POLICY DOCUMENT CONTROL SHEET

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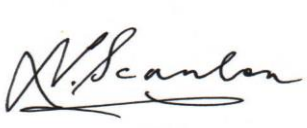
Chairman or Executive Sponsor's Signature	
Date Approved	17 April 2018
Name & Job title of Chairman or Executive Sponsor	Noel Scanlon, Executive Sponsor
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VERSION CONTROL TABLE

Date of Issue	Version Number	Status
Date of issue	**Version number**	**Status**
2004	1.0	Superseded
2006	2.0	Superseded
2008	3.0	Superseded
2010 August	4.0	Superseded
2011	4.1	Superseded
2011 August	4.2	Superseded
2012 January	4.3	Superseded
2012 February	4.4	Superseded
2012 July	4.5	Superseded
2013 May	5.0	Superseded
2015 October	6.0	Superseded
2016 June	6.1	Superseded
2018 February	7.0	Approved

TABLE OF REVISIONS

Date	Section	Revision	Author
2006	Full	Reviewed and amended	Complaints Manager J Foggin
2008	Full	Reviewed and amended	Complaints Manager J Foggin
2010	Full	Reviewed and amended	Complaints Manager J Foggin
2011	Full	Reviewed as part of policy harmonisation.	Complaints Managers J Foggin / S Featherstone
2011 (August)	4	Section 4 reviewed to reflect quarterly CLIP and action planning. Name changes e.g. complaints manager to patient experience officer. Clarification of communicating with Patient Safety Manager. Grading system removed. Introduced consistent process for patient safety	Patient Experience Manager J Salkeld

		involvement. Monitoring Compliance document included.	
2012(January)	4, 15,16, 19, Appendix 2	Section 19 added to include related policies. Section 16 added to include Training. Monitoring Compliance Document updated and moved to section 15. Section 4 reviewed to clarify inclusion of information to the intranet and to clarify the appropriateness of apology to complainants. Revised EIA Tool – appendix 2	Patient Experience Manager J Salkeld
2012 (February)	3.7, 4.7, 14,15	Section 3.7 to state that complaints information is not held within health records. Section 4.7 to include further details of monitoring service improvement and sharing of information with internal and external stakeholders. Removal of section 14. Reporting and learning as this is embedded throughout the document. Training section added as section 14. Section 15, Compliance monitoring to include investigations requirements.	Patient Experience Manager J Salkeld
2012 June	4.2,4.3,4.4, 4.7, 15	To clarify senior manager role re: action plan monitoring and include information regarding identifying and managing severity of complaints	J Salkeld Patient Experience Manager
2013 May	Full	Reviewed and amended	J Salkeld. PEM
2015 October	Full	Full Review	J Salkeld. PEM
2016 June	General Section 4 Section 5 Appendix 9	Improved reference to Complaint Regulations 2009 Introduction of Scheme of Delegation Inclusion of EDO and Care Group AssD / Director duties. Breakdown of delegated responsibility.	 J Salkeld PEM
2018 January	Full	Full Review	J Salkeld PEM

CONTENTS

1 INTRODUCTION

County Durham and Darlington NHS Foundation Trust (CDDFT) welcomes all complaints and concerns from users of its services as this is essential to contribute to the highest standards of care for patients. Feedback is valued as this gives the Trust the opportunity to review and implement changes to continually improve delivery of care. In accordance with the NHS Constitution, we are committed to quality of care, welcome feedback, and learn from mistakes.

The Trust aims to resolve patient/carer concerns locally and as quickly as possible. The Trust will ensure that concerns and formal complaint systems are easily accessible and well publicised to all service users irrespective of age, , disability, race, sexual orientation, religion / belief, sex, marriage / civil partnership, gender reassignment or pregnancy.

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 concerns and complaints 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 concerns and complaints and the procedure to be followed when investigating and responding to concerns and complaints.

3 KEY PRINCIPLES

3.1 CDDFT define 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.' A concern is defined as "a matter where immediate remedial action can be taken for a speedy resolution".

3.2 Complaints and concerns 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 and concerns 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
- **fair and independent** - with the emphasis on providing an objective investigation of concerns raised
- **responsive** - by providing appropriate and proportionate responses and redress of all concerns raised
- **willing to learn and develop** - ensuring concerns and 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 raising a concern or 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 and concerns 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 concern or complaint and to the extent necessary to investigate and answer the issues raised.

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 SCHEME OF DELEGATION

4.1 Signing of Formal Complaint Responses

The complaint process Scheme of Delegation identifies which powers and functions the Chief Executive shall perform personally and those which have been delegated to other Directors and Associate Directors.
In the absence of the Chief Executive, the powers of the Chief Executive, regarding the complaint process, are delegated to the Executive Director of Operations.
In the absence of the Executive Director of Operations, a Director or Associate Director, to whom powers have been delegated, shall be exercised by that Director / Associate Director, unless alternative arrangements have been made.
If the Chief Executive is absent, powers delegated to her may be exercised by the Director who has been duly authorised to act on her behalf.

Responsible person	**Delegation**
Chief Executive Officer	The CEO will sign the final response to complaints that have been received to the CEO office.
Executive Director of Operations.	In the absence of the CEO, the EDO will sign the final response to complaints that have been received to the CEO office. In the absence of the EDO, the response will be signed by a delegated Director or Associate Director of the Trust.
Care Group Director and Associate Directors -Family Health -Integrated Adult Care -Clinical Specialist Services -Acute and Emergency Care -Surgery -Corporate Services	The Directors and Associate Directors will sign complaint responses that have been received to the CEO office, in the absence of the EDO. The final response to complaints that have been received to the Patient Experience Team, will be signed by the appropriate Director or Associate Director for the specific area of complaint. In the absence of the Care Group Director or Associate Director, the complaint response will be signed by a supporting Director or Associate Director of an alternative Care Group.

See appendix 9 for a breakdown of responsible person roles per Care Group

5 DUTIES

5.1 Chief Executive Officer

The Chief Executive Officer (CEO) is responsible for ensuring compliance with arrangements made in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Statutory Instrument 2009 No.309) and in particular, ensuring that action is taken if necessary in light of the outcome of a complaint. The Chief Executive Officer will either respond in writing to all complaints received to the CEO Office, sign the final response to the complainant, or will ask a named delegate(s) to respond on his/her behalf.

5.2 Executive Director of Operations

In the absence of the CEO, The Executive Director of Operations is delegated to respond in writing to complaints received to the CEO Office, and sign the final response to the complainant.

5.3 Director of Nursing

The Director of Nursing is the executive director responsible for the Complaints and Concerns Policy. The Director of Nursing is responsible for ensuring that detailed procedures are developed and implemented throughout the Trust and are monitored as appropriate and in accordance with arrangements made in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Statutory Instrument 2009 No.309). The Director of Nursing will ensure that a central database of complaints is maintained, performance is monitored and reports are provided to the Trust Board as required.

5.4 Care Group Director and Associate Directors

Care Group Directors and Associate Directors are responsible for signing the final response to the complainant, of formal complaints received to the Patient Experience Team.

5.5 Associate Director of Nursing, Patient Experience and Safeguarding

The Associate Director Nursing, Patient Experience and Safeguarding is responsible for the implementation of the complaints and concerns procedures, and for the evaluation of the policy taking into account national and local policy. The Associate Director Nursing, Patient Experience and Safeguarding will act in the absence of the Director of Nursing.

5.6 Patient Experience Manager

The Patient Experience Manager will:

- Manage the procedure for handling and considering issues raised by patients, carers and relatives in line with the Making Experience Count DoH Guidelines, February 2009.

- Provide overall management to the Patient Experience Officers, Assistants and Administrators.
- Undertake regular surveys of complainants' views and experiences about the concerns and complaints process.
- Maintain a programme of audit regarding the complaints process.
- Implements a system that provides information to Care Group managers in order to monitor improvements.

5.7 Patient Experience Officer (PEO)

- Observe the principles of being open and honest.
- Ensuring file notes of any conversation with the complainant are made and recorded within the complaint file via the IT (Safeguard) System.
- Ensuring all issues identified in the complaint have been addressed in the investigation.
- Collate investigation responses and write Trust response.
- Ensure quality checks via peer review are undertaken for each final response letter to complainant prior to the point of Chief Executive or delegated person signing.
- Provide response to the Chief Executive / delegated person for signature within the timescale agreed with the complainant.
- Ensuring equal access to the complaints system.
- Attend meetings, with complainants, when appropriate.
- Collate complaints statistics for central reporting purposes.
- Provision of monthly updates on complaints and concerns handling.
- Deliver a programme of training through Trust Induction days.
- Ensure support and advice is available to Care Group Investigating Officers.
- Provide guidance when second letters to complaint responses are received.
- Handle complaints referred to external bodies e.g. Parliamentary Health Service Ombudsman

5.8 Patient Experience Support Officer (PESO)

- Observe the principles of being open and honest.
- Receiving all formal complaints and concerns from the Patient Experience Administrator.

- Ensure all new complaints and concerns are registered on the Trust IT (Safeguard) System within the timescales agreed of 3 working days.
- Ensure that consent is obtained for each complaint where appropriate.
- Acknowledging receipt of complaints within 3 working days offering complainants a telephone conversation to agree: -
  - ✓ the main concerns
  - ✓ a way forward
  - ✓ the timescales within which a written response will be sent/or meeting arranged
- Determining who is required to investigate the complaint.
- Assessing the complexity of concerns raised and determines the appropriate method of response.
- To determine the severity of the complaint. All complaints that identify a potential patient safety issue will be forwarded to the appropriate Patient Safety Officer who will oversee the completion of the incident report.
- Forwarding the complaint to the relevant party/parties for investigation with timescale for response. (appendix 1)
- Ensuring file notes of any conversation with the complainant are made and filed within the complaint file via the IT (Safeguard) System.
- Co-ordination of family meetings between Care Group staff and Complainants including advocacy representatives as required

5.9 Patient Experience Administrator (PEA)

- Receiving all formal complaints and concerns.
- Ensure all new complaints and concerns are registered on the Trust IT (Safeguard) System upon receipt of complaint.
- Handover new complaints to Patient Experience Support Officer (PESO)
- Support the PESO in the co-ordination of family meetings between Care Group staff and Complainants, including advocacy representatives as required.

5.10 Senior Managers

Senior Managers lead the complaint process for their Care Group

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. Evidence of locally based forum meetings are held within the Care Group Team

- A Care Group Thematic Action Plan will be prepared by the Patient Experience Team biannually and provided to Care Group Senior Managers to record actions in response to themes identified through patient experience measures.
- Evidence of service improvement will be discussed at Safety Committee by Senior Managers following completion of the Care Group Thematic Action Plan. The action plans will be monitored on a quarterly basis.
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5.11a Care Group Governance Lead

The Care Group Governance Lead is responsible for receiving the complaint from the PET and co-ordinating the response from the Care Group within requested timescales

5.11b Investigating Managers

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

- Undertaking the investigation
- 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
- Assess the severity of the complaint and ensure a Patient Safety Incident Report is completed where appropriate. To determine if a serious case review should be carried out
- Preparing an investigation report, including a detailed action plan, to be taken as a result of the complaint
- Observe the principles of being open and honest, ensuring the report and action plan is completed using the appropriate Investigation Report and Action Plan documentation (appendices 2 and 3) and include 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
  - ✓ All issues identified by the complainant have been addressed

- ✓ Actions taken as a result of the complaint
- ✓ A detailed Action Plan of all issues that were founded or partly founded
- ✓ Ensure staff involved have been debriefed and offered on-going support

- Ensuring the report is e-mailed to the Patient Experience email account by the deadline provided.
- Ensuring an action plan is e-mailed to the Patient Experience Team by the deadline provided, 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.

5.12 Line Managers

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

5.13 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 co-operate with the investigation.

5.14 Safety Committee

- Complaints,Litigation, Incidents and PALs (CLIP) data will be presented at the Safety Committee on a quarterly basis by Patient Experience Manager, Legal Services Manager and Patient Safety Officer
- Aggregation of complaints, litigation, incidents and concerns (PALs) will be undertaken quarterly Safety Committee will review activity and trends from each service and identify any cross-cutting themes, using qualitative and quantitative analysis which will be discussed at the meeting.
- 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. Managers will monitor their respective complaint action plans at Care Group local Clinical Governance forums
- A Care Group Thematic Action Plan will be requested by the Patient Experience Team and provided to Senior Managers to update actions in order to address themes identified through patient experience measures
- Evidence of service improvement will be shared at Safety Committee via Care Group senior managers completion of the Care Group Thematic Action Plan following review at care group Governance Meetings.

- The Safety Committee will review the Thematic Action Plans and monitor outcomes bi annually.
- A selection of complaint and concerns lessons learnt will be shared via the intranet and Patient Experience Newsletter
- A summary of the CLIP report is shared internally via a sub committee of the Trust Board and externally with Commissioners at the Quality Review Group. The Patient Experience Manager will provide an update to Healthwatch representatives upon request.

5.15 Integrated Quality Assurance Committee

The Integrated Quality Assurance Committee will receive a quarterly report (CLIP Report) providing assurance of effective complaints management.

6 THE PROCESS

The Trust listens and responds to concerns and complaints in three ways:

- At the point they arise (Refer to section 5.1 and appendix 4)
- From a concern (Refer to section 5.2)
- Formal complaint. (Refer to section 5.3)

6.1 Handling Patient Concerns at the Point they Arise.

The Trust will provide a culture in which patients, their relatives and carers can speak openly about their concerns and will provide staff with the support to respond to concerns raised with courtesy, confidence and sensitivity. Patients, their relatives and carers will not be treated differently as a result of raising a concern.

Complaints are most likely to be initiated informally through front-line staff or with departmental managers. All staff within the Trust are encouraged to respond to concerns raised verbally by patients, their relatives and carers and to provide answers and explanations locally as quickly as possible. Front-line staff can deal with complaints, either by resolving the concern on the spot or by passing them to a relevant colleague. All locally resolved complaints will be recorded at ward or department level using the Locally Resolved Complaint Record (appendix 5) which is forwarded to the Patient Experience Team. Whilst front-line staff should always encourage complainants to be forthcoming in expressing their concern, apprehension, or anxiety, particularly where they are dissatisfied with the care they have received, this should never be done at the expense of overriding the right of the complainants to make their complaint formally to the Patient Experience Team or the Chief Executive. All written complaints, however addressed, should be passed immediately to the Patient Experience Team who will offer advice to members of staff who require support at any point during this process. A flow chart for the process of handling complaints and concerns at ward level is attached at appendix 4.)

6.2 Concerns

The Patient Experience Team provide on the spot help and assistance to patients and their relatives/carers who have concerns about any aspect of the services provided by the Trust. If a concern is raised the Patient Experience Team provide a service to patients/carers primarily through telephone contact. Patient Experience Officers will contact relevant Care Group(s) staff members, to gather information to facilitate a resolution for patients/carers. It is deemed good practice that the service involved contact the patient/carer to provide a satisfactory resolution, however, where not practical, the Patient Experience Officer can respond on behalf of the Care Group(s). In all cases the Patient Experience Officer should be informed of the outcome in order to achieve closure of cases.

Concerns are recorded on the Trust IT (Safeguard) System; reports are provided quarterly to Safety Committee and a sub committee of the Trust Board

Leaflets are available in wards and departments, and on Trust website which describe how to raise complaints and concerns. The leaflet is available in a variety of languages on the Trust website. Staff can download where applicable.

6.3 Procedure for Handling Formal Complaints

The Complaints Procedure reflects the latest Department of Health regulations, published in February 2009, which were effective from 1 April 2009. See section 6.4 for a breakdown of the complaints process.

The procedure is divided into two stages known as Local Resolution and Independent Review (Parliamentary Health Service Ombudsman). Independent Review is explained in section 6.12 of this document

The process by which the investigating manager conducts the complaint investigation and the quality of the reports and other documentation collected may be disclosed to external bodies e.g. Parliamentary Health Service Ombudsman if the complainant is not satisfied with the outcome of the Trust's investigation.

Local Resolution

The investigation and response to complaints and concerns is referred to as Local Resolution. The primary objective of Local Resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as possible, aiming to satisfy the complainant, ensuring we make experiences count whilst being fair to staff.

6.4 Flow Chart Complaint Process

Trust receives complaint via email or letter. Correspondence received by PEA and logged onto IT system (safeguard). A CD reference number and folder is created. PEA attaches letter to IT system, and informs PESO and PEO

Complainant will be contacted by PESO where possible, to clarify issues to ensure appropriate response and agree method of resolution. Timescales for response to the complaint will be agreed with the complainant.

Complaint is acknowledged via letter to the complainant by the PESO within three working days of receipt.

Details of the complaint will be logged onto the IT Safeguard database by PESO . The agreed response timescale will be logged on the IT system within 3 working days of receipt by PESO.

The complaint letter together with the Investigation Report template identifying issues, and Action Plan template, will be sent by the PESO to the Care Group Governance Lead by email with timescales applied, for reports to be returned to the Patient Experience Inbox. The PEA will save into the G Drive and forward to PEO.

The Investigating Officer will draft a full response and action plan (if founded or partially founded) and send to the Care Group Governance Lead who will send to PEO within the timescale originally identified.

Correspondence in relation to complaint investigations **must be filed separately** from the patient's medical notes. This will assure the confidentiality of the patient/carer when they raise concerns, avoid staff making judgements and affecting the staff/patient relationship.

The PEO will formulate the final response and through quality control ensure all issues have been addressed and apologies have been made where applicable.

A Peer Review quality check will be carried out by another member of the patient experience team and checklist completed and saved electronically.
A random selection of complaints will be reviewed by Healthwatch and reported to a sub committee of the Trust Board

Cover letter, Investigation Report and Action Plan will then be forwarded to the Chief Executive/Nominated Director/Associate Director for approval and signature within the timescale agreed with the complainant at the beginning of the process by PEO. Complaints received through the CE office will be signed by the CEO or delegated officer. (Please note Scheme of Delegation section 4)

The signed letter together with the Investigating Report and Action Plan is returned to the PEO and sent to the complainant. The response will also include details of PHSO (Ombudsman) for information.

Correspondence pertaining to the complaint is recorded onto the Trust IT Safeguard System together with Action Plans by PEOs by the 15th of following month. Closing the file, will include: closing all safeguard tabs, activating the evaluation form, uploading to safeguard all G drive documents and filing of hard copy records including cover sheet, complainant correspondence and consent form.

6.5 Investigating a Complaint

Complaints will be classified by the Patient Experience Team according to the complexity of the complaint. The level of investigation required is identified within the framework for the classification of complaints and is attached at appendix 1.

The Patient Experience Support Officer will contact the complainant to confirm the issues they wish to address, their expectations of the outcome and timescales for response.

- The investigation must be timely, open and honest

- The investigation must be proportionate to the concern, be thorough and comprehensive with a review on closure

- Staff involved in the investigation and response to complaints should be open and honest in their communication with patients and/or their carers and adhere to principles of Being Open in line with the Trust Being Open Policy

The Patient Experience Officer will support the Investigating Manager. This will include consideration of whether a meeting with the complainant would be the most appropriate way of addressing the concerns raised. This may also include undertaking an initial review of the patient notes and determining the specific information to be obtained from the staff involved. The framework for the classification of complaints (attached at appendix 1) describes the level and type of investigation required according to the complexity of the complaint.

The Investigating Manager will co-ordinate the investigation of the complaint and discuss the issues raised with all members of staff involved and the circumstances which gave rise to the complaint. The Patient Experience Support Officer and / or Patient Experience Officer will liaise with the Care Group representatives at appropriate intervals to discuss the progress of the investigation and to provide further advice and assistance as required. This may include reviewing the information/reports obtained to determine whether any additional issues have been identified and whether further investigation is required.

The Patient Experience Officer is responsible for ensuring that information obtained during the investigation is entered in an accurate and timely fashion on the IT (Safeguard) System to enable monitoring of the progress of the complaint. This includes all file notes of telephone conversations held with the complainant, dates and times of all contacts and meetings held with members of staff.

Where a meeting is required due to the complexity of the complaint, or where a meeting would be helpful in trying to resolve the complaint, the Patient Experience Officer will have agreed this in the resolution plan.

If a meeting is arranged with the complainant at any point in the process of dealing with a complaint, the Investigating Officer, in collaboration with the Patient Experience Team, will ensure that:

- An appropriate time and setting for the meeting has been arranged

- Enough time for discussion has been allowed

- The complainant should be advised they can bring a friend, relative or member of an external agency to the meeting

- The relevant Trust personnel are present at the meeting

- The meeting is attended by the Investigating Officer and appropriate staff depending on the issues to be discussed

- The introduction will include clarity of mutual respect and acceptable behaviours.

- If a Straight to Meeting is taking place (without prior investigation) minutes of the meeting will be provided to the complainant in writing.
- The complainant will be informed that the minutes will be an overall summary of the meeting including recommendations and actions. It will not be a verbatim account
- The meeting will normally form part of, or be subsumed into an agreed action plan
- The Patient Experience Officer will within 4 weeks maximum of the meeting provide to the complainant a written record using the Being Open Template (see appendix 8), summarising what was said and agreed, in the form of a letter
- If it is the Trust's intention that the complaint be closed via this formal written response, the text should clearly indicate that local resolution has been exhausted
- All of the foregoing should be explained to the complainant before the meeting commences
- If a Local Resolution Meeting is taking place (following full investigation and response) an audio recording will take place. Please refer to SOP: *Audio Recording of NHS Complaints Meetings* via Patient Experience page of staff intranet.

The Patient Experience Officer and Investigating Manager will liaise regarding setting the agenda, the number of Trust employees attending; development of meeting report and any identification of special needs requirements e.g. interpreters.

Guidance for meeting arrangements are available in appendix 7.

If a patient or their representative complains about a member of staff, and the staff member is asked to provide information for a report, he/she will be kept fully informed at all times as to how the complaint is proceeding by the investigating manager.

Members of staff who may be the subject of a complaint will not contact the complainant or patient personally at any time.

In the event that a complainant indicates in a letter or verbally that they have or may be treated differently as a result of making a complaint, or if the Investigating Manager / Patient Experience Officer / any other member of staff have reason to believe this, the Investigating Manager / Patient Experience Officer must inform the Care Group Manager immediately.

6.6 Complaints Involving Serious Incidents

The procedure for the investigation of serious incidents is separate from the complaint procedure. The PET should acknowledge the complaint as per complaint process, and the complainant kept informed of progress, pending the completion of the investigation by telephone where possible or holding letters. Timescales for the complaint, will commence following completion of Serious Incident investigation, if any outstanding issues remain requiring investigation. The PET team will liaise with the Patient Safety Team to ensure the complainant is kept informed.

If the investigation of a complaint reveals the need to take action under the Serious Incident procedures, the PESO will inform the Patient Safety Team together with the Investigating Manager. A decision will be taken on a case by case basis on how to proceed with the complaint.

6.7 Complaints Involving More Than One Care Group

Complaints involving more than one Care Group/service/specialty will be co-ordinated by the area which is the primary subject of the complaint. The Patient Experience Officer will forward details of the complaint to each service involved and will liaise with the lead Investigating Manager to ensure a comprehensive investigation and response. The response provided by the Investigating Manager of the secondary service provider must be in the same format to that of the primary report outlined in appendices 2 and 3. In circumstances where it is unclear which is the lead Care Group, this should be agreed by dialogue between the Care Groups and referred to the Associate Director of Nursing (Patient Experience and Safeguarding) or Director of Nursing, if agreement cannot be achieved.

6.8 Responding to the Complaint

Assistance will be provided by the Patient Experience Officer as required. The response will summarise the nature and substance of the complaint, describe the investigation and summarise its conclusions, and provide details of the right to refer the complaint to the Parliamentary Health Service Ombudsman.

In exceptional circumstances, when due to the complexity of the case, a response to the complaint is not possible within the agreed timescale, the Patient Experience Officer must contact the patient as soon as is practical. Ideally this should be by telephone or when verbal contact cannot be made, by letter. The complainant must be advised of the reasons why an extension to the time limit for a response is required and this must be agreed with the complainant and documented on IT (Safeguard) System. A request for an extension to the time limit for a response should only be done where this is genuinely felt to be necessary to achieve local resolution of the complaint and should be made in a timely manner. The complainant must not be put in a position where they have to pursue their complaint. If further extensions are required, the Investigating Manager will contact the complainant and offer sincere apologies, explaining the reasons for further extension to timescale.

6.9 Complaints Occurring Out of Hours

Whilst every effort should be made to resolve any dissatisfaction on the spot at ward/department level, this is not always possible, particularly for complaints occurring out of normal office hours.

When this situation occurs, and complaints cannot be resolved, the on call manager may be contacted via switchboard.

6.10 What Happens if the Complainant is not Satisfied?

The complainant will be informed of further steps available to them should they not be satisfied. This may include an offer to bring the complainant and their representative, and the clinician involved, together if a meeting has not previously been agreed to. The Trust is committed to

resolving complaints at a local level and will make every effort to ensure that all possible action has been taken before a complainant approaches the Parliamentary Health Service Ombudsman.

Complainants who are dissatisfied with the Trust's response may make a request to the Parliamentary and Health Service Ombudsman to investigate their concerns within one year of the date on which the aggrieved person first had notice on the matters alleged in the complaint. However, the Ombudsman may consider cases outside this timescale where there are good reasons for not requesting an Independent Review earlier e.g. bereavement or not being made aware of the second stage of the complaint process and will consider these on an individual basis.

6.11 Complaints Involving Multi Agency Care

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.

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.

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.

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

6.12 Parliamentary and Health Service Ombudsman (PHSO)

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

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’. (PHSO 2008).

6.13 Experience of the Complaints and Concerns Process

Complainant experience surveys are conducted to obtain the views of complainants on how their complaint or concern was handled. The survey includes a question asking if complainants feel they have been treated differently as a result of making a complaint. The results are shared with Patient Experience staff. If the complainant indicates issues pertaining to the complaints and concerns process, actions are identified and issues highlighted within the Complaint Audit process.

6.14 Learning from Complaints and Concerns – How the Organisation Makes Improvements

Individual Action Plans

The Patient Experience Officers will work with Investigating Managers during the investigation of complaints and concerns to identify care management and/or service delivery issues and recommend actions to address the cause of these. Timescales for completion of actions will be agreed and an action plan (Appendix 3) recorded within the IT (Safeguard) System. All action plans as a result of complaints that are partially founded or founded, are sent to the complainant together with the Investigation Report.

Progress against individual complaint action plans will be monitored and reviewed by the appropriate Care Group Governance arrangements.

Thematic Action Plans

A Care Group Thematic Action Plan identifies the main themes of complaints within a 6 month period. The Thematic Action Plan is provided by the Patient Experience Manager bi annually to the Care Group Manager to provide evidence of improvements made as a result of complaints. The Thematic Action Plans are reviewed at care group governance meetings, reviewed at Safety Committee and shared at a sub committee of the Trust Board via the CLIP Report for assurance purposes.

CLIP Report

The Patient Experience Manager will provide the Care Group with quantitative information relating to complaints and concerns on a quarterly basis (CLIP Report). This will include number (including number of unfounded, partly founded and founded complaints), type and specialty, areas most frequently receiving complaints and correspondence performance. The aggregation of complaints and concerns information with claims and incidents will enable common themes and trends to be identified and ensure a coordinated approach to the management of risks identified through the analysis of complaints, concerns, claims and incidents.

The Safety Committee will receive aggregated information from complaints, concerns, claims and incidents to identify key themes for Care Group and where necessary, Trust-wide action on a quarterly basis.

Care Group Quality Forum

The Care Group Governance Committees are responsible for scrutinising the CLIP report to ensure that root causes of adverse events are identified, that themes and trends are identified, experiences count and sustainable solutions are implemented. Minutes of Care Group Forums are held within respective Care Groups. Care Group Integrated Governance Reports are shared at a sub committee of the Trust Board. Any matters for escalation will be reported to and reviewed by a sub committee of the Trust Board.

Sharing Lessons

In addition to the above mechanisms, key safety or experience lessons arising from complaints that require Trust-wide dissemination will be inserted into the Trust newsletter or

global emails. This could include immediate policy/practice changes, new or additional training requirements or raising awareness of a potential safety issue.

6.15 Reporting Arrangements

The Patient Experience Officer will provide complaints and concerns data to be included in the quarterly CLIP Report and Care Group Integrated Governance Reports.

An annual Complaint Report presents data for a period of 12 months ending 31st March, and will be presented to the Integrated Quality Assurance Committee. The annual Complaint Report will be made available to any persons upon request.

Complaints and concerns information will be analysed together with incidents and claims to identify risk management trends and presented within the CLIP report.

Complaints and concerns activity and trends information will be made available via the Trust intranet site for all staff to access.

The Trust will provide a summary of complaints to the Quality Review Group (Commissioners).

Lessons learned are shared within the CLIP report, Patient Experience Newsletter and staff intranet site.

6.16 Exclusions

The Patient Experience Officer will identify whether a complaint falls within the NHS Regulations. There are some exclusion that Patient Experience Officers may encounter:

- 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)

6.17 Time Limits for Making a Complaint

A complaint should be made within 12 months of the event, or within 12 months of the date of discovering the problem. Any complaint raised outside this time frame is at the discretion of the Patient Experience Manager and Associate Director of Nursing - Patient Experience having regard to all the circumstances and whether it is possible to investigate the complaint effectively and efficiently.

6.18 Use of Advocacy for Complainants

The Trust welcomes the use of advocacy and other support. This might involve Independent Complaints Advocacy (ICA), Citizens Advice Bureau, MPs, Councillors, support for patients with learning difficulties, disabilities (including learning disabilities) and mental health issues, patient support group representatives, as well as friends, relatives and carers.

The Patient Experience Team will access interpreter services for non-English speaking patients/carers and those people requiring sign language support.

6.19 Consent

Complaints made on behalf of patients must be made with the patient's signed consent. This is to comply with the most recent Data Protection regulations and Caldicott requirements.

Where a complaint is received from a third party in respect of a capable adult or child, the Patient Experience Officer or Support 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

Exceptions include the following:

A young adult. If, in the course of investigating a complaint, it becomes clear that the young adult is mentally, emotionally and physically capable of pursing a complaint themselves then the Patient Experience Officer will make a judgement on whether consent should be obtained from the young adult in consultation with appropriate members of staff within the Care Group.

If the patient is physically incapable or with lack of capacity within the meaning of the Mental Capacity Act 2005) 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.

In cases where consent is not given, this is not to be used as a reason not to investigate a situation that warrants attention. However, communication of the outcome will be restricted. This situation will be documented and managed within the formal complaint system.

In cases where a patient lacks capacity, concerns relating to professional practice, in accordance with Trust and professional body guidelines, may be accepted from third parties. If a patient lacks capacity, the classification of a complaint should be reviewed and consideration given regarding safeguarding. Concerns regarding a patient who lacks capacity should be encouraged and reassurance given that the quality of their care will not be affected.

6.20 Who May Complain?

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.

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.

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.

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.

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

Anyone wishing to complain will be informed of the independent advice and assistance available from the local Independent Complaints Advocacy (ICA).

6.21 Confidentiality

Information about individual patients conveyed in a complaint or concern will be treated in the strictest confidence and will only be shared with individuals who are involved in the investigation. For this reason any correspondence relating to a complaint **must be** filed separately from the patient's medical notes.

The care or treatment of any patient or carer raising a concern will not be compromised as a result of any complaint or concern being raised.

Staff involved in complaints must be aware that reports generated may be requested under the Freedom of Information Act and may be disclosed in any subsequent legal claim. The identity of staff directly involved in the complaint will not be disclosed in response to a complaint and personal letters of apology will not be provided.

6.22 Case File Management

The Patient Experience Department will retain all master files for a period of ten years. All complaint correspondence will be kept in this file. Hard copy files are retained up until July 2011. IT (Safeguard) System holds files from Aug 2011.

7 HABITUAL OR VEXATIOUS COMPLAINANTS

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.

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.

7.1 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

7.2 Dealing with Habitual or Vexatious Complainants

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.

This notification may be copied for the information of others already involved in the complaint, e.g. practitioners, conciliator, ICA, Member of Parliament. A record must be kept for future reference of the reasons why a complainant has been classified as habitual or vexatious.

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 NHS England, National Health Service Executive, or other relevant agencies.

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.

8 TRAINING

The Trust Mandatory Induction Programme provides an introduction to the complaints process. Although not mandatory, the Great Expectations Programme is available to trust staff as part of the Life Long Learning 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.

Who needs to read and how it will be implemented.

9 MONITORING COMPLIANCE

Monitoring Criterion	**Response**
Who will perform the monitoring?	Patient Experience Manager/ Delegated member of Patient Experience Team
What are you monitoring?	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 & external stakeholders to share safety lessons. 6. A process for following up of complaint action plans. 7. Process for progressing complaints depending on severity
When will the monitoring be performed?	1, 2, 3. Weekly KPI's and monthly Complaints audits.. 4. CLIP review,Sub-committee quarterly. TAPs biannually 5. Monitored at Sub-committee, Quality Review Group and upon request to Healthwatch. 6. Complaint action plans are shared and reviewed at Care Group local governance forums and monitored by Care Group

	senior managers. 7. Complaints Handling audit.
How are you going to monitor?	1. Weekly KPIs. 2. Complaints handling audit and action plan. 3. Complaints handling audit and action plan. 4. Feedback from Thematic Action Plans, lessons learned via CLIP, Sub- committee. 5. Monitored via stakeholder attendance at QRG, Sub -committee and requests from Healthwatch 6. Complaint action plans are monitored by senior managers and progress minuted at local governance forums. 7. Monitor process via complaints audit.
What will happen if any shortfalls are identified?	Audit findings, KPI findings and discussion at Safety Committee and Sub-committee will identify areas to address, and actions to be implemented and reviewed.
Where will the results of the monitoring be reported?	Sub -committee, Safety Committee
How will the resulting action plan be progressed and monitored?	Monitored via CLIP review at Safety Committee Communicated at Sub- committee.
How will learning take place?	Lessons learned shared to ensure organisational learning via CLIP review and Sub-committee meetings.

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.

10 EQUALITY AND DIVERSITY

The Trust is committed to the provision of services that are fair and equal to all patients and complainants regardless of age, disability, sex, religion or belief, race or nationality, sexual orientation, gender reassignment, pregnancy, marriage or civil partnership.. All complainants are asked to complete an equality monitoring document to enable monitoring of fairness, although this is not compulsory. All language and interpreting services are available at any stage of the process.

11 REFERENCES

Department of Health, NHS Complaints Reform: Making Experiences Count (2008)

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

National Patient Safety Agency, A risk assessment tool for assessing levels of incidents and complaints, July 2003

National Health Service, Statutory Instrument 2009 No. 309, The Local Authority Social Services and (Complaints) Procedure (2000)

NHS Executive, Complaints: Listening, Acting, Improving: Guidance on implementation of the NHS Complaint Procedure, (1996)

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

12 DOCUMENTATION

Further related policy documents:

- Training Needs Analysis, Monitoring and Evaluation Policy
- Being Open Policy
- Claims Policy
- Supporting Staff Policy
- Learning from Experience Policy
- Policy for Policies

13 APPENDICES

CLASSIFICATION OF COMPLAINTS: COMPLEXITY AND LEVEL OF INVESTIGATION **Appendix 1**

CLASS	COMPLEXITY	LEVEL OF INVESTIGATION	Correspondence	RESPONSE TIMESCALE
LOW	**May be simple, non-complex issues:** **example** • Delayed, cancelled appointments • Event resulting in minor harm i.e. cut/strain • Loss of property • Lack of cleanliness • Transport problems • Single failure to meet care needs • Medical records missing	**Low level investigation:** • Enquiries to relevant staff /departments and information obtained recorded on IT Safeguard System • Investigated by ward/department manager if concern or Investigating Officer if formal complaint • Complainant choice regarding processing as formal complaint or concern	If managed as concern, liaise with ward manager. If investigated as a formal complaint, send initial letter of complaint and agreed timescales for completion to: Care Group Governance Lead, Care Group Manager, Associate Directors of Nursing (Care Group), Associate Director Nursing & Patient Experience, Patient Experience Manager. If complaint involves a patient with learning disability, send to LD Lead, If complaint involves named medical staff send to Associate Director Corporate Medical Services, Revalidation Officer and People & OD Manager. If patient is deceased send to mortality inbox for review, If complaint identifies a patient safety issue send to Patient	If concern – within 5 working days. If complaint – timescale to be agreed with complainant

CLASS	COMPLEXITY	LEVEL OF INVESTIGATION	Correspondence	RESPONSE TIMESCALE
			Safety Manager to oversee completion of Incident Report.	
MODERATE	**Several issues relating to short episode of care service:** • Event resulting in moderate harm i.e. fracture, • Delayed discharge • Miscommunication/misinformation • Medical errors • Incorrect treatment • Staff attitude or communication • Failure to meet care needs	**Moderate level investigation:** • Enquiries to relevant staff /departments and information obtained recorded on IT Safeguard System • Investigated by Investigating Officer if formal complaint • Complainant choice regarding processing as formal complaint or concern	As above	Timescale to be agreed with the complainant.
HIGH	**Multiple issues relating to a longer period of care, often involving more than one organisation or individual.** see moderate list • Event resulting in serious harm i.e.	**High level investigation:** • Enquiries to relevant staff /departments and information obtained recorded on IT Safeguard System • Investigated by Investigating Officer. Obtain reports from staff involved as	As above. Include the Director Of Nursing when closed (Initial letter of complaint, Investigating report and action Plan if applicable)	Timescale to be agreed with the complainant.

CLASS	COMPLEXITY	LEVEL OF INVESTIGATION	Correspondence	RESPONSE TIMESCALE
	damage to internal organ	appropriate on specific issues identified (particularly where possible negligence and serious harm) ⇒		
EXTREME	**Multiple issues relating to serious failure, causing serious harm:** • Events resulting in serious harm or death • Gross professional misconduct • Abuse or neglect • Criminal offence (e.g. assault)	**Extreme level investigation** • Serious Incidents (SI) will be investigated by a SI Panel with the final report shared with the patient/complainant as appropriate • Any outstanding issues following the report may be investigated within the complains framework if requested by the complainant • Where the issues are subject to a Coroner's Inquest the report will be shared with the patient/complainant as appropriate via Patient Safety Team	As above	Agree with complainant in consideration of the SI timescales and the date of the Coroner's Inquest.

Investigation Report **Appendix 2** **Complaint Ref No**:				
Patient Name: **Address:**	**Complainant Name: (if different)** **Address:**			
Name of Investigator:	**Designation:**			
Departments Involved	**Site:**			
Issues Identified:				
How the Complaint has been Investigated				
Have staff involved in this complaint been immediately debriefed?	Yes		No	
Have staff involved in this complaint been offered on-going support?	Yes		No	
If the answer to either question is no, please explain why. **n/a** ☐				
Background: **Findings:**				
Conclusion:				
Founded ( ) **Partly Founded ( )** **Unfounded ( )**				
Action to Be Taken as a Result of the Complaint:				

Appendix 3

COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST

Action Plan Following Complaint

Complaint Number:
Name of Patient:
Ward/Department:
Care Group:

Problem Identified	Further action to be taken/lessons learned	By Whom	Timescale for completion

What do you now do differently?

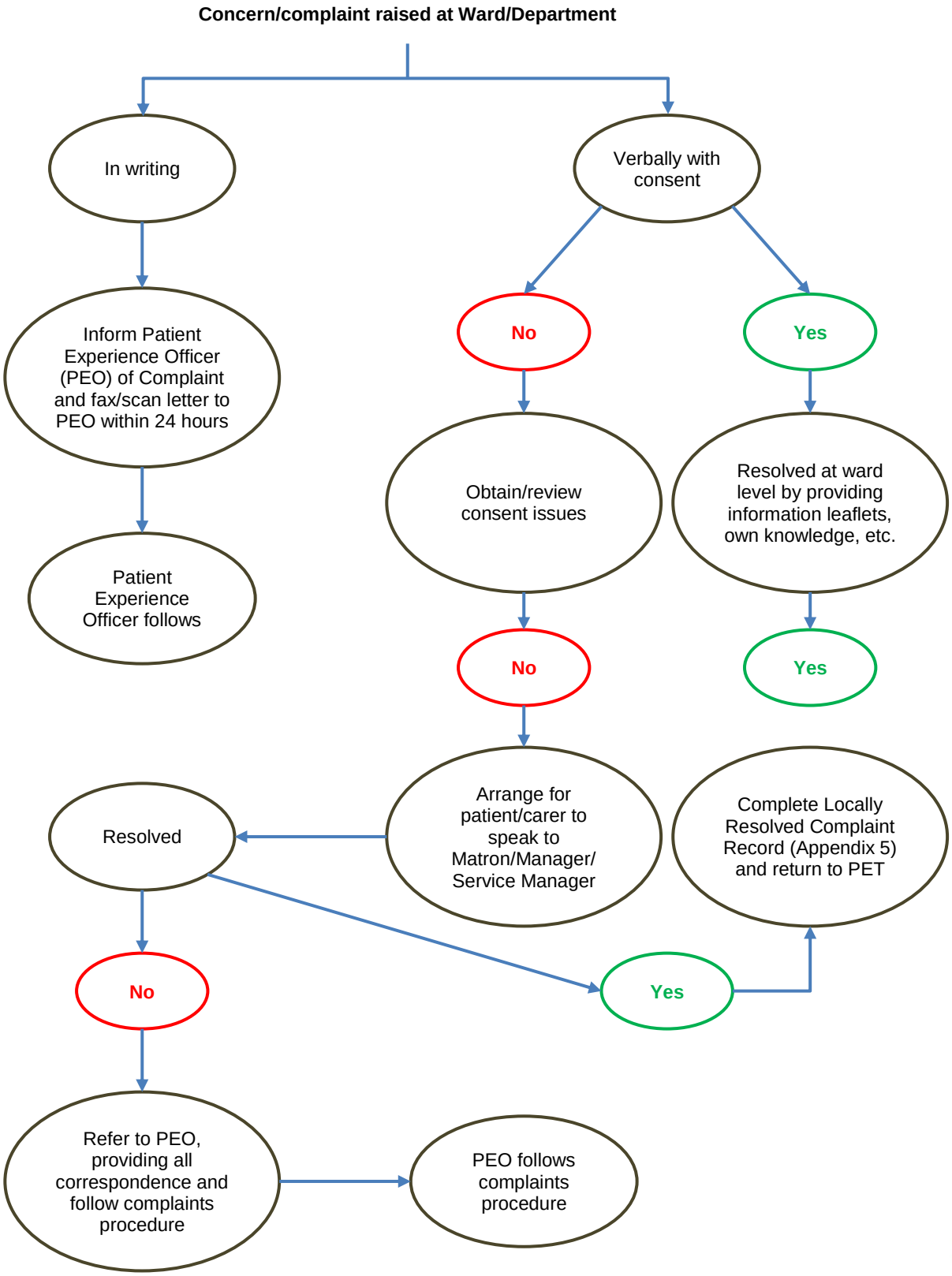
Department outcome: **Founded/Unfounded/Partly Founded (F-U-P)** ☐

Overall outcome: **Founded/Unfounded/Partly Founded (F-U-P)** ☐

Signed: ……

Date: …….
Investigating Officer

DEALING WITH CONCERNS/COMPLAINTS AT WARD LEVEL Appendix 4



LOCALLY RESOLVED COMPLAINT RECORD Appendix 5

This form must be completed upon receipt of all complaints made by patients, relatives or carers, by telephone or in person. A copy must be forwarded to your line manager and Patient Experience Team. If the complaint relates to a death of, or serious harm to a patient, please inform senior management without delay.

Date received:	Time:
Received by:	Contact Tel No:
Complaint received in person or by phone?	
Complainants name:	
Address: Postcode:	
Telephone Number:	
Complainant's status: Patient ☐ Relative ☐ Other ☐ (please specify) …….. *If the complainant is the patient's representative patient authorisation may be required)*	
Patient's name:	
Date of Birth:	
Address: Postcode:	
Telephone Number:	
Complained against (name and contact details):	
Which service does the complaint relate to	
Does the complaint relate to a specific date and time? If so, please state	

Brief description of the complaint:		
Action taken:		
Complaint resolved	Yes	No
Would you say the complaint was *(please tick)*:		
Founded ☐	Partially Founded ☐	Not Founded ☐
Have you identified any areas for service improvement? Please outline:		
Date, time and nature of further action/contact agreed with complainant		

Please forward a copy of completed form to cdda-tr.PatientExperienceCDDFT@nhs.net in order that the complaint can be logged. Complaints will be analysed with a view to identifying and sharing good/best practice.

Appendix 6

Complaints Monthly Audit

Module: Customer Services

Audit date:

Audit to take place after 15th of following month.
Ie: January data audited after 15th February

CD Number / PEO	
Date:	
Scoring:	

	1	0	1
	Yes	No	N/A
Correct category completed			
Is telephone contact with complainant within 3 days of receipt of complaint evidenced in safeguard			
Does date received on original letter match date received on safeguard system			
Is the description of the data item clear, grammatically correct with correct spelling?			
Are recommendations uploaded (if required)			
Are Action Plans uploaded (if required)			
Is there evidence of all documents uploaded to Safeguard by 15th of following month.			
Is there evidence that the final contact field is completed by 15th of following month. (complaint closed)			
Evidence of peer review has been completed and evidence uploaded onto safeguard.			
Evidence that all complaints that came to us via CEO were signed off by CEO			
Evidence that correct version of cover letters have been used.			
Comments			

- It is recommended that 5 forms are audited for each module per month, each form is worth 8 points, making a total score out of 40
- Always ensure Complaints are closed when they are audited
- Audit at least one from each inputter and manager

Score:
Total score:

Appendix 7

Resolution Meeting – Guidance

Misunderstandings and miscommunication is often the root cause of most complaints. Meetings can therefore be a good way of resolving complaints.

Make sure before organising the meeting that the meeting and/or type of meeting are appropriate for the complaint.

1. Before the meeting clarify:

Purpose:

Be clear to the complainant what the meeting is for; explain it is to establish facts.

Manage expectations including appropriate behaviours and be clear about what the meeting can and cannot offer.

Prior to the meeting request that the complainant identify a list of questions which if shared before meeting can aid in all getting the most out of the process.

Venue

This can be a hospital site or other venue; however the complainant may wish to meet in a more neutral venue. Meeting in persons home often allows for a more relaxed environment, where the person making the complaint feels more comfortable. If the meeting is at the complainant's home a risk assessment must be carried out prior to the meeting.

Attendees:

Depending on the complaint issues identify who is the most appropriate to attend. Complaints meetings which are small are less intimidating to the complainant and less likely to end in defensive responses.

Complainants should always be informed of their right to advocacy or to bring a friend or family member. Both complainant and Trust representative present should be aware of who is attending and why before the meeting. The person complained about would not normally be present unless they specifically feel this would benefit resolution and the complainant is happy for the person to be there.

Time:

This really depends upon the nature of the complaint; however it is advisable to ensure that 1 hour is provided for the meeting as a minimum. Any meeting longer than 2 hours will need an allocated break.

Evidence:

Copies of appropriate sections of medical records should be available, alongside any policies

and procedures relevant to the complaint in hand (e.g. NICE guidance). These should be available for the complainant to review in the meeting and ideally copies to take away

Recording the Meeting:

Straight to Meeting (No prior investigation) a written response will be provided to the complainant

Ensure that the meeting will be documented using the Being Open Template.

Explain at the beginning of the meeting, that a summary of the meeting together with agreed recommendations and actions will be recorded and minutes provided to the complainant. This is not a verbatim account of events.

Ensure appropriate administrative support is available prior to arranging the meeting, particularly if it is a complex meeting.

If Local Resolution Meeting (Following full investigation and written response)

LRM meetings will be electronically recorded using audio recording equipment. Please refer to SOP *Audio recording of NHS Complaint Meetings* for further guidance. Available on Patient Experience page of staff intranet

2. At the meeting:

This is an advised structure for complaints meeting; however each meeting may be different:

Introductions, thanks, clarification of purpose and boundaries, expectations.

Complainant highlights issues, summarises questions/list so form an agenda basis.

Go through each point and respond with questions and answers.

Summarise after each point covering all the issues raised, explain clearly why a course of action was taken.

Apologise for mistakes made and discuss what actions will be taken to prevent a re-occurrence.

Concluding, go through action points, acknowledge any differences reiterate options for taking complaint forward, thank person again.

Try to be non-defensive: It is very easy to become defensive especially if you are being blamed.

Be open and honest, the complainant will often only be trying to understand, if defensive this will antagonise the situation and jeopardise the meeting. If there are points of disagreement acknowledge these, state these are noted and move on.

3. Following the meeting:

If Straight to Meeting

The administrator will complete actions and/or minutes and send copy to all present (with option to alter if required), these can be in draft copy, ensuring that when returned with alterations the final copy can be sent via PET from the Associate Director with a 'sign off letter'

Ensure details of next stage provided (these will be provided in the 'sign off letter' as well)

Carry out actions and monitor action plan.

If Local Resolution Meeting

Please refer to SOP *Audio recording of NHS Complaint Meetings* for further guidance. Available on Patient Experience page of staff intranet

Appendix 8

Being open template

COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST

BEING OPEN REPORT

Patient Name / ID Number:

Date and Time of Being Open discussion:	
Place of discussion:	

Present at meeting:	**Designation or relationship to patient:**

Questions raised by patient and/or their carers:
Issues raised

Explanations / Answers given:
Notes of the meeting

Action to be taken (*Attach action plan if applicable)* **:**
Bulleted actions

Progress notes relating to the clinical situation and summary of points explained:
Any progress from initial response / complaint (actions)

Plans for providing further information to the patient and/or their carers and plans for follow-up of discussions:

Information relating to agreed timescale for notes and action plans to be sent to complainant

Offers of assistance and the patient and/or their carers response

Outstanding issues: Resolved ☐ Partly resolved ☐ Unresolved ☐

Lead Name: ……

Support Name:……..

Date copy sent to patient/carer…….

Appendix 9

Scheme of Delegation per Care Group

Signing of Formal Complaints

Complaints received to CEO
CEO
Executive Director of Operations

All Complaints received to PET to be signed by:

Acute and Emergency Care
Associate Director of Nursing
Associate Director of Operations
Care Group Director
Surgery
Associate Director of Nursing
Assistant Director of Operations
Care Group Director
Clinical Specialist Services
Associate Director of Operations
Care Group Director
Integrated Adults
Associate Director of Nursing
Associate Director of Operations
Care Group Director
Family Health
Associate Director of Nursing
Associate Director of Operations

Care Group Director
Corporate Services
Associate Director of Patient Experience and Safeguarding
Director of Nursing and Patient Experience
Executive Medical Director
Deputy Medical Director
Commercial Director
Director of Finance
Director of Estates and Facilities
Associate Director Facilities

Equality Analysis / Impact Assessment Appendix 10

Full Assessment Form **v2/2011**

Division/Department:	Patient Experience Nursing & Patient Experience
Title of policy, procedure, decision, project, function or service:	Complaints and Concerns 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, Review Group.

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

Existing	☐
New/proposed	☐
Changed	X

with you all the way

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?

Aligns to those described in section 11 and 12

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 Experience Team, Patient Experience Forum members.

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 28 of policy.