Group arrangements:
Salford Royal NHS Foundation Trust (SRFT)
Pennine Acute Hospitals NHS Trust (PAT)

Northern Care Alliance NHS Group

Complaints Handling Policy

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Document Summary Sheet

Complaints Handling

The Northern Care Alliance NHS Group (NCA) is committed to providing high standards of care centred on patients and service users. As part of this process the Group will deliver an efficient and effective complaints procedure, not only because it is legally required to do so, but because it is committed to identifying and implementing service improvements and enhancing patient experience as a result.

Key Principles

The following key principles must be applied in order to deliver this:

- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties;
- All complaints and concerns must be dealt with in line with the Group's Duty of Candour (DOC) policies (refer to your organisation's DOC policy: North East Sector CO's "Incident Reporting & Investigation Serious Incidents, Never Events, Duty of Candour and Learning from Deaths" EDQ008 or Salford CO's "Duty of Candour: Being Open Policy" TC20 (06)
- High standards of conduct are expected from all staff at all times to ensure that service users/representatives will be treated respectfully, courteously and sympathetically;
- The requirement to maintain confidentiality during the complaints process will be absolute (where a safeguarding concern is raised, sharing of information may be necessary without the consent of the patient);
- All patient or service users and their families will be advised how they can raise a concern or make a formal complaint via information leaflets available on all wards and clinical service units and the internet;
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint;
- As far as possible, people who make complaints will be involved in decisions about how their complaints are handled and considered;
- The Group will aim to resolve complaints within the Group as part of local resolution (first stage of the national complaints procedure), wherever possible;
- Complainants receive a meaningful apology when appropriate;

- The Group will co-operate with other organisations when a complaint involves other outside organisations or multiple agencies;

- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint;

- Violence, racial, sexual, verbal or any other forms of harassment are unacceptable and will not be tolerated on the part of staff or people who make complaints.

1. What is this policy about?

1.1 It describes the requirements and procedures for the investigation and management of formal and informal complaints, received across the Group.

2. Where will this document be used?

2.1 This document is for use by staff members working throughout the Group.

3. Why is this document important?

3.1 As a Group employee you need to follow this policy so that the Group can ensure compliance to best practice and legal obligations to demonstrate that:

- Any service users of the Group, their family, or members of the public are given the opportunity to seek advice, raise concerns, and/or make a complaint about any of the services it provides
- That a person who raises a complaint, receives a high quality response in a timely manner;
- Lessons learned from complaints are acted upon and shared throughout the organisation to improve standards of care and prevent avoidable harm/ poor experience

3.2 Adherence to the policy will ensure that complaints are investigated and managed in line with:

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 www.opsi.gov.uk/si/si2009/uksi_20090309_en_1
- The NHS Constitution for England https://www.gov.uk/government/publications/the-nhs-constitution-for-england
- The Parliamentary and Health Service Ombudsman's (PHSO): My expectations for raising complaints and concerns 2014 http://www.ombudsman.org.uk/myexpectations
- The Local Government and Social Care Ombudsman (LGO) **http://www.lgo.org.uk**
- The CQC responsiveness requirements
- The PHSO principles of good complaint handling

4. What is new in this version?

4.1 Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust policies have been combined to form a Group policy and replace:

Salford Royal NHS Foundation Trust: ECPSE4(06) Customer Services policy responding to Patients concerns and complaints
Pennine Acute Hospitals NHS Trust; EDG004 Complaints Handling policy

4.2 Procedures have been updated to accurately reflect current practice. There is also reference to the Local government and social care requirement for ASC complaints which are handled by complaints staff within the Adult Social Care Division.

5. Policy

5.1 What can a complaint be made about?

5.1.1 A complaint can be made to the Group about any matter reasonably connected with the exercise of its functions including:

- Care or treatment provided;
- Anything to do with the hospital or healthcare environment;
- Any member of staff;
- How services are organised if this has affected treatment or care;
- Complaints about the Group's staff or facilities relating to the care provided to any patient or service user, in a private pay bed (but not to the private medical care provided by the Consultant outside of their NHS Contract);
- Care, treatment or an establishment that has been commissioned by the Group to provide care on behalf of the NHS

5.2 Who may complain?

5.2.1 The Regulations specify that complaints may be made by:

- A person who receives or has received services from the Group; or
- Any person who is affected or likely to be affected by any action, omission or decision of the Group;
- A Person who is acting as a representative of:
  - a person who has died;
  - a child;
  - a person who is unable to make the complaint themselves because of lack of physical incapacity or lack of mental capacity,
  - any individual who has otherwise asked the representative to act on their behalf

Where a complaint is made by a representative, the representative must demonstrate that they have the appropriate authority or consent to act. Consent is not required from MPs when they act directly on behalf of a constituent, as the Group may assume that the MP has obtained sufficient consent to release relevant confidential information (see section 17 S1 2002 (2905)), but is required when acting on behalf of a third party (e.g. complaint by a daughter on behalf of her mother's care being represented by the MP).

Where a complaint is made on behalf of a person who has died, it is important to check that the person making the complaint is the deceased patient's next of kin or is acting with their authority. Where this is not the case, the consent of the next of kin should be sought in writing and they will be asked by the Complaints Department to complete a Form of

Authority. In doing so, the Group will offer the next of kin the opportunity to review the complaint that has been made.

Where a representative makes a complaint on behalf of a child or a person who lacks capacity, prior to investigating the complaint, Group staff will satisfy themselves that there are reasonable grounds for the complaint to be made by the representative rather than by the child or the person who lacks capacity. Group staff will also satisfy themselves that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is being made. If not satisfied, the representative will be notified in writing of the reasons for refusing to investigate the complaint.

- **Young people aged between 16 and 19** – unless there is clear medical evidence that they lack mental capacity, their express authority should be obtained before responding to the complaint if it will involve disclosing confidential patient information.
- **Children under the age of 16** – if a complaint is made by a child who is 'Gillick competent' (i.e. of sufficient intelligence and maturity to consent to treatment), their agreement should be obtained before responding to the complaint if doing so will involve disclosing confidential patient information. If, however, a complaint is made on behalf of a child under the age of 16 who is not Gillick competent, no authority from the child will be needed to respond to those with parental responsibility.

5.3 Time limits for making a complaint

5.3.1 The Regulations require that a complaint must be made within twelve months of:

- The date on which the matter which is the subject of the complaint occurred; or
- The date on which the complainant became aware of the matter which is the subject of the complaint (if later than the date on which the matter occurred).

However, where a complaint is made outside this time limit, the Complaints Department may exercise discretion to waive the time limit where it can be demonstrated, and satisfied that:

- The Complainant had good reasons for not making the complaint within the time limit and,
- It is still possible to investigate the complaint effectively and fairly

Local experience is that complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

If it is not possible to waive the time limit, and where the complaint is not accepted into the Complaints Procedure, an explanation of this will be provided to the Complainant.

5.4 How to make a complaint

5.4.1 Complaints can be made verbally or in writing either via letter or electronically to the Chief Executive, Chief Officers for each CO, the Complaints Department, or via the Care Organisations' websites. The Complaint's Department will review, and a decision will be made whether to register the concerns raised as either a formal or informal complaint.

5.5 How the Group will respond

5.5.1 All written formal complaints received by the Group will be sent to the Complaints Department. These will be processed for investigation in line with the Complaints Process Flowchart (Appendix 3).

5.5.2 Formal complaints

All patients / service users / representatives have the right to have their complaint treated as a formal complaint. A formal complaint is acknowledged in writing within 3 working days. A written response will be provided following an investigation into the issues raised, or following a local resolution meeting (which can take place following investigation), usually within 25 working days or up to a maximum of 60 where a case is complex or the subject of an incident investigation. Where a complaint response and an incident investigation are deemed appropriate, responses can be combined or sent separately.

In some circumstances, and in line with the Complaints Regulations 2009, we will agree different timescales with the complainant to respond to their concerns, within a maximum period of 6 months (see Levels of Resolution chart, Appendix 1)

5.5.3 Informal complaints

An informal complaint is where an issue is raised as a complaint (or a concern, via PALS or to ward staff) but it is possible to resolve at a local level to the service user/representative's satisfaction, without going through the formal complaint process, as described above. The issue could be raised at the time the service or care is being provided to the service user or at some point after. It may be possible for the member of staff who received the informal complaint to resolve the issue at the time. If not, the issue should be passed to the appropriate senior colleague. Although the service user/representative may submit an informal complaint, the nature of the complaint may contain serious concerns, and should be triaged in the same manner as a formal complaint.

It is important to let the service user/representative know how you are progressing the complaint and advise them of the formal complaints procedure if they remain dissatisfied.

5.5.4 Duty of Candour

A culture of openness, transparency and candour is essential to improving patient safety and service quality. Patients who have been harmed during their healthcare treatment are owed an explanation of what went wrong, as soon as possible after an incident. Apologising and explaining what has happened helps healing, acceptance and perspective. It helps staff come to terms with the consequences of errors. The Group is

committed to supporting its staff in achieving a culture of openness, transparency and candour. The Francis Report 2012 defines these characteristics as:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it

5.5.5 Complaint Investigation

- Verbal complaints received in wards and departments by staff will be addressed promptly and fully by those staff, involving more senior management within the Division as appropriate. This is the most effective method of dealing with complaints; it reduces tension and conflict, demonstrates understanding and empathy and builds confidence in Group staff and services.
- Verbal complaints received by PALS will be addressed promptly and fully by those staff, involving more senior management within the Division as appropriate.
- Written complaints or verbal complaints where a written response has been requested will be risk assessed by the Group Associate Director of Patient Responsiveness /Complaints & PALS Manager along with the relevant Case Manager. Details of the Complaints Grading Matrix are contained in Appendix 1.
- Written complaints will be acknowledged within 3 working days of receipt in the Complaints Department.
- The Chief Executive Officer (CEO) has overall responsibility for managing all complaints; however, has delegated authority to the Chief Officers of the respective Care Organisations and their nominated deputies.
- All complaints received by the Group will be acknowledged by the Complaints Team (i.e. when a letter comes to the CEO, it is forwarded to the Complaints Team same day and they acknowledge the complaint). This will minimise delays and any confusion regarding appropriate process.
- If the individual(s) who has raised a concern contacts the CEO office during the course of an investigation, it will be referred back to the Complaints Team, who will allocate an appropriate person to have a discussion with the individual(s)/ service user.
- When necessary a complaint may be investigated without the line management
- All formal complaints will receive a signed response letter.

5.6 Reference to external agencies

5.6.1 If a review of a complaint reveals a possible case of criminal activity or other serious matter, the person in receipt of the complaint should ensure the Chief Nurse is notified via the CO, and has access to the appropriate AIR information immediately.

In such cases it will be necessary to refer the matter/s raised to an external agency or agencies e.g. Police, Her Majesty's Coroner, etc. The Chief Nurse will be responsible for triggering such a referral.

5.7 Process for handling joint complaints

5.7.1 Please refer to the Salford CO Protocol for handling joint Complaints

5.7.2 Complaints from a Managed service or Hosted Service.

Hosted services:

Where a clinical service is provided on a particular site but staff are managed and responsible to different Directors.

Should a complaint be received regarding a Hosted service, relating to one discipline of staff, the complaint will be lodged against the relevant Care Organisation. If there are more than one disciplines involved, the Associate Directors of Governance will identify which Care Organisation will take responsibility for the complaint.

Managed Services:

Managed Services may be provided on each of the hospital sites, but managed by one particular Care Organisation. Should the circumstances within a complaint relate to one site but involve a service managed by another CO, a decision is required regarding where the complaint is lodged.

Once again, in a similar process to the allocation of Incident Investigations, the Associate Directors – Governance will decide based upon the content of the complaint, which Care Organisation will take responsibility for the complaint and who will be the Lead Investigator.

In complaints where there is more than one discipline or involving more than one site, the AD's-Governance will agree which CO will take responsibility and who will be the Lead Investigator.

Complaints which are from Hosted or Managed Services will be included in the Monthly Patient Responsiveness Report.

5.8 Unresolved complaints

5.8.1 In situations whereby the service user/representative is dissatisfied with the response provided to their complaint and they communicate this to the relevant Organisation, this complaint will be logged as a dissatisfied complaint. The following criteria defines a dissatisfied complaint:

- Feedback from the service user / representative expressing dissatisfaction at the complaint response;
- Where no new issues are raised as part of this feedback by the person making the complaint;
- Where local resolution is not exhausted.

5.9 The 2nd Stage – Responding to the Ombudsman

5.9.1 The remit of the PHSO or LGO is to assess complaint cases where local resolution has been unsuccessful. Once the Complaints Case Handler has forwarded contact details for the PHSO or LGO onto the individual raising concerns, it is up to the individual to pursue their case with the PHSO or LGO.

The Group will comply with all requests and recommendations made by the Parliamentary and Health Service Ombudsman (PHSO) or the Local Government and Social Care Ombudsman (LGO).

5.10 Communication with Patient/Carer/Individual raising concerns

5.10.1 Regular contact and appropriate record keeping is essential to record action taken to resolve issues of concern. Answers provided must be full, frank, open and honest with all points addressed.

5.10.2 All staff will make every effort to deal with issues as they arise, informally and promptly. This includes informing senior clinicians and managers where it has not been possible to resolve concerns, and ensuring appropriate advice is given about how to take their issue forward. Voice your appreciation, comment or concern leaflet to be available across the Group and leaflets displayed.

5.10.3 Patients/ service users, their relatives or carers who raise a complaint or concern, must not be discriminated against and it is inappropriate for correspondence relating to a complaint or concern to be filed in the patient's health records. The Complaints Department will retain comprehensive records of all correspondence and documents relating to the complaint in the files held on behalf of the Group Executives. Similar records will be held regarding concerns raised through PALS.

5.10.4 Services will not be withdrawn from a patient because he/she makes a complaint or raised a concern. On rare occasions, where there may be a mutual loss of confidence and trust to the extent that the relationship between patient/service users and clinician is no longer sustainable, the Group will ensure ongoing treatment and care is provided by alternative means.

5.10.5 Where the Group's version cannot be reconciled with those of the individual who has raised concerns then this will be made explicit.

5.11 Support for people making a complaint

5.11.1 Making a complaint can be daunting and evidence confirms many people who might wish to complain do not because they do not know how to or they find the process intimidating. The Group therefore loses valuable feedback from its patients.

The Independent Complaints Advocacy Service (ICA) has been established to assist people who wish to complain. It will aim to ensure persons who raise concerns have the support they need to articulate their concerns and navigate the complaints system so that their concerns can be resolved more quickly and effectively. The

service can be accessed through a variety of routes including PALS and Complaints staff. It will advertise locally through a variety of means agreed with ICA managers.

5.12 Supporting staff

5.12.1 It is important to recognise that complaints investigations can have a significant impact on the staff involved.

Staff involved in the complaints investigation process must be given support, which may include some or all of the following: Support from their line manager or professional lead, the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

The Group is clear that the complaints investigation itself is separate to any other legal and/or disciplinary process. The Group will advocate justifiable accountability when required but will operate a policy of zero tolerance for inappropriate blame and those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process.

5.13 Providing advice and assistance

5.13.1 Clear information on how to make a complaint must be made available to the public through leaflets throughout Group premises and information on the Group/ Care Organisation web-sites.

5.14 Lessons learned and action arising from complaints

5.14.1 The Group will learn from complaints by identifying trends at a local and strategic level, which will assist in the prevention and recurrence or more serious incidents or other similar complaints occurring in the future.

5.14.2 The Lead Investigating Officers are responsible for preparing action plans arising from individual complaints and for ensuring that these are implemented. Action plans should cross reference to actions of other providers (e.g. other NHS Trusts or Social Services departments) where appropriate, with a link to quality improvement practices across the Group.

5.14.3 Lessons learned arising from complaints is a critical part of complaints management. Investigating Officers will be responsible for providing feedback, in respect of complaint outcomes, to appropriate individuals who can take action and ensure lessons are learned. Lessons are also required to be shared across relevant meetings at Ward/Department, Directorate, Divisional and Care Organisation level.

Internally, this will be through the provision of reports to Group Committees in Common on a quarterly basis which specifically highlight reports from the Parliamentary and Health Service Ombudsman.

Any theme or issue recognised which poses an immediate risk to the Group will be escalated to the relevant Executive outside of the normal reporting schedule.

5.14.4 Reports are available to monitor new complaints received, the age of the complaint and complaint trends via the CO's Complaints Dashboard.

5.14.5 Complaints handling to be reviewed as follows:

- Monthly by the complaints Review Panel at Salford CO.
- Monthly by the Complaints Review Panel at NES CO.

These review functions are chaired by a Non-Executive Director and has a senior medical officer as part of the core group. These review functions will provide external scrutiny of the Group's complaints handling.

5.14.6 A monthly summary of all completed complaint investigations, age of complaints, new complaints received and trends will be submitted to the Care Organisations, Quality & Patient Experience Committees.

5.15 Claims for compensation

5.15.1 Requests for compensation should be processed in accordance the NHS Resolution Service rather than through the Complaints procedure.

5.15.2 There may be circumstances in which the individual raising concerns indicates that an ex-gratia payment would be appropriate under the NHS Complaints Procedure and this should be processed in accordance with the Group's Scheme of Delegation at the discretion of the Divisional Management Team.

5.15.3 Guidance on financial remedy can be sought by the complaints team from the Parliamentary and Health Service Ombudsman or the Local Government and Social Care Ombudsman..

5.16 Unreasonably demanding individuals

5.16.1 Please refer to the NCA Policy: Dealing with Unreasonably Demanding, Persistent or Vexatious Complainants Policy

5.16.2

The Policy for dealing with Unreasonably Demanding, Persistent or Vexatious Complainants aims to address the challenges presented by persistent comebacks from people who are generally deemed to be 'difficult' and 'vexatious'. This document also provides advice as how best to deal with them. The intention is to provide clear yet flexible strategies.

It remains the responsibility of staff to ensure that all issues raised by individuals are thoroughly considered and addressed. Individuals with concerns should be kept informed of what is happening. Staff should always be willing to answer queries that patients or visitors may have or refer them to an appropriate person, ensuring that in the process they have enough information to satisfy their immediate needs. When a complaint is made the complainant needs to be kept informed of progress and the deadlines we aim to achieve.

It is important to try to resolve matters using appropriate and sometimes alternative approaches before invoking this procedure. The implementation of this procedure should only be used as a last resort and after all reasonable measures have been taken to try to resolve the complaint.

6. Roles and responsibilities

6.1 All staff

Frontline staff are usually best placed to address issues and complaints raised by those who use the Group's services. By taking prompt and effective action many issues can be addressed without the need for recourse to the formal complaints procedure. This approach is better for the individual raising concerns and for staff. It reduces tension and conflict, demonstrates understanding and empathy and builds confidence in Group staff and services.

All employees have a responsibility to ensure that:

- They observe and comply with this policy and associated procedures.
- They proactively address issues raised by those who use the Group's services in order to minimise the number of complaints.

- Where faced with a verbal concern they make every effort to rectify the problem immediately by:

    - Investigating the issues and providing a response;
    - Contacting the most appropriate person to find out the information required, if necessary seeking advice from their line manager;
    - Passing the issue on to a named person and informing the individual raising concerns why they have done so, who this is and when they can expect a response.

- They co-operate fully with complaint investigation and resolution;
- They support the implementation of action plans arising from complaints.
- They protect the interests of vulnerable adults and children. Reference to the Group's Safeguarding Team is advised if staff are unsure about this aspect.
- They should not seek to influence vulnerable individuals for the purpose of financial, personal or professional gain.
- They are aware that failure to adhere to the standards set by the Group for the management and investigation of incidents and complaints may result in disciplinary investigation and subsequent action.
- They are mindful of the Data Protection Act and their NHS responsibilities in terms of patient confidentiality, particularly where a complaint is made by a representative on behalf of another individual.
- They are aware that all documents generated in the course of a complaints investigation (including internal memoranda / comments etc.) are generally liable to be disclosed under the Data Protection Act or in any subsequent legal claim.
- They are aware that the PHSO may request to see any information that is gathered as part of the complaint investigation. Equally, it may be necessary to

disclose such correspondence to a complainant or their representative in any subsequent legal proceedings.

- They are aware that all Group staff dealing with complaints must consider the needs of vulnerable people such as adults with learning difficulties, children, some older people or people with particular disabilities, (such as visual impairment or hearing impairment), and will offer support from relevant agencies to such individuals.
- They are aware that all Group staff dealing with complaints must consider the need for language or sensory support, in line with Group policy on Interpretation & Translation (EDH023), in order to make sure that the complaints procedure is accessible to all.
- They are aware that Correspondence about concerns/complaints being handled by PALS or the Complaints Department should be kept separate from health records, subject to the need to record in the health records any information which is relevant to the patient's clinical management. When concerns are handled by clinical or nursing staff documentation may be filed in the patient's health records (documentation placed in a sealed envelope in the records when a concern has been raised by a patient's relative/carer/friend). Patients will be advised at the outset that investigation of their complaint may require examination of medical records and associated documents.

6.2 Group Committees in Common (CiC)

The CiC will ensure that:

- Complaints are taken seriously within the organisation;
- Complaint handling, particularly lessons learned, is integrated within governance & risk management processes and systems for improving the patient experience;
- Complaints handling is supported by adequate resources;
- It approves arrangements for dealing with complaints
- It is receipt of the LFE report following approval from each Care Organisation's Quality and People's Experience Committee (QPE) and Care Organisation Assurance and Risk Committee (COARC)

6.3 Chief Executive

As accountable officer, the Chief Executive must ensure that responsibility to manage complaints, including informal complaints / PALS within the Group is delegated to an appropriate executive lead, as outlined in the executive portfolios;

The Chief Executive (or nominated deputy) will review, approve and provide signatory to all complaint responses. This may also include the Medical Directors, Directors of Nursing, Directors of Social Care and Chief Officers for each CO.

6.4 The Group Associate Director - Patient Responsiveness (GAD)

The GAD is the senior manager with responsibility for complaints policy development, implementation and for managing the procedures for handling complaints in accordance with the regulations.

The GAD will ensure that:

- The Group's complaints handling policy reflects national regulations and guidance;
- Systems and processes in place are sufficient to provide the Chief Executive with assurance that robust arrangements are in place;
- The Group meets all performance standards in respect of complaints management;
- Systems are in place to ensure that the Group CiC , Chief Executive and managers throughout the Group receive regular reports on key performance indicators and are made aware of trends in complaints so that they can take action through the relevant clinical governance and risk management processes;
- An annual report on complaints is provided to the Group CiC and published, to provide an assurance to the Group CiC of compliance with Care Quality Commission outcome 17. A programme of staff training in complaints handling is developed and implemented across the Group

The GAD or nominated deputy will review and approve complaints responses prior to review by the relevant Site Executive. The GAD will refer any complex clinical complaints to an appropriate senior professional clinician internally e.g. Care Organisation Director of Nursing/Medical Director, or externally, if required.

6.5 Complaints Team (Group Associate Director of Patient Responsiveness, Complaints Managers, Case Managers and Administrative staff)

The Complaints Team will ensure that:

- All complaints received are processed in line with this policy;
- Complaints/ PALS staff balance the needs of complainants and staff;
- Complainants are supported through their complaints in a sympathetic and understanding manner, and are advised on the most appropriate route to resolve their complaint, involving other staff or agencies as required;
- Staff are supported through the complaints process;
- Appropriate responses to the required standard are prepared in conjunction with Divisional and Directorate staff, within the relevant timescales;
- Trends in complaints are identified and drawn to the attention of senior managers and regular key performance indicator and trend analysis reports are provided;
- They provide support to front line staff in dealing with immediate situations and provide advice to all staff with regard to formal and informal resolution of complaints

- Queries or concerns about draft responses are raised with relevant clinical staff, Divisional or Directorate managers so that an appropriate response is provided to the complainant
- The need for independent review of any complaint is identified and arrangements for such reviews (to be undertaken by someone not employed by the Trust) are put into place

Case Managers assist those who use the Group's services by providing advice, information and acting as liaison with Care Organisation staff.

6.6 Divisional Directors

Divisional Directors are responsible for ensuring that complaints concerning their Division are investigated in line with this Policy.

Divisional Directors will ensure that:

- They assign a senior person/an Investigating Officer for any received complaints. This person must not be directly involved in the complaint being made;
- The Investigating Officer for all complaints must be independent and not be someone who:
    - is directly involved in the complaint;
    - had direct involvement in managing the care and treatment of the patient;

or

an independent clinical view will be sought.

- Any RED graded complaints, deemed to be an SI, must be investigated in line with Incident Reporting & Investigation Policy EDQ008) V6.3 that states that *'For all SI investigations within the Trust, including red rated complaints deemed to be SI, at least one member of the investigation team must be trained in RCA methodologies.'*
- All new RED triaged complaints and Serious Incidents will be reported at the relevant weekly Divisional Management Team Meeting.
- Staff throughout the Division proactively address issues raised by those who use the Group's services in order to minimise the number of complaints;
- Staff throughout the Division are empowered to resolve complaints informally and to provide explanations to those who use the Group's services so that issues raised are addressed as locally as possible without the need to enter into a formal process;
- An objective and comprehensive investigation is carried out into complaints received so that full, complete and readily understandable information is provided for the complaint response;
- Staff throughout the Division co-operate fully with complaint investigation and resolution;
- They have agreed the draft version of complaint responses prior to submission for signature in line with relevant timescales;

- Action plans are prepared and implemented when lessons learned are identified during complaint investigations;
- They identify and act on risks and ensure that these are discussed and managed through the relevant Division, clinical governance and risk management processes;
- Root Cause Analysis (RCA) is undertaken where major / catastrophic or recurring issues or themes are identified.

6.7 Investigating Officer and process of investigation

Investigating Officers will ensure that an appropriate investigation is carried out in respect of complaints received, by:

- Obtaining relevant statements, evidence etc. and liaison with other service teams within the Group to ensure a robust investigation is undertaken to the concerns raised
- Completing the Resolution Summary template to summarise the investigation into all concerns raised and ensure that the response covers all issues
- Provide a written overview to the investigation that evokes the tone and sentiment to be conveyed in the response
- Monitoring any action plans that arise from complaint investigations, in liaising with Governance Managers and ensure corrective actions are fully completed
- Ensuring timescales within the investigation request are met; this involves liaising with colleagues within the Group as necessary
- Meeting with Complainants as necessary
- Ensuring risk registers are maintained if any risks are identified and that any serious issues are escalated within the Division as necessary
- Ensuring that staff involved in complaints receive feedback on the investigation and action plan

6.8 Complaints Case Manager

- Jointly, with the GAD/ Complaints & PALS Manager, triage any complaints received;
- Ensure timely communication is maintained with anyone raising a complaint or concern;
- The Complaints Case Managers will provide reports to any group, sub-committee, committee as required;
- The Complaints Case Managers will review and approve all complaints responses prior to the GAD/ Complaints & PALS Manager
- Complaints Case Managers will consider the possibility of mediation, conciliation or other forms of dispute resolution where this may be an appropriate method of resolving a complaint.

6.9 Divisional Governance Managers

To triangulate the actions and learning or themes from complaints within the wider governance agenda, to ensure continuous improvements in patient safety and experience are maintained within the clinical divisions.

To provide assurance to the monthly complaints review panel, chaired by Non Exec Director, that the content and issues raised in complaints and PALS are regularly discussed at Divisional Governance Board Meetings.

6.10 Patient Advice & Liaison Service (PALS) Officer

- Responsibility for co-ordinating responses to any query that is received via PALS processes, including working with appropriate individuals to help resolve informal concerns;
- Ensure communication is maintained with anyone raising a complaint or concern

7. Monitoring document effectiveness

7.1

- **Team responsible for monitoring:** Complaints Department
- **Frequency of monitoring:** Monthly
- **Process for reviewing results and ensuring improvements in performance:**

    - Quarterly Review of 'Learning from Experience Report' to the Quality & Performance (Q&P) Committee. This will contain qualitative and quantitative analysis of number and nature of complaints claims and incidents to enable targeted improvements where required
    - Weekly summary of completed complaint investigations, age of complaints, new complaints received and trends submitted to the Senior Management Team (SMT) meeting.
    - Monthly summary of all completed complaint investigations, age of complaints, new complaints received and trends submitted to the Patient's Experience Committee.
    - Independent review of complaints handling processes by trust auditors will take place at least once every 3 years and prior to the date of the next review of this policy.
    - A quarterly Quality Assurance Group (QAG), chaired by a Non-Executive Director will review a cross-section of complaint responses to ensure policy has been adhered to.

8. Abbreviations and definitions

8.1 Abbreviations

CEO Chief Executive Officer
CNST Clinical Negligence Scheme for Trust
CQC Care Quality Commission
HMC Her Majesty's Coroner
LFE Learning From Experience Report
LTPS Liabilities to Third Parties
MP Member of Parliament
NHSLA NHS Litigation Authority
NICE National Institute of Clinical Excellence
NPSA National Patient Safety Agency

PAT Pennine Acute Hospitals NHS Trust
PALS Patient Advocacy & Liaison Service
PHSO Parliamentary & Health Service Ombudsman
Q&P Quality & Performance
RCA Root Cause Analysis
SRFT Salford Royal Foundation Trust
SMT Senior Management Team
SI Serious Incident

8.2 Definitions of Terms used

The Group adopts the principles of the 4 C's as laid down by the Department of Health:

Complaint - A complaint is an expression of dissatisfaction requiring a response.

Comment - A comment can be a remark or observation that does not require a formal response;

Concern - A concern is a minor criticism or informal complaint which is dealt with in the first instance by the Patient Advice and Liaison Service (PALS) if it cannot be resolved at Ward / Clinical Service Unit (CSU) level;

Compliment - An expression of gratitude as a result of services provided to service users, relatives, carers or members of the public to Group staff.

Unreasonably Demanding Persistent and VexatiousComplaintants - On occasions when there is nothing further which can be done to assist a complainant to rectify a real or perceived problem. These complaints take up a disproportionate amount of staff time and resources and dealing with the complainants can cause undue stress to staff. Such complaints are considered to be unreasonably demanding, by virtue of being habitual or persistent. Where a complaint meets two or more of the following criteria it may be defined as being unreasonably demanding.

- Persistence by the individual in pursing an issue or complaint after the NHS complaints procedure has been fully and properly implemented and exhausted;
- Changing the substance of the issue or complaint, continually raising new issues or continually raising further concerns / questions whilst the complaint is being addressed or upon receipt of a response in order to prolong contact (new issues which are significantly different from the original complaint will not be included within this category and may need to be addressed as separate complaints);
- Unwillingness to accept documented factual evidence or to accept that facts can be difficult to verify if a long period of time has elapsed;
- Will not identify the precise subject matter of the complaint;
- Harassing any member of staff or being personally abusive or verbally aggressive or racially abusive (see Trust's 'Policy for Managing Violence, Aggression & Unacceptable Behaviour' EDE005, available via the Document Management System) Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;

- Threatening or using actual physical violence (Trust's 'Policy for Managing Violence, Aggression & Unacceptable Behaviour' EDE005); Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant;
- Meetings or face-to-face / telephone conversations tape recorded by the complainant without the prior knowledge or consent of other parties involved;
- Unreasonable demands / expectations made and failure to accept these may be unreasonable;
- Repeated refusal to follow alternative avenues open to the complainant (e.g. refusal to refer the complaint to Ombudsman).

9. References and Supporting Documents

9.1 References

- Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Data Protection Act
- Freedom of Information Act
- NHS Constitution (DH, 2009)
- The Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman, 2008)
- The Local Government and Social Care Ombudsman-Principles of complaints handling
- Department of Health (2009) Listening, improving, responding: a guide to better customer care
- NHSLA Litigation Authority guidance about complaints
- My Expectations for Raising Complaints and Concerns (Parliamentary & Health Service Ombudsman, 2014)
- Care Quality Commission Core Standards

9.2 Related PAT/NCA/SRFT documents

PAT

- EDH024 Induction and Mandatory Training Policy
- EDQ012 Risk Management Policy
- NCWC011 Protection of Adults at Risk
- EDN010 Safeguarding Strategy
- EDE010 Security Policy and Guidelines

NCA

- NCAPS001(18) Incident Reporting and Investigation, Serious Incidents, Never Event, Duty of Candour and Learning from Deaths
- NCAG006 Inquests
- NCAG020(19) Dealing with Unreasonably Demanding Persistent or Vexatious Complainants Policy

SRFT

- LD2(08) Mandatory Training Policy
- TG10(03) Risk Management Strategy
- RM7(06) Safeguarding Adults
- RM23(06) Security Policy

10. Document Control Information

It is the author's responsibility to ensure that all sections below are completed in relation to this version of the document prior to submission for upload.

Nominated Lead author:	Name Lynne Logan	Group Associate Director - Patient Responsiveness
Lead author contact details:	Full contact telephone number 0161 918 4297	Lynne.Logan@srft.nhs.uk Lynne.Logan@pat.nhs.uk
Lead Author's Manager:	Jayne Downey	Director of Governance and Corporate Nursing
Applies to:	Northern Care Alliance Group (NCA)	
Document developed in consultation with :	Josephine McCreath (Case Manager, NES CO) Ben Vickers (Complaints Manager, Salford CO) Complaints Department Governance	
Keywords/ phrases:	Complaints, Concerns, PALS, Unreasonably Demanding Complainants, accident, incident, near miss, reporting, candour	
Communication plan:	To be published on the Trust Document Management System available via the Trust intranet ('Policies & Documents') Notification via email to Executive Directors, Divisional Medical Directors, their management teams and key advisors. Training will be provided for staff in relation to this policy as follows: • Induction – All new staff (incorporated as part of the Trust's Clinical Governance Module) • Customer Service training • What makes a good complaint investigation and response – targeted at Investigating Officers and Senior Managers RCA Training – targeted at Investigating Officers of Serious Incident Investigations (cohort of staff trained in the organisation – see Incident Reporting & Investigation Policy)	
Document review arrangements:	This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.	
Approval:	Group Risk and Assurance – Sir David Dalton, Chief Executive Committees in Common- Jim Potter Chairman:	
	25.03/19	
How approved:	Chair's actions	Formal Committee decision X

11. Equality Impact Assessment (EqIA) screening tool

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/ involvement with service users, staff or other groups in relation to this document? If yes, specify what.	Yes Please state: Complaints Case Managers Deputy Complaints/PALS Manager, Director of Governance and Corporate Nursing
1b) Have any amendments been made as a result? If yes, specify what.	Yes Please state: Complaints Case Managers Deputy Complaints/PALS Manager, Director of Governance and Corporate Nursing

2) Does this policy have the potential to affect any of the groups listed below differently?

Place an X in the appropriate box: *Yes, No or Unsure*

This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

Protected Group	Yes	No	Unsure
Age *(e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)*		X	
Sex *(e.g. is gender neutral language used in the way the policy or information leaflet is written?)*		X	
Race *(e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)*	X		
Religion & Belief *(e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)*	X		
Sexual orientation *(e.g. is inclusive language used? Are there different access/prevalence rates?)*		X	
Pregnancy & Maternity *(e.g. are procedures suitable for pregnant and/or breastfeeding women?)*		X	
Marital status/civil partnership *(e.g. would there be any difference because the individual is/is not married/in a civil partnership?)*		X	
Gender Reassignment *(e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)*	X		
Human Rights *(e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)*	X		
Carers *(e.g. is sufficient notice built in so can take time off work to attend appointment?)*		X	
Socio/economic *(e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)*	X		

Disability *(e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.*	**X**		

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? *(e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)*	**X**		

3) Where you have identified that there are potential differences, what steps have you taken to mitigate these?
As a result of the impacts I have identified I will ensure that the existing best practice principles and elements related to the protected characteristics in the Salford and Pennine policies will be included within the final NCA policy

4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken?
As a result of the impacts I have identified I will ensure that the final NCA policy delivers a process that allows individual complainants communication and other support needs to be met.

5) Where the policy, procedure, guidelines, patient information leaflet or project impacts on patients how have you ensured that you have met the Accessible Information Standard – please state below:
The process ensures that patients/complainants are communicated with based on their individual needs.

EDI Team/Champion only*: does the above ensure compliance with Accessible Information Standard*

- X Yes
- No

If no what additional mitigation is required:

Will this policy require a full impact assessment? Yes
(*a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on* equality@pat.nhs.uk)

Author: Type/sign: Lynne Logan Date: 18.4.19

Sign off from Equality Champion: Tara Hewitt Date: 21.5.19

12. Appendices

Appendix 1

Grading Matrix (Risk Assessment) & Levels of Resolution

When a formal complaint is received, it is graded to assess the type of response required, and the time length within an investigation needs to be completed. Using the Risk Assessment Tool, the grading process involves considering three questions before a decision is reached:

1. How serious is the complaint (i.e. what the effect has been/could have been on the people involved and how complex the issues are)?
2. What are the potential risks to the organisation?
3. How likely is the issue to reoccur?

The risk assessment Tool:

How serious is the issue?

Seriousness	Description
Negligible Minor	Unsatisfactory service or experience – not directly related to care. No impact or risk to the provision of care. OR A single resolvable issue relating to care. Minimal impact and relatively minimal risk to the provision of care or service. No real risk of litigation.
Moderate	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.
Major Catastrophic	Significant issues regarding standards, quality of care, safeguarding or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation. Possibility of litigation or adverse local publicity. OR Serious issues that may cause long-term damage, such as grossly sub-standard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. High probability of litigation and strong possibility of adverse national publicity.

How likely is the issue to reoccur?

Likelihood	Description
Rare	Isolated or a “one off” incident. A slight or vague connection to service provision.
Unlikely	Do not expect this to happen again, but it is possible
Possible	May re-occur occasionally or happens from time to time.
Likely	Will probably re-occur several times a year, but not a persistent issue.
Almost Certain	Re-occurring and predictable. A persistent issue.

Based upon the questions considered, and choices picked from the tables above, the below table is then used to work out the most appropriate grading for the case:

		Likelihood				
		Almost Certain	Likely	Possible	Unlikely	Rare
Seriousness	Catastrophic					
	Major					
	Moderate					
	Minor					
	Negligible					

	High
	Medium
	Low

Under normal process, cases graded “High” will be responded to within 60 working days and all cases graded “Medium” or “Low” within 25 working days. However, there may be circumstances in which the response time will need to be either shortened or lengthened, depending on the specifics of the case. In such circumstances, the timescale will need to be agreed with the complainant, and must be within 6 months of receiving the complaint, in line with the Complaints Regulations 2009. The below “Levels of Resolution” table provides guidance on the decision making process for response times.

Level 1 – Service managed resolution (response timescale: by end of next working day) HELP Phone can support this process
Issues/concerns that can be responded to without a formal investigation where there is no barrier to the service resolving the matter. E.g. appointments, questions around medication, staff attitude, patient property, waiting times, facilities and estates issues, food.
Criteria:
Reported to be arising from circumstances resulting in minor injury, damage or loss
No likelihood of litigation / No reputational risk
No barrier to local resolution. E.g. no conflict of interest, no resource issues limiting ability to respond, no breakdown in relationships
Level 2 – Resolution with PALS involvement – Standard (response timescale: within 5 working days)
Issues/concerns that can be responded to without a formal investigation where there is a barrier to the service resolving the matter.
Criteria:
Reported to be arising from circumstances resulting in minor injury, damage or loss.
Little or no likelihood of litigation / reputational risk.
Barrier to local resolution. E.g. conflict of interest, resource issues limiting ability to respond, breakdown of relationship between service and enquirer, inhibited communication between enquirer and service.
Level 3 – Resolution with PALS involvement – complex (response timescale: within 10 working days)
Issues/concerns that can be responded to without a formal investigation where there is a barrier to the service resolving the matter, where multiple services and/or issues, agencies or parties involved. Meetings, phone calls, emails correspondence.
Criteria:
Reported to be arising from circumstances resulting in moderately serious injury, damage or loss
Multiple services or issues, agencies or parties involved
Little likelihood of litigation / reputational risk
Barrier to local resolution. E.g. conflict of interest, resource issues limiting ability to respond, breakdown of relationship between service and enquirer, inhibited communication between enquirer and service
Level 4 – Complaint (response timescale: within 25 working days)
Issues/concerns that require formal investigation into low number of issues relating to a low number of services. Single organisation.
Criteria:
Reported to be arising from circumstances resulting in harm / potential harm. Potentially life threatening to a person or substantial damage or loss to self or property.
Possible likelihood of litigation / reputational risk
Multiple issues (10 or more) or Divisions (3 or more) or multiple organisations
Level 5 – Complex Complaint (response timescale: Upto 60 working days or to be determined by escalation to Director of Governance, DDNS, to be discussed with the complainant)
Issues/concerns requiring formal investigation, where other processes are ongoing or will be required (SIARC, SUI, Safeguarding or legal proceedings)
Criteria
Reported to be arising from circumstances resulting in life threatening events, extremely serious harm or death, substantial damage or loss
High probability of litigation / high risk to reputation of Trust
Complexity requiring Board-level awareness and oversight

Appendix 2

Template Resolution Summary

Pride in Pennine — Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS Trust

From June 2017

Complaint Resolution Summary

Complaint reference	
Name of complainant (on behalf of patient)	
Date first received	
Date of acknowledgement	
Recommended Resolution Method (Complete only the appropriate section below based on this recommendation. Contact complaints to discuss if there are queries about this)	☐ **Written Response** ☐ **Telephone Resolution** **Tel No.** ☐ **Meeting requested**
Date this Resolution Summary is due back to complaints	

Key issues/questions of the complaint:

1.
2.
3.

a) Investigation Findings For A Written Complaint Response

Methods of Investigation

In order to investigate these concerns fully, insert name of the investigating officer:
- Examined the medical records, and clinic letters
- Met/Obtained comments from name, title
- List all people who have provided information

Investigation Findings

Try to respond in a tense as if the director signing-off is talking to the complainant about your investigation. Use plain speech and explain any clinical terms.
i.e. "Matron Joan Bloggs advises me that you were admitted following reports of a suspected Grand Mal Seizure (a type of seizure in which you lost consciousness and were shaking violently)"

Use the key issues/questions at the head of this form as headings and respond to each point separately.

Chairman, Mr Jim Potter — Chief Executive, Sir David Dalton

Please remember to provide full names ALL staff involved in the care, and provide accurate dates and times when events happened. If you refer to a policy or protocol in any of your responses please state which it is under the relevant point
What actions are we going to take or have already taken as a result of this complaint: PLEASE COMPLETE THE ACTION PLAN FOR ALL COMPLAINTS AND SUBMIT ALONG WITH THE RESOLUTION SUMMARY
Additional notes Insert any special notes or instructions to the complaints team here remembering this is a disclosable document

Reviewed and Approved by KCS	List the names and titles of any key clinical staff involved in the investigation and the date they approved the above information.
Name and title of Investigating Officer Completing this	
Date of submission to Complaints Team	

b) Investigation Findings relayed by telephone to the complainant *Only complete this section if complaints team are aware you are going to contact the complaint by phone to resolve*
Name and title of person calling complainant (if not the IO)
Date of call
Summary of discussion Please write a summary of the discussion.
Did the complainant indicate they were happy with the resolution? This is important as complaints will write to them confirming our understanding that the complaint is resolved and can be closed.
What actions are we going to take or have already taken? PLEASE COMPLETE THE ACTION PLAN FOR ALL COMPLAINTS AND SUBMIT ALONG WITH THE RESOLUTION SUMMARY

Pride in Pennine | Quality-Driven Responsible Compassionate

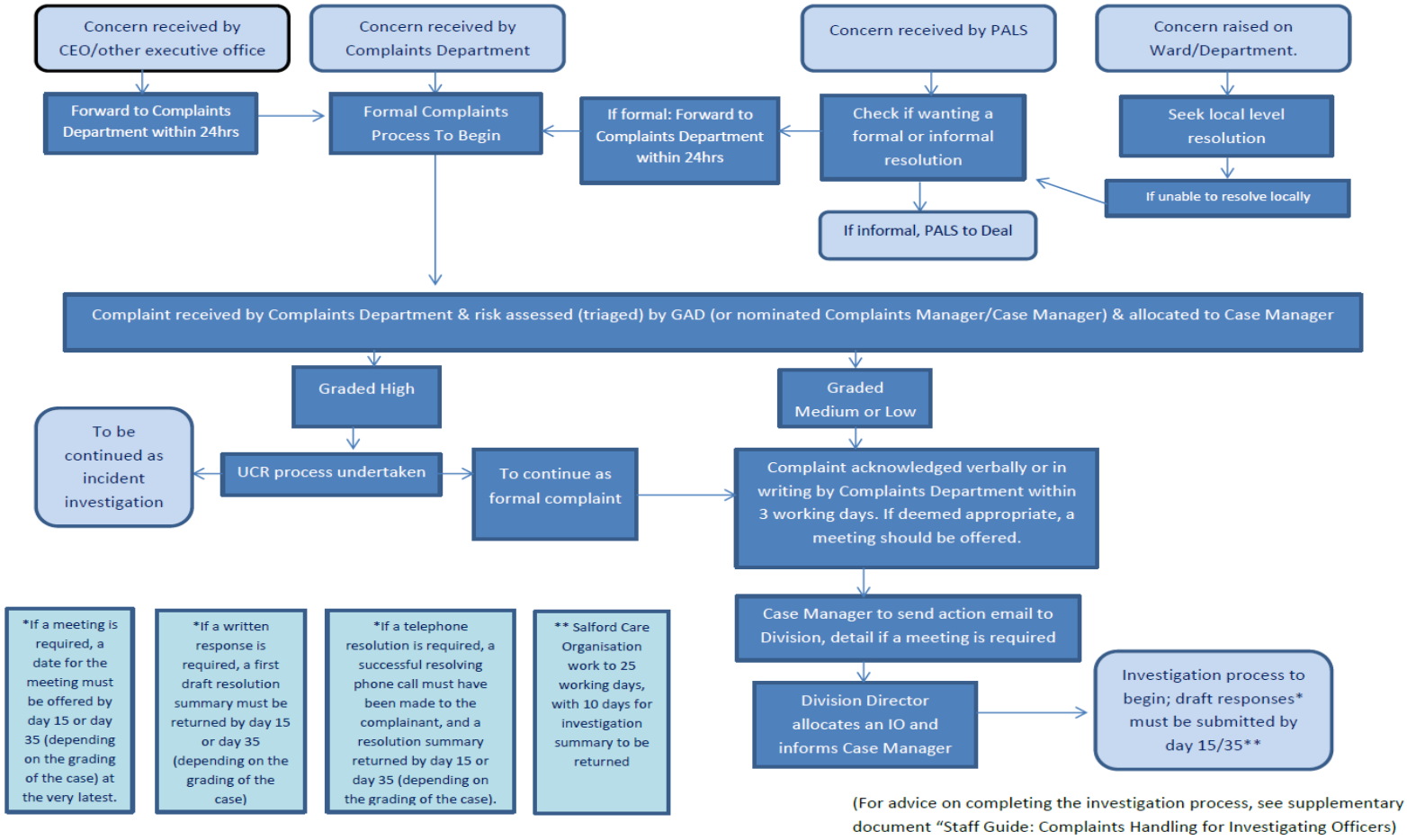
The Pennine Acute Hospitals NHS Trust

Name and title of Investigating Officer Responsible	
Date of submission to Complaints Team	

c) Investigation Findings to be relayed by a face-to-face Meeting	
Name and titles of people who will be attending the meeting	
Name and contact number of divisional staff member who will be setting up the meeting	
Name and title of Investigating Officer who confirms the issues have been fully investigated	
Brief Summary of investigation findings Just a few paragraphs about the findings of the investigation so that complaints team know an overview of what is going to be relayed at the meeting. This section must be filled out if we are meeting with the complainant so that there is full assurance that the meeting will relay findings and that all staff are fully prepared with the answers.	
What actions are we going to take or have already taken? PLEASE COMPLETE THE ACTION PLAN FOR ALL COMPLAINTS AND SUBMIT ALONG WITH THE RESOLUTION SUMMARY	
Date of submission to Complaints Team	

Appendix 3

Complaints Process Flowchart



(For advice on completing the investigation process, see supplementary document "Staff Guide: Complaints Handling for Investigating Officers)