
MANAGING CONCERNS AND COMPLAINTS POLICY AND PROCEDURE

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Purpose of Agreement	The purpose of this policy is to describe the Trust's policy with regard to managing concerns and complaints in accordance with national guidance. The policy explains the means by which a patient or their representative can raise a concern or complaint and the responsibilities of staff to whom the complaint is addressed.
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1. INTRODUCTION AND PURPOSE

1.1 The purpose of this policy is to describe the Trust's policy with regard to managing concerns and complaints in accordance with national guidance. The policy explains the means by which a patient or their representative can raise a concern or complaint and the responsibilities of staff to whom the complaint is addressed. It also outlines the action to be taken by the service involved and offers guidance on good practice at each stage of the process. The pathway for managing concerns and complaints is summarised in Appendix 1.

1.2 This policy aims to ensure that:

- All complaints are well managed as quickly as possible and in accordance with national assurance frameworks
- Staff are empowered to deal with complaints as they arise in an open and non-defensive way
- The learning from complaints is identified and used for improvement
- The complaints service is accessible, well publicised, open and transparent
- The complaints procedure is supportive for those who find it difficult to complain

1.3 The Trust will ensure that all complaints are reviewed at the highest level of the organisation to identify learning opportunities for those services directly involved in the complaint and the organisation as a whole.

1.4 The Trust is committed to promoting equality and diversity. No patient, or any other person involved in the investigation and resolution of a concern or complaint will receive unfair treatment as a result of raising a complaint or on the grounds of age, race, colour, ethnic or national origin, religious or equivalent belief system, political beliefs, gender, marital or partnership status, sexual orientation, disability, gender reassignment, pregnancy/maternity status, or any other condition or requirement which cannot be justified and which causes disadvantage. Appropriate assistance including reasonable adjustments should be offered to any person who may be at a disadvantage for any of these reasons.

1.5 The Trust Board will ensure that there are clear policies and procedures for the handling of concerns and complaints and that appropriate expertise and resources are available to enable its responsibilities to be effectively discharged.

2. DEFINITIONS and SCOPE

2.1 **A complaint is** 'an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a response. There is no difference between a 'formal' complaint and an 'informal' complaint. Both are expressions of dissatisfaction', The Patient's Association, 2013.

2.2 **A concern** is a problem raised that can be resolved / responded to straight away by the service (by the end of the next working day or earlier). Although concerns that are resolved in this way do not need to be recorded as complaints, the service must give the details of the issues raised and resolution to the PALS and Complaints team (see complaints toolkit). If it is not possible to resolve the concern within this time frame, the issue will need to be recorded as a formal complaint and managed according to the complaints policy.

- 2.3 **A plaudit** is an unsolicited expression of praise or thanks received by a department or service in relation to the service, care or treatment provided. Paudits are reported to the PALS and Complaints team following the 'process for reporting plaudits' (see Complaints toolkit).
- 2.4 This Concerns and Complaints Policy applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation.
- 2.5 Responsibility for ensuring compliance with this policy rests with the **Chief Nurse**.
- 2.6 The **PALS and Complaints Manager** is responsible for ensuring that all concerns/complaints are fully investigated and responded to within the agreed timeframe.
- 2.7 **All staff** have a responsibility to read this policy and understand its impact on their area of work. Staff should be able to respond appropriately to a complainant and endeavour to achieve immediate resolution. If this is not possible, all staff have the responsibility to escalate the concern/complaint in accordance with this policy.

2.8 Openness Transparency and Candour

- 2.8.1 Following the Francis Report (2013) it is a requirement for clinicians to be candid with patients about avoidable harm and for safety concerns to be reported openly and truthfully. Solent NHS Trust must be accurate, candid and must not provide misleading information to the public, regulators and commissioners.
- 2.8.2 Definitions of Openness, Transparency and Candour are as follow:
- **Openness** - enabling concerns and complaints to be raised freely without fear, with questions asked being answered;
 - **Transparency** - accurate information about performance and outcomes to be shared with staff, patients, the public and regulators;
 - **Candour** - any patient harmed by a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made.
- 2.8.3 Being open involves:
- Acknowledging, apologising and explaining when things go wrong;
 - Conducting a thorough investigation into the incident, complaint or claim;
 - Reassuring patients, their families and carers that lessons learnt will help prevent incidents occurring; and
 - Providing support for those involved to cope with the physical and psychological consequences of what happened.
- 2.8.4 Solent NHS Trust and everyone working for the organisation must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest open and truthful.

3. NATIONAL GUIDANCE

- 3.1 The National Guidance underpinning this policy includes the following:
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the Regulations 2009)

- NHS Constitution (2009)
- Making Experiences Count – A New Approach to Responding to Complaints (June 2007)
- Principles of Good Complaint Handling, Parliamentary and Health Service Ombudsman (2009)
- My Expectations for raising Concerns and Complaints, Parliamentary and Health Service Ombudsman, Local Government Ombudsman (LGO) and Healthwatch England (HWE), 2014
- A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged, Parliamentary and Health Service Ombudsman, 2015
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
- Berwick Review: A promise to learn – a commitment to act; Improving the Safety of Patients in England (2013)
- Clwyd & Hart: A Review of the NHS Hospitals Complaints System: Putting patients back in the picture (2013)
- Office of the Children’s Commissioner: Child Friendly Complaints Processes in the Health Service (2013):
- Hard Truths: Mid Staffordshire NHS FT public inquiry; government response (2014)
- Transforming Care: A national response to Winterbourne View Hospital: DH final report (2012)
- Office of the Children’s Commissioner: Child Friendly Complaints Processes in the Health Service (2013): Common Principles for a Child Friendly Complaints Process
- Good Practice Standards for NHS Complaints Handling, Patient’s Association, 2013
- NHS England’s Accessible Information Standards 2015

4. PRINCIPLES OF GOOD PRACTICE FOR RESOLVING CONCERNS AND COMPLAINTS

4.1 The Trust follows the PHSO’s Principles of Good Complaints Handling as set out below:

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

4.2 The Trust will also encompass the following key objectives:

- To provide an operational strategy at corporate and service level to facilitate the effective management of concerns/complaints to meet statutory requirements;
- To provide easy access to complainants wishing to raise concerns ensuring that issues raised are managed in a consistent, fair and just manner for both complainant and complained against.
- To provide a simple procedure with common features for concerns/complaints about the Trust's services;
- To provide separation of concerns/complaints from disciplinary procedures;
- To empower all staff to resolve concerns/complaints at a local level and provide training and support to facilitate this proactive approach;
- To provide a rapid and open process ensuring concerns/complaints are used as a mechanism for identifying where improvements in service provision are required;

5. COMPLAINTS THAT CANNOT BE DEALT WITH UNDER THIS POLICY

5.1 The Following Complaints will not be dealt with under the NHS Complaints Regulations 2009

- A Complaint made by any NHS organisation or private or independent provider or responsible body.
- A complaint made by an employee about any matter relating to their employment
- A complaint, the subject of which has previously been investigated under these or previous NHS regulations
- A complaint which is made orally and resolved to the complainant's satisfaction no later than the next working day
- A complaint which is being or has been investigated by the Ombudsman
- A complaint arising out of an NHS Body's alleged failure to comply with a request for information under the Freedom of Information Act 2000
- 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) of the Superannuation Act 1972 or to the administration of those schemes
- Solent NHS trust has been notified that criminal proceedings have been commenced in relation to the substance of the complaint where it will prejudice the proceedings.
- A complaint the subject matter of which is being or has been investigated by a Local Commissioner under the Local Government Act 1974 or a Health Service Commissioner under the 1993 Act .

6. ROLE AND RESPONSIBILITIES OF STAFF IN THE LOCAL RESOLUTION OF CONCERNS/ COMPLAINTS

6.1 **Chief Executive** - The Chief Executive has overall responsibility for concerns/complaints and fulfils the role of the responsible person under the Regulations.

6.2 **Chief Nurse** - The Chief Nurse has executive responsibility within the Trust for concerns/complaints. In addition, the Chief Nurse will review any complaint regarding nursing and/or allied health professional care where the complainant remains dissatisfied with the response or disputes the outcome of the investigation.

6.3 **Chief Medical Officer** - The Chief Medical Officer will review any complaint regarding medical care where the complainant remains dissatisfied with the response or disputes the outcome of the investigation.

6.4 **Clinical Directors** - The Clinical Directors will be responsible for checking and approving those complaints relating to their service line/ care group.

6.5 **Clinical Governance Leads/Service Managers**

6.5.1 It is good practice to respond verbally to concerns/complaints about any services for which they are responsible. It is essential to keep a record and send a copy of the concern/complaint and any action to the PALS and Complaints team.

6.5.2 They should refer any complainant dissatisfied with their response, or any complaint, which involves more than one service line, to the complaints department.

6.5.3 They should refer all written complaints immediately to the PALS and Complaints Manager and comment formally when requested to do so by the case handler and lead investigator.

6.5.4 Clinicians may receive written enquiries where it is not clear if a complaint is being made. Clinical Governance Leads / Senior Managers/Clinicians should consult with the PALS and Complaints team for further advice in such occurrences. The PALS and Complaints Team will, if appropriate, contact the complainant to discuss how to proceed.

6.5.5 Complaints sent directly to the PALS and Complaints team or via the Chief Executive's office will be allocated to a case handler, recorded on Complaints / Incidents system, and sent to the Clinical Director, Operations Director and Clinical Governance Lead, and copied to the Chief Nurse, the Chief Medical Officer and the Chief Operating Officer, for appropriate investigation and response. Staff asked to provide a statement have a responsibility to do so using the Trust's template in a timely manner to avoid delay in completion of the response. Guidance for taking a statement is provided in Solent's Complaints Management Toolkit.

6.6 **Investigators and Case Handlers**

6.6.1 Investigators are responsible for co-ordinating, obtaining and collating comments from appropriate staff and drafting the response.

6.6.2 Investigators will be appointed by the Clinical Governance Lead.

6.6.3 It is the responsibility of the nominated investigator to liaise with staff concerned, as appropriate, and obtain relevant information in relation to all elements of the complaint.

6.6.4 The investigator must ensure that any response detailing matters of medical care or clinical judgement is agreed by the clinician concerned before it is sent to the complaints team for review.

6.6.5 A proactive approach to resolving the complaint is encouraged and should be taken wherever possible. This may involve telephoning the complainant or inviting the complainant in for a meeting with those involved in their care. For housebound patients, an arrangement to meet at their home may be necessary. Investigators wishing to adopt this approach should discuss this with the PALS and Complaints Manager.

6.6.6 Before taking on the responsibility of complaint investigation, all investigators should complete root cause analysis training /appropriate risk management training.

6.6.7 The investigator will ensure any member of staff about whom a complaint is made is advised of the final outcome. The staff member must be offered support by the investigator and any necessary support arranged.

6.6.8 The Clinical Director and Clinical Governance Lead are responsible for allocating designated investigators who may be:-

- Clinical Governance Leads
- Nurse Consultants
- Senior Allied Health Professionals
- Head of Estates (non- clinical issues related to facilities and premises)
- Matrons
- Service Managers
- Senior Pharmacists
- Other Heads of Departments and senior managers

6.6.9 Investigators will, at the request of the complaints department, obtain any further information requested during the course of the investigation.

6.7 PALs and Complaints Manager

6.7.1 Oversees the concerns and complaints procedure in liaison with others involved, including the designated investigator at the local resolution stage, other health organisations and the PHSO as necessary.

6.7.2 Ensures the appropriate investigation of all concerns/complaints and has access to all relevant Trust records essential for the investigation of such complaints.

6.7.3 Is responsible for the final preparation of responses to complaints for agreement and signature.

6.7.4 Ensures all concerns/complaints are recorded on the relevant database (linked to incident reporting) and are assigned an initial risk rating and final risk rating.

6.7.5 Ensures that follow up actions identified on the Action Log have a specific timeframe and responsible owner and they are carried out by their due date. If additional time is required, the responsible owner should contact the complaints team with a new timescale and an explanation.

6.7.6 Ensures that the Trust Board is kept fully briefed about the types of complaints received, response times and actions taken/lessons learned as a result of completed investigations.

6.7.7 Reviews all complaints and prepares quarterly reports for the Board.

7. WHO MAY RAISE A CONCERN/COMPLAINT

7.1 Anyone can complain, including young people. A family member, carer, friend, MP, Independent Advocates, such as Healthwatch, Support, Empower, Advocate and Promote (SEAP), or legal representatives can also make complaints on the patient's behalf but only if they can show relevant consent/authority (see Access to Medical records and Mental Capacity Act 2005 Guidance for staff).

7.2 A complaint can be made about any aspect of care provided by Solent NHS Trust as long as:

- the complainant has received or is receiving services from the Trust, or
- they are someone who is affected, or likely to be affected, by the action, omission or decision of the Trust.

7.3 A complaint may be made on behalf of someone else if the person who has grounds to complain:

- Has died, or
- Is a child, or
- Cannot make the complaint themselves because of physical or mental incapacity, or
- They have been asked to act on the patient's behalf.

7.4 In the case of a third party pursuing a complaint on behalf of the person affected the following information is required:

- Name and Address of the person making the complaint;
- Name, address and date of birth of the affected person;
- Contact details of the affected person (if not deceased) so that they can be contacted for confirmation that they consent to the third party acting on their behalf.
- Authorised consent form (see complaints toolkit).

7.5 Where the patient is assessed as being unable to consent, the Chief Nurse may confirm a person is a suitable representative or refuse to accept a person as a suitable representative and nominate another person to act on the patient's behalf. In any event the matter will be investigated through the complaints process in the best interests of the patient. Where the person has a lasting power of attorney for welfare or is a court appointed deputy they will have the legal authority to act in the person's best interest.

7.6 In instances when a complaint and claim are brought at the same time, the complaints process will still apply unless contrary to the advice of the Trust's legal advisors or insurers.

8. HOW TO RAISE A CONCERN/COMPLAINT

8.1 By telephone or in person in which case a written record must be made setting out the issues requiring investigation. This must be agreed with the complainant and ideally signed.

8.2 In writing, ideally direct to the Chief Executive or PALS and Complaints Manager, by post or e-mail, or via the Trust's website.

8.3 Private Patients can rely on this policy where it applies to local resolution – access to the Parliamentary and Health Service Ombudsman and NHS Complaints Advocacy service is not available to private patients.

9. PROCEDURE FOR HANDLING CONCERNS

9.1 A concern is an expression of dissatisfaction that should be resolved quickly and efficiently to the satisfaction of the complainant, no later than the following working day after which it was raised. If the concern cannot be resolved within 24 hours then it should be escalated to the PALS and Complaints Manager for comment and confirmation of how the concern should be managed. (See Complaints toolkit)

9.2 Local resolution should always include initial attempts at resolution within the relevant service, only escalating to the PALS and Complaints team if unsuccessful or if specifically requested. However, details must be logged with PALS and Complaints team, so that a full record can be maintained. Consideration should always be given to the seriousness of issues resolved at a local level and whether further actions should be taken.

9.3 The method of resolution is decided in discussion with the complainant and should be proportionate to the complexity of the issues raised.

9.4 Anonymous concerns will be logged on the relevant database (Complaints / Incidents system) and be investigated as far as possible, based on the available information, in line with the Complaints Policy

- 9.5 Concerns can be received in writing or by telephone and are sometimes received into the PALS and Complaints department.
- 9.6 The PALS and Complaints Officers will work with services to try to resolve any concerns patients, carers or relatives may have about the care provided or the services they receive as soon as possible. A PALS and Complaints Officer will, at the service's request, attend meetings to discuss concerns/issues as appropriate. In this role the PALS and Complaints Officer will be present to assist and provide support to the patient, carer or relative. They will liaise with Trust staff and other providers to obtain relevant information about any aspect of care; this may include signposting to external organisations. The clinical service is responsible for providing a follow up letter summarising any meetings that take place with the patient or carer and the agreed outcomes. The letter should include details of how to contact the PALS and Complaints team if concerns remain unresolved.
- 9.7 Managers are required to feedback to the PALS and Complaints team to confirm what action has been taken and that the issue has been resolved. Action taken will be recorded on Complaints / Incidents system for inclusion in quarterly reports. The PALS and Complaints team will ensure feedback is obtained within a specified timeframe confirming resolution or escalation of the matter.
- 9.8 The PALS and Complaints team will escalate any failure to respond to their request within the agreed timeframe to the PALS and Complaints Manager and or Chief Nurse.
- 9.9 If the enquirer is not satisfied with the outcome it should be escalated to a formal complaint and follow the appropriate process.

10. PROCEDURE FOR HANDLING COMPLAINTS

- 10.1 See Appendix 1 for the Trust's Complaints Pathway/ timelines.
- 10.2 Where a complaint relates to an incident, the complaint response time may be extended pending completion of the internal investigation, see Appendix 2.

11. COMPLAINTS INVOLVING OTHER ORGANISATIONS

- 11.1 When a complaint involves more than one health and social care organisation the Trust has a duty to co-operate with those organisations to ensure full co-ordination of the handling and response to the complaint. Consideration must be given to patient confidentiality and consent before contacting another organisation and consent sought where appropriate. Where the concern is to be handled by another organisation, the PALS and Complaints team will request follow up to ensure the matter is resolved.
- 11.2 Consent must be obtained from the complainant to liaise directly with the other organisation and it should be agreed if the complainant would like responses sent individually by the organisations or if they require a joint response. If a joint response is required discussion will take place with the other organisations involved to establish who will lead and co-ordinate the response.
- 11.3 The complaint investigation will follow the same process of investigations, as if the complaint had only involved Solent NHS Trust Services.

12. PERFORMANCE TARGETS FOR RESOLUTION OF COMPLAINTS

Time Limits

- 12.1 **Resolution of written complaints** – written complaints should be forwarded to the complaints department immediately on receipt of the complaint into the organisation.
- 12.2 The complaints department will acknowledge receipt to the complainant within three working days, preferably by telephone and with a follow-up acknowledgement letter. This will include information advising the complainant that they may be contacted by the investigating officer as part of the investigation process.
- 12.3 The PALS and Complaints Team will provide the complainant with a copy of the Trust's PALS and Complaints Service Information sheet which includes information about the Parliamentary and Health Service Ombudsman (PHSO) and the NHS Complaints Advocacy Service.
- 12.4 The PALS and Complaints Team will circulate the complaint to the relevant Clinical Director, Operational Director and Clinical Governance Lead for investigation and to assign the investigator. The service must assign a trained investigator who is independent of the events being complained about in order to be able to give assurance on the quality and impartiality of the investigation process.
- 12.5 The investigator will ensure timely investigation that involves gathering and analysis of evidence using root cause analysis methodology. A draft response should be provided to the PALS and Complaints team within 15 working days of receipt of the complaint. On occasions the response and investigation will need to be completed in a shorter time frame, this will be explained to the service when the complaint is first sent to them.
- 12.6 Where possible departments should share learning opportunities identified from complaints investigations with staff in other areas whilst maintaining confidentiality of the complainant and those involved in the complaint. The owner of actions will be responsible for ensuring that any identified actions arising from a complaint are implemented.
- 12.7 It is best practice and Trust policy that the final response is sent to the complainant within 30 working days of receipt of the complaint. However, in exceptional circumstances this can be extended by the complaints department with the agreement of the complainant. The period of extension will be discussed with the investigator to ensure it is realistic. Some complaints may be investigated via the incident route. The Head of Patient Safety will decide whether this is appropriate and an open timeframe will be negotiated with the complainant with the complaints department providing updates as necessary.
- 12.8 **Resolution by meeting** - for those complaints requiring a meeting in the first instance rather than a written response, a suitable date will be negotiated by the service line with the complainant and relevant staff members. If requested by either the service or the complainant, a member of the PALS and Complaints team will also attend the meeting.
- 12.9 An investigator will be appointed to investigate and the timescale will fit in with the date of the meeting.

- 12.10 Notes of the meeting will be taken by the clinical service representative (with the complainant's consent) and provided together with a written summary of the issues discussed/action to be taken.

13. UNRESOLVED COMPLAINTS

- 13.1 Where the complainant is dissatisfied with the Trust's response and further explanation is required it should be given if possible; a complainant meeting may be appropriate if this has not previously been explored. If it is not possible to assist further, the complainant can seek review by the Parliamentary and Health Services Ombudsman.
- 13.2 Any new concerns raised should be dealt with as a new complaint.

14. CONFIDENTIALITY AND CONSENT

- 14.1 It is not necessary to obtain a patient's express consent to use his/her personal information to investigate a complaint, the exception being when contacting another organisation for comment; in such circumstances written consent should be requested and received.
- 14.2 If the complainant is not the patient and the complaint relates to treatment received by the patient, consent will be required. If the patient lacks capacity to consent to the complaint the complaint should be brought where possible by the patient's personal representative in law, such as lasting power of attorney for welfare or court appointed deputy. Alternatively, the Chief Nurse will confirm whether or not a person is a suitable representative or nominate an appropriate person. In any event the complaint will be investigated through the complaints process in the best interests of the patient.
- 14.3 Where a complaint is made on behalf of a patient who has not provided consent, care must be taken not to disclose personal health or patient-identifiable information.
- 14.4 Proof of identity as next of kin/personal representative will be required if the complaint is made on behalf of a deceased patient in accordance with the Trust's Access to Health Records policy.
- 14.5 Only those investigating the issues should access a patient's personal information.
- 14.6 A member of staff requested to provide a statement as part of the investigation should be given access to the relevant information, as necessary, to aid investigation.
- 14.7 A complaint should only be made known to those directly involved in responding to or investigating the issues raised i.e. on a "need to know" basis.
- 14.8 All staff must comply with the requirements of the Data Protection Act 1998.

15. PROVIDING A STATEMENT

- 15.1 There are occasions when, as part of the complaint investigation, it is necessary to obtain statements to record a staff member's account of the facts relating to their involvement in the sequence of events and give a useful first-hand account of the incident. This may be when, for

example, the complaint is a result of the alleged behaviour of a member of staff and there is no written record of the incident.

- 15.2 The investigator should make arrangements to obtain statements as soon as possible in the investigation process.
- 15.3 The purpose is to provide written evidence to assist the investigation. If the complaint is also the focus of a HIRI or SIRI these may already have been obtained.
- 15.4 A statement template is provided in the complaints toolkit.
- 15.5 Statements provided for investigation of a complaint can be disclosed to the complainant or their representative under the Data Protection Act 1998.
- 15.6 If staff have any difficulty preparing a statement they should contact their line manager or the complaints department for assistance.
- 15.7 If a student is involved, their University or education provider needs to be informed and / or involved.

16. PROVIDING A WRITTEN RESPONSE

- 16.1 The investigator will ensure the written response is in an appropriate format for the complainant, covers all points raised by the complainant, as far as possible, and identifies where, if any, changes to practice have been made as a result of the complaint. If there is a reason why a specific issue cannot be addressed this should be explained. A template response letter is provided in the complaints management toolkit.
- 16.2 Where it is apparent from the response that it raises a risk of litigation, the Chief Nurse, Chief Medical Officer and Clinical Director should be alerted and referral made to the NHS Litigation Authority for consideration before the response is sent to the complainant.
- 16.3 The draft response must be factually correct and should:
 - Include an apology
 - Address each of the points raised with a full explanation or give the reason(s) why it is not possible to comment on a specific matter
 - Give specific details about the investigation
 - Give details of action taken as a result of the complaint and what lessons have been learned
 - Include details of further action the complainant can take, including an offer to meet with the service, if appropriate, and the details for the PHSO
- 16.4 The draft response should be sent via e-mail to the PALS and Complaints team for approval. Where clarification is required from the PALS and Complaints team, the investigator should respond promptly to avoid delay in the response being sent to the complainant.
- 16.5 The response will then be reviewed and approved by the Clinical Director.
- 16.6 Following approval by the Clinical Director, the Complaints team will forward the response to the Chief Executive for review and signature. This role will be delegated to the Chief Operating Officer, Chief Medical Officer or Chief Nurse in the Chief Executive's absence.

16.7 An e-mail response should only be provided at the complainant's request with the complaints department having informed the complainant that such communication may not be secure at the point of acknowledgement.

17. THE PROVISION OF REDRESS AND EX-GRATIA PAYMENTS

17.1 Remedying injustice or hardship is a key feature of the Ombudsman's Principles for Remedy suggesting that where there has been maladministration or poor service, the public body restores the complainant to the position they would have been in had the maladministration or poor service not occurred.

17.2 Financial redress will not be appropriate in every case but the Trust will consider proportionate remedies for those complainants who have incurred additional expenses as a result of poor service or maladministration.

17.3 This does not include a request for compensation involving allegations of clinical negligence or personal injury where a claim is indicated.

18. MONITORING PERFORMANCE MANAGEMENT AND DATA COLLECTION

18.1 The Trust, via the PALS and Complaints service, will maintain a record of:

- Each concern/complaint received
- The subject matter and outcome of each concern/complaint
- Whether the Trust regards the complaint as having been well-founded
- Lessons learned and follow up actions taken.

18.2 Each complainant, where appropriate, will be invited to complete a satisfaction survey after receipt of the Trust's final response letter. The survey will be based on 'My Expectations', a series of statements seen from the complainants perspective published by the PHSO. The results will be reported to the Board.

18.3 The Quality Improvement and Risk group reporting to the Assurance Committee will be responsible for monitoring the effectiveness of the policy including:

- Ensuring the process of investigating complaints is consistent, reliable and meets national quality standards
- Reviewing trends in complaints and appropriate risk management actions
- Identification of significant risks for inclusion on the Trust's Risk Register
- Consideration of lessons which can be learned from complaints, particularly for service improvement and ensuring lessons learnt in one service line are shared across all services
- Consideration of the findings of the complainant survey which will be reported annually.

18.4 The Trust ensures that it provides information to the Health and Social Care Information Centre via completion of the central return KO41(A) which is reported quarterly.

18.5 Equality and Diversity data will be collected where possible by the PALS and Complaints team as required by the Department of Health. The investigator will provide such information to the complaints department, if known, about staff members involved.

- 18.6 The Equality Impact group will receive an annual report on those complaints relating to equality and diversity issues.
- 18.7 The PALS and Complaints Manager will be responsible for providing reports for Board, Commissioners, the Quality Account, external regulators and internal reporting purposes as required.
- 18.9 An annual audit will take place as one method of providing assurance regarding compliance with this policy.

19. COMPLAINTS INVESTIGATION AND RISK MANAGEMENT

- 19.1 The procedures for managing complaints, incidents and claims for negligence are dealt with under separate policies. However, if during the course of investigating an incident, a complaint is received, the incident procedure should take precedence in terms of investigation. If the investigation of a complaint reveals the need to take action under the serious incident procedure, the investigator should inform the Chief Nurse or Chief Medical Officer and again the incident procedure should take preference in terms of investigation. In these circumstances the complainant should be informed of the investigation, kept updated on progress and informed of the outcome. The flowchart in Appendix 2 describes this process.
- 19.2 It may not always be clear whether a complainant is intending to make a claim. It may be that an open approach will satisfy the complainant. A hostile or defensive reaction is more likely to encourage the complainant to seek remedy through the courts.
- 19.3 Complaints correspondence and accident/adverse incident reporting information will **not** be regarded by the courts as privileged (although there continues to be some uncertainty about the legality of a claim of privilege in respect of documents created in the course of an internal Trust investigation into an adverse outcome). This means that all correspondence and papers generated in the course of a complaint investigation, including staff statements etc. may have to be disclosed if a claim for negligence is subsequently brought.
- 19.4 In line with the Data Protection Act 1998, complaints documentation is classified as personal data. Patients are able to request copies of complaints files in the same way as they do for their health records.
- 19.5 If the investigation of a complaint reveals a possibility that there may have been negligence the Head of Patient Safety will be informed. The existence of negligence does not prevent a full explanation being given and if appropriate, an apology. An apology is not an admission of liability.
- 19.6 Risk rating - assessing the seriousness of a complaint will determine the correct level of investigation required. All complaints will be given an individual initial risk rating by the complaints department at first contact (see Appendix 3). The investigator will be responsible for the final risk rating score depending on the outcome of the investigation.

20. FILE STORAGE AND ARCHIVING

- 20.1 The PALS and complaints team aim for a paperless working environment relying on Complaints / Incidents system to record information and electronic storage of files.
- 20.2 The PALS and Complaints team will hold a comprehensive record of all documentation related to a complaint including all internal correspondence, such as e-mails and file notes, investigation records and statements from staff which should be timed and dated where possible.
- 20.3 In accordance with the NHS Complaints Procedure copies of concern/complaint correspondence must **not** be kept in the patient's medical records, subject to the need to record any information which is strictly relevant to their health. Concerns/ complaints correspondence must be kept and stored separately whether in paper or electronic format.

21. PUBLICITY

- 21.1 The Trust ensures that the right to raise a concern/complaint, is well publicised to all patients, other users of its services and to Trust staff.

22. COMPLAINTS AND DISCIPLINARY PROCEDURES

- 22.1 In accordance with Section 4 of "Guidance on Implementation of the NHS Complaints Procedure" the Complaints Procedure is separate from any investigation under the Disciplinary Procedure; referral to one of the professional regulatory bodies; an independent inquiry into a serious incident, under Section 84 of the National Health Service Act 1977 or an investigation of a criminal offence.
- 22.2 The purpose of the complaints procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants and to learn any lessons for improvements in service delivery. If, however, a complaint identifies information about a serious matter which indicates a need for disciplinary action, this will be managed under the Trust's Disciplinary Policy.

23. COMPLAINANTS WITH COMMUNICATION DIFFICULTIES

- 23.1 The Trust will ensure that its Concerns and Complaints Procedure is accessible to complainants and reflects NHS England's Accessible Information Standards 2015.

24. PERSISTENT AND UNREASONABLE CONTACT AND UNUSUAL COMPLAINTS

- 24.1 There are those complainants who raise a number of concerns in a short space of time, repeat complaints with the same elements, or constantly bring new elements to the same complaint. This would be deemed **persistent** or **unreasonable** contact.
- 24.2 On such occasions the case will be referred to the Chief Nurse by the PALS and Complaints team to decide whether the complainants behaviour would be considered unreasonable and they will be written to and advised of the action to be taken (the possible options are summarised in the Complaints Toolkit).
- 24.3 On occasions there will be complaints raised that have distinct differences in the way that they are handled and responded to. Such complaints include when the complainant puts limits on

who may be interviewed, complainants who do not accept the findings and refuse to go to the Parliamentary Health Service Ombudsman, or complainants who contact the organisation by writing and phoning a number of people in the organisation. It is important that complainants do not feel that Solent NHS Trust is placing barriers in the way that the complaint is handled, or that they feel disadvantaged in making their complaint. Guidance on how best to handle these complainants is provided in the Complaints Toolkit.

25. OUT OF HOURS CONTACT ARRANGEMENTS

- 25.1 The PALS and Complaints team is available between 9.00am and 5.00pm, Monday to Friday. Issues raised outside these hours should be directed to the appropriate Ward/Service Manager, or to the duty on-call manager.
- 25.2 Any immediate clinical need **must** be passed to the appropriate clinician.
- 25.3 If the concerns do not require immediate action, as much detail as possible, including the person's contact details, should be obtained and forwarded to the complaints department by the next working day. The complainant should be informed of the action taken and given the direct telephone number for the complaints department.

26. TRAINING

- 26.1 The PALS and Complaints Manager is responsible for providing training in the Concerns and Complaints Procedure to all relevant staff to ensure that staff are fully aware of their responsibilities when dealing with issues of concern raised by complainants.
- 26.2 Staff who have responsibility for investigating a complaint or chairing meetings with complainants should receive training as part of their local induction organised by their line manager.
- 26.3 The Risk Management team provide training in Root Cause Analysis and investigation procedures and all staff who have responsibility for investigating complaints must attend training. Attendance is monitored as part of the general training needs analysis within the Learning and Development Department.

27. STAFF SUPPORT AND WRITING A STATEMENT

- 27.1 It is acknowledged that being the subject of a complaint can be stressful and the Trust is committed to ensuring staff are adequately supported. All staff members who are the subject of a complaint should be sent a staff support letter by the investigating officer advising them to seek support and advice from their line manager, occupational health, staff support counsellors or the Employee Assistance programme if needed.
- 27.2 Staff who are required to give a statement following a complaint should be supported throughout the investigation by their line manager.
- Formal and informal debriefing should be offered to all those involved in the complaint throughout any investigation by their line manager
 - Information should be given on the support services available i.e. Occupational Health, Employee Assistance Programme.

27.3 Statements must be presented in the format set out at in the Complaints Toolkit. A statement is a written or spoken declaration, especially of a formal kind; a written or spoken report of events, a description. When investigating a complaint it is essential that as much factual information as possible is obtained in order to respond to the complainant and any member of staff named in a complaint may be asked to give an account of their involvement. Giving a statement will provide the Trust with an overview of events; the Trust will base the final response on all information received. When writing a statement it is important to remember that although the majority of statements will go no further, it can be copied to the complainant or used as evidence in defending a legal claim.

27.4 Staff requiring additional information should contact their line manager, complaints department or their professional organisation.

28. LEARNING FROM COMPLAINTS

28.1 It is essential that lessons are learned and shared as a consequence of complaints. Following the final sign off of the written response, the service is required to share the actions taken/ learning from the complaint with the PALS and Complaints team who are responsible for collating this information across all service areas and reporting on actions learned. Sharing of lessons will also take place regularly within the Quality Improvement and Risk meetings and at the Patient Experience Forum

29. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

29.1 The policy will be reviewed by the PALS and Complaints Manager against updated national regulations and guidelines, including from NHS England, the Care Quality Commission, the Trust Development Authority and the PHSO on an annual basis or earlier as required. In addition, all complainants will be offered the opportunity to complete a survey on their experience of the complaints process. Surveys will be returned to the PALS and Complaints Manager who will address individual issues as necessary and report on learning which will be monitored via the Patient Experience Forum and monthly via the Quality Improvements and Risk group. Any subsequent issues/findings resulting from the review of the policy against national guidance and survey results will be incorporated in an updated version of the document.

30. REVIEW

30.1 This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

31. LINKED DOCUMENTS

Complaints Toolkit

Patient Experience Strategy 2015-2018

Deprivation of Liberty Complaints / Incidents systems Mental Capacity Act Policy (CLS02)

Consent to Examination and treatment Policy (CLS04)

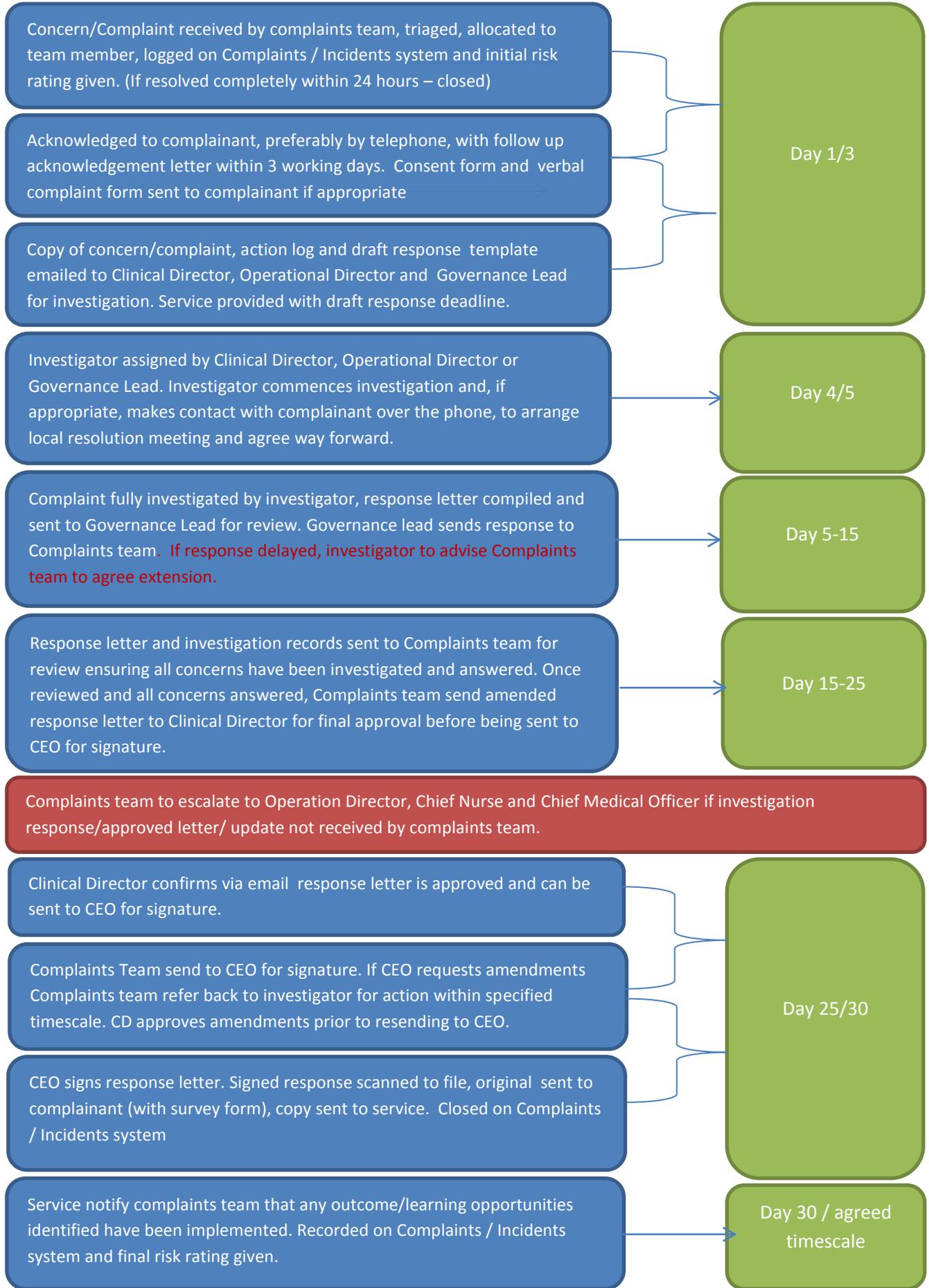
Self-neglect and Adult Complaints / Incidents systeming Policy (CLS12)

Complaints / Incidents systeming Vulnerable Adults Policy
Complaints / Incidents systeming Children and Young Person's Policy vs 2 (CP001)
Being Open Policy (G005)
Claims Management Policy (G006)
Supporting Staff Policy (G007)
Information Governance Policy (IG01)
Data protection, Caldicott and Confidentiality Policy (IG02)
Access to records Policy (IG04)
Investigation Policy (HR15)
Employee Well-being and Stress Risk Assessment Policy (HR10)
Francis Report: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013);
<http://www.midstaffspublicinquiry.com/report>
Mid Staffordshire NHS FT public inquiry: government response; Hard Truths
<https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response>

32. GLOSSARY

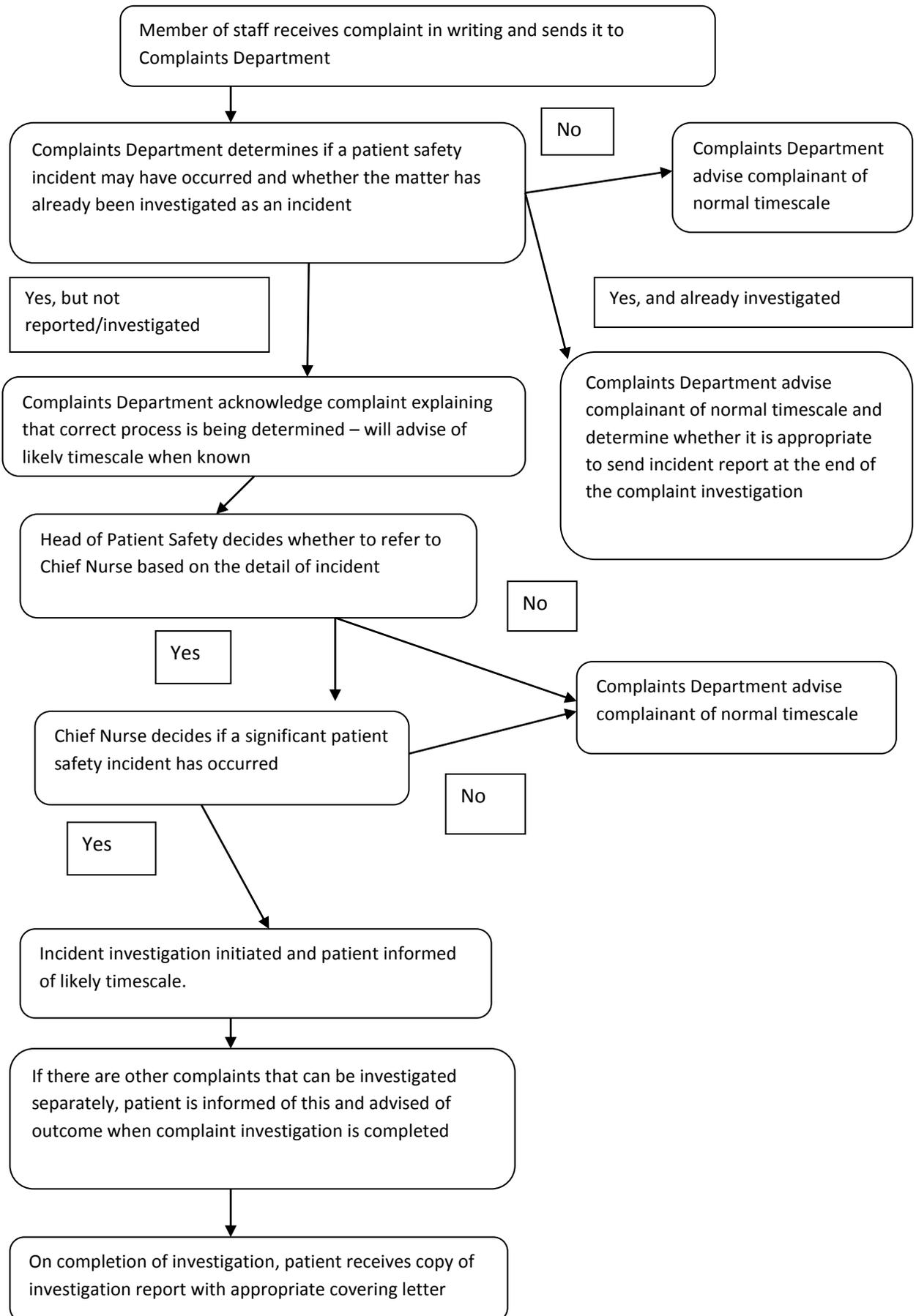
PALs- Patient Advice and Liaison service
PHSO- Parliamentary Health Service Ombudsman
SEAP-Support, Empower, Advocate, Promote

Appendix 1 Solent NHS Trust – Complaints Pathway/Time frames



Appendix 2

Complaints and Incidents Flowchart



Appendix 3 Assessing the seriousness of the complaint

Assessing the seriousness of a complaint correctly will ensure that an appropriate investigation is conducted. All concerns/complaints received will be triaged to assess the level of investigation required.

Seriousness	Description
Low	<p>Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care OR</p> <p>Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.</p>
Medium	<p>Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.</p>
High	<p>Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity OR</p> <p>Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.</p>

Step 2: Decide how likely the issue is to recur

Likelihood	Description
Rare	Isolated or 'one off' – slight or vague connection to service provision.
Unlikely	Unusual but may have happened before.
Possible	Happens from time to time – not frequently or regularly.
Likely	Will probably occur several times a year.
Almost certain	Recurring and frequent, predictable.

Step 3: Categorise the risk

		Potential Severity Consequence				
		Insignificant	minor	moderate	major	catastrophic
		1	2	3	4	5
Likelihood						
Almost Certain	5	yellow	yellow	orange	red	red
Likely	4	yellow	yellow	orange	red	red
Possible	3	green	yellow	orange	red	red
Unlikely	2	green	green	yellow	orange	red
Rare	1	green	green	yellow	orange	red

Appendix 4 (My Expectations, PHSO, Health Service Ombudsman, Local Government Ombudsman (LGO) 2014

Diagram 1: A user-led vision for raising concerns and complaints in health and social care



- I knew I had a right to complain
- I was made aware of how to complain (when I first started to receive the service)
- I understood that I could be supported to make a complaint
- I knew for certain that my care would not be compromised by making a complaint

- I felt that I could have raised my concerns with any of the members of staff I dealt with
- I was offered support to help me make my complaint
- I was able to communicate my concerns in the way that I wanted
- I knew that my concerns were taken seriously the very first time I raised them
- I was able to make a complaint at a time that suited me

- I always knew what was happening in my case
- I felt that responses were personal to me and the specific nature of my complaint
- I was offered the choice to keep the details of my complaint anonymous and confidential
- I felt that the staff handling my complaint were also empowered to resolve it

- I received a resolution in a time period that was relevant to my particular case and complaint
- I was told the outcome of my complaint in an appropriate manner, in an appropriate place, by an appropriate person
- I felt that the outcomes I received directly addressed my complaint(s)
- I feel that my views on the appropriate outcome had been taken into account

- I would complain again, if I felt I needed to
- I felt that my complaint had been handled fairly
- I would happily advise and encourage others to make a complaint if they felt they needed to
- I understand how complaints help to improve services

Appendix 5

EQUALITY IMPACT ASSESSMENT

<u>Step 1 – Scoping; identify the policies aims</u>	Answer		
1. What are the main aims and objectives of the document?	To ensure staff are aware of the pathway for managing and responding to concerns and complaints raised by patients or their representative.		
2. Who will be affected by it?	All staff across the organisation and potentially all service users.		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Listening and learning from feedback from concerns and complaints; positive feedback from complainants on how complaints and concerns have been dealt with and resolved, local and national reporting requirements.		
4. What information do you already have on the equality impact of this document?	There should be no adverse equality impact on this policy. All groups should benefit from application of policy. The principles of the policy ensure all groups are treated equally and fairly.		
5. Are there demographic changes or trends locally to be considered?	Principle of policy is to ensure accessibility to complaints management process for all groups.		
6. What other information do you need?	None		
<u>Step 2 - Assessing the Impact; consider the data and research</u>	Yes	No	Answer (Evidence)
1. Could the document unlawfully against any group?		X	
2. Can any group benefit or be excluded?		X	The document, if complied with, will ensure the rights are upheld for all those, and their carers or representative, where there are concerns or a complaint raised.
3. Can any group be denied fair & equal access to or treatment as a result of this document?		X	As above
4. Can this actively promote good relations with and between different groups?	X		By promoting resolution to concerns complaints raised and including signposting to advocates.
5. Have you carried out any consultation		X	The policy refers to best practice national guidance

internally/externally with relevant individual groups?			including the PHSO My Expectations document which was subject to public consultation.
6. Have you used a variety of different methods of consultation/involvement		X	See above
Mental Capacity Act implications	X		Mitigated in policy pathway and processes ensuring compliance with MCA.
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	X		See above

If there is no negative impact – end the Impact Assessment here.

<u>Step 3 - Recommendations and Action Plans</u>	Answer
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Described in above section
3. Are there likely to be different outcomes with any modifications? Explain these?	No
<u>Step 4 - Implementation, Monitoring and Review</u>	Answer
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	PALS and Complaints Manager
<u>Step 5 - Publishing the Results</u>	Answer
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	