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Approval

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Document Control Information

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1 Introduction

All NHS Trusts are required to respond to complaints in an objective and fair manner in accordance with The Local Authority Social Services and National Health Service Complaints *England) Regulations 2009 (Statutory Instrument 2009 No.309) and with due regard for the rights of those concerned.

The Complaints Procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants, whilst remaining fair to staff. It is also to learn any lessons from the complaint to facilitate improvement in service delivery. It is acknowledged, however, that some complaints will identify information about serious matters, which may indicate a need for disciplinary investigation.

Complainants should be made aware that they have the opportunity to discuss privately and confidentially, matters relating to their treatment with consultants, senior medical staff or with the clinical head of service. Staff should encourage complainants to speak openly and refer them to a member of the Patient Experience Team, or a Senior Manager if they do not wish to speak to those involved in their care.

Early resolution is the key to a successful outcome. Most minor complaints and misunderstandings can be resolved satisfactorily by a conciliatory and speedy response. Personal attention by staff on the spot, or by the Matron/Head of Department, can often provide patients and their families with the reassurance that action is or will be taken in relation to their concerns without them having to resort to the formal complaints procedure.

Where the recipient is unable to investigate or resolve the concerns locally, the complaint should be referred to the Patient Experience Team for formal investigation and response. The investigation process will be followed for all complaints and is not dependent on the nature or severity of the complaint.

2 Purpose

The purpose of this document is to ensure all staff are aware of their responsibilities in relation to the management of complaints and the procedure to be followed when investigating and responding to complaints.

3 Key Principles

3.1 County Durham and Darlington NHS Foundation Trust defines a complaint as ‘an expression of dissatisfaction about care or treatment or Trust services, requiring a considered corporate response in line with the Principles of Good Complaints management set out by the Health Service Ombudsman.’

3.2 Complaints are an important source of feedback about the quality of our services and provide the Trust with an opportunity to continuously improve these.
3.3 The focus, therefore, will be placed firmly on the prevention of recurrence rather than
the apportionment of blame.

3.4 For the Trust’s complaints procedure to be effective and work for the people it
affects, we believe it needs to:

- **be open and easy to access** - by being flexible in the way people can
  complain and providing effective support for people wishing to do so,
  including information about the complaints procedure being available in
  different formats
- **be fair and independent** - with the emphasis on providing an objective
  investigation of concerns raised
- **be responsive** – by providing appropriate and proportionate responses and
  redress of all concerns raised
- **be willing to learn and develop** - ensuring complaints are viewed as a
  positive opportunity to listen and learn from patients’ views to drive continual
  improvement in services.

3.5 Patients and service users should be treated with courtesy at all times.

3.6 People will not be treated differently as a result of making a complaint.

3.7 County Durham & Darlington Foundation Trust staff will not record information
relating to a complaint in a patient health record.

3.8 The Trust’s response will not be defensive. If errors have been made, these will be
acknowledged and where appropriate, an apology given.

3.9 Where necessary, appropriate action will be taken to ensure similar problems do not
occur in the future and the complainant will be informed of this action.

3.10 Complaints will be recorded electronically to enable analysis to identify trends and
ensure appropriate action is taken.

3.11 Personal health information will only be available to those investigating the complaint
and to the extent necessary to investigate and answer the complaint.

3.12 Any member of staff involved in a complaint will be informed of the nature of the
complaint by their Care Group Investigating Manager and given an opportunity to
comment. The member of staff will be kept informed throughout the complaints
process and this should include informing him/her of the outcome of the investigation.

4 **Duties**

4.1 **Chief Executive**

The Chief Executive will either respond in writing to all complaints, or will ask a named
delegate(s) to respond on his/her behalf.
4.2 The Patient Experience Officer

The Patient Experience Officer will be responsible for the following: -

- Receiving all formal complaints
- Recording complaints information on Safeguard management system
- Acknowledging receipt of complaints within 3 working days offering complainants a telephone conversation with the Patient Experience Officer to agree: -
  i) the main concerns
  ii) a way forward
  iii) the timescales within which a written response will be sent/or meeting arranged
- Determining who is required to investigate the complaint.
- To determine if risk management need to be involved by liaising with the Patient Safety Manager. The Patient Experience Officer will request that an IR1 is completed via the Care Group if required. This request will be copied to the Patient Safety Manager.
- Forwarding the complaint to the relevant party/parties for investigation with timescale for response.
- Ensuring file notes of any conversation with the complainant are made and filed within the complaint file.
- Ensuring all issues identified in the complaint have been addressed in the investigation.
- Collate investigation responses and write Trust response.
- Provide response to the Chief Executive for signature within the timescale agreed with the complainant.
- Ensuring equal access to the complaints system.
- Organise and attend meetings, with complainants, when appropriate.
- Collate complaints statistics for central reporting purposes.
- Provision of monthly updates on complaints handling.

4.3 Senior Managers

Senior Managers are responsible for ensuring all complaints relating to their Care Group are responded to within the required timescales and for ensuring that there is a nominated person for each specialty to co-ordinate the investigation and response. Senior managers need to ensure staff are supported throughout the complaint process.

Senior Managers are responsible for ensuring all complaints are discussed at their appropriate Clinical Governance based forum meetings to ensure shared learning and monitoring of action plans.
4.4 Investigating Managers

The nominated lead for the specialty will be responsible for the following:

- Establishing who has been involved and request statements from those involved
- Reviewing patient records to establish facts/review care as required
- Collate statements and ensure all issues have been responded to appropriately
- Ensuring all aspects of the complaint have been addressed by the respondents
- Preparing an investigation report, including a detailed action plan, to be taken as a result of the complaint
- Ensuring the report includes the following as appropriate
  - An apology that there has been cause for complaint
  - Condolences if a death has occurred
  - An apology where appropriate.
  - Is written in a factual, non-defensive manner
  - Actions taken as a result of the complaint
  - A detailed Action Plan of all issues that were founded or partly founded.
- Ensuring the report is e-mailed to the Patient Experience Complaints email account by the deadline given. A hard copy should be forwarded by post.
- To determine if risk management need to be involved and/or a serious case review should be carried out.
- Ensuring an action plan is e-mailed to the Patient Experience Team by the deadline given.
- Indicating whether the complaint is Founded, Unfounded or Partly Founded
- Ensuring all detailed actions are completed and that there is evidence of improvement
- Ensuring appropriate staff attend meetings with complainants as required

4.5 Line Managers

The Line Manager is responsible for providing immediate and ongoing support to staff involved in a complaint.

4.6 All Staff Involved in the Circumstances of a Complaint

All staff must comply with a request for a statement in relation to a complaint and cooperate with the investigation.

4.7 Complaints, Litigation, Incidents and Patient Advice and Liaison (CLIP) Group

- Aggregation of complaints, litigation, incidents and PALS will be undertaken quarterly.
• Managers from the above services will meet to review activity and trends from each service and to identify any cross-cutting themes, using qualitative and quantitative analysis.
• Care Group representatives will provide the group with insight into any underlying facts or issues and provide updates on action plans, in response to identified learning.
• An overarching action plan will be collated by the Patient Experience Team and provided to Care Group representatives in order to address themes identified through patient experience measures.
• Evidence of service improvement will be brought to the CLIP group by Care Group leads by completion of the overarching action plan.
• The CLIP group will review the overarching action plan and monitor outcomes.
• A report will be produced for the Quality and Health Care Governance Committee.
• Themes will be identified and a selection of lessons learned will be shared via the intranet.
• A summary of the CLIP report including safety lessons are shared internally via the Quality & Healthcare Governance Committee and externally with Commissioners at the Quality Review Group. The Patient Experience Manager will provide Local Involvement Networks (LINks) with the CLIP report quarterly.

4.8 Quality and Health Care Governance Committee

The Quality and Health Care Governance Committee will receive a quarterly report and provide assurance to the Trust Board of effective complaints management.

5 Who May Complain

5.1 A complaint may be made by:
• a patient, current or former
• any person who is affected by the issue which is the subject of the complaint.
• by a person acting on behalf of a patient who
  ⇒ has died;
  ⇒ is a child;
  ⇒ is unable by reason of physical or mental incapacity to make the complaint himself; or
  ⇒ has requested the representative to act on his behalf.

5.2 In the case of a patient or person affected who has died or is incapable, the representative must be a relative or other person who, in the opinion of the Patient Experience Officer, had or has a sufficient interest in his welfare and is a suitable person to act as representative.
5.3 In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

5.4 If in any case the Patient Experience Officer is of the opinion that a representative does or did not have a sufficient interest in the person’s welfare or is unsuitable to act as a representative, he/she must notify that person in writing stating his/her reasons.

5.5 Where an anonymous complaint is received, it will be investigated and a response will be held centrally within the Patient Experience Department.

5.6 Anyone wishing to complain will be informed of the independent advice and assistance available from the local Independent Complaints Advisory Service (ICAS).

6 Consent

6.1 Complaints made on behalf of patients must be made with the patient’s signed consent. This is to comply with the Data Protection Act 1998 and Caldicott requirements. (refer to the Trust’s Caldicott for Beginners leaflet).

6.2 Where a complaint is received from a third party in respect of a capable adult or child, the Patient Experience Officer must obtain that person’s signed consent for the Trust to:

- Accept and respond to the complaint from a third party; and
- Access personal health information, to the extent necessary to investigate and respond to the complaint.

6.3 Exceptions include the following:

6.3.1 A child. If, in the course of investigating a complaint, it becomes clear that the child is mentally, emotionally and physically capable of pursing a complaint themselves (Gillick Competent) then their consent must be obtained to allow someone to act on their behalf.

6.3.2 If the patient is incapacitated or has died. If a patient is incapacitated either mentally or physically, consent is not needed. If the Chief Executive is of the opinion that the person acting on behalf of an incapable individual or in respect of someone who has died, is not a suitable person, he may refuse to deal with that person and nominate another person to act in accordance with the Mental Capacity Act. This discretion will be exercised in only exceptional circumstances.

7 Timescales

7.1 A complaint should be made within twelve months of the date on which the matter which is the subject of the complaint occurred;
Complaints Handling Policy

or

Within twelve months of the date on which the matter which is the subject of the complaint came to the notice of the complainant.

7.2 Where a complaint is made after the expiry of the period mentioned above, the Patient Experience Officer may investigate it if he/she is of the opinion that:

i. having regard to all the circumstances, the complainant had good reasons for not making the complaint within that period:

and

ii. notwithstanding the time that has elapsed it is still possible to investigate the complaint effectively and efficiently.

7.3 The Trust will send the complainant a letter confirming receipt of the complaint within three working days of it being received by the Trust. A complaints leaflet explaining the complaints procedure will also be sent with this letter, together with details of ICAS, an equality monitoring form, and freepost envelope. The Patient Experience Officer will attempt to make verbal contact with the complainant within five working days to discuss the complaint, clarify their main concerns, agree a way forward and a timescale for the investigation. The complaint will be sent to the complaints coordinator/investigating officer to begin the investigation. The investigation will be completed in a timescale agreed with the complainant and the patient Experience Officer. This will be stated in the acknowledgement letter.

7.4 The complainant will receive a letter of response to the complaint, within the timescale agreed.

7.5 In cases where the Investigating Manager considers it appropriate to seek an extension of the time limit, for example because of the complexity of the case, they should contact the Patient Experience Officer to discuss, before a decision is made about whether to request an extension from the complainant. No pressure must be placed on the complainant to agree the extension but the Patient Experience Officer may, in suitable cases, consider it appropriate to explain that a comprehensive response may not be possible to achieve within the timescale agreed. The key considerations are whether an extension will genuinely enable local resolution of a complaint to be achieved, and that the complainant is involved in the discussion. Patient Experience Officers should ensure that they record the details of any discussion and agreed/disagreed extensions.

8 Exclusions

8.1 The following are excluded from the scope of this complaints policy:

- A complaint where it appears a criminal offence may have taken place and consideration is being given to a police investigation taking place.
A complaint where the subject matter has already been investigated.
A complaint made by an NHS body which relates to the exercise of its functions by another NHS body;
A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services;
A complaint made by an employee of an NHS body about any matter relating to his contract of employment;
A complaint made by an independent provider or an NHS Foundation Trust about any matter relating to arrangements made by an NHS body with that independent provider or NHS Foundation Trust.
A complaint which relates to the provision of primary medical services in accordance with arrangements made by a Primary Care Trust with a Strategic Health Authority under section 28c of the 1977 act or under a transitional agreement.
A complaint which is being, or has been, investigated by the Parliamentary Health Service Ombudsman (PHSO).
A complaint arising out of an NHS body's alleged failure to comply with a data subject request under the data protection act 1998 (a) or a request for information under the Freedom of Information Act 2000 (b).
A complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services) or section 24 (compensation for loss of office).

9 Patient Confidentiality

9.1 Care will be taken at all times throughout The Complaints Procedure to ensure that any information disclosed about a patient is confined to that which is relevant to the investigation of the complaint. Such information will only be disclosed to those people who need to have access to this information for the purpose of carrying out the investigation and patients will be advised that information from their health records may need to be disclosed to relevant staff members in order to resolve the complaint.

9.2 All internal email correspondence regarding complaints, which contains patient identifiable information will be password protected. All external email correspondence containing patient identifiable information must be send via NHS.Net accounts.

9.3 No reference to a complaint will be included in or on a patient's healthcare record.
10 Case File Management

10.1 The Patient Experience Department will retain all master files within the department for a period of seven years. This will be extended to 25 years when the subject of the complaint is a child. All statements and complaint correspondence will be kept in this file.

10.2 Care Groups do not need to retain copies of complaints once they have been resolved and any necessary action has been taken, as long as all statements etc have been passed to the complaints department.

11 Complaints Involving Multi Agency Care

11.1 Where a complaint involves more than one health care agency, i.e. hospital and commissioners, the Patient Experience Officer should agree, where possible, who will co-ordinate/lead the investigation and the provision of a joint response.

11.2 Where the matters are complex, the Patient Experience Officer may decide that each organisation will respond separately and the complainant must be made aware of this.

11.3 Where the complaint relates solely to a service that is provided on Trust premises but is provided by another Trust, the complaint will be forwarded to the Trust providing the service and the complainant will be informed of this, and their consent will be sought to pass their complaint to another Trust.

11.4 Complaints relating to both healthcare and social services, will be responded to jointly. The lead agency will be, whichever organisation the complainant approaches.

12 Habitual or Vexatious Complainants

12.1 Occasionally there will be times when there is nothing further which can reasonably be done to rectify a real or perceived problem and a complainant may be identified as vexatious.

12.2 A review should take place to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that even habitual or vexatious complainants may have issues which contain some genuine substance.

12.3 Definition of a habitual or vexatious complainant
A complainant and/or anyone acting on their behalf may be deemed to be habitual or vexatious where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted, or make unreasonable demands and/or have unreasonable expectations, and fail to accept that these may be unreasonable.

- Change the substance of a complaint or continually raise new issues whilst the complaint is being addressed or upon receipt of a response.

- Are unwilling to accept documented evidence of treatment given as being factual, e.g. medical or nursing records, or deny receipt of an adequate response, in spite of correspondence specifically answering their questions, or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to have investigated, despite reasonable efforts of Trust staff to help them specify their concerns.

- Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point.

- Have threatened or used actual physical violence towards staff or their families or associates at any time or have harassed or been personally abusive to staff.

- Have in the course of addressing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff.

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

12.4 Dealing with Habitual or Vexatious Complainants

12.4.1 Where a complainant has been identified as habitual or vexatious in accordance with the above criteria, the Chief Executive (or appropriate deputy in their absence) will determine what action to take. The Chief Executive (or deputy) will notify the complainant in writing of the reasons why they have been classified as a habitual or vexatious complainant and the action to be taken.

12.4.2 This notification may be copied for the information of others already involved in the complaint, e.g. practitioners, conciliator, ICAS, Member of Parliament. A record must be kept for future reference of the reasons why a complainant has been classified as habitual or vexatious.
12.4.3 The Chief Executive (or deputy) may decide to deal with the complainant in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed “agreement” with the complainant, setting out a code of behaviour for the parties involved if the Trust is to continue processing the complaint.

- Insisting on a particular form of contact, i.e. all communication to be in writing. If staff are to withdraw from a telephone conversation with a complainant it may be helpful for them to have an agreed statement available to be used at such times.

- Notify the complainant, in writing, that the Trust has responded fully to the points raised and there is nothing more to add by continuing contact. The complainant should be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

- Temporarily suspend all contact with complainant, or investigation of a complaint, whilst seeking legal advice or guidance from the Strategic Health Authority, National Health Service Executive, or other relevant agencies.

12.4.4 This status may be withdrawn at a later date if the complainant subsequently demonstrates a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate.

13 Parliamentary and Health Service Ombudsman (PHSO)

13.1 Where local resolution of a complaint is not achieved, the complainant will be advised of the right to refer to the Health Service Ombudsman for consideration of an independent review of their complaint.

13.2 The Ombudsman will review the complaint handling in relation to the document ‘Principles of Good Complaints Management’. In addition, services involved in the complaint will be reviewed in relation to the ‘Principles of Good Administration’.

14 Training

The Trust mandatory Induction programme provides an introduction to the complaints process. Although not mandatory, the Customer Care, Complaints and Communication Workshop is available to trust staff as part of the Life Long Learning
Complaints Handling Policy

Directory. Training is available for the management of investigations within the Root Cause Analysis Training and can be found within the Life Long Learning Directory.

In addition to the monitoring outlined in section 15, attendance at Essential Training is recorded by P&OD and entered onto the Trust Training Management System, OLM. Monitoring of non-attendance will be in line with the Training Needs Analysis, Monitoring and Evaluation Policy and carried out by P&OD. Please refer to this policy for detailed information.

15 Monitoring Compliance.

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<tr>
<td>Who will perform the monitoring?</td>
<td>Clinical Audit. Patient Experience Manager/ Associate Director Patient Experience.</td>
</tr>
<tr>
<td>What are you monitoring?</td>
<td>1. Duties / listening and responding to complaints of patients, relatives and carers. 2. Process for handling joint complaints between organisations. 3. Ensuring patients, relative and carers are not treated differently as a result of raising a complaint. 4. A process re: how the organisation aims to improve as a result of a complaint being raised. 5. Communicating with internal &amp; external stakeholders to share safety lessons. 6. A process for following up of relevant action plans.</td>
</tr>
<tr>
<td>When will the monitoring be performed?</td>
<td>1, 2, 3. KPI’s Monthly / Complaints Handling audit annually. 4. CLIP meetings quarterly. Q &amp; HcGCommittee quarterly. 5. Monitored at CLIP meetings to ensure Quality Review Group and Local Involvement Networks (LINks) receive information quarterly. 6. Action plans are shared and reviewed at Care Group local governance forums. A Care Group overarching action plan is presented, monitored and reviewed at CLIP group.</td>
</tr>
<tr>
<td>How are you going to monitor?</td>
<td>1. Monthly KPIs. 2. Complaints handling audit and action plan. 3. Complaints handling audit and action plan. 4. Overarching action plan as a result of CLIP analysis via CLIP meetings and actions via Q&amp;HcGCommittee 5. Monitored at CLIP meetings to ensure Quality Review</td>
</tr>
</tbody>
</table>
Group and LINks receive a summary of the CLIP report quarterly.  
6. Action Plan feedback provided and followed up at CLIP group. Discussed at Q & HC Governance Committee

<table>
<thead>
<tr>
<th>What will happen if any shortfalls are identified?</th>
<th>Audit, KPI outcomes and discussion at CLIP Group will identify areas to address, and actions to be implemented and reviewed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where will the results of the monitoring be reported?</td>
<td>CLIP meetings. QHcG Committee.</td>
</tr>
<tr>
<td>How will the resulting action plan be progressed and monitored?</td>
<td>Monitored quarterly at CLIP meetings. Communicated at Q&amp;HcG Committee</td>
</tr>
<tr>
<td>How will learning take place?</td>
<td>Lessons learned shared internally and externally. To ensure organisational learning via CLIPs and Quality Healthcare Governance meetings.</td>
</tr>
</tbody>
</table>

In addition to the monitoring outlined in the above table, attendance at Essential Training is recorded by P&OD and entered onto the Trust Training Management System, OLM. Monitoring of non-attendance will be in line with the Training Needs Analysis, Monitoring and Evaluation Policy and carried out by P&OD. Please refer to this policy for detailed information.

16 Equality and Diversity

16.1 The Trust is committed to the provision of services that are fair and equal to all patients. All complainants are asked to complete an equality monitoring document including the nine protected characteristics, to enable monitoring of fairness, although this is not compulsory.

17. References


Department of Health, Handling Complaints in the NHS – Good Practice Toolkit for Local Resolution

Guidance on the Development and Writing of Statements (2006), Trust Legal Services Department
National Patient Safety Agency, A risk assessment tool for assessing levels of incidents and complaints, July 2003


Parliamentary and Health Service Ombudsman (2008), Principles of Good Complaints Handling

Parliamentary and Health Service Ombudsman (2008), Principles of Good Administration

Parliamentary and Health Service Ombudsman (2008), Principles of Remedy

18 Documentation
18.1 Other related policy documents.

- Training Needs Analysis, Monitoring and Evaluation Policy
- Being Open Policy
- Claims Policy
- Supporting Staff Policy
- Incident Management Policy
- Learning from Experience Policy
- Policy for Policies
- CLIPs Document
## Action Plan Following Complaint

**County Durham and Darlington NHS Foundation Trust**

### Complaint Number:

### Name of Patient:

### Ward/Department:

### Care Group:

<table>
<thead>
<tr>
<th>Problem Identified</th>
<th>Further action to be taken/lessons learned</th>
<th>By Whom</th>
<th>Timescale for completion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What do you now do differently?

---

No action required, please tick  

Founded/Unfounded/Partly Founded (F-U-P)  

Signed:  

Date:  

Investigating Officer
# Equality Analysis / Impact Assessment

**Full Assessment Form**

| Division/Department: | Patient Experience  
<table>
<thead>
<tr>
<th></th>
<th>Nursing &amp; Service Transformation</th>
</tr>
</thead>
</table>
| **Title of policy, procedure, decision, project, function or service:** | Complaints Handling Policy  
|                     | POL/COMP/0003 |
| **Lead person responsible:** | J Salkeld  
|                     | Patient Experience Manager |
| **People involved with completing this:** | Patient Experience Manager, Patient Experience Officers, Associate Director of Patient Experience and Safeguarding. |
Complaints Handling Policy

Type of policy, procedure, decision, project, function or service:

- Existing
- New/proposed
- Changed

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?
To ensure all staff are aware of their responsibilities in relation to the management of complaints and the procedure to be followed when investigating and responding to complaints.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

The policy will benefit all personnel with key responsibility, for carrying out specific functions within the complaints handling process. This ultimately will benefit patients, carers and relatives involved in the complaints process.

What outcomes do you want to achieve?

A clear understanding of the complaints process for all stakeholders to ensure a positive experience of the complaints process when a negative experience has occurred. To learn from negative patient experiences.

What barriers are there to achieving these outcomes?

Not adhering to the policy.

How will you put your policy, procedure, project, decision, function or service into practice?
Ensure all stakeholders involved are clear about their roles and responsibilities. Annual audit of policy ensuring actions are reviewed and monitored.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

No

Step 2 – Collecting your information

What existing information / data do you have?

- Complaint Policy audit reports
- KPIs
- Equality Monitoring data

Who have you consulted with?

- Complainants who have been involved in the process via evaluation monitoring.
- Patient Safety and Patient Experience teams
What are the gaps and how do you plan to collect what is missing?

Identifying specific categories regarding the reason for complaint, and cross referencing with patients / carers / relatives from a protected characteristic group

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No

Sex/Gender

No
Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership
No

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No

Step 4 – What are the differences?
Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No – as reasonable adjustments have been taken to provide access to information in easy read version and the use of interpreters are available when required. Sign posting to advocacy services are available.

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

No X

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4
If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Policy is active. This is a review of the policy.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

Policy is active. This is a review of the policy. Monitored annually via audit.

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

As per monitoring compliance document – page 14 of policy.

Step 6 – Publish your results

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk