University Hospital Southampton
NHS Foundation Trust

Handling concerns and complaints policy

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Contents		Page
	Executive summary	2
2	Scope and purpose	2
2	Definitions	4
3	Details of complaints procedure to be followed	4
4	Roles and responsibilities	14
5	Communication Plan	14
6	Process for monitoring compliance/effectiveness of this policy	14
7	Quality impact assessment	15
8	Arrangements for review of this policy	15
9	References	15

Appendices		Page
Appendix A	Flow chart describing concerns, complex concerns and complaint process	16
Appendix B	Process flow chart	17
Appendix C	Protocol for handling of inter-organisational complaints in the Wessex region	18
Appendix D	Complaints involving third party independent providers	20
Appendix E	Managing care home complaints	21
Appendix F	Handling vexatious or hard to manage complaints	22
Appendix G	Complaint assessment tool	24
Appendix H	Roles and responsibilities	26
Appendix I	Complaint action plan report	29
Appendix J	Complaints equality and diversity monitoring form	31
Appendix K	Audit tool for policy compliance	32
Appendix L	Quality impact assessment tool	33

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Executive summary

The purpose of this policy is to explain how University Hospital Southampton NHS Foundation Trust (UHS) implements the statutory legal framework for The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, and how the Trust meets the requirements of the NHS Constitution. The policy makes clear what people should expect when they complain (NHS Constitution) and supports a culture of openness, honesty and transparency (duty of candour). Trust practice is informed by the Parliamentary and Health Service Ombudsman (PHSO) good complaint handling guidance and principles of remedy.

The policy deals with the handling of concerns and complaints (regarding Trust services, buildings or the environment) received from patients, patients' relatives, carers, visitors and other service users. In most circumstances, the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise or as soon as possible after this (early local resolution).

In circumstances where early local resolution is not possible, this policy describes the processes in place to ensure concerns and complaints are handled efficiently and investigated thoroughly.

Patient and family relations (P&FR) are responsible for the overall management of concerns and complaints. P&FR combines the patient advice and liaison service (PALS) and the complaint handling functions to provide a flexible approach to resolving people's concerns and complaints.

The policy promotes the use of people's experience of care to improve quality. By listening to people about their experience of healthcare, the Trust can resolve mistakes faster, learn new ways to improve the quality and safety of services, and prevent the same problem from happening again in the future.

The reporting and monitoring of trends, themes and lessons learnt is undertaken through divisional governance structures, the patient experience and engagement steering group, quality committee and the quality governance steering group, and is used to ensure compliance with commissioner, regulatory and good practice requirements.

The Trust is committed to providing safe, effective and high quality services. However, it is recognised that things can occasionally go wrong. When concerns or complaints are raised, the Trust has a responsibility to acknowledge the concern or complaint, put things right as quickly as possible, prevent reoccurrence and identify service improvements.

Written information regarding how the Trust deals with concerns and complaints will be made available in all departments, the main reception, patient and family relations, the Trust website and through local clinical commissioning groups (CCG), The Advocacy People and other patient forums.

1.0 Scope and purpose

The purpose of the policy is to:

- outline the Trust policy on handling concerns and complaints
- describe the procedure followed to respond to concerns and complaints
- confirm the roles and responsibility associated with this process
- provide staff with guidance on how to respond to a concern and complaint
- describe how this policy links to the National Complaint Handling Framework
- promote a learning and improvement culture

- positively seek feedback
- be thorough and fair
- give a fair and accountable decision

The aim is to explain how UHS implements the statutory legal framework for The Local Authority Social Services and NHS Complaints (England) Regulations 2009, meets the requirements of the NHS Constitution and duty of candour, and ensures compliance with commissioners, regulatory and good practice requirements.

The aims and outcomes of this policy promote early, local and prompt resolution involving the complainant in deciding how their concerns are handled. Likewise, good complaint handling and continuous learning is endorsed throughout the policy, promoting improvements in the quality and safety of services at UHS and facilitating positive patient experiences.

Aims

- To listen, to acknowledge mistakes, explain what went wrong and to consider prompt, appropriate and proportionate remedy to put things right.

- To provide a consistent approach to the timely and efficient handling of all concerns and complaints, and establish an agreed plan with the complainant with an emphasis on early resolution, sharing learning and improving our services.

- To ensure organisational openness and an approach that is conciliatory and fair to people both using and delivering services.

- To respect the individual's right to confidentiality and treat all users of this policy with respect and courtesy.

Outcomes

- The policy and procedure will, as far as is reasonably practicable, be easy to understand, accessible, publicised in ways that will reach all service users and include information about support and advocacy services, if relevant.

- All staff will receive an appropriate level of training to enable them to respond positively to concerns and complaints, and endeavour to resolve issues quickly.

- The Trust will ensure that service users and carers can raise a concern or complaint without their care, treatment or relationship with staff being compromised.

- Investigations will be thorough, fair, responsive and appropriate to the seriousness of the complaint. They will also be conducted within the timescales agreed with the complainant.

- The format of the response to the concern or complaint will be agreed with the complainant. This may be verbal, by phone or at a meeting, or written by email or letter.

- The Trust will strive to resolve all complaints locally while reminding people of their right to take the matter to the Parliamentary and Health Service Ombudsman if they are not satisfied.

- Within divisions and care groups, local leadership and accountability will facilitate early resolution and ensure concerns and complaints are responded to promptly and used to initiate actions and opportunities for service and staff improvement.

- Divisional governance structures will be used to ensure organisational learning from complaints and the sharing of best practice.

2.0 Definitions

It is sometimes difficult to clearly demarcate between a concern and a complaint. For this reason they should be viewed along a continuum. However, for the purpose of this policy, the following definitions will apply:

Term	Definition
Concern	Defined as a matter of interest, importance or anxiety. Concerns are received in PALS and throughout the organisation. PALS aim to investigate and resolve a concern to the complainant's satisfaction within ten working days. Where this has not been possible, the complainant can choose to either continue with the plans in place for an early resolution or to have their concern investigated as a complaint under the NHS Complaints Regulations (2009). NB: All concerns, whether resolved by the next working day or not, will be recorded and reported and will be reviewed, collated and analysed along with data recorded from complaints.
Complaint	Defined as an expression of dissatisfaction, or a perceived grievance or injustice. All complaints will be dealt with under the NHS Complaints (England) Regulations (2009). The outcome of our investigation is usually shared in a written response from our CEO or via a face to face meeting facilitated by the complaints handler. Please see Appendix A for flowchart.

3.0 Details of complaints process – refer to Appendix B for process overview.

3.1 Raising a concern or making a complaint

Service users and the public who contact P&FR to make a complaint will receive appropriate assistance from the Trust to enable them to understand the procedure and, if required, will be signposted to complaint advocacy (The Advocacy People).

3.1.1 How to raise a concern or make a complaint

Information on how to raise a concern or make a complaint can be found on both our internal and external webpages.

Concerns and complaints may be made about any matter reasonably connected with the exercise of the functions of the Trust, both clinical and non-clinical. They can be made verbally, in person or via telephone, or in writing either in a letter or an email. A concern or complaint may be raised with any member of Trust staff, P&FR (PALS or complaints team) or the chief executive. Alternatively, the complainant may choose to address their concerns to their local commissioner, NHS England and NHS Improvement, a member of parliament or another third party, such as The Advocacy People.

3.1.2 Who may raise a concern or make a complaint

Concerns and complaints may be made by a patient, their representative, or any persons who are affected by or likely to be affected by the action, omission or decision of the Trust. This includes family, carers, advocates, care homes and nursing homes, MPs, clinical commissioning groups (CCG), and NHS England and NHS Improvement. When complaints are made by persons other than the complainant, the need for consent will be assessed.

In the above circumstances where the Trust does not intend to consider a complaint, the complainant will be notified of the reasons for this decision in writing.

We provide information and support to enable people who have accessible information or communication needs to speak up, and also recognise other factors that may be a barrier to raising a complaint. Complainants will be made aware of independent complaints advocacy for help and support to make a complaint (The Advocacy People). Other specialist advocacy agencies covering areas such as mental health, learning disabilities, elderly or disadvantaged groups, and independent mental capacity advocacy (IMCA) are also available for general support. Details are available from PALS and the complaints team.

3.1.3 Consent if the complainant is not the patient

In cases where a patient's representative makes a complaint, consent will be obtained from the patient, or person legally responsible for the patient, for permission to access their health records for the purpose of the investigation, where required, and to release the details of the investigation to the representative.

If the patient lacks capacity to consent to the complaint, an individual who holds Lasting Power of Attorney (LPA) for Health and Welfare, or a deputy appointed by the Court of Protection, can make a complaint on the patient's behalf. They will be able to provide consent for this to be investigated and for the details to be released to them. If the complainant lacks capacity to consent to the complaint and there is no LPA or court appointed deputy in place, the chief nursing officer or head of P&FR will determine whether or not a person is a suitable representative to ensure that the investigation of the complaint is conducted in the best interests of the patient.

Where a complaint is made by a representative on behalf of a child, P&FR must be satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child before considering the complaint. If P&FR is not satisfied, the representative is notified in writing and informed of the reason for the decision.

If the complaint is being made on behalf of a patient who has died, the Trust will need the permission of the patient's personal representative. This includes sharing the outcome of an investigation with any other parties who are not next of kin or LPA holders, but in these circumstances we would contact the next of kin or LPA holder to ensure that are happy for the details to be shared.

In circumstances where a complaint is made by a third party when the patient has not authorised the complainant to act on their behalf, this does not preclude the Trust from undertaking a full and thorough investigation into the concerns raised. Specifically, if the complaint raises concerns about patient safety or the conduct of staff, the relevant Trust policies will be invoked. Without consent, a response to the third party will be limited so as to avoid disclosing confidential personal and health information and the reasons for this should be explained to the complainant.

3.1.4 Concerns and complaints relating to Private Patient Services

For complaints relating to private patient services at UHS, the patient should refer to the private patient policy, which includes the private patient complaints procedure for patients wishing to raise a concern regarding their private treatment at the Trust.

3.1.5 Concerns and complaints excluded from the scope of this policy

The Trust is not required to consider the complaint in the following circumstances. However, the Trust will consider each case individually and, as soon as reasonably practicable, notify the complainant in writing of its decision and the reason for the decision.

a) A complaint made by a responsible body (local authority, NHS body, primary care provider or independent provider who provides care under arrangements made with an NHS body).

b) A complaint by an employee of a local authority or NHS body about any matter relating to that employment.

c) A complaint which has been investigated previously or either has been or is currently being investigated by the Parliamentary and Health Service Ombudsman.

d) A complaint arising out of the alleged failure to comply with a request for information under the Data Protection Act 2018, or a request for information under the Freedom of Information Act 2000. Please refer to the UHS information governance policy.

e) Complaints about private treatment provided in the Trust. Please refer to the private patient policy. However, any complaint made about the Trust's staff or facilities relating to care in their private bed will be investigated under this policy.

f) Lost property claims, which are investigated and handled directly by the care group manager. However, any claim for lost property made as part of a complaint will be dealt with under this policy.

g) Complaints concerning incidents or events which occurred over 12 months from the date the complaint was submitted. These are seen as out of time in the NHS complaints process – see 3.2.8.

3.2 Specific considerations when dealing with concerns and complaints

3.2.1 Concerns or complaints involving a vulnerable adult or child protection

Where it is known that the complaint involves a vulnerable adult or child, the executive lead for child protection or vulnerable adults will be informed and the most appropriate route of investigation agreed. The most appropriate route may not be the complaints procedure.

3.2.2 Concerns or complaints that include a never event (NE), serious incident requiring investigation (SIRI) or serious event, clinical (SEC).

If the content of the complaint is only about the 'event', the patient safety team (PST) will lead and co-ordinate a systems-based patient safety investigation, explain duty of candour and respond to the complainant. If there are matters that need to be investigated outside of this, an agreement will be made between the PST and the complaints team about which will not be covered by the PST investigation and will therefore need to be investigated through the complaints process.

In these circumstances, the PST will notify P&FR of appropriate timescales for completion and release their investigation report. P&FR will then agree the timescale for the final complaint response with the complainant and will usually continue to be the main point of contact for the complainant. This is dependent on the nature of the incident; sometimes different arrangements are agreed at the SIRI review meeting.

If there is a need for a dual approach to investigation, this will be explained to the complainant. Usually a written response to the whole complaint (i.e. including both investigations) will be offered, explaining the extended period of time required for the Trust to respond. Where a written response is required, this will be produced by P&FR with support from PST. Where the investigation has uncovered significant failings in care and treatment, oversight of this process will be provided by the head of P&FR working in partnership with legal services, head of patient safety, and Trust medical lead for complaints as appropriate.

The complainant will also be offered the opportunity to meet with Trust staff to discuss the findings of the PST investigation and provide an opportunity for Trust staff to respond to any outstanding queries. Alternatively, the complainant may choose to receive the outcome of the two investigations in separate written responses.

3.2.3 Concerns or complaints that are related to Overseas Visitors

If a patient considers that they have been charged incorrectly, they should raise this with the overseas visitor manager (OVM) in the first instance to discuss on what basis they have been found to be chargeable and whether the provision of further documentary evidence is required.

Where there continues to be a disagreement about how the Charging Regulations have been applied to a particular patient, the patient may want to seek the services of PALS. Where a patient is unhappy with the healthcare they have received, they or someone on their behalf and with their consent, can use the NHS complaints procedure as set out in this policy. The OVMs will ensure that chargeable patients are aware of the complaints procedure. Complaints regarding charging will be fairly heard by an impartial person who is independent of the overseas visitors charging operation within the Trust.

3.2.4 Clinical negligence, personal injury or other claim.

If the complainant indicates a clear intention to bring legal proceedings for clinical negligence, personal injury or other claim, the use of the complaints procedure is not necessarily precluded. The complaints team will discuss the nature of the complaint with the litigation and insurance services department or Trust solicitor, if required, to determine whether the progression of the complaint might prejudice subsequent legal or judicial action.

If there is no legal reason why the complaint should not be investigated, the complaints team will continue to investigate the complaint in accordance with Trust policy.

In cases where there are legal reasons why a complaint should not be dealt with under this policy, the complaint investigation will cease. The complainant will be advised of this fact and requested to ask their legal representative to contact the claims department. The complaints team can continue to investigate any issues raised within the complaint that are not part of the claim.

3.2.5 Disciplinary or professional investigation, or investigation of a criminal offence

Cases regarding professional conduct where a complaint is found to be justified may require an internal disciplinary investigation to be undertaken. Such an investigation may result in the involvement of one of the professional regulatory bodies, the police, or the counter fraud team, depending on the nature of the allegations.

Appropriate action will be taken in accordance with the Trust disciplinary procedure. In such circumstances, the complainant will be informed that a disciplinary investigation will be undertaken but that they have no right to be informed of the outcome of the investigation.

Any other issues raised in the complaint which do not form part of the disciplinary or criminal investigation may continue to be dealt with under the complaints policy.

3.2.6 Coroner's inquest

In complaints involving a death that is referred to the coroner, the PST will lead and co-ordinate the investigation. This ensures clear lines of communication and investigation for clinicians and families. The complaints team will advise the family that their concerns will be investigated by the PST in preparation for the inquest hearing and that HM Coroner's Office (HMCO) will endeavour to include all concerns raised. Any separate issues can be investigated by the complaints team under the NHS Complaints Regulations.

3.2.7 Allegations of fraud or corruption

Any complaint concerning possible allegations of fraud and corruption is passed immediately to the NHS counter fraud service for action.

3.2.8 Media interest

In cases where a complainant has contacted, or expresses their intention to contact, the media, the director of communications will be informed and will take appropriate action regarding Trust communication and media management.

3.2.9 Time limit for making a complaint

A complaint should be made within 12 months of the date on which the matter occurred, or 12 months of the date on which the matter came to the notice of the complainant.

Where a complaint is made after this time, the complaint may be investigated if the complainant had good reasons for not making the complaint within the above time limits and where, given the time lapse, it is still possible to investigate the complaint effectively and efficiently.

In circumstances when a complaint is not being investigated on this basis, the complainant will be informed of the reason for that decision and advised that they may still ask the Parliamentary and Health Service Ombudsman to consider their complaint.

3.2.10 Handling of joint complaints between organisations

In cases where a complaint involves more than one NHS provider, commissioner, local authority or third party independent provider, and the complainant so wishes, the Trust will work with the other relevant organisations in seeking resolution.

There is a jointly agreed protocol for the 'Handling of NHS Inter-organisational Complaints in Hampshire and the Isle of Wight', (Appendix C). This provides a framework for the handling of joint complaints between organisations, clarifies roles and responsibilities of organisations, enhances inter-organisation co-operation and reduces confusion for service users. The lead organisation will provide a single response on behalf of all organisations involved, ensuring that the complainant receives a seamless, effective service.

The procedure for dealing with multi-agency complaints involving third party independent providers can be found at Appendix D.

3.3.11 Complaints received from nursing and care homes on behalf of their residents

See Appendix E

3.3.12 Harassment and vexatious/intractable complainants

Harassment

Violence, racial, sexual or verbal harassment towards staff will not be tolerated; neither will language that is of a personal, abusive or threatening nature, either written or verbal. If staff should encounter this behaviour, they should seek support from their line manager and complete an adverse event form (AER). Where appropriate, the complainant will be informed in writing that their behaviour is unacceptable. Please see the UHS eliminating bullying and harassment policy. Racial abuse will be reported to the police.

In the event that the complainant has harassed or threatened staff dealing with their complaint, all personal contact with the complainant will be discontinued. The complaint thereafter can only be pursued through written communication.

Vexatious or intractable complainants

In a minority of cases, people pursue their complaints in a way that can either impede the investigation of their complaint or can have a significant resource issue for the Trust and cause undue stress for staff. Unfortunately, despite patience and sympathy, there are times when there is nothing further that can reasonably be done to assist the complainant to rectify a real or perceived problem.

Judgement and discretion must be used when considering potential persistent, habitual or vexatious complainants. The criteria and procedure can be found at Appendix F and authorisation of vexatious status will be made by the head of P&FR.

3.3 Responding to concerns and complaints of patients, their relatives or carers

3.3.1 Local resolution

Local resolution is the first line of investigation and is undertaken within the Trust. Local resolution enables the Trust to provide the quickest opportunity for a full and thorough investigation and respond with the emphasis on a positive outcome rather than the process. The local resolution response will:

- acknowledge failures
- apologise
- quickly put things right when they have gone wrong
- use the opportunity to improve services.

3.3.2 Early local resolution

Concerns are often raised directly to the staff involved. This is often front line staff in wards, clinics or reception. As a means of improving service provision, all Trust staff will welcome the complainant's concerns or complaint positively.

In most circumstances, the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise or as soon as possible after this (early local resolution). Upon raising a concern or complaint, the complainant will be listened to, treated courteously and have their confidentiality assured. Discussions should include seeking an understanding of how they would like their concern or complaint managed and what outcomes they are seeking. Every opportunity should be taken to resolve concerns at the outset and de-escalate the complaint.

If the staff member approached is unable to deal with the issue, they will refer the matter to a more senior member of staff on duty at the time, such as ward sister, matron, head of department or site manager.

A complainant may simply require an apology, explanation, clarification of a misunderstanding or remedial action to be taken and therefore should not be automatically referred to P&FR unless this is the complainant's wish.

3.3.3 Complaint assessment and acknowledgement

On receipt of a complaint in the PALS or complaints team, the first responsibility is to ensure that the patient's immediate health needs are being met; ideally this will occur within 24 hours. In cases where a complaint that is being investigated under the NHS Complaint Regulations is received verbally, a transcript of the concerns should be made and sent to the complainant for agreement before the start of the investigation.

The nature, complexity and seriousness of the complaint are assessed and graded using the complaint assessment tool (Appendix G). Any immediate actions are undertaken which may include, but are not restricted to: contact with Trust directors or divisional leads, PST, claims, communications, child protection, vulnerable adults, infection prevention, and human resources. An assessment will also be made as to the requirement for consent to be sought before any investigation can proceed.

Complaints are acknowledged within three working days and this includes details of advocacy services and 'Raising a concern or complaint' (previously 'Have your say') leaflet detailing the Trust's complaint process. Complaints received via email out of hours will receive an automated acknowledgement of receipt of email. The complaint handler will establish a relationship, offer an apology or empathy, clarify issues for investigation and seek to understand what resolution looks like for the complainant. They will also discuss and agree the management of the complaint, including any opportunity for early resolution, the timescales and the method of response.

3.3.4 Complaint investigation planning

The nature and grade of the complaint will influence the level of investigation and the level of notification or cascade throughout the organisation. This is based on the complexity and severity score of the complaint (negligible, minor, moderate, major or catastrophic) and the primary focus or professional group who are the subject of the complaint (medical, nursing, allied professionals, managerial or administrative).

Higher graded complaints require prompt action, more robust investigations and may require the involvement of investigation contributors:

- external to the division but internal to the organisation
- external to the organisation

The complaint handler will assess the complaint and plan the scope and approach to the investigation. This includes identifying the key staff required to contribute to the investigation (complaint investigation contributors). Where the contributors are adversely commented upon in the complaint, care is taken to ensure they are informed of the complaint by the complaint lead or line manager to ensure they receive support throughout the process.

The complaint lead can add an additional level of scrutiny and modify or validate the complaint investigation plan prior to the start of the investigation, usually within three days. Staff directly involved in the complaint will not be allocated the role of complaint lead.

3.3.5 Complaint investigation

Complaints will be thoroughly investigated in a manner appropriate to resolving the issues speedily and efficiently within the agreed timeframe. The complaint handler remains responsible for keeping the complainant up to date with the progress of the investigation and negotiates any necessary extensions to the agreed timeframe.

For all complaints assessed as ‘major' or 'catastrophic’, where possible a scoping meeting will be held by the PST to identify any immediate actions and to support investigation planning. This meeting may be virtual or face-to-face, involving the complaint lead, complaint handler and care group clinical lead or matron.

The complaint lead will oversee the quality and timeliness of the investigation and validate the conclusions, outcome and actions agreed for inclusion in the complaint response.

On completion of the investigation, the complaint handler will review the complaint investigation to ensure that it has been thorough and addresses all the issues raised by the complainant.

The complaint lead will support the complaint handler to scrutinise the findings, draw conclusions, agree the complaint outcome and consider whether there is evidence of service failure or maladministration. The compliant lead will also ensure that a robust action plan is formulated to cover all upheld elements of the complaint.

3.3.6 Complaint Response

When responding to a complaint, staff will give a clear, balanced account of what happened based on the established facts. Staff will be open and honest when things have gone wrong and where improvements can be made. All complaints will receive a fair and honest response. The complainant may prefer to receive this via letter, email, or at a meeting. The latter will usually be followed up in writing or via email. The response will address all issues raised, provide a full explanation, an apology as appropriate, any decisions regarding remedy and any actions that have or are planned to be undertaken to put the matter right. Details will also be given of what actions should be taken should the complainant believe the response has not adequately answered the issues raised. Where possible, the response will be in a format suitable for the complainant, such as large font or translation into another language.

The complaint handler is responsible for producing a draft response for validation by the complaint lead once all contributors have had the opportunity to comment. The written response may take the form of a complaint response letter or a letter of apology, together with a separate investigation report or recorded audio disc.

A final internal quality assurance check is undertaken before sending the response letter to the CEO or delegated deputy for signing and sending out by registered mail.

A main complaint category is identified with the complainant and this is used to determine the status of the complaint on closure by the complaint handler. Where the main category is found to be upheld, the complaint is recorded as upheld. If the main category is not upheld but some or all of the remaining categories are upheld, the complaint is closed as partially upheld.

3.3.7 Remedy

If a complaint is upheld or partially upheld, the Trust will decide whether the maladministration or service failure has caused an injustice (Health Service Ombudsman's Principles of Remedy). The Trust should, as far as is possible, put the individual back into the position they would have been in if the maladministration or service failure had not occurred. If that is not possible, the Trust should compensate appropriately.

The Trust will consider suitable and proportionate financial and non-financial remedies for the complainant and, where appropriate, for others who have suffered the same injustice. An appropriate remedy may be an apology, an explanation or remedial action. Financial compensation will not be appropriate in every case, but should be considered.

Appropriate and proportionate financial remedy will be considered by the care group manager (CGM, budget holder for the service complained about) and complaint handler in the first instance. If an agreement cannot be reached, the head of P&FR will review, make comparisons to similar cases and reach agreement for any financial remedy with the chief nursing officer and, where appropriate, the key internal stakeholders involved. This provides consistency in evaluating the amount of financial remedy that is fair, reasonable and proportionate to the injustice suffered.

On agreement with the CGM, any financial remedy is then offered to the complainant explaining the amount, why this has been offered and who to contact to accept the offer.

The governance framework includes monitoring of the decision-making processes and recording payments of financial remedy offered to complainants. This will be reported quarterly to the patient experience and engagement steering group.

This policy does not relate to medico-legal claims for compensation which will be dealt with through the legal services department in conjunction with the NHSLA.

3.3.8 Re-investigation of a complaint

In cases where the complainant is not satisfied with the Trust response, the complaint will be re-opened. This may be because the complainant considers the initial investigation to be inadequate, incomplete or unsatisfactory, or the complainant believes that their issues have not been addressed, fully understood or new questions have been raised.

The complaint will be reassessed and the issues that remain unresolved for the complainant will need to be clarified and a new complaint investigation plan agreed. The same investigative procedure will be followed.

Independent advice or a second opinion may be considered on the element of the complaint that has been re-opened for investigation. Meeting with the complainant is encouraged to aid resolution of the complaint. In some circumstances, and in agreement with all parties, conciliation or mediation could also be considered.

If local resolution has been completely exhausted and the complainant still remains dissatisfied, the complainant is informed of their right to go to the PHSO.

3.3.9 Stage 2: Parliamentary and Health Service Ombudsman (PHSO).

In cases where the Trust has been unable to resolve a complaint to the complainant's satisfaction, the complainant has the right to refer their complaint to the PHSO for independent review. The PHSO is independent of the NHS and is appointed by the government, and will undertake an independent investigation into complaints where it is considered that the Trust has not acted properly, fairly or has provided a poor service.

The Trust will fully comply with all PHSO requests for information. As appropriate, divisional management teams and directors will be notified by P&FR of any complaint that is being investigated by the PHSO, or any recommendations made by them.

The PHSO can be contacted at: www.ombudsman.org.uk

Parliamentary and Health Service Ombudsman
Millbank Tower
30 Millbank
Westminster
London SE1P 4QP

Telephone: 0345 015 4033

3.4 Confidentiality and record keeping

3.4.1 Confidentiality and ensuring patients, their relatives and carers are not treated differently as a result of raising a concern or complaint

Information about complaints and all the people involved is strictly confidential, in accordance with Caldicott principles. Information is only disclosed to those with a demonstrable need to know or a legal right to access those records under the Data Protection Act 2018.

All data will be processed in accordance with Trust policy. Complaints will not be filed on health records, but maintained in a separate case file subject to the need to record any information that is strictly relevant to their health record. Complaints must not affect the patient's or complainant's treatment and the complainant must not be discriminated against. Any identified discrimination will be reported to HR and managed as per Trust policies.

3.4.2 Record keeping

A complete documentary record will be maintained for each concern or complaint on the Ulysses database. This will include all written or verbal contacts with the complainant, staff involved in the investigative process and all actions taken in investigating the complaint.

The complaint file is a confidential record. It will be stored securely and should be easily retrieved and understood in the event of further enquiry. In accordance with the UHS records management policy 2010, complaint files are kept and disposed of confidentially. Complaint files are retained for eight years.

3.5 Support for complainant and staff

See Appendix H describing roles and responsibility of staff who can provide support.

3.3.6 Process by which the organisation aims to improve as a result of concerns and complaints being raised

Every concern and complaint received should be regarded as an opportunity to learn and improve services.

3.6.1 Development of action plans

P&FR will request a completed action report (Appendix I) from the complaint investigation contributors involved in all complaints that are upheld or partially upheld. In some cases, the actions required may already be completed and documented within the complaint response. In this situation, the complaint lead should inform P&FR that a separate plan is not required and this should be recorded on the complaints database.

The complaint lead is responsible for validating the action plan identified within the report. The divisional director of operations (DDO), or delegated person, is responsible for ensuring the action plans arising from concerns and complaints are completed within the agreed timescales and processes are in place for the action plans to be reviewed and monitored by the local governance groups. The DDO, or delegated person, is supported by the divisional governance manager (DGM).

3.6.2 P&FR - support of learning

The P&FR team will support divisional complaint information hubs, allowing real-time information to be accessed by divisions and care groups as to the number of complaints for each clinical area and identified key themes. Each division will have an identified lead within P&FR to support development of their individual approaches to learning and they will attend divisional and care group governance with the division.

3.6.3 Complainant feedback

P&FR will ensure every complaint response is sent out with a patient satisfaction survey and the results are monitored, reported annually to QGSG and used to consider quality improvements.

4.0 Roles and responsibilities

See Appendix H describing roles and responsibilities of staff involved in resolving complaints.

5.0 Communication plan

This policy will be displayed on the Trust website and Staffnet and sent to divisional management teams to ensure dissemination throughout each division to all staff groups.

An introduction to complaints is provided within the staff induction programme and further training is available via the Trust VLE portal in electronic format. Bespoke face-to-face training will be provided by the P&FR team on request to all staff groups.

Monitoring of this policy by P&FR team will be used to identify areas where further training may be required.

6.0 Process for monitoring

- Quarterly complaints report to QGSG
- Patient experience and engagement strategy group
- Quarterly PCT contract performance report
- Annual report to board
- Bi-annual quality report to quality committee
- Equality and diversity monitoring (Appendix J)
- Care group and divisional governance boards will review quality and completion of complaint action plans and monitor trends of complaints.
- Compliance of this policy will be undertaken annually and reported within the annual complaints report using the audit tool (Appendix K). Any identified areas of non-adherence arising from this monitoring will result and/or embed learning.

7.0 Equality Impact Assessment

See Appendix L.

8.0 Arrangements for review of the policy

This policy will be reviewed every three years or earlier if any amendments to the NHS Complaints Regulations are made, or if any aspect of the policy is found to be inadequate.

9.0 References

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and ‘My expectations for raising concerns and complaints, PHSO 2014’.

Appendix A

Managing concerns & complaints

Processing concerns and complaints in the PALS and complaints team

Concern received into PALS.

The role of patient support officers (PSOs) and the complaint coordinator is to listen, understand concerns and risk assess situation. PSOs and/or administrator to register issue on Ulysses, consider whether consent is required, categorise concern and discuss with complainant how they would like the matter resolved.

Low level to medium level of seriousness and can be resolved in 24 hours or up to 10 days

Categorise as a CONCERN

Managed by PALS manager, ward liaison PALS advisor or PSOs

- Identify actions needed. Provide feedback to care group if issues are for feedback only
- Escalate any concerns to B6/B7/matron/consultant
- Signpost to other teams or bodies where relevant, such as The Advocacy People
- Investigate
- Find resolution
- Respond to complainant at the earliest opportunity and within 10 working days
- Identify learning and share with care group

Resolved – Yes

- Record outcome and close case

Resolved – No

- Review whether concern needs to be managed as a complaint

Medium to high level of seriousness and requires investigation via the NHS complaints process.

Categorise as a COMPLAINT

Managed by complaints team

- Further risk assessment such as PST or safeguarding
- Investigate in accordance with the complaints policy
- Respond within 35 working days with a Trust letter or hold complaint resolution meeting to share outcome of investigation
- Identify learning and share with care group and divisional governance

Resolved – Yes

- Record outcome and close case on Ulysses.

Resolved – No

- Re-open case on Ulysses
- Discuss and agree further actions or investigation plan with complainant
- Respond within 35 working days with a Trust letter or share outcome with complainant at resolution meeting

Resolved – Yes

- Record outcome and close case on Ulysses

Resolved – No

- Direct complainant to the Parliamentary and Health Service Ombudsman or litigation

Appendix B

Complaint process

Appendix C

Protocol for the handling of inter-organisational complaints in Wessex (Hampshire, Dorset and the Isle of Wight)

Introduction

1.1 Health and social care organisations in Wessex are committed to high standards in the management of complaints which are fundamental to ensuring that service users and patients who complain either to social services or to the NHS are provided with a prompt, open and honest response to their complaint.

1.2 The Local Authority Social Services and NHS Complaints (England) Regulations 2009 is the legislative framework for managing complaints and includes the duty to cooperate in the handling of complaints that cross organisational boundaries.

1.3 The NHS Constitution outlines to the public their rights when making a complaint, including a proper investigation and the right to be kept informed of progress. The NHS also pledges to treat complainants with courtesy, to provide an appropriate apology and explanation, and to ensure that learning from complaints is translated into service improvements.

1.4 This protocol promotes collaboration and integrated working across all NHS and local authority complaint handling services in Wessex, aligning with Sustainability and Transformation Plans to build services to meet the needs of whole populations, not just individual organisations.

1.5 The organisations that have CEO approval and have agreed to work within this protocol are listed in Appendix A.

Aims

2.1 To provide a framework for dealing with complaints involving more than one of the participating organisations and ensure that complainants receive a seamless and effective service, regardless of which organisations are involved.

2.2 Reduce confusion for the public and provide complainants with a single point of contact and a single response to their complaint, unless the complainant prefers otherwise.

2.3 Minimise delays in the handling of concerns and complaints relating to services that cross organisational boundaries.

2.4 Provide clarity of role and responsibility for each organisation through effective inter-organisation communication and collaboration.

2.5 Provide opportunity for organisational learning and service improvements arising from complaints covering more than one organisation.

Protocol

3.1 When a complaint is received by one organisation which also involves a complaint about another organisation, the receiving organisation is responsible for acknowledging the complaint.

3.2 On occasion, a complaint which is concerned in its entirety about one organisation is sent to another. This may be due to lack of understanding about which organisation is responsible for the service, or because the complainant chooses to entrust the information to a professional person with whom they have a good relationship.

3.3 The complainant should always be asked how and by whom they would like their complaint handled. This may determine the lead organisation.

3.4 If the complainant does not express a choice regarding the lead organisation, the receiving organisation should contact the other organisation/s to agree: how the

concern or complaint will be investigated; a realistic timeframe for response; and to agree which organisation takes the lead role. This is based on:

a) The organisation who leads the service or holds the contract for the workforce relating to the most serious or complex part of the complaint. If this does not apply;
b) The organisation with the higher proportion of issues raised in the complaint. If neither apply;
c) The organisation who originally received the complaint.

Occasionally, complainants will raise their complaint with many organisations concurrently. In this case, a pragmatic approach to communication and application of criteria (a) and (b) should still be applied. Any acknowledgement of the complaint should be copied to all organisations involved to ensure consistent, open and transparent communication and complaint handling. It is not appropriate for the receiving organisation to agree with the complainant how a concern or complaint relating to another organisation will be handled before this discussion has taken place with the other organisations involved.

3.5 If the receiving organisation has been unable to contact the complainant to discuss the handling of the complaint, the process should not be delayed further and a letter should be sent detailing what action has been taken.

3.6 Consent should be sought to share information across services and noted in line with standard practice. The only circumstances in which a complainant's lack of consent could be overridden would arise if the complaint included information which needed to be passed on in accordance with safeguarding children or protection of vulnerable adults procedures, or other service user safety issues. In such cases, the complainant would be entitled to a full written explanation as to the organisation's duty of care and its obligation to pass on the information. This should be provided by the receiving organisation.

3.7 Copies of the complaint and acknowledgement should be sent to all participating organisations and the lead organisation should co-ordinate the investigation and response.

3.8 There should be one final complaint response that embraces the response/s from all organisations involved. Ideally, this will be a single, composite letter that provides a clear and coordinated account of the investigation, outcome and recommendations. If this is not possible, copies of the complaint response from each organisation should be sent together, with a single covering letter from the lead organisation explaining how the investigation was undertaken, the overall conclusion and outcome, and any recommendations. In this case, the lead investigating organisation needs to be clear that the content of all responses is consistent.

3.9 Where there is a difference of view between organisations, the lead organisation should escalate this to the relevant executive lead. Where appropriate, an external review should be undertaken.

3.9 The lead investigating organisation will share the draft response with the other organisation/s before the reply is sent to the complainant. This process needs to be taken into consideration when agreeing timeframes with the complainant. The lead investigating organisation's standard advice regarding the actions the complainant should take if they are not satisfied will apply.

3.10 Resolving the individual complaints is only part of the process. All complaint responses, where complaints are upheld or partially upheld, should include detail of learning and service improvement/s. This may also include communication and procedural, operational or strategic learning applicable to PALS and complaint services. This should be a standard agenda item at the Wessex Complaints and PALS Managers Network meetings.

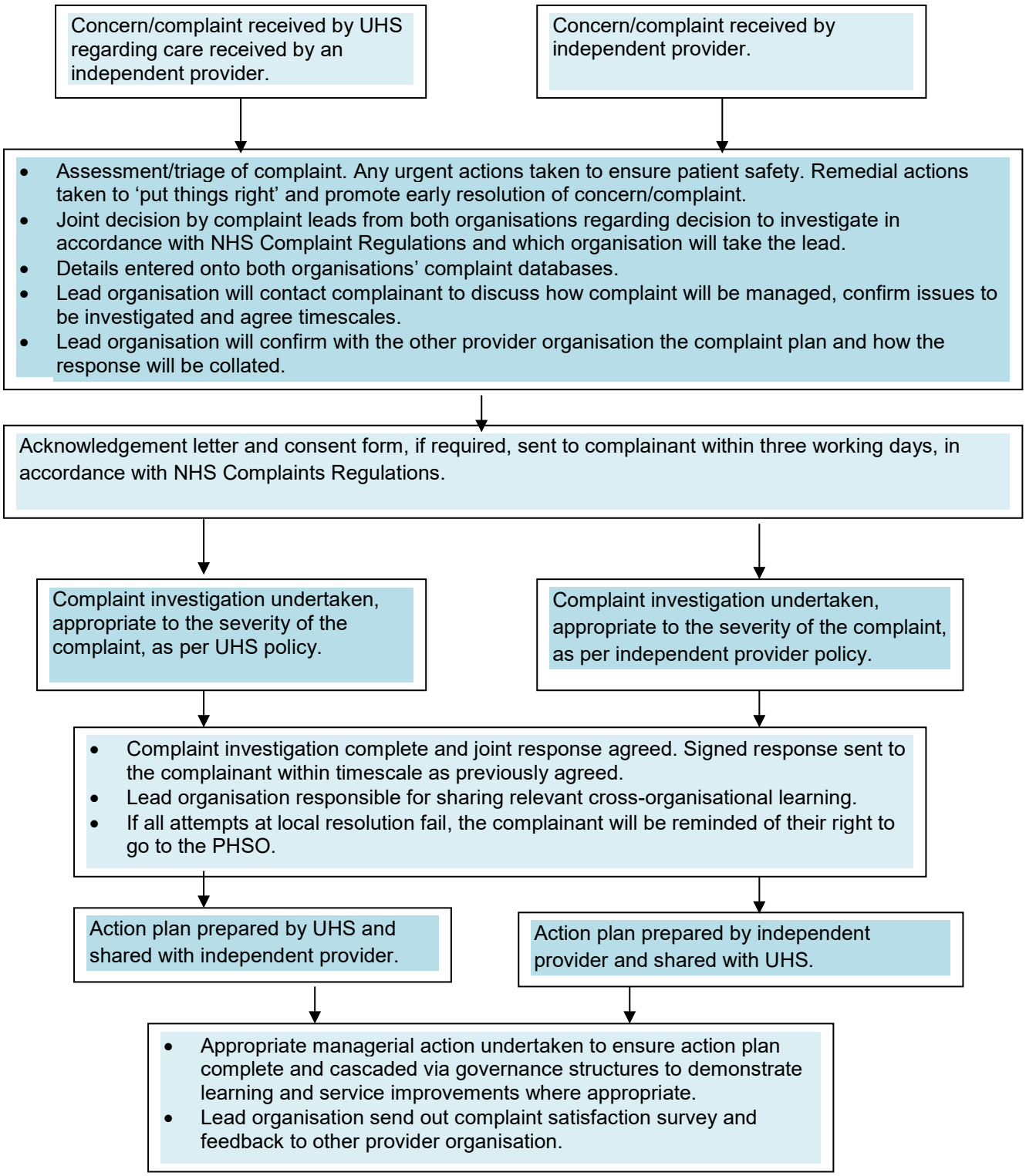
3.11 Complaints activity will be reported separately by the complaints services in accordance with their own agreed procedures.

Protocol last reviewed October 2017.

Appendix D

Procedure for dealing with complaints involving third party independent providers

Amended July 2017



Appendix E

Process for managing care home complaints in the PALS or complaints team

Complex concerns and complaints raised by the Clinical Commissioning Group (CCG) and care home managers.

- Log concern or complaint on Ulysses, allocate case number and set up electronic (registering as a care home complaint) and paper file.
- Acknowledge within three days (both care home and CCG).
- Consider consent issues.
- Assess risks, for example: alert patient safety team, safeguarding, dementia, mental health, learning disability.
- Update case on dashboard on 'G' drive.
- Use matrix to grade seriousness of complaint and determine level of management.

Low to medium level of seriousness and CCG/Care Home agree that we can resolve concerns outside of the NHS complaints process.
Categorise as a CONCERN

Managed by PALS manager, ward liaison manager or complaint coordinators

- Investigate
- Agree how we will respond, e.g. letter or meeting and timescales
- Investigate and seek resolution
- Respond verbally, in writing, or via a meeting within 10 days
- Identify learning and share with care group and divisional governance

Resolved – YES

- Record outcome and close case on Ulysses

Resolved – NO

- Review concerns and manage as a complaint

Medium to serious and requires investigation via the NHS complaints process.
Categorise as a COMPLAINT

Managed by complaints manager or complaint coordinators

- Further risk assessment, e.g. patient safety team, safeguarding etc.
- Investigate in accordance with the complaints policy
- Respond within 35 working days with a Trust letter or hold complaint resolution meeting to share outcome of investigation.
- Identify learning and share with care group and divisional governance

Resolved – YES

- Record outcome and close case on Ulysses

Resolved – No

- Re-open case on Ulysses.
- Discuss and agree further actions or investigation plan with CCG or care home
- Respond within 35 working days - Trust letter or share outcome with complainant at resolution meeting

If the reopened case is resolved, the outcome should be recorded and the case closed on Ulysses

If the reopened case is not resolved, the complainant should be directed to the parliamentary and health service ombudsman

Appendix F

Procedure for handling vexatious or hard to manage complainants

Definition: Persistent, habitual, may be deemed to be annoying, irksome or infuriating, have a repeated or obsessive pursuit of:

- unreasonable complaints and/or unreasonable outcomes, or
- reasonable complaints in an unreasonable manner

A vexatious complainant usually meets two or more of the following criteria:

- Persists in pursuing complaint when NHS complaints procedure has been properly followed and exhausted
- Seeks to prolong contact by continually raising new issues (address as a new complaint)
- Unwilling to accept documentary evidence as factual
- Denies receipt of an adequate response despite questions being specifically answered
- Displays unreasonable demands or expectations and fails to accept they are unreasonable
- Does not clearly identify the precise issues they want to be investigated
- Focuses on trivial matters for which their sense of significance is out of proportion
- Excessive number of contacts with the Trust placing unreasonable demands on staff
- Has harassed or been personally abusive or verbally aggressive on more than one occasion to staff, even when reasonable allowances have been made for levels of stress and anxiety experienced by the complainant
- Has threatened or used actual physical harm towards staff, or sent or given indecent or offensive material to staff
- Is known to have recorded meetings, face-to-face conversations or telephone conversations without prior knowledge or consent from other parties and used these recordings without prior permission

Options for dealing with vexatious complainants

- Head of P&FR to write to complainant to explain why their behaviour is causing concern and ask them to change their behaviour
- If case is being supported by Advocacy or MP, inform them of the situation
- Head of P&FR to notify in writing that the chief executive has responded fully, there is nothing more to add and continuing contact serves no useful purpose. Further letters or contact will be acknowledged but not answered or acted upon
- Inform complainant that their behaviours may be classified as vexatious and provide a copy of vexatious policy to the complainant
- Draw up a signed agreement with the complainant involving the relevant divisional clinical director/consultant/other member of staff, which sets out a code of behaviour which needs to be adhered to in order for the complaint to be processed
- Restrict the complainant to one form of communication, via an advocate or via one nominated member of staff
- Inform the complainant that the Trust will not reply to or acknowledge any further contact regarding that specific topic of complaint
- Inform the complainant that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors
- In extreme circumstances, consider referring matter to the police or taking legal action
- Temporarily suspend all contact with the complainant while seeking advice from NHS England and NHS Improvement (Wessex), National Health Service Executive or other relevant agencies

Withdrawing vexatious status and record keeping

There needs to be a mechanism to withdraw this status at a later date if complainants subsequently demonstrate a more reasonable approach, or submit a further complaint that is appropriate. Status should be reviewed every three months by the head of P&FR. Adequate written and electronic documentation should be made to detail reasons why such actions have been taken and all contacts to and from the complainant.

Appendix G

Complaint assessment tool

- The complaint is assessed in terms of the impact on the people involved and the adverse consequence that might arise for the organisation. The effect on the organisation and effects for the individual may be very different, especially in circumstances of poor health, communication difficulties or a recent bereavement.
- The seriousness/consequence score (Table 1) and likelihood score (Table 2) are based on the highest descriptor applicable.
- The scores are plotted (Table 3) and the colour band will determine: a) any immediate action required; b) the appropriate level of investigation; c) level of organisation involvement/awareness (Table 4).

Table 1: seriousness/consequence score

			Consequence score (severity levels) and descriptors		
Impact on patient /family	**1.Negligible**	**2.Minor**	**3.Moderate**	**4.Major**	**5.Catastrophic**
Impact of COVID-19 on clinical care	The few patients outside waiting times are at no clinical risk and / or are delayed through their own choice. The reasons for these delays are understood. Waiting lists are appropriately managed. Changes in pathways and actions to increase capacity have been completed. Patients awaiting treatment are at no risk of harm or disease progression.	Changes to pathways expose patients to the risk of minor, non-permanent harm, but are required for effective infection control. Patients awaiting treatment have been clinically risk assessed and are at minimal risk.	Patients awaiting treatment have been clinically risk assessed and are at risk of moderate harm or disease progression, e.g. requiring additional treatment and / or pain relief. Patients suffer psychological impact of delayed treatment.	Patients awaiting treatment may not have been clinically risk assessed and / or are at risk of major harm or disease progression, e.g. requiring additional procedures or intervention. The treatment plan may differ significantly from the original treatment plan. Patients are at risk of attending ED for the same condition.	Patients awaiting treatment may not have been clinically risk assessed and / or are at catastrophic clinical risk, e.g. irreversible treatment progression resulting in severe harm or death.

Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis
Statutory duty/inspections	No or minimal impact or breach of guidance/statutory duty	Breach of legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Inadequate CQC rating or in special measures with NHS England and NHS Improvement Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with < 3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the Houses of Parliament) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/Loss of >1 per cent of budget Failure to meet specification/slippage Loss of contract/payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence score - EXAMPLE				
Impact on patient /family	**1. Negligible**	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
E.g. cancelled clinic	*Single cancellation*	*Two to three cancellations. Leading to upset /inconvenience*	*Cancellation leading to anger, frustration. Potential impact on clinical symptoms & care pathway*	*Cancellation leading to significant increase in symptoms/ delay in treatment with longer term implications.*	*Delay in treatment with irreversible damage/death.*

Table 2: Likelihood Score (L)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain/certain**
Proximity: How soon might we expect the risk to occur	The risk may materialise next year.	The risk might be expected to materialise within the next twelve months.	The risk is expected to materialise this quarter	The risk is expected to materialise this month	The risk is expected to materialise this week or next week
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Likelihood of it occurring within a given time frame	<0.1 per cent	0.1–1 per cent	1–10 per cent	10–50 per cent	>50 per cent

Table 3: Complaint matrix score = C (Consequence) x L (Likelihood)

Likelihood	Consequence				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic/ Death
Rare 1	Green 1	Green 2	Green 3	Yellow 4	Yellow 5
Unlikely 2	Green 2	Yellow 4	Yellow 6	Orange 8	Orange 10
Possible 3	Green 3	Yellow 6	Orange 9	Orange 12	Red 15
Likely 4	Yellow 4	Orange 8	Orange 12	Red 16	Red/Red 20
Almost Certain/Certain 5	Yellow 5	Orange 10	Red 15	Red/Red 20	Red/Red 25

Table 4: Complaint Timeframes

We will aim to close all UHS complaints within 35 working days.

Any complaints requiring input from multi agencies i.e. other NHS Trusts, social services, SCAS, will be negotiated with everyone involved but are not to take more than 50 working days.

Appendix H

The role and responsibilities of the CGM, complaint lead & complaint investigation contributor

1. Role and responsibility of care group manager (CGM)

- Ensure procedures are in place to work collaboratively with P&FR team to complete investigations and provide a complaint response of an appropriate quality and within the timeframes agreed with the complainant for all complaints that relate to the care group services and/or staff.
- Ensure the 'Raising a concern or complaint' poster and leaflets are widely available in the care group, including the advertising of complaints advocacy.
- To ensure staff adhere to P&FR escalation processes and timeframes or inform P&FR at the outset if this is not going to be possible.
- In circumstances where P&FR have been unable to secure adequate contribution to a complaint investigation, take action to support the P&FR escalation mechanism to ensure response targets are met.
- Achieve complaint handling performance targets and/or ensure actions are in place to improve performance. Manage staff who have repeatedly failed to respond to complaints in line with Trust policy.
- Ensure governance processes are in place to develop and evaluate action plans, and share learning.
-

- Ensure appropriate training is in place for all staff groups and that staff are aware of their individual responsibilities. P&FR responsible for ensuring availability of training and/or training resources are available. Ensure all investigation contributors are sent a copy of the final signed complaint response.
- As overall care group lead for complaints handling processes, meet with P&FR team on a regular basis to ensure adequate complaint performance is maintained.

2. Role and responsibility of complaint lead

The complaint lead is nominated by P&FR and this is dependent on the primary focus (medical, nursing, AHP, managerial) and level of complaint (negligible, minor, moderate, major, catastrophic).The complaint lead will not have had direct involvement in the events leading to the complaint.

- Agree or advise modifications to complaint investigation plan ideally within 24 hours, at most within three working days.
- For all ‘major’ and ‘catastrophic’ complaints, attend or contribute to a scoping meeting, usually within 48 hours of the complaint being received. At a minimum this will involve the CGCL and/or matron, depending on the nature of the complaint. The scoping meeting may be virtual or face-to-face.
- Support P&FR in the scrutiny of the complaint and whether an external review or an internal review from another division may be appropriate.
- Directly notify any junior/trainee staff who are named in the complaint prior to P&FR sending out the complaint notification email.
- Ensure staff who have been asked to contribute to the complaint investigation understand what is required of them and by when, or signpost them back to P&FR. In circumstances where questions have been inadequately answered, the information provided is conflicting or P&FR are unable to draw definitive conclusions, scrutinise the investigative findings, test the evidence and arbitrate and support P&FR to reach reasonable conclusions.
- Attend meetings with complainants to support early complaint resolution.
- Validate the action plan for any part of the complaint that is upheld.

3. Role and responsibility of complaint investigation contributor

- If this role is new to the complaint investigation contributor, they will be directed by P&FR to the various sources of support available. This information can also be found on Staffnet.
- The complaint investigation contributor may be asked to attend a scoping meeting if the complaint has been assessed as 'major' or 'catastrophic'.
- The patient's healthcare records will be requested and delivered to the key investigation contributor and you will be informed as to where you can access them.
- The complaint and the questions posed in the complaint investigation plan should be reviewed as soon as possible and P&FR contacted for any clarification required.
- A complaint investigation report and action plan is sent to the complaint investigation contributor for completion. This guides consideration of the questions: What should have happened? What did happen? What actions can be taken to prevent reoccurrence? The action plan should be completed and sent to P&FR together with the answers to the questions. This enables P&FR to more accurately establish facts, draw conclusions and decide if the complaint is upheld or not.
- The complaint investigation contributor may choose to use the Trust statement form, using the Trust guidance on the Staffnet. All questions posed should be answered openly and honestly, accounting for decisions and actions taken, acknowledging any mistakes and ensuring there is clear differentiation between what is documented in the healthcare records and what is based on recall. Descriptive statements that do not answer the questions asked are not acceptable. It is important that the Trust gets the investigation right first time.
- It is important that investigative statements are provided within the timeframe requested because the Trust has already spoken with the complainant and agreed a date for responding.
- The complaint investigation contributor must notify P&FR within three working days if they believe they are not the most appropriate person to investigate the complaint, know someone else who may be able to contribute and/or are unable to respond within the timeframe requested. This will enable P&FR to keep the investigation on track and update the complainant as required.
- P&FR will consider all investigative statements and may need to contact the complaint investigation contributor again to aid understanding of a specialist body of knowledge or to seek answers to additional questions.
- P&FR will then draft a complaint response that is open, transparent, evidence based, logical and easily understood. P&FR aim to reach a balanced conclusion by considering and judging both the complainant's perspective and the complaint investigation contributor's findings. Adding an element of impartiality from the P&FR team will ensure care groups are not seen to be treating themselves more favourably. Where appropriate, an apology is offered as well as consideration of a fair and proportionate remedy, if the complaint is upheld.
- The complaint investigation contributor will not usually be asked to comment on the specific wording of the draft response letter but will be asked to verify clinical or technical content where appropriate.
- The complaint lead will validate the draft complaint response and the final version is jointly agreed by the complaint lead and P&FR before it is reviewed and signed by the CEO.
- The complaint investigation contributor can expect to receive a copy of the final written response sent to the complainant and should contact their CGM if this has not been made available to them. This should be used to contribute to the complaint action plan addressing upheld elements of the complaint.

Appendix I

Complaint action plan report

Patient's surname and/or complainant's surname		**Complaint date received**	
Case number		**Author's job title**	
Report author		**Care group**	
Division		**Report date**	
Department/ward			

Brief summary of the complaint

Investigation outcomes

Any incidental findings not directly related to the complaint that can lead to additional lessons being learned

Support provided for any staff directly involved

Notification of report sign off

Approval as per divisional agreement and once approved to be returned to patient and family relations.

Which committee/s, group/s or individual/s approved the final report and on what date		
	Date	**Name and designation (if appropriate)**
Complaint lead approval		
Divisional sign off as agreed by division		

Appendix J

Complaints equality and diversity monitoring form

NHS
University Hospital Southampton
NHS Foundation Trust

Patient feedback survey

Complaints equality and diversity monitoring form

We would be grateful if you could take a little time to complete and return this form to the complaints team. The information you provide will be held in the strictest of confidence and will only be used to see how our complaint policy and activity affects various sections of our communities. The form will not be stored in your case file or form part of your medical records. Please go through the questions and tick the category that most accurately describes you.

1. You are?

☐ The patient ☐ The person making a complaint on behalf of the patient

2. What age category are you in?

☐ 16-24 years ☐ 25 - 34 years ☐ 35 - 44 years ☐ 45 - 54 years
☐ 55 - 64 years ☐ 65+ years ☐ prefer not to say

3. Marriage or civil partnership?

☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Co-habiting ☐ Same sex civil partnership

4. Do you consider yourself to have a physical disability/impairment?

☐ Visual impairment ☐ Hearing impairment ☐ Mental Health
☐ Physical disability ☐ Long term illness or condition

5. Are you a carer?

☐ Yes ☐ No ☐ Prefer not to say

6. To which gender do you identify?

☐ Male ☐ Female ☐ Trans Male ☐ Trans female
☐ Gender neutral ☐ Other ☐ Prefer not to say

7. What is your sexual orientation?

☐ Heterosexual ☐ Bisexual ☐ Gay ☐ Lesbian
☐ Other ☐ Prefer not to say

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8. What is your ethnicity? Please circle

☐ White British / English / Irish / Scottish / Gypsy / Traveller / Polish / Other white ethnic group

☐ Mixed or multiple ethnic group

☐ Asian / Asian British / Asian Scottish /Asian Irish

☐ African

☐ Other Ethnic group

9. What is your religion or belief?

☐ Christian ☐ Muslim ☐ Hindu ☐ Jewish
☐ Sikh ☐ Other ☐ No religion or belief
☐ Prefer not to say

10. Your language

☐ English ☐ Polish ☐ Spanish ☐ Russian
☐ Urdu ☐ Farsi ☐ Punjabi ☐ Other

Please return your completed survey to email: pals@uhs.nhs.uk, or post: Patient Support Services, University Hospital Southampton, C Level, Centre Block, Tremona Road, Southampton, SO16 6YD.

If you need a translation of this document, an interpreter or a version in large print, Braille or on audiotape, please contact Patient Support Services at the address above, or telephone 023 8120 6325 for help.

Protecting your information

- We will ensure that your information is kept secure at all times
- Use your information to provide the best care possible
- Not share your information with anyone else unless permitted to do so by the law.
- Provide you with copies of your health records, upon request

Thank you for taking the time to complete this survey.

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Appendix K

Audit tool to monitor policy compliance

Element of policy to be monitored	Specific actions/questions	Method of data collection	Reporting methodology
Complaint process	• Review of closed complaint file. Were all elements of the process completed and recorded on database?	Complaint and complex concern file (10 per month)	Report to QGSG in annual report
Complainant experience	• What % of complainants received a response to their complaint within the agreed timeframe? • What percentage of complainants were satisfied with their experience of the procedure? • What percentage of complaints were returned as dissatisfied	Data analysis Review of complaint files (10 per month) Complainant satisfaction survey Data analysis	Report quarterly to QGSG and summary in annual report
Process for ensuring that patients are not treated differently as a result of raising a concern	• Do healthcare records contain any information about the complaint made? • Complaints file does not contain any inappropriate comments or evidence of discriminatory behaviours.	Review of six health records/complaint files	Summary in annual report
Process by which the organisation aims to improve as a result of concerns/complaint being raised	• Trends and themes from complaints are reported quarterly to divisions. • All upheld/partially upheld complaints have action plans identified within one month of investigation being completed. • Actions agreed as a result of a complaint are completed within agreed timescales.	Quarterly divisional report Care group governance meeting evidence provided by divisional governance manager	Quarterly QGSG report and annual report to Trust board Summary in annual report

This audit tool will be electronically stored by the head of P&FR. A summary of the audit findings will be presented to quality governance steering group.

Appendix L

Quality Impact Assessment Tool

This impact assessment relates to:

- a Trust report
- a Trust policy which impacts across the whole organisation
- a new service development, service change or change management proposal
- a commissioning or procurement proposal

Title of policy/proposal/report	**Handling Complaints and Concerns policy**
Name of person initiating policy, proposal or report	**Vicki Havercroft Dixon**
Name of receiving committee	**Quality Governance Steering Group**
Details of stakeholders consulted in process	David French, Gail Byrne, Juliet Pearce, Serena Gaukroger-Woods, Ellis Banfield, divisional governance managers for dissemination to DMT, PEESG, Trust governors, QGSG

Does the policy/proposal affect one group more or less favourably than another based upon the nine protected characteristics	**More favourably YES/NO**	**Less Favourably YES/NO**	**Comments/Information considered to reach this decision**
Age	**NO**	**NO**	
Sex/gender	**NO**	**NO**	
Disability (mental, physical and learning)	**NO**	**NO**	
Race/ethnicity	**NO**	**NO**	
Religion or belief	**NO**	**NO**	
Sexual orientation	**NO**	**NO**	
Pregnancy/maternity	**NO**	**NO**	
Marriage/civil partnership	**NO**	**NO**	
Gender re-assignment	**NO**	**NO**	

If you have answered ‘yes’ to any of the above, you must complete the comments column explaining what information you have considered which has led you to reach this decision. Please continue overleaf if required.

How would you rate the level of impact/risk to the organisation? low

Document Monitoring Information	
Approval Committee:	Patient experience steering group
Date of Approval:	02 June 2021
Ratification Committee:	Quality Governance Steering Group (QGSG)
Date of Ratification:	02 June 2021
Signature of ratifying Committee Group/Chair:	Chair of QGSG
Lead Name and Job Title of originator/author or responsible committee/individual:	Juliet Pearce, Deputy Chief Nurse for Quality
Target audience:	All staff
Key words:	Concerns and complaints
Main areas affected:	Trust wide
Summary of most recent changes if applicable:	Reducing document size and redesigning appendices.
Consultation:	David French, Gail Byrne, Juliet Pearce, Serena Gaukroger-Woods, Ellis Banfield, divisional governance managers for dissemination to DMT, PEESG, Trust governors, QGSG
Equality Impact Assessment completion date:	02 June 2021
Number of pages:	34
Type of document:	Policy level 1
Does this document replace or revise an existing document	Replaces previous version
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.