainants are becoming an increasing problem for NHS staff. The difficulty in handling such complaints is placing a strain on time and resources and is causing undue stress for staff who may need support in difficult situations. NHS staff are trained to respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

1.2 In determining arrangements for handling such complaints, staff are presented with two key considerations:

- The first is to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that even repeated complaints may have aspects which contain some genuine substance. The need to ensure an equitable approach is crucial.
- The second is to be able to identify the stage at which a complaint has become unreasonable. One approach to the situation is to develop an approved policy, which is formally incorporated into the complaints procedure. Implementation of such a policy would only occur in exceptional circumstances. Information on the handling of unusual or unreasonable complaints could also be made available to the public as part of the material on the complaints process as a whole.

2. PURPOSE OF THIS PROCEDURE

2.1 The aim of this procedure document is to identify situations where the complainant might be considered to be unreasonable and to suggest ways of responding to these situations.

2.2 The procedure should only be implemented following careful consideration by, and with the authorisation of, the Chief Executive of the Trust or their deputies in their absence.

3. DEFINITION OF AN UNREASONABLE COMPLAINANT

3.1 Complainants (and/or anyone acting on their behalf) may be deemed as “unreasonable complainant behaviour” or be raising “unreasonable persistent complaints” where previous or current contact with them shows that they meet TWO OR MORE of the following criteria:

3.2 Where complainants:

- Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (e.g. where investigation has been denied as "out of time", where the Care Quality Commission has declined a request for Independent Review).
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints.
- Are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, General Practitioner manual or computer records, nursing records or deny receipt of an adequate response in spite of correspondence

specifically answering their questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the Trust's staff and, where appropriate, the Care Quality Commission, to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.
- Focus on a trivial matter to an extent, which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a 'trivial' matter can be subjective and careful judgement must be used in applying this criteria).
- Have threatened or used actual physical violence towards staff or their families or associates at any time – this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidents should be documented).
- Have in the course of addressing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section, using judgement based on the specific circumstances of each individual case).
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment).
- Are known to have recorded meetings or face-to-face/telephone conversations without the prior knowledge and consent of other parties involved.
- Display unreasonable demands or patient/complainant expectations and 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 normal recognised practice).

4. OPTIONS FOR DEALING WITH UNREASONABLE COMPLAINANTS

4.1 Where complainants have been identified as unreasonable in accordance with the above criteria, the Assistant Director for Safety and Quality will advise the Chief Executive (or appropriate deputy in their absence) what action to take. The Chief Executive (or deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as unreasonable and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. conciliator, Care Quality Commission, Independent Health Complaints Advocacy (ICHA), and Member of Parliament.

4.2 A record must be kept for future reference of the reasons why a complainant has been classified as unreasonable. The Chief Executive (or deputy) may decide to deal with complaints in one or more of the following ways:

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

- Once it is clear that complainants meet any one of the criteria above, it may be appropriate to inform them in writing that they may be classified as an unreasonable complainant, copy this procedure to them, and advise them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that complainants seek advice in processing their complaint, e.g. through the ICHA.
- Decline contact with the complainants either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party.
- Notify the complainants in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should be notified that correspondence is at an end and that further letters received will not be acknowledged.
- Inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable complaints to the Trust's solicitors.
- Temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Regional Office, National Health Service Executive, or other relevant agencies.

5.0 WITHDRAWING 'UNREASONABLE' STATUS

5.1 Once complainants have been determined as 'unreasonable' 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. Staff should previously have used discretion in recommending 'unreasonable' 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 (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

APPENDIX 2: THE PROCEDURE FOR HANDLING COMPLAINTS, CONCERNS AND COMMENTS

1. DESCRIPTION AND PROCESS

1.1 **Compliment:** a positive way of informing the Trust when services are working well. Compliments are often received at ward, speciality or Divisional level. Staff are encouraged to bring praise received to the attention of their managers. This allows figures to be collated within Divisions. These figures are forwarded to the Patient Experience Department (PED) for inclusion in the quarterly performance reports for the Patient Experience Committee.

1.2 **Comment:** comments can be made anonymously by any user of the Trust about any aspect of service provided, by way of the Trust's patient and visitor comment card. Comments can be negative or positive and do not require a response. Trust staff should encourage patients and relatives to complete these cards which are collated by the PED and reported to the Board. These comments will then feed into the performance reporting for the Board of Directors and Patient Experience Committee. Comments can also be made direct to the PED.

1.3 A **concern** or **complaint** is 'any expression of dissatisfaction that requires a response'. It is how the person raising a concern/complaint would like it addressed that helps define whether the expression of dissatisfaction requires an 'informal' or 'formal' response. It is therefore not always the complexity or severity of a concern/complaint that defines its formality or informality as described below:

- **Concern:** issues of concern that are usually of a minor nature which are raised, often with front line members of staff, or PALS, at the time they occur, and can be resolved within 24 hours. It may be possible for the member of staff to resolve the issue at the time, if not the issue should be passed to the appropriate senior colleague. Some patients, relatives and carers wish to raise concerns about the care and treatment they may have received or witnessed but express a wish not to make a formal complaint. The Trust will investigate concerns in a way agreed with the complainant.

- **Complaint:** any concern or issue, either verbal or in writing (including email correspondence) about any aspect of service provided by the Trust which the patient or representative (with the patient's consent) or any person has specifically asked to be addressed formally.

1.4 A c**oncern** or **complaint** can also be made anonymously if the complainant wishes although this may not always be possible as names may be required in order to facilitate a full investigation. The complainant should be made aware of this at the time of raising the concern/complaint.

2. RECEIPT OF COMPLAINTS AND CONCERNS

2.1 Complaint letters are normally received either via the Chief Executive's office or direct to the PED. Formal complaints can be made:

Verbally – either in person or by telephone to 01392 402093

By letter to the Chief Executive's office which should be

scanned and forwarded to PED within 24 hours.

By email to rde-tr.complaints@nhs.net

2.2 If a complaint is received by a clinician, ward or department either verbally (face to face or telephone) or letter, it must be acknowledged by the person it is addressed to

within 3 days of receipt and consent must be sought from the patient/complainant before this can be forwarded to the PED. Once consent has been obtained the letter must be either scanned and emailed to the PED or brought to the department by hand on the day consent was received. (If e-mailed the original letter must be posted to the PED via the internal mail). The timescale for commencing an investigation starts when the letter of complaint is received in the Trust, **not** when it is subsequently received in the PED.

3. RISK ASSESSMENT

3.1 In order to understand the impact of complaints on the individuals involved and the organisation, the complaint is graded by the PED in line with the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedures. The system used is detailed in the risk matrix available on HUB and it is essential to assess all complaints received using this matrix. The PED apply the grading when they receive the complaint, although subsequent investigation may reveal a different grade. The grade can be adjusted following the completion of the investigation if required.

3.2 All complaints graded as medium or high risk must be escalated immediately they are received to the Assistant Director of Nursing within the relevant Division and Assistant Director for Safety and Quality, who will escalate to the Deputy Chief Nurse, Deputy Chief Executive/Chief Nurse, Chief Executive or Medical Director where necessary

3.3 The actions taken as a result of all investigations must be included in the response to the complainant. If a moderate or full incident investigation is also being undertaken (as defined in the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedures) the Patient Experience Lead should discuss with the incident investigation lead to determine if the incident picks up all the complaint issues. The division Patient Experience Lead should contact the complainant to advise of the new contact and the lead incident investigator should also contact the complainant to introduce themselves and advise the way forward. Regular contact must be maintained throughout the investigation. A letter must be sent to the complainant to confirm. It is essential that the results of these investigations are communicated to the patient and also reflected in the original complaint on Datix.

4. PROCEDURE FOR COMPLAINTS AND CONCERNS (TAKEN VERBALLY OR IN WRITING)

(See Flowchart – Appendix 3)

4.1 Any Complaint received by the Chief Executive's Office should be passed direct to PED within 24 hours of receipt. Complaints received by anyone else must be dealt with as per paragraph 2.2 above.

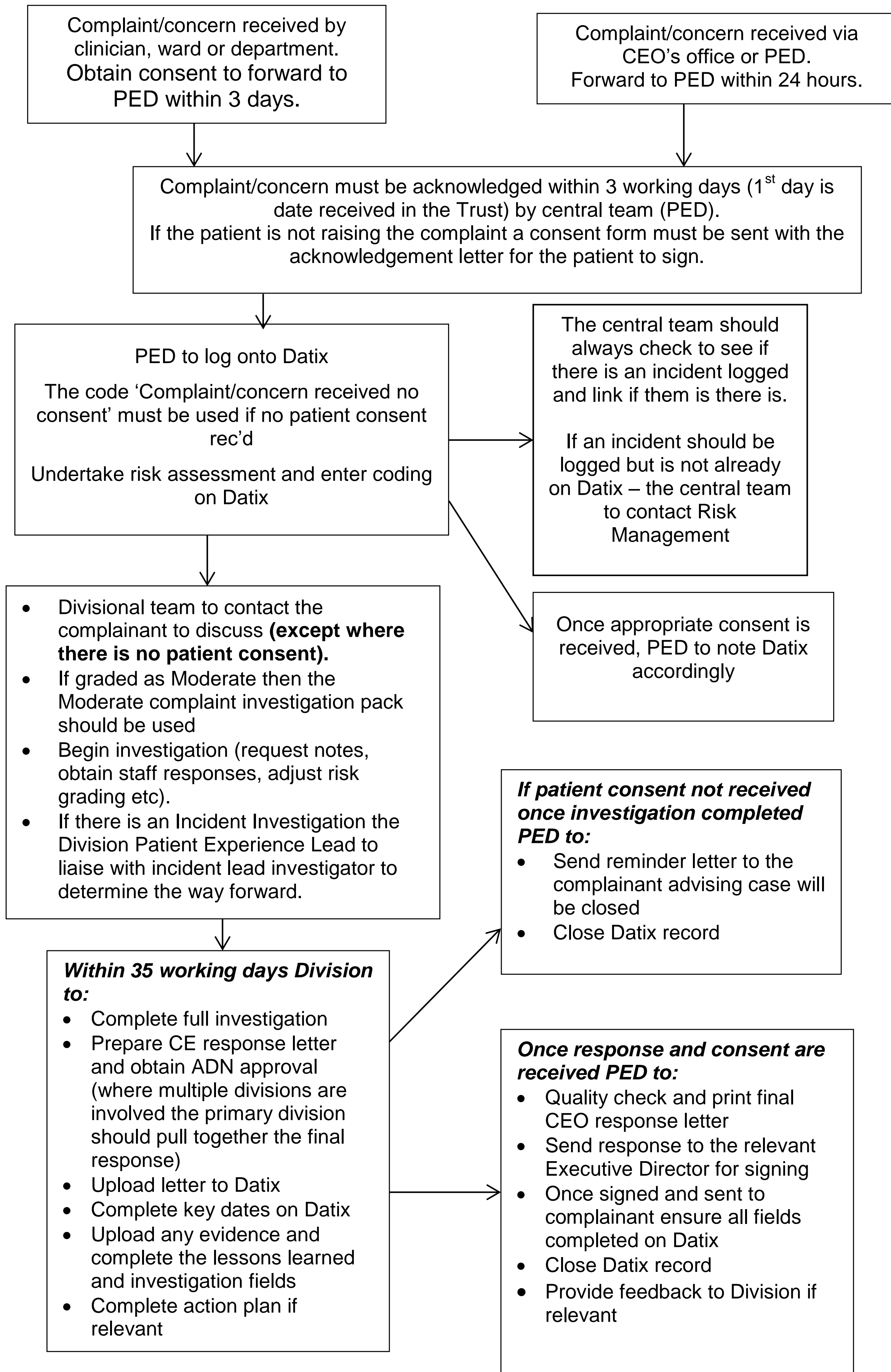
4.2 In some cases the complaint may have been dealt with instantly (i.e. face to face) in which case the nominated lead must alert the PED so that the correct letter is sent from the Chief Executive.

4.3 PED to acknowledge receipt of complaint in writing within 3 working days (using a standard template available on the Complaints pages of HUB) of receipt into the Trust. If the complaint has been taken verbally the issues raised by the complainant will be included in the acknowledgement letter and written consent requested to include confirmation that the details of the complaint and the action to be taken are correct.

4.4 PED to check Datix to see whether an incident or claim has been logged for the same

episode of care and if so, to link the cases on the incident, complaint and claim modules of Datix. If an incident has not been logged and is deemed to be applicable, PED to contact the Risk Manager for advice.

Complaints/concerns - Flowchart



4.5 The initial acknowledgement will:

i) Thank complainant for their letter, email or call

ii) Confirm or establish the precise nature of the complaint if taken verbally

iii) Confirm the extent to which the Complaints Procedure can respond to the issue i.e. if compensation requested to advise if this can be dealt with under the Complaints Procedure

iv) Advise of other options available to the complainant, e.g. the role of the IHCA or IMHA.

v) Advise the Trust timescale for a full response to the complaint

vi) Identify any special requirements in relation to Equality and Diversity, e.g. response in another language, large format, etc.

vii) Confirm the preferred means of communication, e.g. letter, email, telephone

4.6 The Divisions involved will be emailed with the details for investigation.

4.7 Divisional Lead to contact the complainant to discuss the precise nature of the complaint, the complainant's expectations and timescales (except where consent has not been received) (see 'Guidance on conducting a complaint investigation' and 'Guidance on writing a statement for a complaint investigation').

4.8 Division to ensure that if the complaint is being made by a third party, the consent of the patient has been obtained by the PED before sharing confidential information with the third party. If it is not possible to obtain such consent, e.g. if the patient has died or is incapable of giving it, senior managers will consider the particular circumstances in deciding whether to investigate the complaint. Advice on this point is available from the Senior Nurse for Safety and Patient Experience.

4.9 It is the Divisional Patient Experience Lead's responsibility to ensure a thorough and objective investigation is carried out, involving all the relevant staff and reviewing necessary documentation, within the agreed timeframe. Each issue raised should be clearly responded to in detail and the response should include:

- a clear apology where expectations have not been met or where there has been shortcomings
- whether the issues raised have been upheld/not upheld
- details of any learning or actions taken as a result of the complaint, along with an appropriate timeframe for completion

4.10 When a complaint has been graded as Moderate the investigation should be undertaken by using the relevant templates (Section 10) in order to obtain as much information as possible.

4.11 Division to keep in regular contact with complainant to provide an update on progress.

4.12 If an incident investigation is implemented the Patient Experience Lead and the incident investigation lead should discuss the issues and contact the complainant as described in paragraph 3.3 of Appendix 2.

4.13 Division to draft response to complainant from Chief Executive which should be approved by the Assistant Directors of Nursing. The response should be

attached to the documents section on Datix and complete 'Response done' field under 'Key Dates' (see Guidance on preparing a letter of response).

4.14 Division to complete investigation report, action plan and outcome sections of Datix.

4.15 PED to email response for signing to the relevant Executive Director who is the assigned deputy acting on behalf of the Chief Executive at that time. Once signed, PED to post within 24 hours. If the response does not pass the final quality check by PED it is sent back to author for revision.

4.16 PED close complaint file and check data completeness on Datix of investigation report, action plan and outcome sections. If sections not completed Divisional Lead to be contacted.

5. PROCEDURE FOR CONCERNS (TAKEN VERBALLY, IN WRITING OR VIA PALS)

5.1 Concern received by Chief Executive's Office, passed direct to PED/PALS, or to clinician, ward, department either verbally (face to face or telephone) or letter, passed to nominated lead within the Division within 24 hours of receipt.

5.2 Concern passed to PED from above routes within 24 hours of arrival in those areas, to log on Datix. In some cases the concern may have been dealt with instantly (i.e. face to face) in which case the nominated lead must forward the outcome to PED.

5.3 PED to acknowledge receipt of a written concern in writing within 3 working days of receipt into the Trust. The initial acknowledgement will:

i) Thank complainant for their letter, email or call

ii) Confirm or establish the precise nature of the concern

iii) Confirm the extent to which the Complaints Procedure can respond to the issue i.e. if compensation requested to advise if this can be dealt with under the Complaints Procedure

iv) Advise other options available to the complainant, e.g. the role of the Independent Complaints Advocacy Service (IHCA)

v) Advise the Trust timescale for a full response to the complaint

vi) Identify any special requirements in relation to Equality and Diversity, e.g. response in another language, large format, etc.

vii) Confirm the preferred means of communication, e.g. letter, email, telephone.

5.4 The Divisions involved will be emailed with the details for investigation.

5.5 Divisional Lead to contact the complainant to discuss the precise nature of the concern, the complainant's expectations and timescales (except where consent has not been received) (see 'Guidance on conducting a complaint investigation' and 'Guidance on writing a statement for a complaint investigation').

5.6 PED to check Datix to see whether an incident or claim has been logged for the same episode of care and if so, to link the cases on the incident, complaint and claim modules of Datix. If an incident has not been logged and is deemed to be applicable, PED to contact the Risk Management Department for advice.

5.7 Ensure that if the complaint is being made by a third party, the consent of the patient is obtained before sharing confidential information with the third party. If it is not possible to obtain such consent, e.g. if the patient has died or is incapable of giving it, senior managers will consider the particular circumstances in deciding whether to

investigate the complaint. Advice on this point is available from the Patient Engagement and Experience Services Manager.

5.8 Division to keep in regular contact with complainant to provide an update on progress.

5.9 Concerns may be responded to from the Division rather than the Chief Executive if appropriate but must always be checked by the Assistant Director of Nursing (or equivalent in non-clinical areas) before being sent.

5.10 If written response from Chief Executive requested by complainant, attach draft response to documents section on Datix and complete 'Response done' field under 'Key Dates'. Assistant Directors of Nursing to check quality of response.

5.11 If verbal response requested by complainant, Divisional Lead to attach the completed Telephone Outcome Form to Datix and complete 'Response done' field under 'Key Dates'.

5.12 Division to complete investigation report, action plan and outcome sections of Datix and attach the summary of the conversation.

5.13 If written response required from the Chief Executive's, PED to email response for signing to the relevant Executive Director who is the assigned deputy acting on behalf of the Chief Executive at that time, and once received back to post within 24 hours.

5.14 PED close complaint file and check data completeness on Datix of investigation report, action plan and outcome sections. If sections not completed Divisional Lead to be contacted.

6. ORGANISING MEETINGS WITH COMPLAINANTS

6.1 When organising meetings with complainants, Trust staff will advise the complainant of their right to have a representative, whether from IHCA or otherwise to support them (see Guidance to Best Practice on Meeting with Complainants on HUB).

7. PATIENT CONFIDENTIALITY AND CONSENT

7.1 If those raising complaints and concerns are acting on behalf of a patient, personal health information must not be disclosed to the complainants. The PED will obtain consent prior to the release of any clinical information.

7.2 The investigation however must start on receipt of the original letter of complaint, concern or comment and not when the letter is returned providing consent. There are rare occasions when the Chief Executive will seek consent before the formal investigation begins and this decision will be based on the content and nature of the complaint received.

7.3 Verbal consent will be accepted at the discretion of the Senior Nurse for Safety and Patient Experience. If through physical or mental incapacity the patient is unable to give consent the concern or complaint can be investigated through the NHS Complaints Procedure. In this situation staff will give particular attention to respecting patient confidentiality and to any requirement expressed by the patient on disclosing information to third parties.

7.4 If the Trust does not receive authorisation from the patient, the complainant cannot be given a full response or details of care provided to the patient. The Trust will

however, ensure the patient is receiving the correct care and that any issues in the concern or complaint are investigated and rectified.

7.5 In situations where the child is deemed competent and has received medical care in the Trust without parental knowledge or consent, the confidentiality of the child will be maintained.

7.6 With a concern or complaint relating to the treatment and care of a deceased patient, information is shared only with the next of kin or representative of the deceased. If there is any doubt or discrepancy, Patient Experience staff will access the patient's medical record and act in accordance with who the recorded next of kin was at the time of death.

7.7 For more information on patient confidentiality and consent contact the Senior Nurse for Safety and Patient Experience

8. COMPLAINTS RECEIVED FROM TRANSGENDER PATIENTS

8.1 Under Section 22 of the Gender Recognition Act 2004, complaints are not allowed to be forwarded in the normal way if the complainant advises they already have, or are currently, undergoing transition and are applying for a full Gender Recognition Certificate (GRC). It is the responsibility of the recipient of the complaint to either remove the Person Identifiable element, and then request the Patient Experience Manager or clinician to answer the complaint, or if this is not possible, to remove the information that the complainant is undergoing or has undergone transition and that they have been granted or applied for a GRC before forwarding the complaint to be investigated.

9. STORAGE OF COMPLAINT RECORDS AND ASSOCIATED DOCUMENTATION

9.1 Complaints, concern or comment records must be kept separate from health records and must not be filed in the medical notes unless specifically requested by the patient. This is to ensure confidentiality and that a patient's care and treatment is not affected by the concerns/complaint that they have raised.

9.2 It is important to ensure that patients/clients, their relatives or carers are not treated differently as a result of raising a concern. To ensure this, staff will be reminded of this duty at induction or other complaints training. Any issues of concern raised must be recorded and filed separately and not with the patient records. The Trust complaint leaflet will confirm the Trust's commitment to treating everyone fairly and without prejudice. Many complainants/patients/clients feel that their care may be compromised, or they will be disadvantaged or discriminated against if they have made a complaint. If a complainant and or patient/client is receiving clinical treatment, e.g. attending an outpatient appointment or using any service area, the complaint must **not** be discussed in this situation unless raised by the complainant or patient/client first, in which case, it should be recorded appropriately in the records.

9.3 If a patient requests that information relating to a complaint, concern or comment is added to their medical record, the PED will seek advice from the Trust's Data Protection Officer.

9.4 Computer records of all complaints received are recorded on the Trust's Datix database system. Hard copy files will be archived periodically (usually 6 months) and records stored for 10 years, or 27 years if it involves a child. Records will be disposed of in accordance with the Health Records Policy.

10. USEFUL TEMPLATES AND FURTHER GUIDANCE

10.1 The Complaints pages of HUB contain the following templates and further guidance to assist staff in the investigation and processing of complaints and concerns:

1. Letters of acknowledgement and consent form
2. Telephone Outcome Form
3. Guidance on Conducting a Complaint Investigation
4. Guidance on Writing a Statement
5. Guidance on Preparing a Response Letter
6. Guidance to Best Practice on Meeting with Complainants
7. Moderate Complaint Investigation Templates
    a. Investigation Front Sheet
    b. Patient Contact Form
    c. Staff Statement document
    d. Nurse Response
    e. Consultant Response

APPENDIX 3: COMMUNICATION PLAN

Royal Devon and Exeter
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	Executive Directors, Clinical Directors, Clinical Directorate Managers, Lead Nurses, Trust Solicitor, Head of Governance, Pastoral Care Lead, Risk Manager, Governance Managers; Patient Experience Leads, Nursery Manager, Assistant Directors of Nursing, Senior Nurses, Matrons, Governance Managers, Assistant Director for Safety and Quality, Head of Midwifery, Information Governance Manager, Nurse Consultant for Safeguarding
The key changes if a revised policy	Minor amendments made to reflect current practice Paragraphs 2.5, 2.6, 5.2, 14.3, Appendix 2: Paragraphs 2.2, 3.3, Flowchart, 4.15, 5.13
The key objectives	The purpose of this policy is to provide clear guidance to patients, members of the public and staff as to how the Trust will manage complaints, which is in line with the Local Authority Social Services and NHS Complaints (England) Regulations 2009, No. 309.
How new staff will be made aware of the policy and manager action	Cascade by email from manager, induction process. Will also be presented at the Patient Experience Committee and Patient Experience Leads meetings
Specific Issues to be raised with staff	Staff should be made aware of the policy.
Training available to staff	Support is available from the Patient Experience Department
Any other requirements	
Issues following Equality Impact Assessment (if any)	The complaints process could be indirectly discriminatory on grounds of age, disability and race, if those who are not able to take part in the process due to communication issues arising from these protected

	characteristics. The process could be discriminatory on grounds of disability, if arrangements for meetings are not disability-sensitive. Transgender patients may hold the Trust liable if their previous gender identity is disclosed during the complaints process.
Location of hard / electronic copy of the document etc.	The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

APPENDIX 4: EQUALITY IMPACT ASSESSMENT

Name of document	Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments
Division/Directorate and service area	Trust wide
Name, job title and contact details of person completing the assessment	Simon Harrison, Patient Equality Lead
Date completed:	5 December 2019

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To provide clear guidance to patients, members of the public and staff as to how the Trust will manage complaints, in line with the Local Authority Social Services and NHS Complaints (England) Regulations 2009, No. 309.

2. **Who does it mainly affect?** *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. **Who might the policy have a 'differential' effect on, considering the "protected characteristics" below?** (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☒	☐
Race	☒	☐
Religion / belief	☒	☐
Sexual orientation – *including: Marriage / Civil Partnership*	☒	☐

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by

homelessness, bariatric patients, end of life patients, those with carers etc.)?

The complaints process could be indirectly discriminatory on grounds of age, disability and race, if those who are not able to take part in the process due to communication issues arising from these protected characteristics. The process could be discriminatory on grounds of disability, if arrangements for meetings are not disability-sensitive. Transgender patients may hold the Trust liable if their previous gender identity is disclosed during the complaints process.

5. **Do you think the document meets our human rights obligations?** ☒

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

A variety of support measures have been included in the policy, such as: - Easy Read leaflet on complaints made available, which benefits anyone who prefers simple, illustrated English. - Interpreters and translators are available to support complainants, both for those whose first language is not English and BSL users. - There are specific provision for representatives to make complaints on patients' behalf, which would also benefit those who struggle to communicate for themselves. - There is provision for complaints to be made entirely verbally, without anything having to be put in writing. - Complainants with specific communication needs, as well as special needs are encouraged to seek IHCA (Independent Health Complaints Advocacy) support. Guidance to division of investigating officers reminds them to be sensitive to equality issues during their work. Detailed guidance on arranging meetings includes prompts about specific disability-related access issues. The policy lays down specific actions to be taken to protect the previous gender history of transgender complainants.

7. **If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact** please note this below and how this will be monitored/addressed.

“Protected characteristic”:	

Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	