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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Directorate of Performance Assurance

POLICY AND PROCEDURE FOR THE MANAGEMENT OF COMPLAINTS, CONCERNS, COMMENTS AND COMPLIMENTS

Reference:	DCP071
Version:	1.4
This version issued:	19/09/16
Result of last review:	Minor changes
Date approved by owner (if applicable):	N/A
Date approved:	15/09/16
Approving body:	Trust Governance & Assurance Committee / Trust Board
Date for review:	September, 2019
Owner:	Wendy Booth, Director of Performance Assurance
Document type:	Policy
Number of pages:	47 (including front sheet)
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Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

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Appendices:

1.0 Introduction

The Northern Lincolnshire and Goole NHS Foundation Trust welcomes complaints, concerns, comments and compliments (4 C's) and recognises that an effective Policy on Handling Complaints, Concerns, Comments and Compliments is essential to contribute to the highest standards of care for patients. Complaints, Concerns and Comments are valued as they provide an opportunity to examine and improve services. The Trust is committed to listening to suggestions for improvements, to investigating and responding to complaints and concerns appropriately and to learning lessons. This policy is in line with the Trust's Risk Management Strategy and governance arrangements. The Trust, in responding to complaints and concerns will also observe the principles of 'being open' as per the 'Being Open' and 'Duty of Candour policy.

2.0 Purpose

2.1 This policy and procedure is designed to ensure the timely, open and honest investigation and resolution of all complaints and concerns in accordance with the complainant's wishes. The complaints process will be managed in a climate where:

- Complainants receive, so far as reasonably practical, assistance to enable them to understand the procedure in relation to complaints and concerns or advice on where they can obtain assistance
- Complainants feel confident that their complaints, concerns and comments are listened to and acted upon
- Complainants do not feel inhibited by concerns that their care may be compromised or that they or their families may be treated differently because a complaint has been made
- Complainants are treated equally irrespective of their age, sex, ethnicity or religion
- Investigations are customer focused, open and accountable and result in fair and proportionate actions to remedy any wrong
- Complainants receive a timely and appropriate response promoting the Duty of Candour
- Complainants are advised of any remedial action to be taken and offered appropriate remedy
- Clear explanations are provided to patients who have concerns/complaints and apologies are given in regard to the "Saying Sorry" NHS Litigation Authority Leaflet
- Complainants are kept updated throughout the complaint process
- Staff are not defensive and respond positively when patients/their families/carers complain and ensure that the complaint does not adversely affect the way they treat the complainant

- Staff are provided with support at all stages of the complaints process and feedback is provided to staff involved
- Lessons are learned and outcomes shared, within the organization to encourage continuous service improvement, and with Commissioners
- Training is provided to ensure that staff have an understanding of the philosophy underpinning the policy, the benefits to be gained from complaints and the role of all staff within the procedure

2.2 Staff grievances are not dealt with under this Complaints Procedure but under the Trust's Grievance Policy.

2.3 Complaints about private medical care are not covered by this Policy. It does cover complaints about NHS staff or facilities relating to private pay beds.

3.0 Area

This policy and procedure applies in all areas of the Trust, and to all staff working within the Northern Lincolnshire and Goole NHS Foundation Trust.

4.0 Definitions

4.1 **Concerns** – A concern is a matter which an individual wishes to be considered on an informal basis. It is expected that the majority of concerns raised will be dealt with by the complaints process. All staff are expected, on a routine and daily basis, to deal with patients' concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational areas. The objective will be a speedy, informal resolution of the concern without recourse to correspondence/formal procedure. If made to and dealt with by front line staff a record of the concern should then be made by either entering it into the informal complaint book for the department/ward/area or informing the PALS team who will then record this on the Trust's database (Datix).

4.2 **Complaints** – A complaint is a matter which the complainant wishes to be registered and investigated in accordance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009. A complaint may be written or oral and will be investigated by senior staff and a full response will be provided.

4.3 **Comments** – These are statements expressing a personal opinion or attitude, or can be a judgemental commentary. These will be forwarded to the relevant service area for action as appropriate. Suggestions implemented may be included in the 'You said, we did' boards.

4.4 **Compliments** – These are verbal or written expressions of praise, admiration or congratulation sent of a person's own volition, and will be recorded on Datix, circulated to the appropriate staff and management, and included in quarterly reports. 'Thank you' cards or gifts received by individuals, wards or departments, responses to surveys, or praise contained in response to 'sought-after' comments will not be classed as compliments for recording purposes.

4.5 **Local Resolution** – Local Resolution refers to any action taken within the Trust to resolve concerns and complaints leading up to, but excluding, a request for the Parliamentary and Health Service Ombudsman to review a complaint. The aim of Local Resolution is to provide the fullest possible opportunity for the investigation and resolution of a concern or complaint, as quickly as possible, aiming to satisfy the complainant whilst being scrupulously fair to staff and ensuring that any necessary lessons are learned. If complainants are not satisfied with a complaint response or outcome, an independent review can form part of the local resolution. The independent review would be concluded by a Non-Executive Director who will review the complaint and provide feedback and recommendations to the Complaint Facilitator/complainant.

4.6 The purpose of investigating a concern or complaint is not to apportion blame but to enable an appropriate response to the complainant and to provide the opportunity to identify any necessary improvements in service and to take the necessary action.

5.0 Complaints Management / Processes and Actions (Please also see Appendices A to G)

5.1 Publicity

5.1.1 Patients have the right to complain. The Trust will ensure that information about the complaints procedure is widely available.

5.1.2 Publicity will include:

- How to get assistance
- Who to complain to
- How to complain
- What will happen when a complaint has been received
- When to expect answers
- Advice on advocacy support
- Contact information for Parliamentary and Health Service Ombudsman and Care Quality Commission
- Patient information, such as:
  - Leaflets –'Tell us What you Think' explaining the role and function of the PALS and Complaints Department Notices – appropriately displayed in all areas and providing the location of the PALS offices and details of the service available
  - Intranet and Internet – The Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments will be available on the Intranet and Internet and will be made available to any member of the public on request

5.2 Who May Complain

Any person who is or has been a patient within the Trust is eligible to make a complaint. Also any person who is affected by or is likely to be affected by the action, omission or decision of the Trust:

- If the person concerned has asked someone to represent them, is unable to act on their own behalf, lacks physical/mental capacity or has died, the complaint may be accepted from a relative, a friend, a suitable representative or a body or individual (e.g. parent, Member of Parliament, solicitor or an independent advocacy service). Where appropriate, consent to liaise with a third party must be obtained

- In the case of a child, the representative must be a parent, guardian or other adult who has care of the child – if in the care of local authority or voluntary organisation, the representative must be authorised by those bodies. A child may however contact the Customer Service Department in confidence and providing they have sufficient understanding to make their own decisions then their confidentiality will be respected

- If the complainant is acting on behalf of a relative or friend over the age of 18, it is necessary to ensure that the patient consents to the investigation

- The Complaints Manager (CM) may exercise discretion in receiving complaints on behalf of a patient but, if the representative is deemed to be unsuitable, that person must be notified in writing and given reasons for this decision

- The issue of consent must not be used to avoid investigating a situation which is clearly warranted but communication of the outcome may be restricted if patient confidentiality may be compromised

- Complainants should not be made to feel inhibited by concerns that their care may be compromised or that they or their families may be treated differently because a complaint has been made

5.3 Joint Agency Complaints

The Trust will comply fully with the duty to co-operate with other NHS providers and Local Authorities in order that a comprehensive response may be provided to a complainant who raises issues about more than one organisation. (Please see Humber MEC Group Protocol for the Handling of Complaints/Comments/Concerns/Compliments that involve more than one organisation (see Appendix H). Also, the Protocol for the Handling of Complaint/Concerns between North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group and the Northern Lincolnshire & Goole NHS Foundation Trust at the Diana, Princess of Wales Hospital site (see Appendix I).

5.4 The Role of the PALs and Complaints Department

5.4.1 The PALS/Complaints Team will aim to resolve concerns as quickly as possible and it is assumed unless the patient has stated otherwise that the team may discuss the issues with the relevant staff in order to resolve the issues. It is the responsibility of the PALS/Complaints staff to ensure that all concerns and complaints are recorded onto the Trust's Datix system and that any actions taken as a result of the concern or complaint are also recorded.

5.4.2 The PALS/Complaints Department will:

- Provide on the spot support and advice
- Enable patients and carers to voice their concerns
- Assist patients and carers to access independent advocacy services
- Assist and advise persons wishing to make a formal complaint
- Assist in the development and implementation of user involvement strategies
- Provide advice to staff and act as an information resource
- Meet outside agencies, support groups etc to publicise the services provided by the PALS/Complaints Department
- Monitor and report issues to the Directorates and Groups, the Quality and Patient Experience Committee and the Trust Board making recommendations for areas of further investigation in order that lessons may be learnt
- Assess all concerns and complaints as to their complexity and the level of investigation required. The time scale and investigation process will be discussed with the complainant and a resolution plan agreed

5.5 Access to the PALs and Complaints Department

5.5.1 The Trust has established an easily identifiable contact point at Diana Princess of Wales Hospital Grimsby and Scunthorpe General Hospital.

5.5.2 PALs/Complaints staff are available Monday – Thursday 09.00-17.00 and Friday09.00 – 16.30pm, but this may be subject to review.

5.5.3 Out of Hours messages, e-mails, voicemails, faxes will be answered within 3 working days.

5.5.4 Patients, relatives and carers are able to access the service by direct contact. Appointments will not normally be necessary.

5.5.5 Out of hours, the Site Manager will be able to assist.

5.6 Confidentiality

5.6.1 The PALS/Complaints Department should advise anyone contacting their service when it will be necessary to refer their concern to another Health Trust or to a non-health body and consent to do so will be agreed.

5.6.2 In some circumstances it may be appropriate for issues to be referred to the Directorate/Groups without identifying a specific patient.

5.6.3 There are certain circumstances where confidentiality cannot be guaranteed and the person contacting the PALS/Complaints Department should be advised that information in the following categories will be passed on:

- Where issues raised are such that a patient , carer or colleague will be endangered if action is not taken
- When not to do so would be breaking the law i.e. safeguarding children/adult issues and certain serious criminal offences

5.6.4 When using a patient's personal information for the purpose of investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation.

5.6.5 Complaint investigations must be conducted with appropriate consideration of the confidentiality due to staff involved in the complaint.

5.6.6 Staff involved in complaints must be aware that documents generated may be requested under the Data Protection Act and are discoverable in any subsequent legal claim.

5.7 Timescales for Concerns

The PALS team will aim to ensure that on the spot help is provided to negotiate immediate solutions to concerns wherever possible. Otherwise, a speedy resolution via the appropriate Operational Group staff will be sought so the concerns do not escalate. Concerns should not be open for more than 5 working days unless agreed by the complainant.

5.8 Timescales for Investigation / Dealing with Complaints

5.8.1 A complaint should be made within:

- twelve months of the date on which the matter being complained about occurred
- twelve months of the date the issue came to the notice of the complainant

5.8.2 Where a complaint is made outside the time limit, the Complaints Manager has discretion to agree to an investigation e.g. if the complainant had good reason for not making the complaint within that period and it is still possible to investigate the complaint effectively and efficiently.

5.8.3 A complaint must be acknowledged within 3 working days. On receipt, complaints must therefore be forwarded immediately to the Complaints Manager.

5.8.4 A complaint response must be provided within a timescale agreed with the complainant and no longer than 6 months.

5.8.5 If it is not possible to respond within the agreed timescale the complainant will be notified in writing, the reasons explained and an extension will be agreed for the response to be sent as soon as reasonably practicable.

5.8.6 If a response is not provided within 6 months the complainant will be notified that they may refer this to the PHSO.

5.8.7 The triaging of complaints is based on the estimated level of investigation required, with each level of categorisation having a defined timescale for response which reflects the complexity of the complaint. Complaints will fall into the following 3 categories when triaged:

- Category 1 – single issue or single group. Final response/meeting completed within 30 working days
- Category 2 - multiple issues with the group. Final response/meeting within 45 working days
- Category 3 – multiple issues with multiple groups. Final response/meeting within 60 working days

5.9 Form of Communication

5.9.1 The form of communication will be agreed with the complainant and may be verbal (by telephone or face to face meetings) or written (including email). Documents sent electronically are deemed to be signed by the authorised person typing their name.

5.9.2 Where a complaint is made orally, a written record will be made and a copy sent to the complainant for agreement of the issues.

5.9.3 If a complainant advises that they are taping the telephone conversation, they must be advised that this is not permitted.

5.10 Meetings, Mediation and Conciliation

5.10.1 Complaints will be managed taking into account the complainant's wishes. It is expected that in many cases there will be a high level of contact with the complainant and that in some cases the complainant will choose a response which involves a meeting with staff.

5.10.2 Meetings to resolve the complaint can take place at any stage of the Local Resolution process with the agreement of the complainant.

5.10.3 Meetings may involve senior clinical/non clinical staff, as appropriate.

5.10.4 Meetings may take place on Trust premises (with care taken to ensure appropriate access/facilities for attendees with any disability) or at the complainant's home. Staff members' safety and the complainant's right to privacy will be considered.

5.10.5 Complainants choosing to meet staff will be advised that they may be accompanied by a friend, relative or representative of an independent advocacy service, but not anyone acting in a legal capacity.

5.10.6 A recording of the complaint meeting will be made, actions agreed by those present will be documented and a copy of the recording will be sent to the complainant unless otherwise agreed.

5.10.7 In some cases it may be appropriate to consider the use of an external mediator/conciliator.

5.11 Response

The Trust's response will be in line with the requirements of the Local Authority Social Services and NHS Complaints (England) Regulations 2009; guidance within the DOH document 'Listening, Responding Improving'; the PHSO' Principles of Good Complaints Handling, and in accordance with Appendix B.

5.12 Remedy

5.12.1 In line with the PHSO Principles for Remedy, suitable and proportionate remedies will be considered where a complaint is upheld and there has been injustice or hardship resulting from poor administration or poor service. The aim is to, where possible, return the person affected to the position they would have been but for the maladministration/poor service. This may include non-financial and financial remedies.

5.12.2 Non-financial remedies:

- These include e.g. apologies, remedial action in the form of reviewing or changing a decision on service provided to an individual

5.12.3 Financial remedies:

- In some circumstances clinical/non-clinical Operational Groups may wish to make ex gratia payments
- Complainants' requests for reimbursement for e.g. lost belongings etc are subject to investigation and, as appropriate, reference should be made to the NL&G Losses and Compensations process

5.12.4 If a complainant requests remedy in the form of compensation for personal injury, the matter must be referred to the Claims & Legal Services Manager for referral to the Trust legal advisors/NHS Litigation Authority.

5.12.5 Reopening of Complaints – Criteria

- The criteria for classifying a complaint as a re-opened is as follows:
  - If the complainant is dissatisfied with the final response and has requested further clarity or discussion
  - If the complainant requests a further meeting from receiving a response to seek resolution
  - If the complainant requires more clarity or further questions are raised from the response
- The criteria for classifying if the original complaint should become a new complaint would be as follows:
  - New issues raised that were not previously documented or discussed prior to the response provided
  - If the complainant/patient has had a new admission

5.13 Closing the Loop – Learning the Lessons from Concerns and Complaints

5.13.1 Identifying remedial action is an integral part of the complaint management process and all complaints and concerns will be reviewed to ensure that lessons are learnt. This is ongoing from receipt of the complaint/concern as immediate action may be required. All complaints/concerns will be reviewed on completion of Local Resolution. Where remedial action is identified, an action plan, which records timescales and responsibilities, will be prepared in draft by the Complaints Facilitator for consideration by the relevant Operational Group on the closure of a concern or no later than 3 months after closure of the complaint and will be monitored regularly by the Operational Group until fully implemented.

5.13.2 Proposed remedial action involving other organisations will be explored with relevant personnel and implemented, as appropriate.

5.13.3 The same Learning Lessons/review process will be followed further to any review carried out by the Parliamentary and Health Service Ombudsman.

5.13.4 Reports of remedial action will be shared within the Trust and with relevant stakeholders to facilitate wider learning.

5.13.5 The Complaints Team will provide reports on complaints and concerns that will include statistical analysis of the types of complaints received, the specialties involved, and examples of remedial action taken. These reports will routinely be submitted to the Quality and Patient Experience Committee and to the Trust Governance & Assurance Committee, Trust Board and Commissioners, and relevant stake holders.

5.13.6 Complaints and concerns data will also be included in aggregated analysis reports on incidents, complaints, concerns and claims. The reports will be both qualitative and quantitative and will identify trends/themes and any subsequent remedial action/changes in practice that result from the investigation of complaints.

5.13.7 Where particular issues are identified from aggregated analysis, action plans will be developed for addressing the issues identified and for ensuring learning and changes as required.

5.13.8 Operational Groups will be responsible for developing strategies for improvement and audit of action taken to address lessons learned.

5.13.9 Learning from complaints will be shared as widely as possible within the Trust, as appropriate, via the Trust's Governance Committee, Health and Safety Committee, and also through "Safety Alerts", Learning the Lessons Newsletters, Risk Management website and risk forums, Learning Lessons Review Group and Branch Governance Groups.

5.13.10 Any changes in service provision made as a result of a concern/complaint/comment, where appropriate, will be fed back to patients, carers, members of the public, by the use of 'you said we did boards'.

5.14 Vexatious and / or Unreasonably Persistent Complainants (Please see Appendix D)

The Trust is committed to addressing complaints in an open, honest, fair and impartial manner, making all reasonable efforts to achieve a satisfactory resolution. This guidance is designed to assist staff dealing with complainants who are considered to be vexatious or unreasonably persistent and allows contact with the complainant (about the subject of the specific complaint) to be specified and limited or to cease entirely. Where complainants are violent or aggressive, staff should refer to the Trust's Violence and Aggression Policy.

5.15 Clinical Incidents / Incident Reporting

During some complaint investigations it may be necessary to make the Head of Risk Management aware of an issue. This will be a matter of judgment for staff in consultation with the Complaints Manager. In some instances it will be clear that the issue/concern raised should also be reported in line with the Incident Reporting System.

5.16 Litigation

5.16.1 Whenever there is a suggestion or possibility of litigation associated with a complaint or where clarification is required on a legal issue, advice will be obtained from the Claims & Legal Services Manager.

5.16.2 Complaints may be made on behalf of a patient by their solicitor. An investigation and response, containing apologies, if required, should be provided but with due regard to ensure that any future litigation is not prejudiced. Advice should also be taken from the Claims & Legal Services Manager. The Trust's legal advisors/NHS Litigation Authority may also be involved at any stage.

5.17 Disciplinary Matters

5.17.1 The Complaints and Disciplinary procedures are different and separate but they may run concurrently. However, if a complaint at any stage is also the subject of a disciplinary investigation or regulatory body enquiry, advice should be sought from the Complaints Manager in order to ensure that neither process is compromised.

5.17.2 Where a complaint includes issues that relate to possible professional misconduct on the part of clinicians, consideration should be given to obtaining a view from the Clinical Director and/or Medical Director to determine whether the complaint falls outside the Complaints Procedure and should, more appropriately, be dealt with through the Disciplinary Procedure.

5.17.3 For other members of staff, the relevant manager must be involved.

5.17.4 The Complaints Manager should be informed in the first instance if a complaint indicates the need for referral to:

- investigation under the Trust disciplinary procedure
- one of the professional regulatory bodies
- an independent enquiry into a serious incident under the National Health Service Act 1977
- an investigation of a criminal offence
- the Health and Safety Executive
- the National Patient Safety Agency

5.18 Involving External Agencies

5.18.1 If it appears that a criminal offence may have been committed, the matter should be reported immediately to relevant Operational Clinical Director/General Manager (see also Incident Reporting Policy), who will decide what action should be taken. The Police should be notified promptly if their assistance is required.

5.18.2 If the issue relates to health and safety and the Health and Safety Manager has not already been informed, this should be done so that consideration may be given to reporting to the Health and Safety Executive or National Patient Safety Agency.

5.18.3 When investigating a complaint care must be taken not to prejudice enquiries by external agencies (including the Coroner) or court proceedings. This does not mean that investigation of related matters which are not prejudicial to such enquiries or court proceedings should be suspended.

5.18.4 Necessary remedial action should not await the outcome of enquiries by external agencies or possible court proceedings. Any member of staff against whom allegations are made or who is involved in these external enquiries must be advised by their Senior Manager to seek the assistance of their professional association/trade union before commenting on such allegations.

5.18.5 If the external agency decides not to institute proceedings, the clinical/non clinical directorate Manager/Director must consider whether further investigation/action is needed e.g. whether disciplinary action is required.

5.19 The Role of the Parliamentary and Health Service Ombudsman (PHSO)

5.19.1 On conclusion of local resolution, the complainant will be advised of their right to refer their complaint to the PHSO.

5.19.2 The PHSO is independent of the NHS and of government. Any complaint accepted by the PHSO must have already been considered at local resolution.

5.19.3 If an investigation takes place the PHSO may uphold the complaint in full or in part and will provide a report of the reasons for the decisions. The PHSO may make recommendations e.g. an apology, an explanation, improvement in practices and/or systems and, if appropriate, financial redress. The Trust will respond appropriately to contact from the PHSO and monitor and audit compliance with any recommendations.

5.20 Judicial Review

The complainant has the right to make a claim for judicial review if they consider that they have been directly affected by an unlawful act or decision of an NHS body. Any indication of an application for judicial review should be reported to the Director of Performance Assurance and the Trust Governance & Assurance Committee.

5.21 The Role of Monitor

5.21.1 As described in the Compliance Framework 2010-11, Foundation Trusts should have in place adequate processes or procedures to identify and report serious complaints to Monitor. A failure to do this may be reflected in a Foundation Trust's governance risk rating. When assessing governance risk, Monitor considers, amongst other relevant information, significant trends in complaints (Monitor 2010).

5.21.2 All serious complaints and significant trends should, therefore, be reported to the Trust's relationship manager at Monitor. Additionally where a complaint, or other matter has arisen, which may result in any material which may impact upon the Trust's reputation, this should also be reported to the Trust's relationship manager.

5.22 Support Offered to Staff

When a complaint is registered the healthcare professionals involved in the patient care may also need emotional support and advice. To support healthcare staff involved in complaints the following arrangements are in place with NLG:

- The Trust has a 'fair blame' culture that discourages the attribution of blame and focuses on 'what when wrong not who went wrong'
- Support and any necessary guidance will be available from their line manager, PALs/Complaints staff or the Complaints Manager. Support is also available from the Confidential Care Counselling Service (0800 085 1375)
- Counselling and support services are also available via Occupational health and 'Confidential Care' a confidential and anonymous support helpline

6.0 Duties

6.1 Chief Executive

6.1.1 The Chief Executive is the person responsible for ensuring compliance with the NHS Complaint Regulations. In this Trust this duty is delegated from the Chief Executive to the Director of Performance Assurance.

6.1.2 The Chief Executive will sign complaint responses unless, exceptionally, otherwise agreed with the complainant. In the Chief Executive's absence the Director of Performance Assurance will sign responses.

6.1.3 Director of Performance Assurance has overall responsibility for the development, implementation and periodic review of the local complaints policy and procedure and for compliance with the Regulations.

6.1.4 Additionally he/she will ensure that the information from complaints is used to identify non-compliance or any risk of non-compliance with the Care Quality Commission Regulations on complaints, and in conjunction with the Chief Executive and/or the relevant General Managers of the operational groups to decide what is to be done to return to compliance.

6.1.5 He/she is responsible for developing the Trust's Complaints Policy, monitoring performance, ensuring compliance with and the effectiveness of this policy, reporting to the Trust Board and external stakeholders as appropriate.

6.1.6 Director of Performance Assurance is responsible for compliance with the arrangements made under the Regulations and Compliance Framework 2010-2011 requirement: reporting serious complaints to Monitor and for taking action as required.

6.2 Quality and Patient Experience Committee

The Complaints Monitoring Committee, comprising Non-Executive members of the Trust Board, the Director of Performance Assurance, public representation, Operational Group representative, will monitor all aspects of the Trust's performance in the management of complaints (please see the Committee's Membership and Terms of Reference).

6.3 Complaints / PALs Function

The Complaints Manager is responsible for the development of the Complaints/Pals department and holds day-to-day responsibility for the implementation of this policy, highlighting any immediate changes to service provision required as a result of concerns/complaints to relevant operational groups. The Complaints Manager is also responsible for the day to day monitoring and co-ordination of complaints, providing advice, support and guidance to the Operational Groups/ staff and Complaint Facilitators.

6.4 Operational Groups / General Managers

6.4.1 Although the management of complaints is centralised it is the responsibility of the relevant operational group to ensure that relevant governance groups and/or manager responsible for governance within the operational group will be responsible for identifying remedial action and monitoring implementation.

6.4.2 Any difficulties encountered in obtaining information for the complaint investigation will be escalated to the General Manager who will be responsible for ensuring the Complaint Facilitator receives the required information.

6.6 All Staff

Any member of staff may be involved in dealing with a concern or complaint. They must co-operate with any investigation in an open and honest manner and, as far as their involvement is concerned, not allow the understanding that a complaint/concern has been made to adversely affect their treatment/response to the patient.

7.0 Monitoring Compliance and Effectiveness

7.1 Monitoring will take place in the following ways.

7.1.1 Quarterly reports comprising:

- The numbers of complaints and concerns received, the subject matter and outcome, whether the response was provided within the agreed timescale or any amendment to that period, remedial actions and complaints referred to the PHSO and:
  - An annual aggregated analysis of complaints, concerns, claims and incidents will be prepared
  - Reports of remedial action will be shared within the Trust and with relevant stakeholders to facilitate wider learning

7.1.2 The reports will be provided to the:

- Quality and Patient Experience Committee
- Trust Board
- Trust & Assurance Governance Committee: comprising that sent to the Trust Board and Quality and Patient Experience Committee and hoc information as required/appropriate
- Operational Groups: comprising that sent to the Trust Board, Quality and Patient Experience Committee, the Governance Group, Commissioners and ad hoc information as required/appropriate, to allow the identification and monitoring of any difficulties or key themes and appropriate action to be taken or remedial strategies to be developed
- Operational Groups' performance on complaints will be subject to quarterly Performance Review
- Complaints which have been reviewed by the Parliamentary and Health Service Ombudsman and upheld will be reported to the Regulators (MONITOR and the Care Quality Commission)

7.1.3 Complaints which have been reviewed by the Parliamentary and Health Service Ombudsman and are upheld or partially upheld will routinely complete a NED Review (Non-Executive Director) to explore further learning lessons or remedial action to take place. The outcome of these NED Reviews will be provided to the relevant Operational Group, the Complaints Quarterly Analysis Report will identify trends and themes from the NED Reviews findings. An annual statistical report to meet the requirements of the:

- Department of Health (KO41A) and the
- Care Quality Commission: by producing a summary of complaints at a time and in the format required to be submitted within the required timeframe
- An annual report to be provided to any individual on request and to the Clinical Commissioning Groups) which arrange for services to be provided by the Trust as soon as possible after the closure of the period; comprising:
  - number of complaints received
  - number of well-founded complaints
  - number of complaints referred to the PHSO
- The subject matter of the complaints received
- Any matters of general importance arising out of the complaints of the way in which the complaints were handled
- Any matters where action has been or is to be taken to improve services as a consequence of the complaint

7.1.4 General:

- Any PHSO recommendations which the Trust implements will be monitored by the Quality and Patient Experience Committee and any shortfalls identified will be addressed with the relevant clinical/non clinical directorate
- Completed complaint files will be reviewed in order to ensure that the complaint has been considered for remedial action and an action plan prepared and implemented. Documentary evidence of implementation will be required and implementation of proposed remedial action will be audited
- Note will be taken of the responses to patient surveys and the Trust will conduct surveys specifically on the conduct of Formal Complaints

8.0 Further Reading and Associated Documents

8.1 Quality and Patient Experience Committee Membership and Terms of Reference (DCT024).

8.2 Humber “Making Experiences Count” Group Protocol for the handling of complaints, comments, concerns and compliments that involve more than one organisation.

8.3 Incident Reporting Policy (DCP009).

8.4 Being Open Policy (DCP043).

8.5 Duty of Candour Policy (Communicating with Patients and/or their relatives/carers following a patient safety incident (DCP043).

8.6 The NHS Litigation Authority leaflet "Saying Sorry"

9.0 References

9.1 The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

9.2 DOH 'Listening, Responding, Improving' – a guide to better customer care.

9.3 PHSO – Principles of Good complaints handling.

9.4 PHSO – Principles of Good Administration.

9.5 PHSO – Principles for Remedy.

9.6 The NHS Constitution.

9.7 NHS Patient Advice and Liaison Service (28 January 2002).

9.8 Care Quality Commission Criterion for assessing Core Standards 2008/2009.

9.9 NPSA (2005) Patient briefing – Saying Sorry When Things go Wrong.

9.10 NPSA (2005) Being Open Communicating Patient Safety Incidents with Patients and their Carers Great Britain (1998) the Data Protection Act.

9.11 Great Britain (2000) the Freedom of Information Act 2000.

9.12 Compliance Framework 2010-11.

10.0 Consultation

10.1 Consultation has taken place with the Quality and Patient Experience Committee, Trust Governance & Assurance Committee, clinical/non clinical directorate Complaint Handlers and Trust employees via the Intranet.

11.0 Approval and Ratification

The Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments has been approved by the Quality and Patient Experience Committee and Trust Governance & Assurance Committee and ratified by the Trust Board.

12.0 Review and Revision

The Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments will be reviewed on a three yearly basis or earlier, in the event of changes to the national policy. It will be subject to the Document control process in place in the Trust.

13.0 Implementation and Training

Staff of the Director of Performance Assurance will provide training in line with the Trust's Training Needs Analysis. Effective complaint management training will be provided as part of the First Class Service Training. Ad hoc training sessions will also be provided in response to developments/ identified needs and specific requests.

14.0 Dissemination

14.1 This document will be sent to all general managers and all clinical Directors in electronic form and hard copy for distribution as appropriate. It is also available on the Intranet, the Internet and will be given to members of the public on request.

14.2 The Trust's approach to complaints management and staff responsibilities is included in the Trust induction and Operational Groups specific induction.

15.0 Equality Act (2010)

15.1 In accordance with the Equality Act (2010), the Trust will make reasonable adjustments to the workplace so that an employee with a disability, as covered under the Act, should not be at any substantial disadvantage. The Trust will endeavour to develop an environment within which individuals feel able to disclose any disability or condition which may have a long term and substantial effect on their ability to carry out their normal day to day activities.

15.2 The Trust will wherever practical make adjustments as deemed reasonable in light of an employee's specific circumstances and the Trust's available resources paying particular attention to the Disability Discrimination requirements and the Equality Act (2010).

The electronic master copy of this document is held by Document Control, Directorate of Performance Assurance, NL&G NHS Foundation Trust.

Appendix A

Procedure for Handling Concerns and Complaints

1.0 Local Resolution

All concerns and complaints received by the Complaints / PALs Team will be initially reviewed and triaged. A decision will then be made as to whether a speedy resolution will resolve the complaint/concern or whether the complaint/concern requires formal investigation.

2.0 Concerns

2.1 The PALs Team will provide on the spot help and assistance to patients and their relatives and carers who have concerns about any aspect of the services provided by the Trust.

2.2 The PALs Team provides a service to patients/carers primarily through telephone contact or face to face with patients/carers. All concerns will be recorded on the Datix database system.

2.3 The PALs Team will contact the relevant Operational Group staff members to gather information to facilitate a resolution for patients/carers. It is good practice that the service involved contacts the patient/carer to provide a satisfactory resolution however, where not practical, a member of the PALs Team can respond on behalf of the Operational Service(s).

2.4 On closure of the concern the staff member dealing with the concern will complete a PALS Action Record (see Appendix E) outlining the outcome of the concern and any remedial actions taken. This will then be forwarded to a member of the PALs Team to be recorded on Datix and to close the concern.

3.0 Complaints

3.1 The Complaints Manager will ensure that the complaint is registered on Datix, a letter of acknowledgment and an information leaflet about the Trusts complaint process will be sent within three working days of receipt of the complaint. Information will include the name and contact details of the Complaint Facilitator and the right of the complainant to assistance from the Independent Complaints Advocacy Service. The complaint is graded according to complexity/severity (see Appendix G). Consent will be obtained as required.

3.2 The Complaint Facilitator will make contact with the complainant as soon as possible after receipt of the complaint (usually within 10 working days) to agree a Complaint Resolution Plan i.e. to confirm the issues the complainant wishes to be addressed, what they expect as an outcome and to agree how best this can be achieved, within an appropriate time scale.

3.3 If the complaint has been made orally, the acknowledgment must be accompanied by a written record of the complaint with an invitation to the complainant to sign and return it in an S.A.E.

3.4 The Complaint Facilitator, in conjunction with staff from the relevant Operational Group(s) will then carry out the investigation. The complaint investigation should be:

- Timely, open and honest
- Appropriate to the severity of the incident and has been thorough and comprehensive. This may include requesting statements from staff involved in the incident, questioning staff and providing an overview or if necessary interviewing staff. The grading of the complaint is to be reviewed on closure
- Is undertaken in a way most appropriate to resolve the complaint to the satisfaction of the person making the complaint
- Is considered by staff who are competent to address the issues raised
- Should involve, as appropriate, someone not involved in the events leading to the complaint, e.g. governance staff, clinical or medical staff

3.5 If a complaint involves Local Authorities/other NHS provider(s), comply with the duty for the organisations to co-operate to provide a coordinated response in a timely, open and honest way. This will be in line with the Humber ''Making Experiences Count '' Group Protocol for the handling of complaints, comments, concerns and compliments that involve one more than one organisation (see Appendix H).

3.6 The consent of the complainant to send the details of the complaint to other organisations will be obtained. If consent is not provided, the complainant will be advised that the response will only deal with the elements of the complaint which relate to this Trust and that a direct approach must be made to the second organisation (contact details will be provided), if a response is required.

3.7 **The complaint response must:**

- Summarise the complaint, describe the investigation and address all issues raised. It must provide explanations based on facts and include the reasons for the decisions made, summarises the conclusions, offers apologies/remedy if appropriate, describes any remedial action and is balanced, clear and easy to understand
- The complaint response must be agreed with the staff who have contributed (and with other external organisations involved)
- Clinical information must be agreed by the relevant clinician
- Offers the complainant the opportunity to return to the Trust if they remain dissatisfied
- Is quality assured by the appropriate General Manager (or designated deputy) and is in an appropriate style
- Is marked Private and Confidential

and that

- receipt of agreed file notes of complaint and/or consent are acknowledged

- where applicable, the Consultant in charge is informed of the complaint
- full and timely co-operation is available from all staff contributing to the investigation to ensure that the response date is meant
- A documented audit trail of the steps taken, decisions reached and of all communications during the course of the complaint, action planning and evidence of implementation is kept in the complaint file and on Datix
- Staff are supported as required through the complaint process
- Any issue that is identified in the course of the investigation, which is not complained, is raised with relevant responsible staff to ensure that nay necessary remedial action is considered
- When all reasonable attempts to exhaust Local Resolution have been made, advice about the second stage of the NHS Complaints Procedure (referral to the PHSO) is provided to the complainant
- On closure of the complaint (at Local Resolution and further to PHSO report)) review of the file will be undertaken by the relevant Operational Group(s) to ensure that any necessary remedial action/planning has been considered. It is the responsibility of the Operational Group(s) to monitor the action plans to ensure that there is documentary evidence of action planning and implementation and that audit is undertaken as required.

3.8 Disciplinary matters and Staff Confidentiality

3.8.1 The sharing of letters of complaint raising disciplinary issues, which are very personal to an individual, for the purposes of obtaining the comments of other staff directly involved/present at the time of the incident which is the subject of the complaint, should be carefully considered.

3.8.2 In many cases it may only be necessary to advise that a complaint has been received about matters relating to the incident which staff have witnessed and to ask them to provide a statement on their involvement/what they have witnessed.

3.8.3 In similar circumstances, though it will very rarely arise, if a professional outside the Trust is involved, care must be taken to ensure that any approach for their views is made through the appropriate channels, perhaps as a service to service matter. Advice should be sought in the first instance from Complaints Manager or Director of Performance Assurance. It must be made clear to staff that any statement they provide as part of the complaints process becomes discloseable.

3.8.4 Before reverting to a complainant e.g. at a meeting where the staff involved will not be present, the matter will be discussed further by the Complaints Facilitator/Matron/Manager with the individual, to agree the approach and, if appropriate, that their statement may be shared with the complainant.

3.9 Timescales

A complaint response must be provided within a timescale agreed with the complainant and no longer than 6 months. Where this is not possible, a clear explanation of the reason for the delay must be made and the complainant invited to agree an extension of

this time. Any further extension of time must be agreed in the same way and the complainant updated at regular intervals.

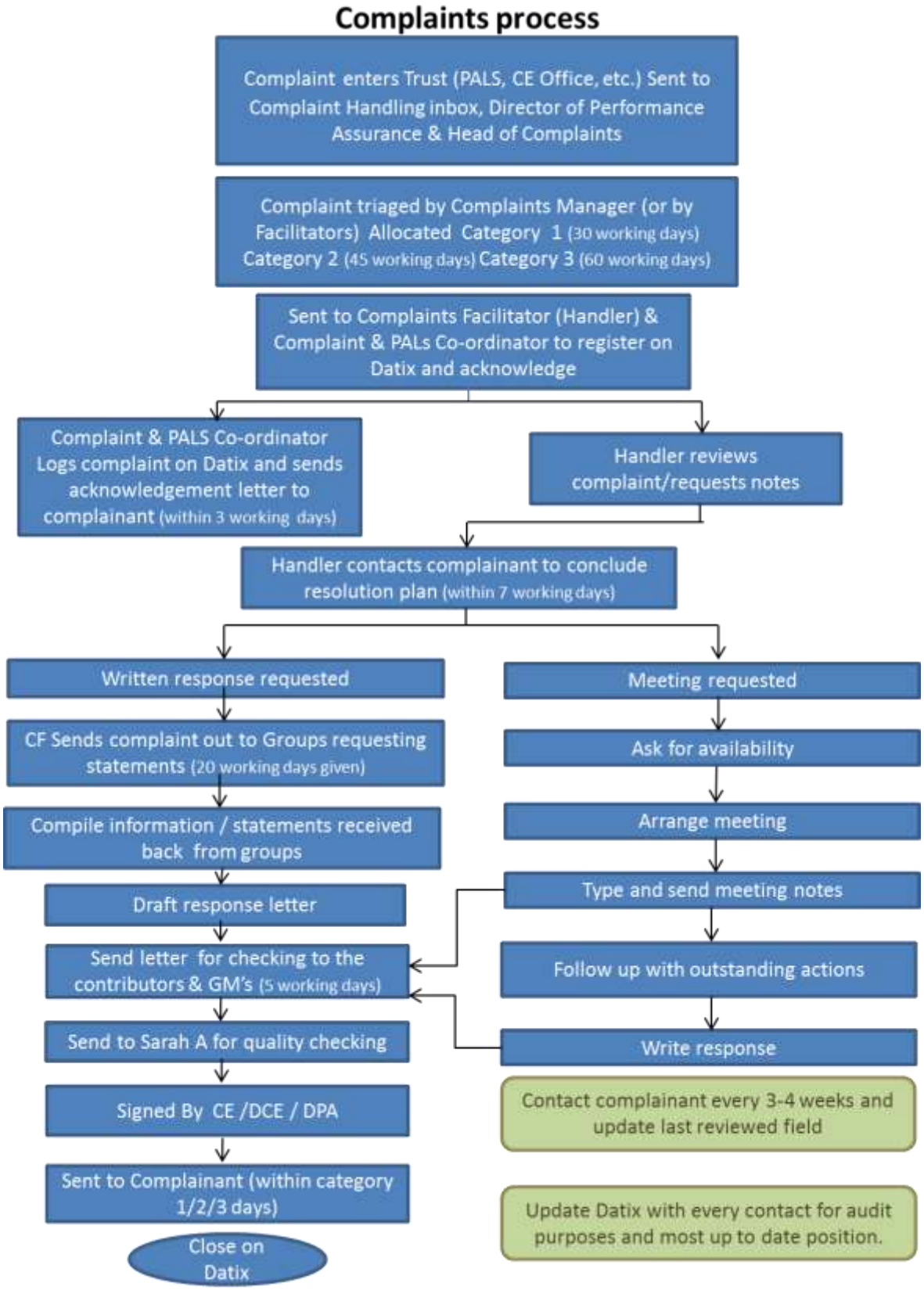
3.10 Remedial Action / Further Action

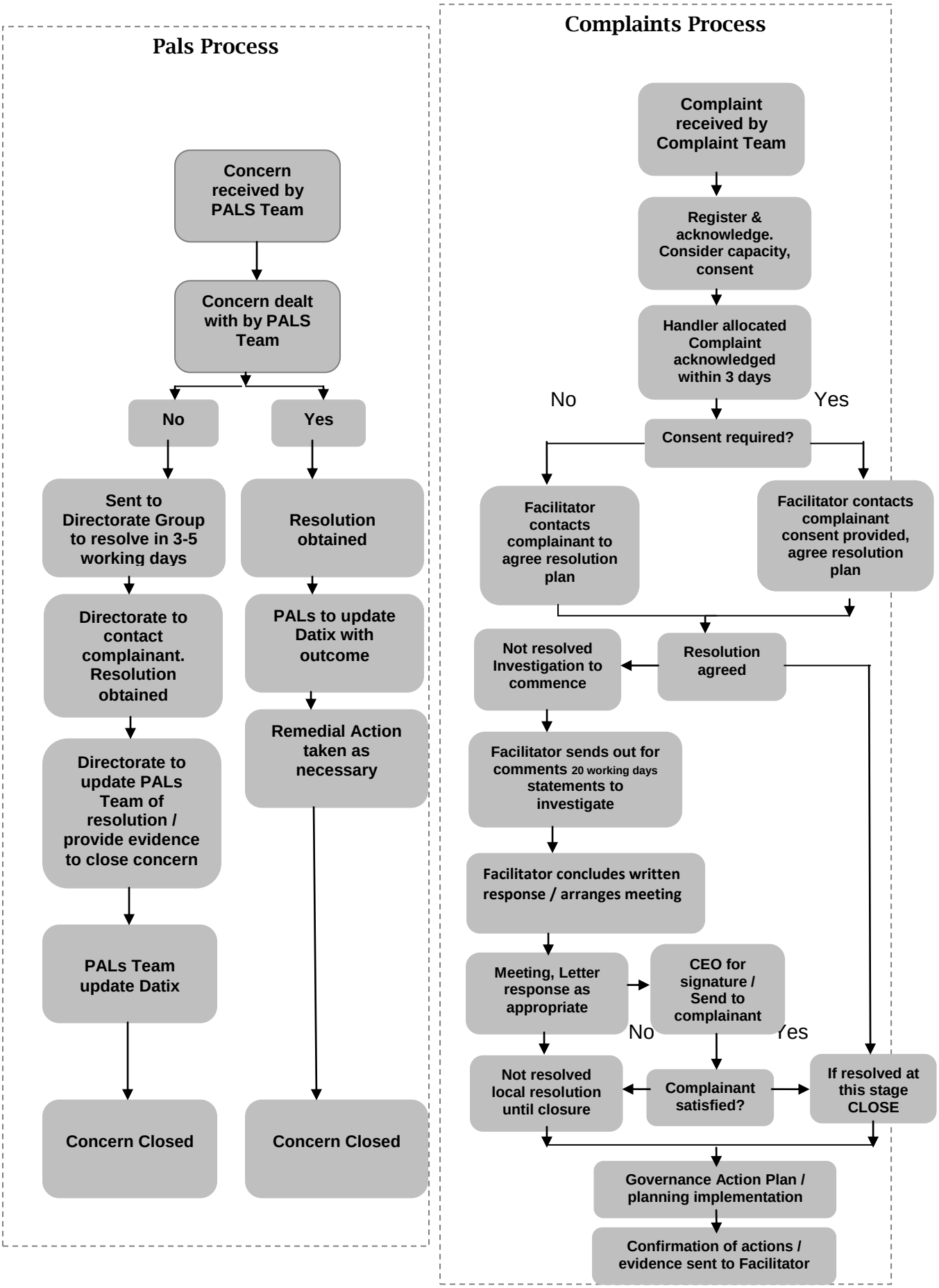
3.10.1 On closure of the complaint (date of final response/meeting), it must be considered under the Operational Group governance arrangements in order to identify any necessary remedial action. The process and implementation must be documented and evidenced and, as a matter of routine, the completed complaint file will be returned to the Complaints manager within 3 months.

3.10.2 If the PHSO has reviewed a complaint and made recommendations for action and further contact with the complainant, the Operational Group must undertake the further Local Resolution, ensuring that any necessary remedial action is implemented and evidenced, (see Appendix D for the action plan template) and the completed complaint file returned to the Complaints Manager, as a matter of routine, within 3 months.

3.10.3 A report must also be prepared for the Quality and Patient Experience Committee.

Appendix B

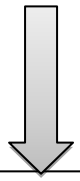

Complaints process
Complaint enters Trust (PALS, CE Office, etc.) Sent to Complaint Handling inbox, Director of Performance Assurance & Head of Complaints
Complaint triaged by Complaints Manager (or by Facilitators) Allocated Category 1 (30 working days) Category 2 (45 working days) Category 3 (60 working days)
Sent to Complaints Facilitator (Handler) & Complaint & PALs Co-ordinator to register on Datix and acknowledge
Complaint & PALS Co-ordinator Logs complaint on Datix and sends acknowledgement letter to complainant (within 3 working days)
Handler reviews complaint/requests notes
Handler contacts complainant to conclude resolution plan (within 7 working days)
Written response requested
CF Sends complaint out to Groups requesting statements (20 working days given)
Compile information / statements received back from groups
Draft response letter
Send letter for checking to the contributors & GM's (5 working days)
Send to Sarah A for quality checking
Signed By CE /DCE / DPA
Sent to Complainant (within category 1/2/3 days)
Close on Datix
Meeting requested
Ask for availability
Arrange meeting
Type and send meeting notes
Follow up with outstanding actions
Write response
Contact complainant every 3-4 weeks and update last reviewed field
Update Datix with every contact for audit purposes and most up to date position.


Pals Process
Concern received by PALS Team
Concern dealt with by PALS Team
No
Yes
Sent to Directorate Group to resolve in 3-5 working days
Directorate to contact complainant. Resolution obtained
Directorate to update PALs Team of resolution / provide evidence to close concern
PALs Team update Datix
Concern Closed
Resolution obtained
PALs to update Datix with outcome
Remedial Action taken as necessary
Concern Closed
Complaints Process
Complaint received by Complaint Team
Register & acknowledge. Consider capacity, consent
Handler allocated Complaint acknowledged within 3 days
No
Yes
Consent required?
Facilitator contacts complainant to agree resolution plan
Facilitator contacts complainant consent provided, agree resolution plan
Not resolved Investigation to commence
Resolution agreed
Facilitator sends out for comments 20 working days statements to investigate
Facilitator concludes written response / arranges meeting
Meeting, Letter response as appropriate
CEO for signature / Send to complainant
No
Yes
Not resolved local resolution until closure
Complainant satisfied?
If resolved at this stage CLOSE
Governance Action Plan / planning implementation
Confirmation of actions / evidence sent to Facilitator

Appendix C

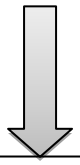
Complaints Escalation Procedure

- Complaint received
- Comments requested from clinicians / staff involved **(20 working days)**

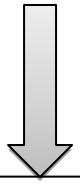


- Comments not received by **20 working days**
- Complaint Facilitator escalates to Complaints & PALs Manager
- Complaint Manager escalates to clinicians / staff involved including Associate Chief Operating Officer (ACOO) / Clinical Director / Assistant General Manager & Director of Performance Assurance **(5 working days)**

CF to have exhausted all options prior to escalation – including phone call, personal contact and not solely rely upon email.
Where appropriate where a member of staff from whom comments are requested is off sick, the need to request another member of staff to comment should be considered by the Directorate.



- Comments not received by **5 working days**
- Complaints & PALs Manager escalates to Director of Performance Assurance to raise with ACOO



- Comments not received by next working day
- Director of Performance Assurance escalates by sending out 'Zero Tolerance Letter' (Appendix J)

Director of Performance Assurance to send 'Zero tolerance' letter and request comments by return.
Information on non-responders to be forwarded to relevant Director and to be included as part of annual appraisal process

Appendix D

Northern Lincolnshire & Goole NHS Foundation Trust

Action Plan Following Formal Complaint Confidential

NAME: **REFERENCE NO:**

	Problem	ACTION	Action Assigned to (name)	Date Assigned	Date Action Completed & Supportive Evidence Submitted	OUTCOME

IT IS ESSENTIAL TO ATTACH EVIDENCE OF COMPLETED ACTIONS e.g. RELEVANT MINUTES OF MEETINGS/EMAILS OR MEMOS TO STAFF etc.

Signature …… **Print name:** ……..

Designation: **NURSING & PATIENT SERVICES MANAGER/SERVICE & BUSINESS DEVELOPMENT MANAGER**

Date: ……..

Appendix E

Northern Lincolnshire and Goole NHS Foundation Trust

Patient Advice & Liaison Service (PALS)

CONCERN FORM

Date of PALS taken:	
PALS Ref No:	
Patient Name & Address:	
Patient Date of Birth:	
Patient Contact Number:	
Hospital / NHS Number:	
Name and contact details of Complainant (if different from above): **Complainant's Address**	
Has the complainant confirmed that the patient was aware the concern was being raised on their behalf? **YES/NO**	
Site:	
Ward / Department:	
Consultant / Specialist of patient:	
Details of concern:	
PALS taken by:	

Appendix F

Guideline – Vexatious, Unreasonably Persistent Complainants

The Trust is committed to addressing complaints in an open, honest, fair and impartial manner, making all reasonable efforts to achieve a satisfactory resolution. It is recognised that the nature of some complaints means that the complainant's behaviour is influenced by grief, anger, despair and may be challenging for staff. This guideline is designed to provide guidance for staff dealing with complainants who are considered to be persistent or vexatious and allows contact with the complainant (about the subject of the specific complaint) to be specified and limited or to cease entirely. Where complainants are violent or aggressive, staff should refer to the Trust's Violence and Aggression Policy.

Threatening and abusive behaviour is readily identifiable but it is recognised that persistent or vexatious behaviour may be more difficult to identify. There is inevitably a degree of subjectivity in identifying such behaviour and the examples offered here are intended as a guide only. Each circumstance must be considered carefully.

It is emphasised that it is expected that this guideline will only be used as a last resort and when all reasonable measures have been taken, for example, local resolution, involvement of PALS/ICA, mediation. It is imperative that the NHS Complaints Policy has been applied and followed scrupulously before this guideline may be implemented.

Implementation of the guideline can be made with regard to one complaint only. Any new matter must be considered on its merits.

In accordance with the Trust's Constitution, any complainant who is subject to sanctions under this guideline is disbarred from being a public member of the Trust.

Examples of vexatious, unreasonably persistent behaviour

The individual(s) involved:

- Persist in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted
- 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. Care must be taken not to disregard new issues which are significantly different from the original complaint
- Are unwilling to accept documented evidence of treatment given as being factual, or deny receipt of an adequate response in spite of correspondence specifically responding to their queries, 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 staff, or other body to try and assist 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

- Have excessive contact and/or inappropriate contact with the Trust, placing unreasonable demands on its staff

- Are known to have recorded meetings of face to face/telephone without the prior knowledge and consent of the parties involved

- Display unreasonable demands or expectations and fail to accept that these may be unreasonable

- Conduct complex, parallel communication (PALS, MP, DoH, Media)

Before looking to implement this procedure, the complainant should be warned that the behaviour is considered to be unacceptable and asked to change or desist.

If the behaviour does not change and the Clinical/Non-Clinical Directorate seeks to implement this guideline, they should refer an account, with documentary evidence where available, of why it is thought to apply, to the Director of Performance Assurance. The Director of Performance Assurance may offer further advice about how to manage contact with the complainant or refer the matter to the Quality and Patient Experience Committee.

The Director of Performance Assurance will ask two Non-Executive members of the Quality and Patient Experience Committee to consider the evidence.

If it is accepted that the complainant's behaviour fulfils the relevant criteria, a record should be made of why a complainant has been classified as habitual or vexatious. These records should be placed in the complaint file.

If the behaviour is not deemed to be unacceptable, the Non-Executive Directors will suggest further means of managing the situation.

Once it has been determined that a complainant meets one or more of the above criteria they should be informed in writing by the Chief Executive that they have been classified as a vexatious or an unreasonably persistent complainant.

A copy of the relevant section of the Trust's policy/guideline should accompany any such letter and advise the complainant to take account of the criteria in any further dealings with the Trust.

The Trust may apply the following measures:

- Decline contact with the complainant in person, by telephone, fax, letter, e-mail or any combination of these provided one form of contact is maintained or alternatively restrict contact to liaison through a third party

- Notify the complainant in writing that the Trust has responded fully to the points raised and considers that all methods of resolving the complaint have been exhausted and either there is nothing more to add or continuing contact on the matter will serve no useful purpose. Further, explaining that correspondence is at an end and that any further letters etc on the specific or closely related matter that are received will be acknowledged but not responded to

- Inform the complainant that in extreme circumstances the Trust reserves the right to pass on unreasonable or vexatious complaint files to its solicitors; or that it will temporarily suspend all contact with the complainant, or investigation of a complaint, whilst it seeks legal advice or guidance from some other relevant agency

Where contact with the complainant continues, the status of being vexatious/unreasonably persistent must be reviewed by the Quality and Patient Experience Committee (or by the Director of Performance Assurance in conjunction with the relevant Non-Executive Directors if appropriate) at regular intervals and in the light of the complainant's ongoing behaviour and should the complainant demonstrate a more reasonable approach, the status may be withdrawn.

Any new complaint received must be processed in the usual manner and not be influenced by the complainant's previous behaviour.

Appendix G

Guideline – Criteria for the Grading of Formal Complaints According to Severity and the Investigation Required

1. On receipt, all formal complaints are graded according to severity/complexity (further to consideration of the consequence and likelihood of recurrence) by the CM. Grading will be recorded on Datix
2. The suggested level of investigation required is based on the level of severity/complexity, in line with the criteria shown below. During the course of the investigation it may become apparent that the severity, and therefore the level of investigation, should be adjusted
3. On completion/closure of the complaint, the grading will be reviewed and re-graded, where necessary, to reflect the result of the investigation of the complaint
4. Feedback to staff and Closing the Loop must take place on the completion of each complaint
5. All complaints will be graded on an individual basis, during the course of the investigation complaints may require or include some or all of these criteria's and will be adjusted accordingly.

GRADING CRITERIA

LOW	**Level of Investigation**
• **Essentially a simple PALS issue which the complainant wishes to be treated as formal** • **A single resolvable problem in the patient experience** • **Issue(s) clear and easily addressed (car parking; delay in clinic)** • **No injury** • **No financial loss**	**Enquiries to relevant member of staff/external contractor (response need not necessarily be in writing but a file note of the advice must be made).** **Review of relevant documentation/electronic information may be necessary e.g. booking forms, medical records**.
MODERATE	**Level of Investigation**
• **Minor issues raised about one or more Directorates/Groups** • **Issues are more complex but easily addressed with little / no impact on clinical care** • **Minor injury** • **Low financial loss (parking fee/mileage/bus fare/ lost property)**	**Review of documentation will be necessary e.g. medical records.** **Request for written advice of responsible clinician/senior/ward/manager. It may be necessary for more junior staff, who had direct involvement with the events complained about, to provide written statements.** **Clarification/additional information may be required from statement authors. Review of statements may be required by more senior staff, e.g. Modern Matrons, Governance leads, Clinical Director.**

SEVERE	**Level of Investigation**:
• **More complex issues, involving one or more Directorates/Groups or other agencies** **e.g. Local Authority/CCG/other acute Trust** • **More significant injury has occurred as a result of medical treatment** **e.g. provided/not provided/delayed/cancelled** • **Moderate financial loss or interruption to activities** **e.g. loss of wages; high mileage/transport costs; lost valuables** • **Possible litigation/adverse publicity**	**N.B. If an Incident investigation/RCA has taken place reference may be made to this but care must still be taken to ensure that all aspects of the complaint are addressed.** **Review of documentation will be necessary e.g. medical records, Incident Documentation / Further Investigation.** **Request for written advice of responsible clinician/senior staff/ward/manager. It is likely that it will be necessary for more junior staff, who had direct involvement with the events complained about, to provide written statements.** **Clarification/additional information may be required from statement authors. Review of statements may be required by more senior staff, e.g. Modern Matrons, Governance leads, Clinical Director. Liaison with C&LSM/Trust's legal advisors.**
CATASTROPHIC	**Level of Investigation**
• **Multiple or complex issues, involving one or more Directorates/Groups or other agencies – further issues may be raised throughout complaints investigation** • **Issues arising over a considerable period of time throughout the patient's experience** • **A Serious Untoward Incident with major / catastrophic consequences** • **A serious accident / injury to patient/visitor causing serious injury/death** • **Involvement of the Police/Coroner/Health & Safety Executive** • **Probable major financial loss** • **Probable litigation** • **Major impact on patients/organisation/with high risk of adverse publicity**	**Review of SUI/RCA documentation and medical records.** **Liaison with SUI lead investigator, C&LSM, Trust's legal advisors, Communications Officer.** **Careful review to ensure that all aspects of the complaint are addressed or further investigation required.**

Appendix H

Protocol for the handling of complaints / comments / concerns / compliments that involve more than one organisation Humber MEC Group

1. Introduction

This protocol applies to feedback (complaints, comments, concerns & compliments) that require co-ordinated handling across organisations. It is approved of and agreed to by the organisations named below. The protocol is to be used by these organisations to address all issues falling under the Making Experiences Count procedure that involve two or more of them.

(See appendix for definitions)

2. Principles

The provision of health and social care services is an increasingly complex arrangement of interagency responsibility. Service users, their carers, friends and relatives cannot be expected to have a detailed understanding of these relative responsibilities and should not have to navigate their way through them in order to have their feedback addressed. This protocol is intended to ensure that any feedback about a jointly provided service or that involves services provided by more than one organisation is dealt with seamlessly, promptly and clearly through a single co-ordinated process. Complainants will be given the advice and assistance they need to make the experience as straightforward as it can be.

This protocol will require:

- openness and co-operation between agencies at each stage of the process
- a designated lead and contact for the complainant
- clarity about the way in which each issue will be addressed
- single response and
- shared learning

3. Process

3.1 Receiving the complaint

- Feedback can be made verbally/in person or in writing at any organisation. Front line staff should be aware that they can take issues relating to other organisations and that representatives (see appendix) should not be asked to make their feedback in another form or at another place
- Any feedback that involves more than one organisation should be passed to the person within the organisation designated to deal with these issues (referred to in this document as the complaints manager, see appendix)

- The 'complaints manager' will be responsible for co-ordination of the complaint along with their counterpart in the other organisation(s)
- The representative should be made aware of any relevant advocacy service

3.2 Establishing the Lead

For each feedback it will be necessary to establish the lead organisation. The complaints manager for the lead organisation will take responsibility for managing the feedback handling, providing the response and keeping the representative informed.

The lead organisation will be that which:

- is responsible for an integrated service
- has responsibility for the majority of issues in the feedback
- Is accountable for the most significant issues
- the representative requests
- received the feedback, should the issues be evenly divided
- is determined by the respective complaints managers

In addition the representative's wishes can be considered

If feedback is received by one organisation, which they have no authority to investigate, the complaints manager will contact the representative within 2 working days and advise them that the feedback will have to be forwarded to the relevant organisation and seeking their consent for this.

3.3 Grading

A feature of the making experiences count process is the initial impact/risk assessment. This assessment looks at the potential significance of the issues raised by the feedback. It begins to determine the means by which the feedback will be addressed by allocating a grading. This process of grading the feedback cannot be carried out by one organisation on behalf of another and therefore must be conducted by each of the organisations concerned in co-operation. It will be the responsibility of the lead organisation to co-ordinate the process but each organisation is accountable for the grading of issues relating to its own services. Where it is necessary to contact the representative for the purpose of grading the complaint agreement will be reached between complaints' managers about how this is best done to avoid repeated contact.

3.4 Resolution Plan

To ensure clarity about the process for addressing the issues raised a resolution plan will be drawn up. This plan will:

- set out each element of the feedback
- state how each element will be addressed & by whom
- establish timescales

- record the preference for method of contact e.g. in person, in writing
- Agree advocacy involvement where appropriate
- Establish the relevant consents (consent should be sought only once & should apply to all organisations involved)

In addition clear agreement should be reached about the process of adjudication, arrangements for the response & organisational sign off.

The complaints manager from the lead organisation will draw the resolution plan together in consultation with the other organisations concerned. All organisations will agree the plan and the plan will be shared with the representative. Once agreed the resolution plan represents a commitment, on the part of each organisation, to co-operate with the efforts to resolve the complaint. It is the responsibility of the complaints manager in each organisation to ensure that the necessary people, records, procedures etc are available to the complaint investigator, without separate requests having to be made, and check that appropriate consent/s have been received.

4. Response

It should always be the aim to have a single response to inter-organisation feedback. In some circumstances this may not be possible, for example if one issue is going to take significantly longer to deal with than others. Representatives should always be advised of this as soon as possible.

If the feedback requires an adjudication/management meeting again this should be a joint process to facilitate the single response. If adjudication cannot be held jointly they should take place within a timescale that would not prolong the response. The appropriate managers in each organisation must agree/sign off the responses before they are sent.

5. Findings

If there has been no formal adjudication then the lead manager should seek to identify, with the officer/s who handled the feedback, whether there are any identified learning issues/actions. The manager will forward to the relevant organisation.

Learning from feedback is a vital feature of the process and inter-organisation feedback handling offers an opportunity for organisations to learn from each other. The process of adjudication should ensure that issues requiring action/service improvements are identified. If the lead complaints manager is involved in the adjudication process they should ensure that any learning points/identified actions are forwarded to their counterpart in the relevant organisation.

The lead complaint manager will follow up with user feedback/satisfaction surveys to the representative.

6. Consent to Information Sharing

In order to deal with feedback effectively it will be necessary for organisations to make information that they hold on individual service users/patients available to investigators from other organisations. Similarly they will be required to give access to internal policies/procedures.

In respect of personal information this must be handled in line with the principles of the Data Protection Act, Caldicott and any confidentiality policies the respective organisations may have. Investigators should also be aware of their responsibilities in respect of confidentiality.

Consent to share information must be sought from the representative and, if different, from the service user/patient. If the service user/patient is deemed not to have capacity in this respect then consent can be sought from their representative (see appendix).

Wherever possible consent should be given in writing, if this is not possible consent should be recorded carefully on file. Consent should be sought only once for each investigation and should apply to each organisation involved.

If consent is not given to share information then it should be explained to the representative that they can (i) take the issues direct to the organisation concerned (ii) pursue their issues through the joint route but with the understanding that the investigation will be compromised through lack of access to information (iii) withdraw feedback that cannot be effectively looked into without access to some records.

Once consent to access to information is given organisations should make every effort to ensure the requested information is readily available to the investigation. This includes verbal information from the staff of the organisation.

Information that is made available to the investigation of a complaint must only be used for the purpose for which it was obtained. Only information that is relevant to the feedback and its investigation should be shared.

Appendix

Definitions

Complaints Manager – Person within the organisation designated to deal with complaints under regulation 4(1)(b).

Feedback – Complaints, comments, concerns & compliments that require action and a response.

Representative – person making the complaint, comment, concern compliment. May be the service user or someone acting on their behalf.

Service user representative/person acting on behalf of the service user – person defined in regulations 5(2), 5(3).

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

Organisations – The organisations to which this protocol applies are as follows:

- East Riding of Yorkshire CCG
- East Riding of Yorkshire Social Services
- Hull & East Yorkshire Hospitals NHS Trust
- NHS Hull CCG
- Hull City Council Adults Services
- Humber NHS Foundation Teaching Trust
- North Lincolnshire and Goole NHS Foundation Trust
- North Lincolnshire CCG
- North Lincolnshire Council Adults' Social Services
- North East Lincolnshire CCG
- Yorkshire Ambulance Service

Appendix I

Protocol for the handling of complaints / comments / concerns between North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group and Northern Lincolnshire & Goole NHS Foundation Trust (Diana Princess of Wales Site)

1. Introduction

This protocol applies to feedback (complaints, comments, concerns and compliments) that require co-ordinated handling across all organisations. It has been agreed to by the organisations named above.

This protocol is to be followed by the named organisations to address all issues falling under the following legislation requirements:

- Children and Family Services: Getting the Best from Complaints 2006
- NHS organisations – Clinical Commissioning Group and NL&G: The Local Authority Social Services and NHS Complaints (England) Regulations 2009.
- North East Lincolnshire Council's Feedback Process

2. Principles

The interagency responsibility of health and social care service provision is a complex arrangement. Service users (including children, young people and families) patients, their carers, friends and relatives cannot be expected to have a detailed understanding of these relative responsibilities and should not have to navigate their way through them in order to have their feedback addressed.

Services commissioned by any of the above organisations who may be involved with the complaints process should also have a clear understanding of the processes and their responsibilities.

This protocol is intended to ensure that any feedback about a jointly provided service or that involves services provided by more than one organisation is dealt with seamlessly, promptly and clearly through a co-ordinated process.

Complainants will be given the advice and assistance they require to make their experience as effective and timely as possible.

This protocol will require:

- openness and co-operation between the agencies
- openness and co-operation at each stage of the process
- a protocol for decision making between the agencies
- a designated single lead and contact for the complainant

- clarity about each step of the complaints process including timescales
- the provision of a single co-ordinated response
- (where practical and agreed with the complainant)
- the commitment to shared learning

3. Process and Establishing the Lead

3.1 Receiving the complaint

Feedback (complaints, comments, concerns & compliments) can be made verbally, in person, in writing or on-line to the above organisations. Any feedback that involves more than one organisation should be passed to the person within the organisation designated to deal with these issues, referred to in this document as the Complaints Manager/Designated Officer/The receiving organisation will contact the complainant to explain the need to obtain agreement to share the complaint with other organisations.

3.2 Establishing the Lead Organisation

For each feedback it is necessary to establish the lead organisation. The Complaints Manager/Designated Officer for the lead organisation will take responsibility for managing the feedback handling, providing the response and keeping the other representatives informed.

- The respective Complaints Managers/Designated Officers should discuss at the earliest opportunity the complaint. Within this discussion it will be established which organisation will be the lead/ co-ordinating organisation.
- The lead organisation will be:
  - that which has responsibility for the majority of issues in the feedback
  - accountable for the most significant issues
  - responsible for receiving the feedback, should the issues be evenly divided
  - determined by the respective Complaints Managers/Designated Officers
  - taking consideration of the complainant's wishes and views regarding timescales if the lead organisation is the Clinical Commissioning Group or NL&G. Where this is the case timescales and response dates will also be negotiated, subject to the complainant's agreement. N.B. if the lead organisation is Children and Family Services the timescales for responding are bound by legislation

The lead Complaints Manager/Designated Officer will be responsible for and co-ordination of the complaint along with the support of their counterpart in the other organisation.

Where Children and Family Services are denoted as the lead organisation, legislation suggests that the agencies work to the lowest legislative timescale (see also 4). The lead Complaints Manager/Designated Officer will acknowledge the complaint within 3 working days of receipt:

- The lead Complaints Manager/Designated Officer is responsible for establishing any relevant advocacy/ support requirements of the complainant. In the case of children and young people making a complaint this service will be commissioned in by the Children's Rights and Representations Team. In terms of the CCG and NL&G ICA can provide advocacy services to support people who wish to make complaint

- The lead Complaints Manager/Designated Officer is required to establish any support requirements for the complainant and prior to commissioning these, establish which organisation will fund

- The Complaints Manager/Designated Officer for each organisation is responsible for appointing an Investigating Officer and in the case of complaints made under the "Getting the Best from Complaints" legislation for Children's Services an Independent Person at stage 2 of the process

3.3 Timescales / Grading

Consideration must be given to the respective legislation for both organisations. Where Children and Family Services are denoted as the lead organisation the agencies will work to the lowest legislative timescale (see also 4).

The **Children and Family Services** complaints legislation, 'Getting the Best from Complaints' 2006, details specifically the timescales at the 3 complaint stages, these are only open to extension with the explicit agreement of the complainant.

The stages and timescales are as follows:

- Stage 1 10 working days (can be extended to 20 days for more complex complaints)

- Stage 2 25 working days (maximum extension to 65 days)

- Stage 3 50 days to the issue of findings

Where a young person is making a complaint an advocate will be offered, where a complaint has been made on behalf of a child consent from the child may be required if the child is deemed to be Fraser (Gillick) competent, i.e. able to make their own decisions.

Consent and agreement to share information will be sought from the complainant (and/or person complained about) and will apply to all organisations involved.

For the NHS organizations/The Local Authority Social Services and NHS Complaints (England) Regulations 2009 complaints legislation process involves an initial impact/risk assessment. This assessment looks at the potential significance of the issues raised by the feedback and is allocated a grading. The process of grading the feedback cannot be carried out by one organisation on behalf of another and therefore must be undertaken jointly. A Resolution Plan will be produced to ensure clarity about the process for addressing the issues raised, a Resolution Plan will be drawn up and will:

- set out each element of the feedback

- state how each element will be addressed

- establish the timescales

- record the preference of method of contact e.g. in person, in writing
- agree advocacy involvement where appropriate
- identify the appointed Investigating Officer

Clear agreement should be reached about the process of adjudication and arrangements for the response organisational sign off.

The lead organisation will gain the relevant consent from the complainant. Consent should be sought only once and should apply to all organisations involved.

It is the lead Complaints Manager/Designated Officer's responsibility to negotiate and agree with their counterpart in the other organisation any costs incurred whilst progressing the complaint.

N.B. Where required, it is the responsibility of the Complaints Manager/Designated Officer in each organisation to ensure that the necessary people, records, procedures etc are available to the Investigating Officer, without separate requests having to be made, and check that appropriate consent is recorded.

4. Response

It should always be the aim to have a single response to inter-organisation feedback. In some circumstances this may not be possible, for example if one issue is going to take significantly longer to deal with than others. In such cases it may be that the organisations agree, with the complainant, to provide separate responses. Where this is the case, the Complaints Manager/Designated Officer will give consideration to providing the responses received to the complainant, and agreeing with them an appropriate date to receive the outstanding response. Complainants should always be advised of this as soon as possible in writing.

If the lead agency is the Clinical Commissioning Group/NL&G and it is considered that the feedback requires an Adjudication/ Management meeting, this should be a joint process, where possible, to facilitate a single response. If adjudication cannot be held jointly it should take place within a timescale that would not prolong the response to the complainant. The lead Complaints Manager/Designated Officer is responsible for ensuring that the appropriate manager in their organisation agrees/signs off the response before it is sent. The response should be shared and agreed with both Complaints Manager/Designated Officers prior to the final sign off and before it is shared with the complainant.

5. Findings

If there has been no formal adjudication then the lead Complaints Manager/Designated Officer should seek to identify, with the officer/s who handled the feedback, whether there are any identified learning issues/actions.

Children and Family Services will hold an adjudication meeting with all Stage 2 complaints.

The lead Complaints Manager/Designated Officer should ensure that any learning points/identified actions are forwarded to their counterpart in the relevant organisation. Any

identified actions and recommendations will be monitored by the lead Complaints Manager/Designated Officer to ensure that they have been completed.

Learning from feedback is a vital feature of the process and inter-organisation feedback offers an opportunity for both organisations to learn from each other. Feedback ensures that issues requiring action/service improvements are identified.

The lead Complaints Manager/Designated Officer will follow up with user feedback/satisfaction surveys to the representative and will advise their counterpart of any findings.

6. Consent to Information Sharing

In order to deal with feedback effectively it will be necessary for all organisations to make relevant information that they hold on the complainant available to any identified investigators from the other organisation. Similarly they will be required to give access to any internal policies or procedures.

In respect of personal information this must be handled in line with the principles of the Data Protection Act 1998 and any confidentiality policies the respective organisation may have. All investigators should be aware of their responsibilities in respect of confidentiality.

The lead Complaints Manager/Designated Officer must ensure at commencement of the complaint that consent is provided by the complainant to share information with all relevant parties. Where the service user/patient is deemed not to have the capacity to give consent then this must be sought from their representative.

Consent should be given in writing, if this is not possible consent should be recorded carefully on file, clearly explaining how the complainant has given permission and the reasons why written consent cannot be provided. Consent should be sought only once for each complaint and will apply to all organisations.

Where consent is not given to share information then it should be explained to the complainant that they can:

- take their complaint direct to the organisation concerned
- pursue their complaint through the joint route but with the understanding that any investigation will be compromised through lack of access to information

Once consent is given all organisations should make every effort to ensure that any requested information is readily available (including verbal contact) during the complaint investigation.

Information that is made available for the investigation of a complaint must only be used for the purpose for which it was obtained.

Only information that is relevant to the feedback and its investigation should be shared.

It is the responsibility of the lead Complaints Manager/Designated Officer to ensure that the storage and retention of any joint complaint information meets with their organisation's legislative protocol.

Definitions

Complaints Manager/Designated Officer – Person within the organisation designated to deal with complaints.

Feedback – Complaints, comments, concerns and compliments that require action and a response.

Service user/Complainant – person making the complaint, comment, concern, compliment. This may be the service user or someone acting on their behalf.

Representative – This is the person (s) acting on behalf of a person wishing to make a complaint subject to the complainant's consent and agreement.

Regulations – The Local Authority Social Services Getting the Best from Complaints 2006 and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Organisations – North East Lincolnshire Children and Family Services and North East Lincolnshire Clinical Commissioning Group and Northern Lincolnshire & Goole NHS Foundation Trust (Diana Princess of Wales's site).

Investigating Officer – Person appointed by the Complaints Manager/Designated Officer to carry out the investigation. In some cases this may be an independent investigating officer.

Independent Person – Person appointed by the Complaints Manager/Designated Officer for children's social care complaints to work alongside the Investigating Officer.

Advocate – Person supporting the complainant during the complaints process.

Complaints Manager – Person within the organisation designated to deal with complaints under regulation 4(1) (b). Suggest that this is the designated lead, which is a generic term.

Feedback – Complaints, comments, concerns & compliments that require action and a response.

Representative – person making the complaint, comment, and concern compliment. May be the service user or someone acting on their behalf. Suggest that you refer to them as the complainant unless representative is the term used in the guidance.

Service user representative/person acting on behalf of the service user – person defined in regulations 5(2), 5(3).

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

Organisations – The organisations to which this protocol applies are as follows:

- East Riding of Yorkshire CCG
- East Riding of Yorkshire Social Care Services
- Hull & East Yorkshire Hospitals NHS Trust

- NHS Hull CCG
- Hull City Council Adults Services
- Humber NHS Foundation Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- North Lincolnshire CCG
- North Lincolnshire Council Adults' Social Services
- North East Lincolnshire CCG
- Yorkshire Ambulance Service
- ICA
- And other organisations by agreement with the group

Appendix J

First Draft 'Zero Tolerance' letter

Dear

Complaints Procedure – Outstanding Request for Comments:
Complaint Reference No: [INSERT]

I have been informed that, despite repeated requests, you have not provided a response to the above complaint.

As you will be aware, participation in the Trust's complaints processes is a contractual requirement. [*For doctors:* It is also a GMC requirement that you "co-operate fully with any formal inquiry in to the treatment of a patient and with any complaints procedure that applies to work". Further, to act "promptly and professionally" to ensure that "patients who make a complaint receive a prompt, open, constructive and honest response".]

Non-compliance with the above requirements place you at risk of disciplinary action. Information on non-compliance could also be used to inform the annual appraisal process.

I should be grateful if you would give this matter your urgent attention and look forward to receipt of your comments by return. These should be sent to Sarah Davy, Complaints & Legal Services Manager, with a copy to me.

If for any reasons you foresee a problem complying with this request, I also need to know by return.

Thank you.

Yours sincerely

Wendy Booth
Director of Clinical and Quality Assurance & Trust Secretary

Cc: Complaints Manager