The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

COMPLAINTS HANDLING POLICY AND PROCEDURE

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Current Author	Helen Ridler
Author's Job Title	Interim PALS & Complaints Manager
Department	Complaints Department
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Owner	Claire Roberts
Owner's Job Title	Associate Director of Patient Experience

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Related Policies	Policy on the Investigation of Complaints Guidelines on Responding to letters of Complaints Policy on Openness and candour Claims Management Policy PALS Operational Policy Support Arrangements for Staff Involved in Potentially Traumatic/Stressful Work Related Situations Investigations Policy Risk Assessment Policy

Stakeholders	Chief Executive Board of Directors Complaints and PALS Team Clinical and Managerial Teams Patient Experience Committee Patient Experience Steering Group Healthwatch England

Version	Date	Author	Author's Job Title	Changes
V1	July 2007	Karl Perryman	Complaints & Litigation Manager	
V2	Sept 2010	Karl Perryman	Complaints & Litigation Manager	Policy updated to reflect the Local Authority Social Services and NHS Complaints (England) Regulations 2009 and the revised requirements of the NHSLA Risk Management Standards (2010/11).
V3	June 2011	Karl Perryman	Head of Complaints & Litigation	Minor updates
V4	July 2012	Joanne O'Neill	Complaints Manager	Re-write of document to reflect the revised requirements of the NHSLA Risk Management Standards (2012/13)
V5	May 2014	Joanne O'Neill-Brown	Complaints Manager	Minor updates noting the outcome of the Francis enquiry (2012) and the Ann Clwyd review of the NHS Complaints System (2013)
V6	April 2015	Helen Ridler	Interim PALS & Complaints Manager	Review and update policy and processes for investigating and responding to complaints, identifying ownership of the investigation, response and follow-up actions

Summary of the policy
Document laying out the Trust's Policy and Procedure for the Handling of Complaints including the definition of a complaint, who may complain, the process for the handling of complaints and clear guidance on who is responsible for investigating and responding to the complaint and subsequent follow up actions.

Key words to assist the search engine
Complaints, Compliments, PALS

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COMPLAINTS HANDLING POLICY AND PROCEDURE

1	**INTRODUCTION**
1.1	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust endeavours to provide the best service it can to its patients. Sometimes patients, carers, families and/or their representatives may have concerns about services provided and it is important that there should be a clear and effective Complaints Handling Policy and Procedure for such matters.
1.2	The NHS Constitution enshrines the right of an individual to make a complaint if that person is unhappy about the care or treatment provided and it explains that this includes a right to complain, have the complaint investigated, and be given a full and prompt reply. It states that individuals have the right to: • Have their complaint dealt with efficiently, and be properly investigated • know the outcome of any investigation into their complaint • take their complaint to the independent Parliamentary and Health Service Ombudsman if they are not satisfied with the way the NHS has dealt with their complaint • make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body • receive compensation if they have been harmed
1.3	The Trust's Complaints Handling Policy and Procedure has been written in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (No 309) (hereafter 'the Regulations'), the Department of Health's Listening, Responding, Improving – A guide to better customer care (the Code of Practice) dated 26 February 2009 and the Health Service Ombudsman's 'Principles of Good Complaint Handling' published 10 February 2009 and the Review of the NHS Complaints System conducted in 2013 by the Rt. Hon Ann Clwyd entitled 'Putting Patients Back in the Picture'. The policy also reflects the recommendations arising from the Robert Francis' report.
1.3	The Trust aims to investigate and respond to all complaints within 30 working days of receipt, unless an alternative timeframe is agreed with the complainant.
2	**PURPOSE**
2.1	The Trust is committed to ensuring that complaints about its services will be properly investigated and dealt with efficiently. The Trust also recognises the pledge under the NHS Constitution that when mistakes happen, they should be acknowledged, the Trust should apologise, explain what went wrong and put things right quickly and effectively.
2.2	The purpose of the complaints process will be to: • 'Listen' to the concern raised by the complainant • 'Respond' to the complaint in a satisfactory, open and candid manner • Ensure that where faults are identified, they are recognised, addressed and where possible remedial action is undertaken • Identify whether the complaint is upheld, not upheld or partially upheld.

2.3	The Trust will attempt to ensure through the application of this procedure that: • There is ease of access for all persons who wish to formally complain and they are provided with advice or assistance to understand the Complaints Handling Policy and Procedure. • The approach to managing complaints is effective and thorough with the prime aim of resolving the concerns of the complaint. • Complainants receive a timely and appropriate response. • There is fairness for staff and complainants alike. • Lessons arising from the complaints are recognised and used to improve services for patients. • There is a separation of complaints from disciplinary procedures. • Complainants are treated with respect and courtesy and they do not face discrimination as a result of making a complaint.
2.4	By doing so the Trust will place emphasis upon the need to identify and address patient concerns quickly, whilst providing the necessary management support to enable speedy remedial action to be taken where indicated.
3	**DEFINITIONS**
3.1	**Formal Complaint**
3.1.1	The Regulations do not define what they mean by the term 'complaint'. The NHS Executive has defined a complaint as 'an expression of dissatisfaction requiring a response.'
3.1.2	The Trust will seek to distinguish between requests for assistance in resolving a perceived problem which may be dealt with immediately by Patient Advice and Liaison Service (PALS) and a formal complaint. All issues will be dealt with in a flexible manner, which is appropriate to their nature and the latter will be dealt with in accordance with the complaints procedure.
3.1.3	For the avoidance of doubt, whenever there is a specific statement of intent on the part of the caller or correspondent that they wish their concerns to be dealt with as a formal complaint, the complaint will be treated as such.
3.2	**Informal Complaint**
3.2.1	An informal complaint is one in which an issue is raised as a complaint but it is possible to resolve it at the time and to the complainant's satisfaction, without going through the formal process outlined below.
3.3	**Local resolution**
3.3	The most satisfactory outcome to complaints often comes when complaints are dealt with fully and effectively at the local level. This is defined as Local Resolution. This seeks to provide prompt investigation and resolution of the complaint at a local level, aiming to satisfy the complainant whilst being fair to staff.

3.4	**The Parliamentary and Health Service Ombudsman**
3.4.1	The Parliamentary and Health Service Ombudsman is an appointed independent regulator responsible for considering complaints that involve the NHS in England to determine whether the NHS organisation has not acted properly or fairly or has provided a poor service.
3.5	**NHS Complaints Advocacy Service**
3.5.1	The NHS Complaints Advocacy Service provides advocacy support to people who wish to make a complaint about the service - or lack of it - that they have received from the NHS. In the Eastern region this is provided by an organisation called POhWER.
3.6	**Patient Advice and Liaison Service (PALS)**
3.6.1	The Patient Advice and Liaison Service (PALS) are in place to ensure that the NHS listens to patients, their relatives, carers and friends, answers their questions and resolves their concerns as quickly as possible.
3.7	**Gillick-competent**
3.7.1	Where a child is deemed to have sufficient intelligence and maturity to consent to treatment
3.8	**Datixweb**
3.8.1	Datixweb is an electronic system for recording and tracking complaints from receipt to conclusion.
4	**RESPONSIBILITIES**
4.1	**Chief Executive**
4.1.1	The Chief Executive is the *'responsible person'*, as defined in the Regulations, with the responsibility for ensuring compliance with this policy and ensuring that action is taken if necessary in light of the outcome of complaints.
4.2	**Director of Nursing**
4.2.1	The Director of Nursing is the designated executive lead for overseeing the handling of complaints within the Trust and ensuring that the organisation has the correct policy and processes in place to be compliant with national guidance on the handling of complaints.
4.3	**Medical Director**
4.3.1	The Medical Director has delegated executive responsibility to support the complaint's process through attendance at meetings with complainants to aid local resolution after initial attempts to resolve the complaint within individual Divisions has not been successful. The Medical Director will re-examine the complainant's concerns and provide an independent assessment of the issues.

4.4	**Associate Director of Patient Experience**
4.4.1	The Associate Director of Patient Experience has operational responsibility for the handling of complaints within the Trust and is responsible for ensuring that the organisation operates a complaint's handling process that is fully compliant with national guidance and recommendations.
4.4.2	The Associate Director of Patient Experience has responsibility for 'signing off' on behalf of the organisation that all complaint responses meet an appropriate standard in terms of content, clinical accuracy, presentation and that the response fully answers the complainant's concerns.
4.5	**Complaints Manager**
4.5.1	The Complaints Manager who, for the purposes of the NHS Complaints Procedure, carries the responsibilities of designated *'Complaints Manager'* (as defined in the Regulations) is responsible for managing the day to day procedure for handling complaints under this policy.
4.5.2	The key duties of the Complaints Manager will be to: • Manage the Complaints Procedure within the Trust • Support the Divisional Directors/Heads of Departments in the implementation of this Policy • Ensure regular information is given to the Board on complaints matters • Coordinate and oversee the investigation of complaints on behalf of the Chief Executive • Advise, help or guide other staff upon complaints matters • To provide support in preparing response letters to complainants for the Chief Executive to review and approve • Ensure that each complaint has been reviewed by a senior member of staff in the departments or divisions concerned to ensure that appropriate lessons are learnt. • Advise the Head of Legal Services of any potential claims. • Advise the Head of Integrated Clinical Governance of any complaint that meets the reporting criteria as a serious incident. • Ensure that lessons learnt that are applicable in other areas of the Trust are communicated to relevant leads for action and implementation.
4.6	**Patient Advice and Liaison Service (PALS) Officer**
4.6.1	In many cases the PALS officer is the first point of call for patients. By listening and confirming what their concerns or queries are the PALS officers can be a valuable resource for resolving issues in real time before they become a problem / formal complaint. If resolution cannot be found, they will advise the client of options on how to proceed.
4.7	**Divisional Directors, Clinical Directors, Associate Chief Nurses**
4.7.1	The three senior leads in each Division will be jointly responsible for ensuring that any complaint referred for investigation is thoroughly read, allocated to an appropriate investigator and signed off by the Division before it is returned to the Complaints Department within the required time frame.

4.7.2	The progress of the investigation and the appropriateness of the response will be overseen by the most appropriate senior lead within the Division but the Divisional Director will maintain overall responsibility for ensuring that the complaint is handled according to the Trust's policy and procedure. For example: complaints regarding nursing care should be overseen by the Associate Chief Nurse and those involving clinical care and treatment by the Clinical Director. In those situations in which the complaint has many aspects one of the senior leads should take overall responsibility.
4.7.3	The three senior leads will be responsible for ensuring that recommended actions following a complaint are followed up and any changes to practice or process are implemented and recorded on Datixweb.
4.8	**Clinical leads and consultant staff**
4.8.1	Clinical leads and consultant staff will be responsible for cooperating with any request to investigate or respond to a complaint affecting their service or department and to undertake an investigation and write a letter of response within the required time frame.
4.8.2	Clinical leads and consultant staff will be responsible for ensuring that recommended actions arising from complaints are implemented as required within their specialty or service.
4.8.3	Clinical leads and consultant staff will be responsible for cooperating with any request from the Complaint's department to attend a local resolution meeting with a complainant and to providing suitable opportunities for a meeting to take place.
4.9	**Matrons/Ward Sisters/Charge Nurses**
4.9.1	Matrons, ward sisters and charge nurses will be responsible for cooperating with any request to investigate or respond to a complaint affecting their service, ward or department and to undertake an investigation and write a letter of response within the required time frame.
4.9.2	Matrons, ward sisters and charge nurses will be responsible for ensuring that recommended actions arising from complaints are implemented as required within their service, ward or department.
4.9.3	Matrons, ward sisters and charge nurses will be expected to try and deal with issues of concern wherever possible at a local level and before matters escalate to a formal complaint. This may involve taking responsibility for communicating with the patient or his/her family arranging meetings with the complainant to deal with matters immediately.
4.9.4	Matrons, ward sisters and charge nurses will be responsible for cooperating with any request from the Complaint's department to attend a local resolution meeting with a complainant and to providing suitable opportunities for a meeting to take place.
4.10	**All Staff**
4.10.1	All staff are required to assist and cooperate in the complaints process and wherever possible try to deal with issues of concern before it becomes a formal complaint.

4.11	**The Board of Directors**
4.11.1	The Board of Directors is accountable for ensuring that the Trust has in place appropriate policies and processes to ensure that the organisation is compliant with the regulations for the management and handling of complaints.
4.12	**The Patient Experience Steering Group**
4.12.1	The Patient Experience Steering Group is responsible for receiving reports on the implementation of the complaint's procedure and the nature of the complaints received by the organisation and for providing assurance to the Board of Directors via the Quality Committee that the process is being appropriately applied and that operational standards are being met.
4.13	**Service Line Quality and Business Boards (SQuaBB)**
4.13.1	The Service Line Quality and Business Boards (SQuaBB) will review all complaints related to their service line and the lessons identified. Where indicated, the Boards will commission in-depth reviews of particular wards/ service lines/ individual clinicians. These will be reported to the Trust's Divisional business meetings via the SQuaBB report.
4.14	**Specialty Meetings**
4.14.1	All complaints and lessons learnt should be discussed in individual Specialty Meetings to ensure lessons learnt and recommended actions are followed up within the service.
4.14.2	The specialty meetings should ensure that lessons learnt are communicated to all staff within local areas through direct communications, newsletters, noticeboards, meetings and via other routes suitable for the individual service.
5	**COMMUNICATION FALLING OUTSIDE THIS POLICY**
5.1	**Informal complaints**
5.1.1	It should be noted that this policy and procedure sets out a formal process for a written complaint. However, some users of Trust services may wish to express concerns or dissatisfaction but not wish to make a complaint.
5.1.2	Accordingly, if issues are raised with the PALS service, Matrons or other staff in an 'informal' manner and can be quickly resolved (in real time), they should not fall under the restrictions of this policy.
5.1.3	If it then becomes apparent that in fact the person wishes to make a complaint as the matter cannot be resolved within one working day, the matter should be referred to the Complaints Department and processed under this policy and procedure in the usual way.
5.1.4	What constitutes a 'complaint' in these circumstances is a matter of 'common sense' to be determined by the professional judgement of the staff concerned, influenced and guided by the approach and wishes of the patient.

5.2	**Complaints to individual staff members**
5.2.1	Some patients may prefer to raise their concerns (orally or in writing) to individual clinicians, managers or other staff. In such circumstances it may be reasonable to assume that unless otherwise indicated, the patient would prefer a direct response from the individual rather than via formal process through the Chief Executive's office.
5.2.1	In difficult or complex cases, however, the matter should be referred to the Complaints Manager for advice, support or other assistance, which may include entering the matter into the Complaints Procedure.
6	**WHO – MAY COMPLAIN?**
6.1	The Regulations specify that complaints may be made by: (i) A person who receives or has received services from the Trust; or (ii) Any person who is affected by or likely to be affected by an action, omission or decision of the Trust about which they complain.
6.1.1	A complaint may also be made by a representative of the complainant falling into one of the above categories.
6.1.2	Complainants may therefore include existing or former patients using the Trust's services and facilities, their families or carers as well as visitors.
6.2	**Making a complaint on behalf of a deceased patient**
6.2.1	Where a complaint is made on behalf of a patient 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.
6.3	**When does this procedure not apply**
6.3.1	The procedure **does not** apply to staff grievances which will be handled separately in accordance with agreed policy via the Human Resources Department. Likewise, complaints from service partners (e.g. GPs, other NHS Trusts, and Commercial partners) do not fall under this policy and procedure. Staff are requested to contact their Human Resources Business Partner
7	**HOW – MAY COMPLAINTS BE MADE?**
7.1	**In Writing**
7.1.1	Complaints may be made in writing or electronically, to the Chief Executive of the Trust or to the Complaints Department.
7.2	**By Telephone or In Person**
7.2.1	Complaints received by telephone or in person will be confirmed in writing to the complainant, as required, by the member of staff who receives the complaint or by the Complaints Department and a copy will be provided to the complainant to approve.

7.2.2	If complainants face difficulty making their complaint due to a disability, the Complaints Manager will arrange for all reasonable necessary assistance to be provided.
7.3	**Out of Hours**
7.3.1	Complaints may be made 'out of hours' to the bleep holder who may enlist the assistance of the On Call Matron and/ or Silver Command. The matter should then be referred to the Complaints Department during normal working hours.
7.4	**Information on how to make a complaint**
7.4.1	The Trust will ensure that information leaflets regarding how to make a complaint are available in all Departments and through PALS.
7.4.2	Information on the complaints process is: • Contained in the In-patient Information Booklet • Available on the Trust's website • Available for staff on the Trust's Intranet • Available on request from the Trust.
7.4.3	Complaints literature will follow the established 'Listening, Responding, Improving' guidance.
7.4.4	Guidance will be available in both standard and easy read versions and will be available in other languages on request.
8	**WHEN – TIME LIMITS FOR MAKING A COMPLAINT**
8.1	The Regulations require that a complaint must be made within 12 months of: (i) The date on which the matter which is the subject of the complaint occurred; or (ii) If later, the date on which the complainant become aware of the matter which is the subject of the complaint.
8.2.1	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 that took place sometime ago. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.
8.2.2	Where a complaint is made outside this time limit the Complaints Manager may exercise discretion to admit the complaint to the procedure if they are satisfied that: (i) The complainant had a good reason for not making the complaint within the time limit; and (ii) Notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly although it is outside of the 2009 NHS Complaints Regulations.
8.3	If it is not possible to waive the time limit and the complaint is not accepted, an explanation of this will be provided to the complainant.

9	**CONFIDENTIALITY – PATIENTS AND STAFF**
9.1	**Patient health records**
9.1.1	Patients will be advised from the outset, that investigation of their complaint may require examination of health records and associated documents.
9.1.2	Correspondence about complaints must 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.
9.2	**When a complaint is made on behalf of another**
9.2.1	If the person complaining is not a patient, but is complaining on behalf of a patient, it is important to check that the patient knows about the complaint and is in agreement with its content.
9.2.2	The complainant must be told that in order to avoid breach of patient confidentiality, any questions relating to the patient's care and treatment can only be answered with the patient's consent.
9.2.3	This does not mean that the matters raised cannot be investigated, but it does require that the reply to the complainant may not be in detail if the patient does not agree to information being shared.
9.2.4	Relatives or others complaining on behalf of patients will be sent a Form of Authority and asked to return it to the Complaints Department. The patient will be asked to sign to confirm their agreement to a reply being sent to the person who made the complaint.
9.3	**When a Patient lacks Mental Capacity**
9.3.1	In cases where the individual is not mentally capable of giving such authorisation then the Complaints Manager will need to be satisfied that their representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made.
9.4	**Young People aged 16 and 17**
9.4.1	If a complaint is made on behalf of a 16 or 17 year old, unless there is clear medical evidence that they lack mental capacity, then their express authority should be obtained before responding to the complaint if it will involve disclosing confidential patient information.
9.5	**Children under the age of 16**
9.5.1	If the complaint is made by a child who is 'Gillick competent' (i.e. of sufficient intelligence and maturity to consent to treatment), then their agreement will be obtained before responding to the complaint if doing so will involve disclosing confidential patient information.
9.5.2	If however a complaint is made on behalf of a child under the age of 16, who is not Gillick competent, then no authority from the child will be needed prior to responding to those with parental responsibility.

9.6	**Member of Parliament (MP)**
9.6.1	If an MP makes an enquiry to the Trust on behalf of an individual patient, or a person authorised to act on their behalf, the Trust may assume that the MP has obtained sufficient consent in writing which the Trust can and should request a copy of to permit release of confidential information only pertinent to the exact subject of the MP's enquiry. No additional incidental confidential information should be disclosed.
10	**RECORDING OF A COMPLAINT**
10.1	On receipt of all complaints, the Complaints Department will cross check the Trust's Datixweb Complaints System to ascertain whether there have been any previous complaints relating to the patient or whether the events complained of have previously been the subject of a reported incident, PALS enquiry or claim. The complaint will then be recorded onto Datixweb and linked if appropriate.
10.2	**Grading complaints**
10.2.1	On receipt of the complaint it will be risk rated.
10.2.2	Firstly the consequence / outcome will be rated using the Trust's Generic Risk Grading Matrix (see appendix D). If the outcome is major or catastrophic, this will be reported to the Trust's Head of Integrated Clinical Governance before starting the investigation as a potential Serious Incident.
10.2.3	Secondly the complaint will then be risk rated by the Complaints Manager using the guidance set out in the Department of Health's 'Listening, Responding, Improving – A Guide to Better Customer Care' (the Code of Practice) dated February 2009.
11	**PROCESS FOR LISTENING TO, INVESTIGATING AND RESPONDING TO COMPLAINTS/CONCERNS**
11.1	**Responding to a Complaint**
11.1.1	The Trust will acknowledge all complaints within 3 working days of receipt in the Trust.
11.1.2	The relevant time period commences when the complaint is received by a member of Trust staff. It is therefore important that complaints should be referred to the Complaints Department **without delay**.
11.1.3	The response should explain the manner in which the complaint is to be handled and the anticipated time period for the investigation and response. An offer to discuss these plans should be made.
11.1.4	The acknowledgement sent to the complainant will include information about the right to assistance from the Independent Complaints Advocacy Service provided by POhWER.
11.2	**Investigation of Complaints**
11.2.1	The essential aim of resolving a complaint does not suggest the need for complex, rigid or bureaucratic procedures but rather the application of flexibility, honesty and effective communication operated at all times with a commitment to openness and candour.

11.2.2	An investigation notification will be sent to the Divisional Director, Clinical Director, and Associate Chief Nurse of the relevant Division or to the Head of Department for non-clinical complaints by the Complaints Manager, requesting that an investigation officer is appointed to investigate the complaint and produce a letter of response for the complainant.
11.2.3	For complaints covering more than one Division, the Complaints Manager will direct the complaint to the Division where it is felt the largest part of the complainant's concerns lie. This Division will then be responsible for producing a unified single response letter, using the statements obtained from the other Divisions and/or Departments.
11.2.4	The complaint, together with an investigation request will be sent via Datixweb email to the appropriate Divisional Director /Clinical Director/ Associate Chief Nurse or Head of Department .
11.2.5	The Divisional Director/Clinical Director /Associate Chief Nurse as appropriate or Head of Department will appoint an investigation officer (IO). This person must be competent in undertaking an investigation using the Trust's (Root Cause Analysis) RCA methodology.
11.2.6	Complaints relating to medical staff or their clinical decisions will be passed to the Clinical Director for investigation and for the production of the response letter to the complainant.
11.2.7	Complaints involving nurses or nursing care will be passed to the appropriate Associate Chief Nurse.
11.2.8	Complaints involving breaches of confidentiality will be passed to the Senior Information Risk Owner and the SIRO / Caldicott Guardian informed.
11.3	**Management of the documentation**
11.3.1	The complaint is sent to the IO to carry out the investigation or 'RCA' where appropriate.
11.3.2	Consideration must be given as to whether it is appropriate to invite the complainant and any other person(s) who would be in a position to assist with the local resolution of the complaint to be interviewed as part of the investigation process.
11.3.3	The Complaints Manager or the IO will as necessary in accordance with their judgement during the investigation and response process to the complaint: • Ensure the complainant is aware of the progress of the investigation and particularly of any delays and their causes • Meet with the complainant individually or with other staff through a Local Resolution Meeting under the 2009 NHS Complaints Regulations • Clarify points of agreement or disagreement • Agree matters of clinical judgement with the clinicians concerned • Advise the complainant on sources of independent information or advice where helpful. This may particularly involve the Advocacy Service or interpreting service • Refer the matter for independent conciliation/external investigation/review • Advise the complainant as necessary throughout the process of their rights under the Complaint Procedure • Inform the complainant of remedial action where identified and appropriate • Ensure that an appropriate and timely written response is prepared.

11.3.4	The investigation officer should contact relevant members of staff for input to the complaint.
11.3.5	Written statements should be obtained from all members of staff involved in the complaint. Any statements, responses or minutes of meetings should then be uploaded onto the Datixweb database and the IO notified. The IO may request further input from additional members of staff to complete the investigation or to support the compilation of a letter of response.
11.3.6	All documentation gathered during the complaint investigation must be uploaded onto Datixweb database.
11.3.7	Divisional Directors, Clinical Directors or Associate Chief Nurses are responsible for completion of the Risk Scoring Matrix within the Complaint Risk Assessment. The Complaints Risk Assessment must be completed on Datixweb on completion of the complaint.
11.3.8	At the conclusion of the investigation into a complaint, the allocated IO will prepare a letter of response to the complainant. This will be checked by the Divisional Director, Clinical Director or Associate Chief Nurse and signed. The IO then sends the signed letter to the Complaints Department. Should the Complaints Manager feel the concerns have not been answered, the letter will be returned to ensure a full and comprehensive response is complete.
11.3.9	The Complaints Manager will quality check the letter before sending it to the Associate Director for Patient Experience (ADPE), to be clinically reviewed and have a final quality assessment. Once the ADPE approves the letter, it will be sent back to the Complaints Department.
11.3.10	A covering letter will be drafted on behalf of the Chief Executive ready for the final review and sign off by the chief Executive. During any absence of the Chief Executive, the letter of response can be signed by a delegated Trust Executive Director, who will act up accordingly.
11.3.11	On occasions the letter of response may be compiled by a person other than the investigating officer, particularly if the nature of the complaint requires a more senior overview. The complaints response should: • State the areas of concern raised by the complainant. • Clearly answer those areas of concerns raised by the complainant.
11.4	**Responding to Complaints**
11.4.1	The Trust aims to investigate and respond to all complaints within **30 working days** of receipt, unless an alternative timeframe is agreed with the complainant.
11.4.2	The cooperation of all staff in providing prompt responses to the investigating officer following requests for information is therefore essential. If for any reason the Trust's response will take longer than initially planned, the complainant should be advised and an alternative timescale agreed in the early stages of the investigation.

11.4.3	The response to the complaint should be sent to the complainant as soon as practicable following investigation of the complaint. Therefore, the complaint response should be returned to the Complaints Manager within the agreed timescale or within **15 working days.**
11.4.4	The Trust's response to the complainant should include: • A recognition of the complainant's concerns • An apology where appropriate • Answers to the complainant's specific questions • Information about the patient's illness and treatment, hospital procedures and tests • An honest acknowledgement of mistakes and failures • An indication of lessons learned • The details of a person for the Complainant to contact if they remain dissatisfied or if matters remain unresolved • Written in words that will be easily understood by complainant • All medical terminology / jargon is to be explained fully
11.5	**Action when a complaint remains unresolved**
11.5.1	If the complaint is not resolved at this stage and there are outstanding issues following the Trust's response, further efforts to find a resolution will take place. These may include further correspondence, meetings or independent consultation, which is at the discretion of the Complaints Manager.
11.5.2	Complainants may be offered further meetings with the Director of Nursing or Medical Director should they have outstanding issues related to care or treatment and if appropriate, with the Chief Executive if the matter continues unresolved.
11.5.3	Complainants should be made aware that they may refer their complaint to the PHSO (The Parliamentary and Health Service Ombudsman) if they are not satisfied with the outcome of their complaint.
11.5.4	This information is usually given to complainants at the time their complaint is acknowledged and they receive an information leaflet about the process that will be followed.
11.5.5	It should also be repeated at the point at which efforts to achieve Local Resolution have been exhausted.
11.6	**Complaint record**
11.6.1	Copies of the Trust's response to the complaint may be sent to any other person to whom the complaint was originally sent, as appropriate.
11.6.2	Staff should be aware that The Parliamentary and Health Service Ombudsman 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.

12	**PROCESS FOR HANDLING JOINT COMPLAINTS**
12.1	In some circumstances, a complaint may concern matters both within and outside of the Trust's area of responsibility.
12.2	The Trust's approach to such 'joint complaints' will be in accordance with each organisations' own complaints policy. Depending upon the substance of the complaint, it may be considered appropriate for there to be one co-ordinated response to the complaint. In such circumstances the relevant Complaints Manager with ensure that: • It is clear between all the parties who is to take the lead in co-ordinating the investigation of the complaint and preparing a response • The complainant is informed of the procedure that has been adopted and from whom a response may be expected • Any final response to the complaint is a matter of agreement between the relevant parties • Any actions identified to the complainant as those that are to be taken consequent upon the complaint are a matter of agreement between the parties • Throughout the process there is a high level of communication between the relevant parties with copying of all communication from any party with the complainant to each of the other parties • Lessons learnt are shared between organisations to aid improvement in the quality of services provided.
13	**SUPPORT FOR STAFF**
13.1	The purpose of the Complaints Handling Policy and Procedure is to investigate complaints with the aim of satisfying the complainant whilst being scrupulously fair to staff. It is however inevitable that in some cases information will be identified which indicates the need for disciplinary investigation.
13.2	If a complaint results in disciplinary action – the outcome will not be shared with the complainant.
13.3	It **will not** be a function of the Complaints Procedure to investigate disciplinary matters. If a complaint indicates a prima case for referral to: • Investigation under the disciplinary procedure • A professional regulatory body; or • An independent enquiry into a serious incident; or • Investigation of a criminal offence The Complaints Manager will: • Ensure the relevant information is passed to the appropriate manager to determine if such action is to proceed. • Inform the complainant if an investigation is to be initiated under the above alternative arrangements. Investigation under the Complaints Procedure will be suspended.

	• Proceed with the arrangement of a complete investigation and management of aspects of the complaint which are not the subject of an alternative procedure. • Ensure that upon completion of any alternative procedure any outstanding aspect of the Complaints Procedure is addressed. This may include informing the complainant in general terms of any disciplinary sanction which might be imposed.
13.4	Staff support and co-operation in the investigation of complaints is crucial. The rights of those involved in a complaint and its investigation will be preserved through the implementation of the following standards: • Employees who are the subject of a complaint will be informed by their direct manager at the earliest appropriate opportunity • Employees will be given the opportunity to comment on a complaint • Employees with have the opportunity if they wish to have a friend, colleague or Trade Union representative at any investigation interview • Staff of the Complaints Department will assist in or advise on the preparation or an appropriate response to a complaint as required and otherwise as appropriate • The approach adopted to management of the complaint should accord with the intention of ensuring fairness for staff and compliments alike • Employees involved will be kept informed of the progress of the complaint as appropriate and desired • The employee will be advised of the outcome of the complaint investigation and will receive a copy of the letter of response to the complainant • Advice and guidance with respect to formal statement writing will be available through the Legal Services Department, as detailed in the Trust's Claims Management Policy • Staff may also wish to seek the advice and support of senior colleagues or professional representatives or the confidential counselling service available through the Trust's Occupational Health Department on Ext 3757 • If managers or individuals become aware that a member of staff is experiencing difficulties in association with a complaint they should consider referring them for advice from any of the sources outlined above.
13.5	Whilst meetings between complainants and staff can prove useful there is also a potential for them to be traumatic. Staff will not be required to attend face to face meetings if it is considered that there is a risk they will be confrontational, abusive or unduly distressing.
14	**REMEDIES AND CLAIMS FOR COMPENSATION**
14.1	The Complaints Procedure is not a vehicle for the negotiation and settlement of claims for financial compensation. The Trust is a member of the Clinical Negligence Scheme for Trusts (CNST) as administered by the NHSLA. The Trust pays an annual premium to the CNST and is required to adhere to the claims management requirements of the CNST. Requests for compensation should therefore be processed in accordance with the procedures of the CNST/NHSLA and through the process outlined in the Trust's Claims Management Policy rather than the Complaints Handling Policy and Procedure.

14.2	It is clear that open and effective management of a complaint might avoid litigation. A complaint and a claim may however arise out of the same facts and the Complaints Procedure may be used as a prelude or adjunct to litigation. It is essential that staff are clear whether they are responding to a complaint or claim as documentation produced in anticipation of Legal proceedings may be covered by legal professional privilege (please see Claims Management Policy for more detail). If progressing a complaint may prejudice subsequence legal action, the complaints process may be put on hold and the complainant advised of this fact.
14.3	In all cases where the facts of a case suggest that there is a likelihood of legal action then the Trust's Legal Services Department should be informed within 24 hours. This will enable the appropriate Claims Management processes to be invoked and a speedy settlement sought where appropriate.
14.4	Non-financial remedies that may be provided under the Complaints Procedure include: • Written explanation or apology • Invitation to meet • Reassurance that the Trust's services have been reviewed to identify opportunities to improve.
14.5	There may be circumstances in which a Complainant indicates that an ex-gratia payment would be appropriate and this should be processed in accordance with the Trust's Scheme of Delegation.
15	**PROCESS FOR LEARNING AND IMPROVING AS A RESULT OF COMPLAINTS/ CONCERNS**
15.1	Many complaints arise from misunderstandings and may be resolved through appropriate explanation and discussion. Other complaints however, will reveal ways in which Trust services may be improved. The Trust recognises the pledge in the NHS Constitution to learn lessons from complaints and use these lessons to improve its services. The Francis Report (February 2013) stated that complaints, their source, their handling and their outcomes provide an insight into the effectiveness of an organisation's ability to uphold fundamental standards and therefore should be valued as a source of accountability and a basis for improvement. Ann Clwyd MP (October 2013) said that patients must have confidence in the in the complaints process. To this end:
15.1.1	Upon receipt of a complaint, relevant senior members of staff should be asked for comments, and asked to review where steps may be taken to avoid repetition.
15.1.2	A complaints action tracker will be held by the Complaints Manager and progress will be required to be reported to the Complaints Manager by the lead officer for each complaint. This will track whether actions are 'open' or 'closed'.
15.1.3	Where the complaint raises any performance issues of particular concern, these should be reported by the relevant Divisional Directors to the relevant Service Manager, Clinical Director, the Medical Director or Director of Nursing, as appropriate.
15.1.4	Where it is clear that improvements to services can be made, these should be explained to the complainant in the response to the complaint.

15.2	Monthly performance reports are submitted to the Board via the Integrated Performance report and include information concerning actions resulting from local resolution meetings.
15.3	Whilst responsibility for managing the Complaints Procedure rests with the Complaints Department, it remains the responsibility of staff of individual Divisions and Departments to identify whether they may learn from the complaints received by the Trust.
15.4	Responsibility for ensuring that all appropriate actions have been implemented will rest with the relevant Divisions and Departments through their established governance arrangements.
16	**REPORTING ARRANGEMENTS**
16.1	Information concerning complaints will be collected on an on-going basis by the Complaints Department utilising the Datixweb Complaints Database.
16.2	This information will be analysed and reported to the Board of Directors on a monthly basis via the Integrated Performance report and to the Patient Experience Steering Group on a bimonthly basis.
16.3	The analysis will be both qualitative and quantitative in nature and will identify any trends or themes within complaints. Reports will go beyond the purely statistical and document trends, themes, causal factors and any changes to practice.
16.1.6	All relevant complaints will be reported by the Complaints Manager on a monthly basis (or more frequently) to all Divisional Directors, Clinical Directors and Divisions for review through local Clinical Governance arrangements.
16.1.7	This wide circulation will allow complaints to assist in providing assurance that the Trust can continue to learn from feedback concerning its services.
16.1.8	The Trust will complete an annual report summarising complaints received, key themes, response times and action taken to address identified issues. This will be submitted to the Quality Committee via the Patient Experience Steering Group.
17	**HABITUAL/REPETITIVE CALLERS OR COMPLAINANTS**
17.1	Habitual or repetitive callers are an increasing problem for Trust staff, reflecting a pattern experienced throughout the NHS. The difficulty in handling such callers is placing a strain on time and resources and causes undue stress for staff, who may need support in difficult situations.
17.1.2	Staff are trained to respond in a professional and helpful manner to the needs of all callers. However, there are times where nothing further can reasonably be done to assist the caller or to rectify a real or perceived problem.
17.2	Complainants may be deemed to be 'habitual' or 'repetitive callers' where previous or current contact with them shows that they meet two or more of the following criteria:

	• Refusing to specify the grounds of a complaint, despite offers of assistance with this from the authority's staff. • Refusing to co-operate with the complaints investigation process while still wishing their complaint to be resolved. • Refusing to accept that issues are not within the remit of a complaints procedure despite having been provided with information about the procedure's scope. • Insisting on the complaint being dealt with in ways which are incompatible with the adopted complaints procedure or with good practice. • Making what appear to be groundless complaints about the staff dealing with the complaints, and seeking to have them replaced. • Changing the basis of the complaint as the investigation proceeds and/or denying statements he or she made at an earlier stage. • Introducing trivial or irrelevant new information which the complainant expects to be taken into account and commented on, or raising large numbers of detailed but unimportant questions and insisting they are fully answered. • Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved. • Adopting a 'scattergun' approach: pursuing a complaint or complaints with the authority and, at the same time, with a Member of Parliament/a Councillor/the authority's independent auditor/the Standard Board/local Police/Solicitors/the Ombudsman. • Making unnecessarily excessive demands on the time and recourses of staff whilst a complaint is being looked into, by for example excessive telephoning or sending emails to numerous hospital staff, writing lengthy complex letters every few days and expecting immediate responses. • Submitting repeat complaints, after complaints processes have been completed, essentially about the same issues, with additions/variations which the complainant insists make these 'new' complaints which should be put through the full complaints procedure. • Refusing to accept the decision – repeatedly arguing the point and complaining about the decision. • Combination or some or all of these.
17.3	The precise nature of the action the Trust decides to take in relation to an unreasonable persistent complainant should be appropriate and proportionate to the nature and frequency of the complainant's contacts with the Trust at that time.
17.3.1	The following list is a 'menu' of possible options for managing a complainant's involvement with the Trust from which one or more might be chosen and applied, **if warranted**. It is not exhaustive and often local factors will be relevant in deciding what might be appropriate action. • Placing time limits on telephone conversations and personal contacts. • Restricting the number of telephone calls that will be taken (for example, one call on one specified morning/afternoon in any week. • Limiting the complainant to one medium of contact (telephone, letter, email etc) and/or requiring the complainant to communicate only with one named member of staff. • Requiring any personal contacts take place in the presence of a witness. • Refusing to register and process further complaints about the same matter.

	• Where a decision on the complaint has been made, providing the complainant with acknowledgements only of letters, faxes, or emails or ultimately, informing the complainant that future correspondence will be read and placed on the file but not actioned. A designated officer should be identified who will read future correspondence. • When a caller has been officially declared a habitual or repetitive caller, the Chief Executive, or in her absence by another of the Trust's Executive Directors, may decide that no further telephone communication will be accepted. • Where there is on-going correspondence or investigation the Complaints Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all relevant staff to ensure consistency of approach within the Trust. • When an investigation or correspondence is completed, the Complaints Manager will, at an appropriate stage, write to the caller informing him/her that the Trust has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The Trust will state that further correspondence will be acknowledged, but not answered.
17.1.3	It should be emphasised that the classification of an individual as habitual or repetitive will not mean that any new issues having no connection with the original complaint or dispute will not be dealt with in the normal way.
18	**HANDLING AND CONSIDERATION OF COMPLAINTS BY THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN**
18.1	If a complainant remains dissatisfied with the handling or outcome of their complaint they have the right to request the Parliamentary and Health Service Ombudsman for an independent review of their complaint. The possible action the Parliamentary and Health Service Ombudsman may take includes: • Taking no further action. • Referring back to the NHS organisation against which the complaint was made, suggesting what further action it might take to resolve the complaint. • Referring the case to other professional regulatory bodies, such as the General Medical Council or Nursing and Midwifery Council. • Undertake an investigation to follow up the issues raised in the complaint. • Undertaking an independent review • The report will be given to the complainant and complained against and will include any recommendations for improving services or actions to rectify the situation.
19	**PROCESS FOR ENSURING THAT PATIENTS, THEIR RELATIVES AND CARERS ARE NOT TREATED DIFFERENTLY AS A RESULT OF RAISING A CONCERN/COMPLAINT**
19.1	The Trust wishes to encourage feedback on its services. Persons who complain about the Trust or its services should not therefore face prejudice or discrimination from the Trust or its staff as a consequence. The fact that a patient has complained should not adversely affect the patient's future treatment.
19.2	The Trust's website will include a public statement that complainants will not face discrimination as a consequence of complaining. This will be repeated in the leaflet provided to all complainants.

19.3	Information on the effectiveness of the Trust's commitment in this regard will be gathered via either a questionnaire or at the time in person by the Complaints Department. This will elicit information from complainants as to whether they feel they have experienced discrimination or adverse consequences as a result of their complaint. Any 'positive returns' will be reviewed by the Complaints Manager to establish if any further action is required or appropriate.
19.4	If a complaint is about a patient's clinical care it may provide an opportunity to improve a difficult situation. It may however, reflect an irretrievable breakdown in the therapeutic relationship. If that is so, it may be appropriate for on-going responsibility for care of the patient to be transferred to another clinician.
20	**TRAINING**
20.1	The Trust will continue a programme of training and information exchange which will aim to ensure that: • The Complaints Manager will oversee an internal training programme. • A training workbook will also be available to staff. • Patients are encouraged to express any concerns to staff. • PALS will visit all wards on a rota basis to increase awareness to staff and patients of how to raise a concern. • Staff are encouraged to address and resolve concerns and problems as they arise. • Staff at all levels recognise the mechanisms for issues of concern to be referred to senior managers, Matrons and the Patient Advise Liaison Service (PALS) as appropriate, thereby avoiding the need for a formal complaint. • Staff are able to advise patients as necessary of the means of access to the Complaints Handling Policy and Procedure and alternative means of raising concerns about the service of the Trust (e.g. through PALS).
20.2	**Customer Service Training and Complaints Handling**
20.2.1	Customer Service Training and Complaints Handling is delivered at induction to ensure that all staff are aware how to assist in the process of dealing with issues and concerns before they become a complaint.
20.2.2	An on-going programme of training will be delivered by the Complaints Manager to inform staff of the complaints process and their responsibilities.
20.3	**Root Cause Analysis Investigation Training**
20.3.1	Root Cause Analysis Investigation Training is provided quarterly as a minimum to ensure that there are sufficient numbers of staff training in investigation techniques.
21	**DISSEMINATION OF DOCUMENT**
21.1	Following approval by the Quality Committee, this Policy and Procedure will be uploaded onto the Trust intranet site under Complaints page. Policy notification will be through a broadcast email.

22	**REFERENCES**
22.1	**Standards** • NHSLA Risk Management Standards 2012-13 • The Local Authority Social Services and NHS Complaints (England) Regulations 2009 • Principles of Good Complaint Handling (Health Service Ombudsman Nov 2008) • 'Listening, responding and improving' – A guide to better customer care (the Code of Practice): Department of Health 26th February 2009 • Department of Health (2009) *Tackling concerns locally*
22.2	**Guidance** • National Audit Office (2008) *Feeding Back? Learning from complaints handling in Health and social care* • Parliamentary and Health Service Ombudsman (2009) Principles for Remedy • Parliamentary and Health Service Ombudsman (2009) *Principles of Good Complaint handling* • The Francis Report • CQC Inspection – QEH (May 2013) • Ann Clwyd Review of the NHS Complaints System – Putting Patients Back in the Picture (October 2013) • Review of the Complaints and PALS Service (February 2014)
23	**EQUALITY IMPACT ASSESSMENT STATEMENT**
23.1	This policy has been subject to an Equality Impact Assessment and includes measures to ensure that individuals who may be disadvantaged due to disability or communication difficulties are able to raise concerns via the Complaint's process. On-going monitoring will be implemented through use of the questionnaire system as detailed in Appendix 1.

24	MONITORING COMPLIANCE

Key elements (Minimum Requirements)	Process for Monitoring (e.g. audit)	By Whom (Individual / group /committee)	Governance committee	Frequency of monitoring
Responsibilities of Individuals	Annual Appraisal	Line Manager	Workforce committee	Annually
	Annual Complaints Report	Complaints Manager	PESG	Annually
	Performance reviews	Executive Directors	BOD	Monthly
Process for listening and responding to concerns/complaints of patients, their relatives and carers	Complainant Questionnaire	Complaints Manager	PESG	Quarterly
Process for the handling of joint complaints between organisations	Audit of outcome	Complaints Manager	PESG	Ad hoc, as necessary
Process for ensuring that patients, their relatives and carers are not treated differently as a result of raising a concern/complaint	Complaints/Satisfaction Questionnaire	Complaints Manager	PESG	Annually
Process by which the organisation monitors the changes that have been made as result of concern/complaints being raised	Audit of effectiveness of changes	Complaints Manager/ Audit Manager	PESG	Annual
				Annual
Process by which the organisation aims to improve as a result of concerns/complaints being raised.	Audit on effectiveness of changes	Complaints Manager/ Audit Manager	PESG	Annual
	Monthly report within the Integrated Performance report	Complaints Manager	BOD	Monthly
Complaints are responded to in line with this policy	Complaints Performance Report	Complaints Manager	BOD	Monthly

APPENDIX A

EQUALITY IMPACT ASSESSMENT

STAGE 1 - SCREENING

Name & Job Title of Assessor: Karl Perryman, Head of Complaints and Litigation	**Date of Initial Screening:** July 2007
Name & Job Title Reviewer: Claire Roberts, Assoc. Director of Patient Experience	**Date of review:** July 2012, June 2014, April 2015
Policy or Function to be assessed: Complaints Policy and Procedure	

		Yes/No	Comments
1.	**Does the policy, function, service or project affect one group more or less favourably than another on the basis of:**		
	• Race & Ethnic background	No	Provision is made to ensure that any complainant who does not have English as their first language has access to an interpreter.
	• Gender including transgender	No	
	• Disability:- This will include consideration in terms of impact to persons with learning disabilities, autism or on individuals who may have a cognitive impairment or lack capacity to make decisions about their care	Yes	Easy read complaints leaflets are available. Support will be provided for the individual as required including access to advocacy support. Leaflets are available for individuals who are partially sighted or blind. Carers are supported to raise concerns on behalf of patients.
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	The policy contains provisions for children.
2.	**Does the public have a perception/concern regarding the potential for discrimination?**	Yes	A complainant may perceive that if they complain it might adversely affect their treatment from healthcare professionals

If the answer to any of the questions above is yes, please complete a full Stage 2 Equality Impact Assessment.

Signature of Assessor: Claire Roberts, Associate Director of Patient Experience Date: April 2015

Signature of Line Manager: Catherine Morgan, Director of Nursing Date: April 2015

STAGE 2 – EQUALITY IMPACT ASSESSMENT

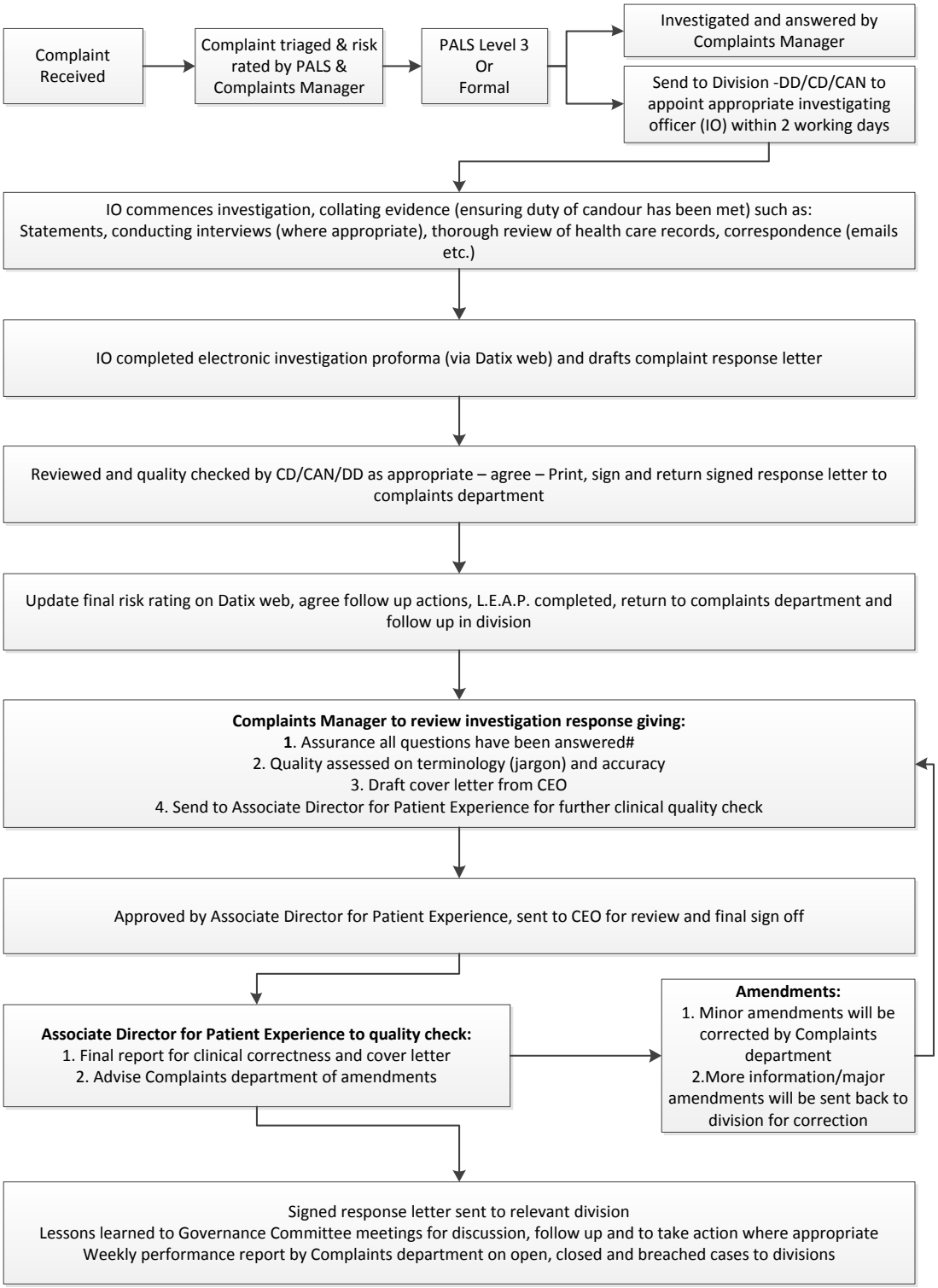
If you have indicated that there is a negative impact on any group in part one please complete the following, is that impact:

		Yes/No	Comments
1.	**Legal/Lawful under current equality legislation?**	Yes	The complaints procedure meets the requirements of the Department of Health guidance.
2.	**Can the negative impact be avoided?**	Yes	Additional measures are in place to support individuals disadvantaged by disability or communication difficulties.
3.	**Are there alternatives to achieving the policy/guidance without the impact?**	No	
4.	**Have you consulted with relevant stakeholders of potentially affected groups?**	No	There has been no local consultation with complainants but this policy reflects the guidance of the Parliamentary and Health Service Ombudsman and includes measures for joint practice that have been agreed with other local health and social care providers.
5.	**Is action required to address the issues?**	No	

It is essential that this Assessment is discussed by your management team and remains readily available for inspection. A copy including completed action plan, if appropriate, should also be forwarded to the Equality & Diversity Lead, c/o Human Resources Department.

APPENDIX B

COMPLAINTS PROCESS FROM RECEIPT



APPENDIX C

COMPLAINTS ESCALATION PROCESS

The diagram below demonstrates the flow of information, the escalation process and how this links with the existing Risk Management systems

Enquiry / Complaint Submitted

↓

Appropriate Manager / Complaints Manager

↓

Assign Consequence Grading

↓

If rating is Moderate or above

→If rating is lower than Moderate follow complaints procedure

↓

Inform Head of Integrated Governance

↓

Head of Integrated Clinical Governance will consult with Executive Leads

e.g

Director of Nursing
Medical Director
Director of Operations
Director of Resources
SIRO
Caldicott Guardian

In addition to

Head of Legal Services

→ If this is not an SI then complaints procedure will be followed

↓

If identified as a Serious Incident then the SI process will be followed

Consequences / Impact / Harm / Penalty for Failure

Select the descriptors which best fit the risk you have identified

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi permanent harm ►Increase in length of hospital stay by 1-3 days ►Affects 1-2 people	►Moderate injury or illness requiring professional intervention to resolve the issue ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Increased length of hospital stay by 4 – 15 days ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►increased length of hospital stay >15 days ►Affects 16 – 50 people	►Incident leading to death ►Multiple permanent injuries or irreversible health effects ►An event affecting >50 people
Environmental Impact	►Potential for onsite release of substance ►Minimal or no impact on the environment	►Onsite release of substance but contained ►Minor impact on the environment ►Minor damage to Trust property – easily remedied <£10K	►On site release of substance ►Moderate impact on the environment ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	►Offsite release of substance ►Major impact on the environment ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K	►Onsite /offsite release with catastrophic effects ►Catastrophic impact on the environment ►Loss of building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day	►On-going low staffing level - minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ► 75 % staff attendance at mandatory / key training	►Ongoing low staffing resulting in moderate reduction in the quality of patient care ►Late delivery of key objective / service due to lack of staff ►Error due to ineffective training / competency ►50% - 75% staff attendance at mandatory / key training	►Unsafe staffing level leading to a temporary service closure <5 days ►Uncertain delivery of key objective / service due to lack of staff ►Serious error due to ineffective training and / or competency ►25%-50% staff attendance at mandatory / key training	►Loss of several significant service critical staff leading to a service closure >5 days ►Non-delivery of key objective / service due to lack of staff ►Critical error leading to fatality due to lack of staff or insufficient training and / or competency ►Less than 25% attendance at mandatory / key training on an on-going basis
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint ►Minor implications for patient safety ►Claim <£10K	►Justified complaint involving lack of appropriate care ►Moderate implications for patient safety ►Claim(s) between £10K - £100K	►Multiple justified complaints ►Findings of Inquest suggesting poor treatment or care ►Non-compliance with national standards implying significant risk to patient safety ►Claim(s) between £100K - £1M	►Multiple justified complaints ►Single major claim ►Ombudsman inquiry ►Totally unsatisfactory level or quality of treatment / service ►Claims >£1M

Descriptor	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Business/ Service Interruption	►Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	►Short term disruption, of >8 hours, with minor impact	►Loss / interruption of >1 day ►Disruption causing impact on patient care ►Non-permanent loss of ability to provide service	►Loss / interruption of > 1 week. ►Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ►Temporary service closure	►Permanent loss of core service / facility ►Disruption to facility leading to significant 'knock-on' effect across local health economy ►Extended service closure
Inspection/ Regulatory Compliance/ Statutory Duty	►Small number of recommendations which focus on minor quality improvement issues ►Minimal breach of guidance / statutory duty ►Minor non-compliance with standards	►Single failure to meet standards ►No audit trail to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	►Challenging recommendations which can be addressed with appropriate action plans ►Single breach of statutory duty ►Non-compliance with > one core standard	►Enforcement action ►Multiple breaches of statutory duty ►Improvement Notice ►Trust rating poor in National performance rating ►Major non compliance with core standards	►Multiple breaches of statutory duty ►Prosecution ►Severely critical report on compliance with national standards ►Zero performance rating ►Complete systems change required
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined ►Use of services affected	►National/ International adverse publicity >3 days. ►MP concerned (questions in the House) ►Total loss of public confidence
Fire Safety/General Security	►Minor short term (<1day) shortfall in fire safety system. ►Security incident with no adverse outcome	►Temporary (<1 month) shortfall in fire safety system / single detector etc (non patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	►Fire code non-compliance / lack of single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	►Significant failure of critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety ►Loss of vulnerable adult resulting in major injury or harm ► Major controlled drug incident involving a member of staff	►Failure of multiple critical components of fire safety system (high risk patient area) ►Infant / young person abduction ►Loss of vulnerable adult resulting in death
Information Governance/ IT	► Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < half a day ►Health records / documentation incident – no adverse outcome	►Minor Breach with potential for investigation ►Unplanned loss of IT facilities < 1 day ►Health records incident / documentation incident – readily resolvable	►Moderate breach of confidentiality – potential for complaint 1 – 5 persons affected ►Health records documentation incident – patient care affected with short term consequence	►Serious breach of confidentiality – more than 5 person or Very sensitive information ►Unplanned loss of IT facilities >1 day but less than one week ►Health records / documentation incident – patient care affected with major consequence	►Serious breach of confidentiality – large Numbers ►Unplanned loss of IT facilities >1 week ►Health records / documentation incident – catastrophic consequence
Projects	►Insignificant cost increase ►Insignificant impact on value and/or time to realise declared benefits against profile	►<5% over project budget ►<5% variance on value and/or time to realise declared benefits against profile	►5 - 10% over project budget ►5 - 10% variance on value and/or time to realise declared benefits against profile	►10 - 25% over project budget ►10 - 25% variance on value and/or time to realise declared benefits against profile	►> 25% over budget ►> 25% variance on value and/or time to realise declared benefits against profile
Financial (Loss of contract / revenue / default payment)	►Small Financial loss < £1K ►Theft or damage of personal property <£50	►Loss <£1k - £50K ►Theft or loss of personal property <£750	►Loss of £50K - £500K ►Theft or loss of personal property >£750 - £10K	►Loss of £500K - £1M ►Theft or loss of personal property £10K - £50K	Loss > £1M ► Theft or loss of personal property > £50K

Likelihood Score (L)

What is the Likelihood of the Consequence Occurring?

Likelihood Score	1	2	3	4	5
Description	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency (How often might it / does it occur)	Not expected to occur within a year	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	Less than 10%	11 – 30%	31 – 70 %	71 -90%	Greater than 90%

Risk Scoring Matrix

LIKELIHOOD						
Almost Certain	5	5	10	15	20	25
Likely	4	4	8	12	16	20
Possible	3	3	6	9	12	15
Unlikely	2	2	4	6	8	10
Rare	1	1	2	3	4	5
		1	2	3	4	5
		Negligible	Minor	Moderate	Major	Catastrophic
		CONSEQUENCE				

APPENDIX E

Useful information and contacts

Patient Advice & Liaison Service (PALS)
Based at the Queen Elizabeth Hospital, they can assist with concerns, enquiries and general advice.
Telephone: 01553 613351, 613359 or 613343

NHS Complaints Advocacy – POhWER
Available for advice and support in making a complaint to the hospital.
Telephone: 0300 456 2370
pohwer@pohwer.net

Age UK Norfolk
Offers a citizen advocacy service for people aged 55 and over.
Telephone: 01603 787111
www.ageuknorfolk.org.uk

Friends in Bereavement
If you have suffered the loss of a loved one, Friends in Bereavement is a group of volunteers who can offer support.
Telephone: 01553 767331

The Parliamentary and Health Service Ombudsman
Millbank Tower, Millbank,
London, SW1P 4QP
Telephone: 0345 0154 033
www.ombudsman.org.uk

The Queen Elizabeth Hospital Website:
www.qehkl.nhs.uk or scan the QR code below that will take you direct to our homepage:

Follow us on Twitter:

@QEHKingsLynnNHS on Twitter

Joanne O'Neill
Complaints Manager
The Queen Elizabeth Hospital
Gayton Road
King's Lynn
PE304ET
01553613890/613359
Minicom: 01553 613888

All letters should be addressed to:
The Complaints Manager
The Queen Elizabeth Hospital
Gayton Road
King's Lynn
PE30 4ET

RP
April 2014
Review Due: April 2016

The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

"Listening"
"Responding"
"Improving"

NHS Complaints Procedure

Patient Information

What if I have any comments, suggestions or complaints about my treatment?

If you are in hospital please speak to either the Ward Manager or Ward Sister in the first instance.

You may also request, at any time, to speak with your Consultant, which can be arranged by Ward Staff.

If you are at home and wish to discuss any problems or concerns you can telephone PALS (Patient Advice and Liaison Service) on 01553 613351, who will be able to advise you.

You may contact the Hospital Complaints Department on 01553 613890 for advice on the formal complaints process.

Written complaints

A complaint should be made as soon as possible after the incident has occurred but not later than 12 months after.

If you are making a complaint on behalf of a patient please be aware of the following requirements:

- The patient must be aware the complaint is being made.
- The patient should sign the complaint letter/form giving authorisation for an investigation, and access to their medical records.

Will my concerns be taken seriously?

YES, all comments are valued because they give us important information, which helps us improve the services we provide.

Will my treatment be affected if I complain?

NO. Please be assured that the care you receive will not be affected in any way. All complaints are treated confidentially and are filed separately from your medical records.

What will happen to my complaint?

- You will receive a written acknowledgement within 3-working days.
- You will be invited to discuss your concerns either on the phone or face-to-face with the Complaints Manager to either resolve your complaint or to agree on how the complaint should be handled, timescales and your expectations of the outcome.
- If appropriate a full investigation will be undertaken.
- You will receive a full response within the agreed timescale or within 30-working days if a timescale has not been agreed.
- If, following our written response, a further explanation is required you will receive a further written response or be offered a conciliation meeting to discuss your concerns with senior doctors and/or nurses.

What if I still remain dissatisfied?

- You will be invited to meet with the appropriate senior staff members to discuss your concerns.
- You have the right to refer the matter to the Heath Service Ombudsman for an Independent Review.