

Handling Complaints Policy, Version 13.0

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Description	Policy to explain how University Hospital Southampton implements the framework for the NHS Complaints (England) Regulations 2009. It clarifies what people should expect when then complain, in accordance with Parliamentary and Health Service Ombudsman’s complaint standards.		
Level and type of document	Trust-wide corporate policy – controlled document.		
Target audience	Staff, patients, relatives, and carers.		
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1 Version control

Date	Author(s)	Version created	Approval committee	Date of approval	Date next review due	Key changes made to document
6.9.2024	Shona Small	6.9.2024	Experience of care committee	10/7/24	10/7/27	To bring in line with Ombudsman’s new complaint standard terminology.

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3 Introduction

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 Services Ombudsman (PHSO) Complaint Standards and Principles of Remedy, including the Scale of Injustice.

The policy deals with the handling of concerns and complaints (regarding Trust services, buildings or the environment) received from patients, patient's 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 resolution).

In circumstances where early resolution is not possible, this policy describes the processes in place to ensure that complaints are handled efficiently and investigated thoroughly. Patient and Family Relations (P&FR) are responsible for the overall management of complaints. P&FR combines the patient advice and liaison service (PALS) and the complaint handling functions, to provide a flexible approach to resolving 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, 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 complaints are raised, the Trust has a responsibility to acknowledge the complaint, put things right as quickly as possible, prevent reoccurrence and identify service improvements.

Written information regarding how the Trust deals with complaints will be made available in all departments, the main reception, patient support services, the Trust website and through the local Integrated Care Bureau (ICB), The Advocacy People and other patient forums.

4 Quick References

None

5 Scope and purpose

The purpose of the policy is to:

- Outline the Trust policy on handling complaints
 - Describe the procedure followed to respond to complaints
 - Confirm the roles and responsibility associated with this process
 - Provide staff with guidance on how to respond to a complaint
 - Describe how this policy links to the National Complaint Handling Framework
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- o Promotes a learning and improvement culture
 - o Positively seeks feedback
 - o Is thorough and fair
 - o Gives 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 complaints 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 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 practical, 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 complaints, and endeavour to resolve issues quickly.
- The Trust will ensure that service users and carers can raise a 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 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 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.

6 Definitions

Please see [Appendix A](#) for flow chart.

For the purpose of this policy, the following definition will apply:

Term	Definition
Everyday Conversations	Defined as every-day issues that with help can be resolved there and then (within 24 hours), without the person becoming dissatisfied and wanting to make a complaint.
Early Resolution	Defined as a more straightforward complaint that can be resolved fairly quickly (within 10 days), e.g., appointment issues, staff attitude, services not provided to expected standards.

<p>Closer Look</p>	<p>Defined as an expression of dissatisfaction, or a perceived grievance or injustice, that needs a closer look. Timescale for resolution is agreed with the complainant.</p>
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7 Details of policy

7.0 Details of complaints process – refer to [Appendix B](#) for process overview.

7.1 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.

7.1.1 How to make a complaint – Stage 1

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

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 electronically. A 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 complaint to their local commissioner, NHS England, a member of parliament or another third party, such a health advocate.

7.1.2 Who may make a complaint – Stage 1

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 home/nursing homes, MPs, Integrated Care Bureau (ICB) and NHS England. 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.

Complainants will be made aware of independent complaints advocacy for help and support to make a complaint. 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.

7.1.3 Consent if the complainant is not the patient – Stage 1

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 is unable to act for themselves, the nominated first contact, or an individual who holds Power of Attorney (POA) for Health and Welfare can make a complaint on the patient's behalf and will be able to provide consent for this to be investigated and the details released

to them. If the complainant is not the patient's nominated first contact or does not hold POA, we will inform the complainant that the nominated first contact, or POA holder needs to confirm they are happy for the outcome of the investigation to be shared with another party.

If the patient has died, the Trust will respect any known wishes that had been expressed by the patient. This includes sharing the outcome of an investigation with parties who are not the nominated first contact or POA holder, but in these circumstances, we will contact the nominated first contact, or POA holder to ensure they 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 evoked. Without consent, a response to the third party will be limited and the reasons for this explained to the complainant.

7.1.4 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 complaint's procedure for patients wishing to raise a concern regarding their private treatment at the Trust.

7.1.5 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. 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 is submitted. These are seen as out of time in the NHS complaints process – see 3.2.8.

7.2 Specific considerations when dealing with complaints

7.2.1 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. The name nurse for safeguarding children or adults (as appropriate) will be consulted and contribute to the decision as to the most appropriate route of investigation agreed. This may not be the complaints procedure. The named nurse will support with advice on additional notifications and communication with the complainant.

7.2.2 Complaints that include a Patient Safety Incident Investigation (PSII)

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

In these circumstances, the PST will notify P&FR of appropriate timescales for completion and release of their investigation. 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 and sometimes different arrangements are agreed at the patient safety case review meeting.

If there is a need for a dual approach to the 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 the P&FR with support from the 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 PSII and provide 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.

7.2.3 Complaints that are relating 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 the chargeable patients are aware of the complaint's procedure. Complaints regarding charging will be fairly heard by an impartial person who is independent of the overseas visitors charging operation within the Trust.

7.2.4 Clinical negligence, personal injury or another claim.

If the complainant indicates a clear intention to bring legal proceedings for clinical negligence, personal injury or other claim, the use of the complaint's 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.

7.2.5 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 and/or police/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.

7.2.6 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 complaint regulations.

7.2.7 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.

7.2.8 Media interest

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

7.2.9 Time limit for making a complaint

Normally 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.

7.2.10 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](#).

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

See [Appendix E](#)

7.3.12 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. 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 them 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.

7.3 Responding to complaints of patients, their relatives or carers

7.3.1 Local resolution

Early resolution is the first line of investigation and response to a complaint 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.

Complaints are often raised directly to the staff involved. This is often frontline staff in wards, clinics or reception. All Trust staff, as a means of improving service provision, will welcome the complainant's concerns or complaint positively.

In most circumstances, the quickest and most effective way of resolving a complaint is to deal with the issues when they arise or as soon as possible after this (early local resolution). Upon raising a 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 complaint managed and what outcomes they are seeking. Every opportunity should be taken to resolve complaints 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.

7.3.2 Early resolution

All complaints are first assessed by our PALS team. If possible, they will agree with the complainant to investigate to achieve early resolution, in a sooner timescale. The PALS team will investigate via the NHS complaints process and provide a written response.

7.3.3 Taking a closer look

If it is not possible to achieve early resolution, the complaint is passed to the complaints team to take a closer look.

• 7.3.3 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.

7.3.4 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 (minimum, minor, moderate, major or severe) 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 (CL) 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.

7.3.5 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 'severe', if appropriate, and 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 complaint lead will also ensure that a robust action plan is formulated to cover all upheld elements of the complaint.

7.3.6 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, at a meeting or as a telephone call. 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 or secure email.

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.

7.3.7 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 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 director of nursing 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.

7.3.8 Re-investigation of a complaint – Stage 2

In cases where the complainant is not satisfied with the Trust response, the complaint will be re-opened, also called Stage 2. 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. However, the Trust can decline a Stage 2 investigation if the team feel that there is nothing more to investigate, add or clarify, and believe that the Stage 1 investigation is complete.

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

7.3.9 Stage 3: Parliamentary and Health Service Ombudsman (PHSO) & The Independent Sector Adjudication Service (ISCAS)

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

ISCAS: Is a scheme that provides independent adjudication on complaints about independent healthcare providers.

ISCAS
CEDR, 3rd Floor
100 St Paul's Churchyard
London
EC4M 8BU

www.iscas.cedr.com

Telephone: 0207 7536 6091

7.4 Confidentiality and record keeping

7.4.1 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/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.

7.4.2 Record keeping

A complete documentary record will be maintained for each 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.

7.5 Support for complainant and staff

See [Appendix H](#) describing roles and responsibility of staff who can provide support.

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

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

7.6.1 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 or divisional governance team 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 plan to be reviewed and monitored by the local governance groups. The DDO, or delegated, is supported by the divisional governance manager (DGM).

7.6.2 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 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. See Action Plan ([Appendix I](#)).

7.6.3 Complainant feedback

The 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.

8 Roles and responsibilities

Roles and responsibilities

See [Appendix H](#) describing roles and responsibilities of staff involved in resolving complaints.

9 Communication and training plans

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.

10 Equality impact assessment (for all policies only)

See [Appendix L and J](#)

Equality and diversity are at the heart of our Trust values. Throughout the development of the policy, we give regard to the need to eliminate discrimination, harassment and victimisation,

to advance equality or opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it.

As part of its development this Complaints policy and its impact on equality has been analysed and approved as being appropriate.

The Policy & Guidance Team hold all equality impact assessments centrally. These are available upon request from Policy&Guidance@uhs.nhs.uk

11 Document review

All Trust policies will be subject to a specific minimum review period of one year; we do not expect policies to be reviewed more frequently than annually unless changes in legislation occur or new evidence becomes available. The maximum review period for policies is every three years. The author of the policy will decide an appropriate frequency of review between these boundaries.

Where a policy becomes subject to a partial review due to legislative or national guidance, but the majority of the content remains unchanged, the whole document will still need to be taken through the agreed process as described in this policy with highlighted changes.

This Complaints policy will be reviewed in three years' time in 2027. 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.

12 Process for monitoring compliance

The purpose of monitoring is to provide assurance that the agreed approach is being followed. This ensures that we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of this policy will be monitored:

Element to be monitored	Compliance to NHS Complaints (England) Regulation 2009 and Parliamentary and Health Service Ombudsman's Complaints Standards.
Lead (name/job title)	Shona Small
Tool	Measure against policies
Frequency	Every three years
Reporting arrangements	Reporting to Jenny Milner

Where monitoring identifies deficiencies actions plans will be developed to address them.

13 Appendices

- **Appendix A**

Managing complaints

Processing complaints in the PALS and complaints team.

Complaint received into PALS & complaints team.

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 COMPLAINT (Early Resolution)

Managed by PALS manager and Patient Support Officers (PSO).

- 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/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 complaint needs to be passed to the complaints team to take a closer look.

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

Categorise as a COMPLAINT (Taking a Closer Look)

Managed by complaints team

- Further risk assessment such as PST or safeguarding
- Investigate in accordance with the complaints policy
- Respond within agreed timescale 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 agreed timescale 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 (PHSO) or litigation

- **Appendix B**

Making a Complaint process

There are different ways to make a complaint. It is usually easier to resolve concerns close to the time they occur by talking to the staff who are looking after you. This may be the ward manager, or matron for the department. They can discuss the things you are not happy with and will try to resolve them for you.

If your concerns have not been resolved by talking to the department, you can contact the Patient Advice and Liaison Service (PALS). Their contact details are:

Telephone: 023 8120 6325.

Text: text 'callback' plus your name and phone number to 07879 667350.

Email: pals@uhs.nhs.uk

Post: PALS, Mail point 81, University Hospital Southampton, Tremona Road, Southampton, Hampshire, SO16 6YD.

In person: by visiting our main reception desk at C level main entrance and asking for directions to the PALS office close by.

You can also make a complaint by writing directly to our Chief Executive.

When you have made a complaint, you can expect your concerns to be acknowledged within three working days. A case handler will contact you in the coming days to introduce themselves. They will explain the process and the timescales involved. We will agree with you how we will respond to you. This may be by email, letter, or via a meeting. Once we have investigated, if we find any failings, we will tell you how we are going to improve our service. We will also signpost you to the Ombudsman if you feel your concerns have not been resolved.

- **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 National Health Service 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

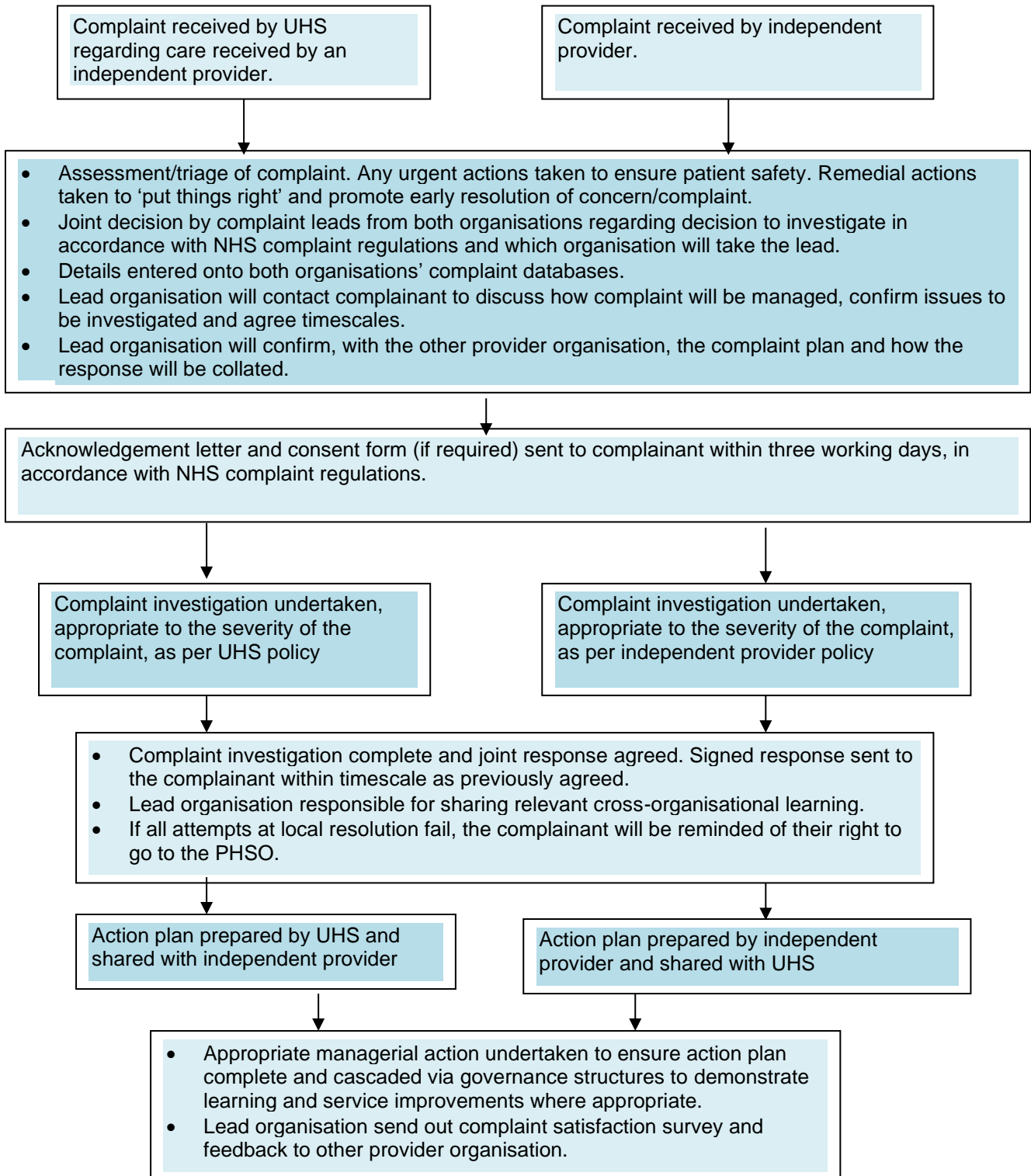
- 3.1 When a complaint is received by one organisation which also involves a complaint about another organisation, the receiving organisation is responsible for acknowledging the complaint.
- 3.2 On occasion, a complaint which is concerned in its entirety with about one organisation is sent to another. 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 s/he has 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/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. NB. It is not appropriate for the receiving organisation to agree with the complainant how a concern/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/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 complaint's services in accordance with their own agreed procedures.

- **Appendix D**

Procedure for dealing with complaints involving third party independent providers

Amended July 2017

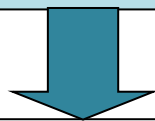


- **Appendix E**

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

Complaints raised by the Clinical Commissioning Group (CCG) and care home managers.

- Log 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 divisional spreadsheet on 'O' 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 complaints as early resolution.

COMPLAINT (Early Resolution)

Managed by PALS manager and patient support officers.

- 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 agreed timescale.
- Identify learning and share with care group and divisional governance

Resolved – YES

- Record outcome and close case on Ulysses

Resolved – NO

- Review complaint and see if it needs to be passed to the complaints team to take a closer look.



Medium to serious and requires complaints team to take a closer look.

COMPLAINT (Take a closer look)

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 agreed timescale 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

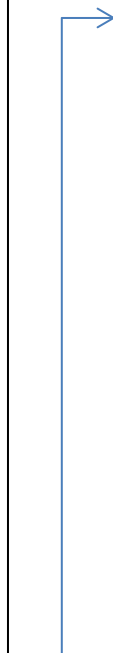
- Record outcome and close case on Ulysses

Resolved – No

- Re-open case on Ulysses.
- Discuss and agree further actions or investigation plan with CCG or care home
- Respond within agreed timescale with 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 or litigation.



- **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

Vexatious complainants usually meet 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 Patient and Family Liaison 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 patient and family relations 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 (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 after three months by the head of patient relations. 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).

Impact (Consequence) Score

Choose the domain you are most concerned about the impact of and use the descriptors to identify the impact of the risk

Domains	1. None/Negligible	2. Low/Minor	3. Moderate	4. Severe	5. Catastrophic
<p>Physical safety.</p> <p>This is a risk which could apply to patients, the public, or staff and may result in physical harm to the individual.</p> <p>Also see the staff safety category below.</p>	<p>No physical harm.</p>	<p>Low physical harm is when all of the following apply:</p> <ul style="list-style-type: none"> • Minimal harm – patient(s)/individual(s) require extra observation or minor treatment. • Unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. • Unlikely to need further treatment beyond dressing changes or short courses of oral medication. • Unlikely to affect that patient's / individual's independence. • Unlikely to affect the success of treatment for existing health conditions. 	<p>Moderate harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and will not need immediate life-saving intervention. • Likely to limit the patient's independence, but for less than 6 months. • Likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm. 	<p>Severe harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Permanent harm/permanent alteration of the physiology. • Needing immediate life-saving clinical intervention. • Is likely to have reduced the patient's / individual's life expectancy. • Likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment. • Likely to have exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions. • Likely to limit the patient's / individual's independence for 6 months or more. 	<p>Death, including still birth or pregnancy loss.</p>

Impact (Consequence) Score

Choose the domain you are most concerned about the impact of and use the descriptors to identify the impact of the risk

Domains	1. None/Negligible	2. Low/Minor	3. Moderate	4. Severe	5. Catastrophic
<p>Psychological safety.</p> <p>This is a risk which could apply to patients, the public, or staff and may result in psychological harm to the individual.</p> <p>Also see the staff safety category below.</p>	<p>No psychological harm.</p>	<p>Low psychological harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Distress that is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit. • Distress that is unlikely to affect the patient's / individual's normal activities for more than a few days. • Distress that is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition. 	<p>Moderate psychological harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Distress that is likely to need a course of treatment that extends for less than six months. • Distress that is likely to affect the patient's / individual's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months. • Distress that is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months. 	<p>Severe psychological harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Distress that is likely to need a course of treatment that continues for more than six months. • Distress that is likely to affect the patient's / individual's normal activities or ability to live independently for more than six months. • Distress that is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months. 	<p>N/A</p>

Impact (Consequence) Score

Choose the domain you are most concerned about the impact of and use the descriptors to identify the impact of the risk

Domains	1. None/Negligible	2. Low/Minor	3. Moderate	4. Severe	5. Catastrophic
<p>Staff safety.</p> <p>This is a risk which could compromise the safety of a staff member. Consider these additional descriptors in conjunction with the descriptors provided above for physical and psychological safety.</p>	<p>No time off work will be needed.</p> <p>Some intervention/support may be needed from line manager.</p>	<p>Time off work for up to 7 consecutive days.</p> <p>First aid treatment and/or diagnosis via a medical practitioner.</p>	<p>When at least one of the following apply:</p> <ul style="list-style-type: none"> Meeting a moderate descriptor for physical or psychological safety. Time off work for longer than 7 days and up to 6 months (which would be RIDDOR* reportable). Other RIDDOR reportable incidents e.g. dangerous occurrences/exposure to biological agents. <p>*RIDDOR reportable incidents are those which must be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013).</p>	<p>When at least one of the following apply:</p> <ul style="list-style-type: none"> Meeting a severe descriptor for physical or psychological safety. Time off work for more than 6 months. This includes RIDDOR/agency reportable incidents meeting the threshold above. 	<p>N/A – use physical and psychological safety descriptors above.</p>
<p>Patient experience.</p> <p>This is a risk which could compromise our ability to provide an excellent patient experience, including the potential to result in complaint(s).</p>	<p>Inability to meet patient preferences but still able to meet the patient's core needs with no impact beyond that moment/episode of care.</p>	<p>Inability to meet patient needs (including health, personal care, emotional, social, communication <i>(including the requirements of the Accessible Information Standard)</i>, cultural, religious, and spiritual needs) but with no longer lasting impact beyond a few days.</p>	<p>Inability to meet patient needs (including health, personal care, emotional, social, communication <i>(including the requirements of the Accessible Information Standard)</i>, cultural, religious, and spiritual needs) with the potential for residual impact lasting up to six months.</p>	<p>Inability to meet patient needs (including health, personal care, emotional, social, communication <i>(including the requirements of the Accessible Information Standard)</i>, cultural, religious, and spiritual needs) with the potential for residual impact lasting longer than six months.</p>	<p>Adverse experience constituting a breach of law, for example breaching the Human Rights Act.</p>

Impact (Consequence) Score

Choose the domain you are most concerned about the impact of and use the descriptors to identify the impact of the risk

Domains	1. None/Negligible	2. Low/Minor	3. Moderate	4. Severe	5. Catastrophic
<p>Effectiveness/ audit/quality.</p> <p>This is a risk which could relate to the quality of patient care, including clinical governance and patient outcomes.</p>	Peripheral element of treatment or service suboptimal.	<p>Overall treatment or service suboptimal.</p> <p>Single failure to meet internal standards.</p> <p>Minor implications for patient safety if unresolved.</p>	<p>Treatment or service has significantly reduced effectiveness.</p> <p>Repeated failure to meet internal standards.</p>	<p>Non-compliance with national standards with significant risk to patients if unresolved.</p> <p>Low performance rating.</p> <p>Critical report (e.g. a CQC rating of inadequate or requires improvement).</p>	<p>Totally unacceptable level of quality of treatment/service.</p> <p>Gross failure to meet national standards.</p> <p>Gross failure of patient safety if findings are not acted upon.</p>
<p>Adverse publicity / reputation.</p> <p>This is a risk which could impact on the organisation's reputation, public trust and relationships with stakeholders (including patients, healthcare providers and the community).</p>	<p>Rumours.</p> <p>Potential for public concern.</p>	<p>Local media coverage – short-term reduction in public confidence.</p> <p>Elements of public expectation not being met.</p>	<p>Local media coverage – long-term reduction in public confidence.</p>	<p>National media coverage with <3 days service well below reasonable public expectation.</p>	<p>National media coverage with >3 days service well below reasonable public expectation.</p> <p>MP concerns (questions in the House).</p> <p>Total loss of public confidence.</p>

Impact (Consequence) Score

Choose the domain you are most concerned about the impact of and use the descriptors to identify the impact of the risk

Domains	1. None/Negligible	2. Low/Minor	3. Moderate	4. Severe	5. Catastrophic
<p>Effectiveness/ audit/quality.</p> <p>This is a risk which could relate to the quality of patient care, including clinical governance and patient outcomes.</p>	Peripheral element of treatment or service suboptimal.	<p>Overall treatment or service suboptimal.</p> <p>Single failure to meet internal standards.</p> <p>Minor implications for patient safety if unresolved.</p>	<p>Treatment or service has significantly reduced effectiveness.</p> <p>Repeated failure to meet internal standards.</p>	<p>Non-compliance with national standards with significant risk to patients if unresolved.</p> <p>Low performance rating.</p> <p>Critical report (e.g. a CQC rating of inadequate or requires improvement).</p>	<p>Totally unacceptable level of quality of treatment/service.</p> <p>Gross failure to meet national standards.</p> <p>Gross failure of patient safety if findings are not acted upon.</p>
<p>Adverse publicity / reputation.</p> <p>This is a risk which could impact on the organisation's reputation, public trust and relationships with stakeholders (including patients, healthcare providers and the community).</p>	<p>Rumours.</p> <p>Potential for public concern.</p>	<p>Local media coverage – short-term reduction in public confidence.</p> <p>Elements of public expectation not being met.</p>	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	<p>National media coverage with >3 days service well below reasonable public expectation.</p> <p>MP concerns (questions in the House).</p> <p>Total loss of public confidence.</p>

UHS Risk Assessment Scoring Matrix

v2 published December 2024

Likelihood Score					
Once you have determined the impact of the reasonably foreseeable outcome, assess the likelihood of that occurring using the descriptors below					
Descriptor	1. Rare	2. Unlikely	3. Possible	4. Likely	5. Certain
Operational risks	This risk will probably not materialise, and it is not thought that it will materialise within the next 12 months.	This risk is not expected to materialise but there is potential that it may occur within the next 12 months.	It is thought that there is a 50/50 chance that this risk may materialise, and it could be reasonably expected that it will occur within the next quarter.	It is expected that this risk will materialise, and it could be reasonably expected that it will occur within the next month.	This risk will undoubtedly materialise, potentially on multiple occasions, and it could be reasonably expected that it will occur this week or next week.
Project and strategic risks (risks relating to time-limited or one-off projects or business objectives)	<10% predicted chance of materialisation.	10 – 35% predicted chance of materialisation.	35 – 65% predicted chance of materialisation.	65 - 90% predicted chance of materialisation.	>90% predicted chance of materialisation.

Risk Scoring Matrix					
Multiply the impact by the likelihood to generate a predicted risk score and rating					
	1. Negligible	2. Minor	3. Moderate	4. Severe	5. Catastrophic
5. Certain	5	10	15	20	25
4. Likely	4	8	12	16	20
3. Possible	3	6	9	12	15
2. Unlikely	2	4	6	8	10
1. Rare	1	2	3	4	5

Risk Rating Key	
Very low	1 - 3
Low	4 - 6
Moderate	8 - 12
Critical	15 - 25

The rating of the risk determines the level of oversight and sign off required, including which committees should have oversight of the risk, as well as how often the risk should be reviewed by the owner. Please refer to the Risk Management Policy on Staffnet for this information.

- **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 '*Have your say*' (now known as '*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 F&PR, and this is dependent on the primary focus (medical, nursing, AHP, managerial) and level of complaint (minimum, minor, moderate, major, severe). 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 severe complaints, attend or contribute to a complaint 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 directly 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 sign post back them to P&FR. In circumstances where questions have been inadequately answered, the information provided is conflicting and 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 complaint scoping meeting if the complaint has been assessed as severe.
- 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 are 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 investigation. 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/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 support services.

- **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

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.

- You are?**
 The patient The person making a complaint on behalf of the patient
- 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
- Marriage or civil partnership?**
 Single Married Separated Divorced
 Widowed Co-habiting Same sex civil partnership
- Do you consider yourself to have a physical disability/impairment?**
 Visual impairment Hearing impairment Mental Health
 Physical disability Long term illness or condition
- Are you a carer?**
 Yes No Prefer not to say
- To which gender do you identify?**
 Male Female Trans Male Trans female
 Gender neutral Other Prefer not to say
- What is your sexual orientation?**
 Heterosexual Bisexual Gay Lesbian
 Other Prefer not to say

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- 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
- What is your religion or belief?**
 Christian Muslim Hindu Jewish
 Sikh Other No religion or belief
 Prefer not to say
- 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	<ul style="list-style-type: none"> Review of closed complaint file. Were all elements of the process completed and recorded on database? 	Early Resolution and Taking a Closer Look (10 per month)	Report to QGSG in annual report
Complainant experience	<ul style="list-style-type: none"> What % of complainants received a response to their complaint within the agreed timeframe? Were at least two attempts made to complete a follow up telephone call post complaint response being delivered to complainant? 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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 PSS. 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	
Name of person initiating policy, proposal or report	
Name of receiving committee	
Details of stakeholders consulted in process	

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			
Sex/gender			
Disability (mental, physical and learning)			
Race/ethnicity			
Religion or belief			
Sexual orientation			
Pregnancy/maternity			
Marriage/civil partnership			
Gender re-assignment			

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? High/medium/low (delete as appropriate).

14 References

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