# COMPLAINTS, CONCERNS AND COMPLIMENTS POLICY

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**DOCUMENT CONTROL**

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**Amendments:** Update of policy to reflect current legislation and Trust practice, in line with Patients Association Standards.

**Document objectives:** To provide information to staff and the public regarding the Trust’s Complaints Procedure and PALS Service.

**Intended recipients:** All Trust staff and members of the public

**Committee/Group Consulted:** Patient and Public Involvement Group; Quality and Performance Committee

**Monitoring arrangements and indicators:** Patient and Carer Involvement Group

**Training/resource implications:** Corporate Induction training.

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**Contact for review** Patient Experience Manager

**Lead Director** Director of Strategy and Corporate Affairs

**CONTRIBUTION LIST Key individuals involved in developing the document**

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1 INTRODUCTION

1.1 The Trust welcomes feedback from all patients and their families and carers. Listening and acting upon feedback is an essential part of providing safe, patient-centred care.

1.2 All feedback from patients and carers, including concerns and complaints, provides essential information about the services the Trust provides. Feedback helps to identify areas which are working well and areas which require a change or need for improvements.

1.3 All health organisations must have a procedure in place for the management of complaints and concerns in order to follow the NHS Complaints regulations (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009).

1.4 All formal complaints received by the Trust are properly investigated in accordance with the regulations and the Patients Association Standards (Appendix H). We aim to resolve all complaints locally, wherever possible and reasonable.

Policy statement

1.5 All staff are committed to listening to patients and carers through responding to compliments, concerns and complaints during the course of their work.

1.6 Patients and their families can feedback to all staff members, nursing staff, ward and service managers, the PALS service and the complaints manager.

1.7 We welcome all feedback verbally, face to face, via the telephone, letters, emails and other online media including social media where the Trust has an account.

1.8 We will support all patients and their families to give feedback, taking into account however they might best communicate with us. We will strive to meet the information and communication support needs of patients and carers where those needs relate to a physical or learning disability, impairment or sensory loss, in line with the Accessible Information Standard.

1.9 No member of staff will treat a patient, carer, relative or representative unfairly because they have raised a complaint or concern.

2 PURPOSE AND SCOPE OF THIS POLICY

2.1 The purpose of this policy is to provide a framework for listening and responding to all patient feedback including complaints.

2.2 The aim of this policy is to ensure that we comply with the user-lead vision for raising concerns and complaints described in the ‘My Expectations’ report (Appendix I):

- I felt confident to speak up.
- I felt that making my complaint was simple.
- I felt listened to and understood.
- I felt that my complaint made a difference.
- I would feel confident making a complaint in the future.

**DUTIES AND RESPONSIBILITIES**

2.3 **All staff** have a duty to respond to complaints and concerns in the first instance, requesting advice and help from their line managers as needed. All staff caring for patients should be familiar with the procedures detailed in this document and other related policies and immediately inform their line manager of any complaints they receive.

2.4 All staff are responsible for responding to patient feedback wherever they can, with the support of their line manager, to apologise and put things right when needed, and to record and promote good practice that is highlighted by patient feedback.

2.5 **The Chief Executive** is the responsible officer for complaints and oversees and agrees all final response letters in reply to all formal complaints received by the Trust.

2.6 The **Trust Board** agrees the policy and its content and is made aware of all formal complaints raised.

2.7 The **Trust Board** is responsible for reviewing learning from complaints and ensuring that this is heard at every level of the Trust.

2.8 The **Director of Strategy and Corporate Affairs** is the Executive Lead for this policy and will ensure policy development and review takes place at least every three years, or sooner in line with local and national guidance.

2.9 The **Director of Nursing and Patient Safety** reviews all new complaints to ensure they are being managed with the appropriate clinical input and risk assessed appropriately.

2.10 **Heads of Division** will be responsible for the management of investigation of formal complaints and will assist the Complaints Manager in providing a comprehensive response to the patient or carer from the Chief Executive. In the complaints procedure they are considered the “Decision Makers”.

2.11 **Service and Team Managers** are responsible for carrying out investigations as requested by the Decision Maker and ensuring that all comments received by Complaints and PALS are properly considered and responded to. In the complaints procedure they are considered the “Investigation Leads”. All Heads of Service should ensure that they have copies of PALS and Complaints leaflets available for enquirers and that the Complaints Poster is on display in a public area in all services; Leaflets and posters are available in a range of formats and languages to meet the diverse needs of the communities of Somerset and managers should obtain the appropriate version/s for their service.

2.12 **Line Managers** are responsible for ensuring all staff are conversant with this policy and related policies. Line managers should seek advice from PALS about outstanding issues, who can offer support to the team and the enquirer. Where
Concerns and comments are received at a service or ward level and a response provided, PALS should be provided with a copy to be logged on the Datix system. All formal complaints should be passed to the Complaints Manager. Managers should support staff in their interaction with patient or carers, particularly in cases where some personal animosity is evident.

2.13 The Patient Advice and Liaison Service (PALS) Staff are responsible for providing the PALS service and ensuring that it is available to all members of the community:

- To support patients and their families through Trust services by providing timely and appropriate information;
- To actively seek views from the public to ensure effective services;
- To alert senior managers of any trends emerging from patient and carer feedback;
- To provide help for staff to negotiate solutions to problems; and
- To keep a log of all issues raised on the Datix database and provide reports to senior management and the Board about the views of patients and the public obtained through the PALS service.

2.14 The Complaints Manager is responsible for:

- monitoring the implementation of the complaints procedure;
- monitoring and oversight of the effectiveness of the PALs and complaints procedures;
- being available and accessible to patients or carers;
- maintaining records of complaints, action taken, and outcome;
- writing reports to the Clinical Governance, Quality and Performance Committee and Patient and Carer Involvement Groups;
- Providing statistical returns;
- Providing information to the Parliamentary Health Service Ombudsman where requested;
- Ensuring the complaints process takes into account diversity needs including access to translation and interpreting services.
- monitoring compliance with the content of this policy at an operational level. This is undertaken through the production of monthly, quarterly and annual reports.

Governance responsibility:

2.15 The Patient and Carer Involvement Group is responsible for reviewing trends data in relation to complaints received.

2.16 The Quality and Performance Committee receives quarterly performance and risk reports from the Patient and Carer Involvement Group.
2.17 The **Quality and Performance Committee** is responsible for monitoring the implementation of action plans produced in respect of recommendations raised by the Parliamentary and Health Service Ombudsman (PHSO).

2.18 The **Clinical Governance Group** is responsible for reviewing and monitoring monthly PALS and complaints reports provided by the Complaints Manager, including the implementation of action plans and PHSO action plans as required.

3 **PATIENT ADVICE AND Liaison SERVICE (PALS)**

3.1 The Trust’s PALS service provides a single point of access for all patients, carers and their families who want to feedback, access support or seek information or advice about their care.

3.2 PALS provides help to patients by:
- receiving feedback about services
- supporting patients to raise concerns and complaints.
- assisting patients in accessing services and answering queries
- providing information and signposting patients to helpful services or information, including advocacy organisations.

3.3 PALS provides a service to the Trust by:
- actively seeking views from the public to ensure effective services.
- identifying trends to senior managers.
- providing on the spot help for staff to negotiate solutions to problems.
- supporting services to involve the public in service changes.

3.4 The PALS service is available Monday to Friday during working hours (9am – 5pm).

3.5 The PALS service can be accessed by telephone, email, face-to-face, written correspondence and text and other online media including social media where the Trust has an account.

3.6 All enquiries will be logged on the Datix database in order to build up a picture of trends in enquiries.

3.7 Leaflets and posters can be made available in a range of formats and languages to meet the diverse needs of the communities of Somerset.

3.8 The standards for our PALS service are set out in Appendix I.

4 **COMPLIMENTS**

4.1 The Trust welcomes thanks and compliments from patients, relatives, the general public and other professionals.

4.2 The Trust seeks to learn from good practice and what patients tell us is important to them.
4.3 Compliments can be given to all staff members, verbally, face to face, in writing and email, via the telephone and other online media including social media where the Trust has an account.

4.4 Service and Team Managers should ensure that they submit a quarterly compliments return to the Governance Directorate which is then reported to the Patient and Carer Involvement Group and to the Trust Board.

5 CONCERNS

5.1 Some patients or their carers or families may have concerns about the Trust’s services that they would like resolved without making a formal complaint.

5.2 All patients and their families must be encouraged to raise concerns in order to resolve any worries or problems with care and improve services.

5.3 Concerns may be raised verbally or in writing. Patients should be encouraged where possible to raise concerns directly with the staff members involved in their care. Alternatively, concerns can be raised with the service/ward manager or the PALS service.

5.4 The PALS Service can help patients or carers with concerns by investigating concerns raised or meeting with the patient or carer, with service staff where this is felt appropriate. These meetings may be called ‘resolution meetings’ and PALS officers can support these meeting by taking notes and facilitating meetings.

5.5 The person raising the concern will be kept informed of all progress made and should be involved in the process.

5.6 If staff are not sure whether a concern should be dealt with informally or as a formal complaint, staff should discuss the issue with either the PALS staff, Complaints Manager or their Line Manager. Emphasis should be placed on resolving the issue quickly and sensitively at a ward or service level where possible.

5.7 Some patients will prefer to raise their initial concern with someone who has not been involved in their care. In these circumstances they should be advised, and assisted if necessary, to address their complaint to the Service Manager, PALS team or complaints manager.

5.8 All concerns raised should be reported to PALS by the service manager in order to keep a record of lessons learned and trends arising across the Trust.

6 FORMAL COMPLAINTS

6.1 Formal complaints are dealt with under the NHS Complaints Regulations and according to the Patients Association Complaints Standards.

6.2 A concern should be handled as a formal complaint if:

(i) the patient or carer wants their concern handled as a formal complaint;
(ii) it cannot be resolved quickly by the service or team manager within a short timeframe (less than five working days) or as agreed with the patient or carer;

(iii) there is important learning for other services or for the Trust;

(iv) the concern relates to a significant issue or a breach of fundamental standards of care.

6.3 In such cases, patients should be encouraged and supported to raise a formal complaint.

6.4 A complaint may be resolved without invoking the full complaints procedure if it has been made verbally and can be resolved within one working day.

6.5 A formal complaint may be made in writing, verbally (over the telephone or face to face) or via email to any member of staff. All formal complaints should be sent to the Complaints Manager or PALS Team for immediate action and recording on the DATIX complaints database.

6.6 The Trust recognises the important role provided by advocacy services in assisting patient or carers through the complaints process. The Trust will ensure that individuals are made aware of how to contact the local advocacy services by publicising these services, particularly through the PALS and complaints process.

6.7 The Trust will ensure people are able to complain in a variety of ways to suit their diverse backgrounds including sensory loss support, language support and those who cannot read or write. The Trust will ensure the services of a professional translator or interpreter if required.

6.8 The Mental Health Act Code of Practice should be referred to for more information about complaints made by or on behalf of patients who are being treated under the Mental Health Act. Patients or carers who wish to raise complaints about care and treatment under the Mental Health Act can do so using the procedures explained in this policy.

7  WHO MAY COMPLAIN

7.1 Complaints can be raised by, or on behalf of, existing or former patients of the Trust.

7.2 Carers and relatives can raise concerns on behalf of patients. Carers can also raise concerns about the care and treatment that they, as carers, have received.

7.3 If the person concerned is unable to act for him or herself, or has died, the complaint may be taken forward by a relative or carer.

7.4 Where the issue is raised by a third party and it directly relates to the circumstances surrounding a patient’s care, it may be necessary to gain patient authorisation/consent in writing from the patient before any information about their care is shared.
7.5 Patients or carers can choose to make complaints or raise concerns anonymously; however, these may be difficult to investigate. This will be discussed with the patient or carer if possible.

7.6 All complaints will be investigated but in order to release the full finding to the patient or carer in cases where a patient is unable to make a complaint due to capacity or death, suitable evidence must be presented to show that the representative has authority to act in this capacity (for example, they hold Enduring Power of Attorney).

7.7 Complaints may be raised by solicitors on behalf of their clients.

7.8 Detained patients should be made aware of their entitlement at any stage to contact the Care Quality Commission (CQC) with complaints (Appendix G), and helped to do so if necessary. (The Commission will not take action until the Trust’s complaints procedure has been completed, but should be kept informed of progress.)

**MP Enquiries:**

7.9 Complaints may be raised by Members of Parliament (MP) on behalf of constituents. However, unless an MP enquiry is clearly referred to as a complaint, it will not be dealt with through the complaints service but instead the investigation will be managed by the Chief Operating Officer and responded to in writing by the Chief Executive Officer.

8 **WHO CANNOT COMPLAIN?**

8.1 Staff of the Trust and other providers or commissioners can only use the NHS complaints procedure if their complaint relates to their own health care or that of a friend or relative. In both situations they are acting as a patient or member of the public and not a member of staff or their relative in line with the criteria set out in section 7.

8.2 Staff grievances cannot be dealt with through the complaints process. The Trust has local procedures for handling staff concerns about health care issues, and established grievance and openness procedures. Staff should refer to their line manager or HR representative for further guidance.

8.3 Other providers or commissioners may raise concerns about Trust services formally but these will not be investigated through the NHS complaints procedure; instead, these will be investigated and a formal response will be sent from the Chief Operating Officer.

9 **TIME LIMITS**

9.1 Ideally, a complaint should be made within one year of the incident, or within one year of the patient or carer realising there is something to complain about. This is because of the difficulties in obtaining accurate information about a patient’s care after such a period of time. However, we will extend this time limit where it would be unreasonable in the circumstances for the complaint to have been made earlier, and/or where it is still possible to investigate the facts of the case.
10 COMPLAINTS PROCEDURE: LOCAL RESOLUTION

10.1 The NHS complaints procedure is in two stages, local resolution and independent review by the Parliamentary and Health Service Ombudsman (see complaints handling diagram Appendix B).

10.2 The primary objective of Local Resolution is to investigate and resolve the patient or family’s complaint and learn from any issues raised.

10.3 The first responsibility of a recipient of a complaint is to ensure, before doing anything else, that the patient’s immediate health and social care needs are being met. This may require urgent action before any matters relating to the complaint are investigated. This is likely to involve speaking to the patient or their family at the earliest opportunity.

10.4 Patients or carers should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they say will be treated with the appropriate confidentiality and sensitivity.

10.5 Our procedure for dealing with a complaint is set out in Appendix J.

11 COMPLAINTS PROCEDURE: INDEPENDENT REVIEW

Parliamentary and Health Service Ombudsman (PHSO)

11.1 Patients or carers who are dissatisfied with the outcome of local resolution have the right to contact the Parliamentary and Health Service Ombudsman. The patient or carer has one year from the end of local resolution to do this. The PHSO will independently review the complaint and decide what action should be taken next.

11.2 They may decide:

- the complaint has been answered fully by the Trust and no further action is necessary;
- the complaint has raised issues the Trust should address. They will then make recommendations to the Trust on how to make improvements for the future and/or appropriate redress.

11.3 This is the last stage of the complaints process and the Ombudsman’s decision is final.

11.4 Contact details for the Ombudsman can be found in Appendix C.

12 ROLES IN THE COMPLAINTS PROCESS

Complaints Team:

12.1 The Complaints Manager is the PALS and Complaints Manager of the Trust. The Complaints Manager is responsible for agreeing a summary of the complaint with the patient or carer, managing the complaints file and administration.

Decision Maker:

12.2 The Decision Maker is usually the Head of Division. They are responsible for assigning the complaint to an Investigation Lead, who will investigate the
complaint. The Decision Maker has the responsibility for reviewing the findings of the investigation and deciding whether the Investigation Lead’s decision is correct.

**Investigation Lead:**

12.3 The Investigation Lead is usually the service or team manager. They are responsible for investigating the complaint, reviewing medical records, interviewing staff and carrying out a thorough investigation. They draft the response letter from the Chief Executive and the Complaints Action Plan.

**Complaints involving other health or social care providers or commissioners:**

12.4 If a complaint is made about care delivered by more than one organisation, a lead organisation will provide a single point of access for investigating the complaint. The Joint Protocol (Appendix F) will be followed.

13 **SERIOUS INCIDENTS AND SAFEGUARDING CONCERNS**

13.1 Where a complaint is considered to be of a serious nature, consideration will be given to the commissioning of an RCA (Root Cause Analysis) Investigation as described within the Serious Incidents Requiring Investigations (SIRI) Policy.

13.2 The Safeguarding Lead for the Trust should be contacted if a complaint or concern received raises an issue relating to safeguarding children or adults.

14 **COMPLAINTS AND DISCIPLINARY ACTION**

14.1 The complaints procedure will only be concerned with resolving complaints and not with the investigation of disciplinary matters, which are managed separately.

14.2 If a disciplinary investigation is felt to be necessary, the Investigation Lead will seek advice from the Human Resources directorate (HR) and follow the relevant HR policies.

14.3 The patient or carer should be informed and reassured that the appropriate policies have been followed.

14.4 Any complaint which concerns possible allegations of fraud and corruption is passed immediately to the Trust Director of Finance for further investigation. (Please refer to the Trust Counter Fraud Policy).

15 **SECURITY OF PATIENT INFORMATION**

15.1 The PALS and Complaints staff will only request and access information about patients on a ‘need to know’ basis, in order to perform their duties and ensure safe patient care.

15.2 Investigation of a complaint does not remove the need to respect a patient’s confidentiality and everyone working within the Trust has a legal duty to keep records confidential (with specific exceptions).

15.3 Correspondence relating to formal complaints will not be filed in the patient’s notes or uploaded to any electronic patient notes system.
15.4 PALS and Complaints records will be kept for a period of 10 years from the date that the record is created. At the end of this 10 year period all information on that case (paper and electronic) will be reviewed and if no longer required by the Trust will be shredded (paper) and deleted (electronic) from the Trust’s systems.

16 UNREASONABLY PERSISTENT COMPLAINANTS

16.1 Patient or carers (and/or anyone acting on their behalf) may be deemed to be ‘unreasonably persistent complainants’ where they meet two or more of the following criteria:

(i) persistence in pursuing a complaint where the NHS complaints procedure has been fully implemented and exhausted;

(ii) refusal to pursue the next stage in the procedure by not applying to the Parliamentary and Health Service Ombudsman (PHSO) whilst still communicating dissatisfaction with the Trust’s response;

(iii) Persistently changing the substance of a complaint or raising new issues during the process of resolution (care must be taken, however, not to overlook new issues which differ significantly from the original complaint. These should be recorded and dealt with as new complaints);

(iv) unwillingness to accept documentary evidence as being factual;

(v) unwillingness to accept that the time elapsed since the situation complained about has been too long to enable verification of facts;

(vi) lack of clarity about the precise issues the patient or carer wishes to be investigated, despite reasonable efforts by Trust staff and, where appropriate, an advocate to help them to achieve this;

(vii) the concerns identified are not within the Trust’s remit to investigate or remedy but this is not acknowledged by the patient or carer;

(viii) unreasonable focus on a trivial matter which appears out of proportion to their significance (in this situation, it is crucial to realise that decisions about the importance of such matters are subjective, and must be made sensitively, taking into account the patient or carer’s personal situation);

(ix) excessive numbers of contacts made by patient or carers in the course of pursuing a complaint. These may be via any communication medium, and/or in person. Judgement based on the specific circumstances of each case will enable an appropriate decision about the point at which contacts are considered to be excessive in number;

(x) recording meetings, face-to-face or telephone conversations without the prior knowledge and consent of the parties involved and/or using these recordings without prior permission;

(xi) refusing to accept a staff member as a single point of contact when this has been requested, and contacting other staff members despite requests not to do so;

(xii) if physical or non-physical violence or aggressive or inappropriate language is threatened or used towards staff or their families/associates.
17 TRAINING REQUIREMENTS

17.1 Training in customer care and complaints resolution is provided at the Corporate Induction training for all new staff.

17.2 Team awareness sessions will be provided on request.

17.3 One to one training sessions will be provided on request.

17.4 Training for Decision Makers and Investigation Leads will be provided.

Complaints relating to Transgender issues

17.5 There are special rules for dealing with any complaints relating to transgender issues. Please see Appendix D at the back of this policy for further information.

18 MONITORING LEARNING AND EFFECTIVENESS

Monthly reports are produced by the Complaints Manager and submitted to the Clinical Governance Group. Reports include:

- Number of complaints;
- Risk profile of each complaint;
- Details of the complaints handling process and the outcome of investigations, including learning;
- Number of PALS enquiries received and by service;
- Any themes identified in complaints and PALS enquiries.

a. In addition to the work undertaken by the Clinical Governance Group, the Patient and Carer Involvement Group considers issues arising from complaints. Quarterly trend analysis reports are provided to the Group to enable consideration of trends in complaints and PALS. Reports also provide a summary risk grading in relation to complaints received to enable the prompt identification and escalation of significant issues.

b. Quarterly reports are provided by the Patient and Carer Involvement Group to the Quality and Performance Committee and to the Council of Governors. This includes the escalation of areas of concern or significant areas of risk. It is the responsibility of the Quality and Performance Committee to escalate emerging risks to the Board via quarterly reporting.

c. Monitoring of action plans produced in respect of recommendations raised by the Parliamentary and Health Service Ombudsman (PHSO) is undertaken via the Quality and Performance Committee.

d. The Complaints annual report details the following information:
   - Breakdown of complaints received by type;
   - Breakdown of complaints received by speciality;
   - Narrative analysis of complaints.
   - The annual report is provided for approval by the Trust Board.
21 COUNTER FRAUD

21.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

22. RELEVANT CARE QUALITY COMMISSION (CQC) – REGISTRATION STANDARDS

22.1 Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 16: Receiving and acting on complaints
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments.

22.2 Under the CQC (Registration) Regulations 2009 (Part 4) the requirements which inform this procedural document are set out in the following regulations:

Regulation 18: Notification of other incidents

22.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

23 NATIONAL POLICIES AND LEGISLATION

a. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

b. The Equality Act 2010

c. Accessible Information Standard

24 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

24.1 References

NHS Guidance on Complaints Handling
‘My expectations for raising concerns and complaints’ – Local Government Ombudsman, Healthwatch England and Parliamentary and Health Service Ombudsman

Assurance of Good Complaints Handling for Acute and Community Care - A toolkit for commissioners – NHS England

24.2 Cross reference to other procedural documents

Being Open and Duty of Candour Policy
Confidentiality and Data Protection Policy
Consent and Capacity to Consent to Examination and Treatment Policy
Equality and Diversity Policy
Grievance and Disputes Policy
Managing Allegations Against Staff Policy
Risk Management Policy
Safeguarding Adults at Risk Policy
Serious Incidents Requiring Investigation (SIRI) Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

25 APPENDICES

For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A  Patient Advice and Liaison Service Enquiry Handling Diagram
Appendix B  Complaints Handling Diagram
Appendix C  Parliamentary and Health Service Ombudsman (PHSO)
Appendix D  Special Rules for Dealing with Transgender Issues
Appendix E  PALS and Complaints Consent Form
Appendix F  Joint Working Protocol for PALS and Complaints Handling
Appendix G  The Care Quality Commission (CQC)
Appendix H  Patients Association Complaints Standards
Appendix I  PALS Standards
Appendix J  Procedure for dealing with Unreasonably Persistent Complainants
Appendix J  My Expectations: I Statements
### COMPLAINTS PROCESS DIAGRAM

<table>
<thead>
<tr>
<th>Working Days</th>
<th>Stage</th>
<th>What happens?</th>
<th>Who is responsible?</th>
<th>What should be on the Complaints file?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Complaint received and triaged</td>
<td><strong>What happens?</strong></td>
<td>Complaints Manager</td>
<td>• Complaint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaint received (written or verbal) and passed to Complaints Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints Manager telephones patient or carer to agree what will be investigated and if there are is anything in particular that the patient or carer is seeking (e.g. an apology / a new appointment etc).</td>
<td>Complaints Manager</td>
<td>• Telephone Note</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acknowledgement letter sent confirming the above.</td>
<td>Complaints Manager</td>
<td>• Acknowledgement Letter</td>
</tr>
<tr>
<td>5</td>
<td>Investigation stage</td>
<td><strong>What happens?</strong></td>
<td>Complaints Manager</td>
<td>• Email</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Email sent to Lead Decision Maker asking them to investigate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision Maker decides who is to investigate (e.g. manager) and sends complaint to them. This person is the Lead Investigator.</td>
<td>Decision Maker</td>
<td>• Documentation e.g.: Patient records / statements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lead Investigator reviews case, takes statements where required, reviews patient records etc. and prepares draft response.</td>
<td>Lead Investigator</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Draft response stage</td>
<td><strong>What happens?</strong></td>
<td>Lead Investigator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lead investigator sends draft response and Action Plan to Decision Maker.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision Maker signs off response and sends to Complaints Team.</td>
<td>Decision Maker</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints Manager reviews response and sends to Director.</td>
<td>Complaints Manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director signs off letter.</td>
<td>Director of Governance</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Final response</td>
<td><strong>What happens?</strong></td>
<td>Chief Executive</td>
<td>• Final letter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaint care file taken to Chief Executive for final sign off and sending.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

CONTACT DETAILS

If you remain dissatisfied at the end of local resolution process, you can put your complaint to the Parliamentary and Health Service Ombudsman. The Ombudsman can carry out independent investigations into complaints about poor treatment or service provided through the NHS in England. The Ombudsman’s services are free.

**PHSO Helpline:** 0345 015 4033  
**Email:** phso.enquiries@ombudsman.org.uk  
**Fax:** 0300 061 4000.  
**Web:** www.ombudsman.org.uk.  
**Post:** The Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London, SW1P 4QP

Note:

Complaints which fall under both health and Local Government services may come under the remit of the Joint Working Committee of the Parliamentary and Health Service Ombudsman and the Local Government Ombudsman.
SPECIAL RULES FOR DEALING WITH TRANSGENDER ISSUES

All staff who are involved in investigating a complaint must be aware of the nine equality groups (protected characteristics) where discrimination could occur:

- age
- disability
- Gender re-assignment
- Marriage or Civil partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual orientation

All staff should refer to the Trust Equality Lead if they feel discrimination has taken place.

Section 22 of the Gender Recognition Act 2004

Section 22 of the Gender Recognition Act (GRA) makes it a criminal offence for any individual who has obtained the information in an official capacity to disclose that a person has applied for a gender recognition certificate (GRC) or, if the person’s application has been successful, to disclose any information relating to that person’s gender history.

Section 22 of the Act is designed to protect the privacy rights of transsexual people under Article 8 of the European Convention on Human Rights by criminalising the disclosure of information relating to their gender history by a person who acquired that information in an official capacity. Section 22 sets out a series of exceptions.

How does this relate to handling patient complaints?

Complaints are often received directly by the Chief Executive or Chair; the legislation is that they are not then allowed to forward on the complaint as they normally would if the patient or carer advises them they already have, or are currently, undergoing transition and are applying for a full GRC.

In this case, it is the responsibility of the recipient’s office to either redact the Person Identifiable element, and then request the Complaints Manager or a clinician to answer the complaint, or if this is not possible, they should redact the information that the patient or carer is undergoing or has undergone transition and that they have been granted or applied for a Gender Recognition Certificate before forwarding the complaint to be investigated.

Disclosure of protected information does not constitute an offence. These concern disclosure for the purpose of obtaining legal advice (article 3), disclosure for religious
purposes (article 4) or medical purposes (article 5), disclosure by or on behalf of a credit reference agency (article 6) and disclosure for purposes in relation to insolvency or bankruptcy (article 7). Article 5 uses the terms “registered medical practitioner” and (in relation to a nurse) “registered”.

Although transsexual people who have not applied for a GRC are not protected by the GRA, their transsexual status would nevertheless constitute sensitive personal data as defined by the Data Protection Act 1998. Procedures should be put in place to safeguard ‘protected information’ as defined by the GRA, and should, where possible, be extended to transsexual people who do not hold GRCs.

For further information see: http://www.legislation.gov.uk/ukpga/2004/7/section/22
## PALS AND COMPLAINTS CONSENT FORM

### CONSENT FORM

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
</tbody>
</table>

I give permission for

…………………………………………………………………………………………………………………………………………………………
name of person raising concerns on my behalf

To receive information about my treatment, care, social or personal information held by Somerset Partnership NHS Foundation Trust in relation to the concerns they have raised on my behalf.

I understand that if I have any concerns over this information I can ask either the Complaints Manager (01278 432022) or staff working with me for advice before agreeing to its disclosure.

I am aware that the Trust may not be able to disclose information if it relates to another person (third party) or may cause serious harm to any living person, even if I have consented to its release.

Please do not disclose *(if applicable)*

<table>
<thead>
<tr>
<th>Patient’s signature</th>
<th>Patient’s name</th>
</tr>
</thead>
</table>

| Date                |

Please return this signed form to the following Freepost address (no stamp required). Please mark the envelope for the attention of PALS.

FREEPOST RSXK-USUL-SUHY
Somerset Partnership NHS Foundation Trust
2nd Floor, Mallard Court
Express Park, Bristol Road
Bridgwater TA6 4RN
An agreement between:

Taunton and Somerset Hospitals NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
Somerset County Council
Somerset Partnership NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Somerset Doctors Urgent Care

Version 2
June 2016
PROTOCOL FOR JOINT
WORKING ON PALS/COMPLAINTS

1 INTRODUCTION

1.1 If a complaint is made about care delivered by more than one organisation named in this protocol, it is important to provide a single point of contact and a single response to the enquirer/complainant.

1.2 This document is an agreed protocol for handling such enquiries or complaints. The aim of this protocol is to:

- help to avoid confusion for the enquirer/complainant
- provide clarity about the responsibilities of each organisation
- encourage regular communication
- help to ensure that the relevant organisations learn from the incident, and provide jointly agreed timescales for resolution

1.3 This document includes:

- confirmation of the signatory organisations
- a flow chart showing how joint PALS/complaints will be handled

2 PURPOSE

2.1 Dealing with a wide range of health and social care organisations can be confusing for people. This protocol aims to address this, by bringing together the various organisations to provide a unified, responsive and effective service for enquirers/complainants.

2.2 This protocol provides a framework for collaboration in handling enquiries and complaints, to ensure:

- a single consistent and agreed contact point for all contacts
- regular and effective liaison and communication between PALS/Complaints Managers and contacts, and
- that learning points arising from enquiries/complaints covering more than one body are identified and addressed by each organisation involved in that case

3 THE ROLE OF THE COMPLAINTS MANAGERS

3.1 The designated PALS/Complaints/Customer Experience Manager in each organisation that signs up to this protocol is responsible for:

- co-ordinating whatever actions are required within jointly agreed timescales
• co-operating with other managers and agreeing who will take the lead role in joint cases

• ensuring that there is someone else to whom any requests for collaboration can be addressed when they are absent

4 IDENTIFYING THE LEAD ORGANISATION

4.1 When determining which organisation will take the lead role in a joint enquiry/complaint, the following will be taken into account:

• which organisation manages integrated services
• which organisation is care managing the individual patient / client
• which organisation is responsible for the most significant element of the enquiry/complaint
• which organisation does the larger number of issues in the enquiry/complaint relates to
• which organisation originally received the complaint (if the seriousness and number of complaints are about the same for each one)
• whether the complainant has a clear preference for which organisation takes the lead

4.2 At the outset of the enquiry / complaint, the lead organisation should clarify with the complainant the outcome the complainant is seeking at the outset and re-visit this, during the process, as appropriate.

5 PROCESS

5.1 The enquirer/complainant should receive one single, co-ordinated response by the method agreed by the lead organisation.

5.2 PALS/Complaints managers will need to co-operate closely, with the agreement and involvement of the enquirer/complainant where appropriate.

5.3 The lead organisation should ensure that the draft response is circulated for comment and agreement before it is sent to the enquirer/complainant as part of the quality assurance for the PALS/complaints process.

5.4 Timescales for due process will be agreed between all organisations and the enquirer/complainant.

6 COMPLAINTS ABOUT ONE ORGANISATION THAT ARE ADDRESSED TO ANOTHER ORGANISATION

6.1 On occasions, a complaint that is concerned in its entirety with one provider’s services is sent to another provider or Trust. The Complaints Manager of the organisation receiving such a complaint should:

• contact the complainant within three working days
• advise them that the complaint has been addressed to the wrong organisation

• ask if they want it to be forwarded to the other organisation on their behalf

6.2 Provided that the complainant agrees, the complaint should be sent to the other organisation immediately and a written acknowledgement should be sent to the complainant, detailing where/to whom the letter has been sent, including the contact details.

7 ENQUIRER’S/COMPLAINANT’S CONSENT ABOUT SHARING INFORMATION BETWEEN ORGANISATIONS

7.1 By law, all organisations have to ensure that information relating to individual service users and patients is protected, in line with the requirements of the Data Protection Act, Caldicott 2 principles and the confidentiality policies of that organisation.

7.2 The enquirer/complainant must give their consent before information relating to the concern/complaint is passed between organisations. Wherever possible, this should be in written form, but otherwise verbal consent should be recorded and logged. The enquirer/complainant is entitled to a full explanation of why their consent is being sought.

7.3 If the enquirer/complainant does not agree to the concern/complaint being passed to the other organisation, the PALS/complaints manager of the receiving organisation should:

- advise the complainant that elements of their complaint involves other organisation(s) and this is essential if they are seeking resolution of those particular elements

- seek to resolve any issues or concerns with the complainant about remit and responsibility

- offer any liaison that could contribute to resolving the matter

- remind the complainant of their entitlement to contact the other organisation directly

7.4 The Data Protection Act requires informed and explicit consent for the sharing of sensitive personal information such as Medical and Social Care records. However, there are a number of exemptions detailed in the Act. The most likely to be encountered is the need to share in accordance with Safeguarding Children or Protection of Vulnerable Adults procedures or other service user safety issues. In such cases, the organisation should refer to their own individual safeguarding procedures and advice.
7.5 It will be the responsibility of the lead organisation to obtain valid consent from the patient or their representative. If there is any doubt as to the veracity of the consent, then an identity check will be sought.

7.6 It is essential for the effective continuity of care and the successful resolution of the complaint, that information is exchanged where appropriate and both NHS and Social Care should do all they can to facilitate the process for the benefit of patients and clients. Close co-operation between PALS/complaints managers is crucial to ensure that confidential case file information is shared appropriately, and that the necessary safeguards are put in place.

7.7 Information exchanged under this protocol can be used only for the purpose for which it was obtained.

8 LEARNING FROM COMPLAINTS

8.1 It is vital to identify communication, procedural, operational or strategic issues within and across each organisation. It may be necessary to share information with other organisations when serious concerns are raised about a health or social care worker.

8.2 If matters come to attention regarding competency and fitness to practice these must be raised through the employing organisation’s HR procedures.

8.3 Enquirers and complainants may be kept updated of learning outcomes following resolution if the complainant has requested this information.

8.4 Learning from individual complaints should be collated by the lead organisation and be included in the joint response letter. It should also be fed back to the other organisations involved in the complaint. There is an expectation that this learning is then taken forward by each individual organisation through their own processes/procedures.

8.5 The protocol will be adopted by each participating organisation by inclusion in their individual complaints policy and approved by each organisation through their usual governance procedures.

8.6 The Duty of Candour will need to be considered. In general, each organisation must discharge their own obligation for Duty of Candour. Where the Duty is shared, or is not clear, then agreement must be reached between relevant organisations about who will take responsibility.
FLOW CHART FOR HANDLING
JOINT ORGANISATION COMPLAINTS

Complaint received – the protocol sets out the factors that determine which organisation will take the lead and new timescales for completion are agreed. If this is not clear, the PALS/Complaints Manager contacts the other organisations involved to jointly agree how the complaint is best dealt with.

Once this is decided the lead PALS/Complaints Manager should contact the enquirer/complainant to discuss their concern/complaint, agree how the concern/complaint will be handled, confirm the issues to be addressed and establish the outcome the complainant is seeking. Explain the implications of a joint organisation concern/complaint and who will co-ordinate the response and advise of timescales set by the organisations involved with the investigation.

Further contact with the enquirer/complainant to be made if the timescales look like they will be breached. New timescales negotiated and shared with organisations involved.

Lead PALS/Complaints Manager to circulate draft response for comment and agreement before it is sent to the enquirer/complainant.

Enquirer/complainant provided with joint organisational response and same shared with all organisations involved.

Action plans are prepared by each organisation to demonstrate learning and organisational improvement where appropriate. These should be shared across the organisations concerned.
THE CARE QUALITY COMMISSION:

The CQC protects the rights and interests of people who are detained in hospital or on community treatment orders under the Mental Health Act.

Complaints can be made by anyone – patients, staff or any member of the public.

The CQC can deal with complaints if it is about the way a member of staff has used their powers under the Mental Health Act.

Powers and duties carried out under the Mental Health Act cover a wide range of services, including receiving care while detained in hospital, or while on a guardianship or community treatment order.

Such complaints can be made to one of the CQC’s Mental Health Act Reviewers, or via post to:

CQC Mental Health Act
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Phone: 03000 616161 - press ‘1’ to speak to the mental health team.

More information is available on the CQC’s website at: [http://www.cqc.org.uk/content/complain-about-use-mental-health-act](http://www.cqc.org.uk/content/complain-about-use-mental-health-act)

Mental Health Act Code of Practice should be referred to for more information about complaints made by or on behalf of patients who are being treated under the Mental Health Act.
Background

Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of care at NHS organisations. It provides a tangible and measurable reflection of the organisation’s commitment to an open and responsive safety culture. Numerous national reports have found that complaints are often handled poorly by the NHS. As long ago as 2004, the Shipman Inquiry stated that “… there is an urgent need for standards which can be applied… in dealing with complaints… These should be established as a matter of urgency…”

In November 2008, the Parliamentary and Health Service Ombudsman published the “Principles of Good Complaint Handling.” The report states:

“Good complaint handling should be led from the top, focused on outcomes, fair and proportionate, and sensitive to complainants’ needs. The process should be clear and straightforward, and readily accessible to customers. It should be well managed throughout so that decisions are taken quickly, things put right where necessary and lessons learnt for service improvement.”

The Patients Association considers that these key principles should be used as the guiding framework for determining whether a complaint was handled well or badly. The Patients Association also believes that a uniform approach to complaint management is required across the healthcare sector as a whole if it is to maintain the confidence of the public at large.

As part of the Health Foundation funded ‘Speaking Up’ project, the Patients Association has been developing tools aimed at improving the quality of complaints handling at Mid Staffordshire NHS Foundation Trust and elsewhere. This included developing a set of good practice standards for complaints handling. These were refined over a two year period by a group including clinicians, lay people and complaint managers.

The work and the standards on complaint handling which we developed as part of this project were commended by Robert Francis, QC, in his recent public inquiry into the problems at Mid Staffordshire NHS FT (MSFT).

Recommendation 113 of the Public Inquiry report published in February 2013 states:

“Trusts should consider the recommendations and standards
developed by the Patients Association in its work with Mid Staffs Hospital…”

This document details those standards. The first eight standards relate to the handling of an individual complaint case. They can be used by any NHS organisation which has to handle formal complaints. The last four standards are organisational standards.

This document is not intended to include all inclusive standards for every complaint investigation as each complaint received and the subsequent investigation that follows is unique. Neither should it be construed as legal advice. However, the standards should allow individuals and organisations to assess their practice, approach complaints handling in a robust and rigorous way and make adjustments to their systems and processes where necessary. Finally, we believe that organisations have a responsibility to learn from each other as much as they can and also agree to share what they know.

**Overarching Principles**

When managing a complaint, all those involved (the complainant, staff members etc.) should be treated with respect, tact, compassion and concern for their wellbeing. It is important to listen carefully to what people say and to conduct the investigation in a fair and objective manner.

The Patients Association also believes that organisations should be able to demonstrate to all stakeholders that the investigation and the decision making processes has been:

- Open and transparent;
- Evidence based;
- Logical and rational;
- Comprehensive and with a level of detail appropriate to the seriousness of the complaint;
- Timely and expeditious;
- Proportionate to the seriousness of the complaint(s) raised.
What is a complaint?

The Patients Association define a complaint as:

“An expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a response. There is no difference between a ‘formal’ and an ‘informal’ complaint. Both are expressions of dissatisfaction.”
The Patients Association Good Practice Standards

**Standard 1.** The Complainant has a single point of contact in the Organisation and is placed at the centre of the process. The nature of their complaint and the outcome they are seeking is established at the outset.

Complainants are provided with a named individual, a single point of contact with whom they can liaise. There is equality of access for all complainants, with particular consideration for those people who may find it more difficult to use the process.

1.1 The complainant is given contact details for a named person with whom they can liaise with throughout the process.

Best thought of as a ‘case worker’, complainants should be able to establish a working relationship with a named person who can act as their liaison throughout the process. References to “on behalf of the team” or similar would not constitute a named person. If an assigned case worker is away, ideally, complainants should be informed of an alternative point of contact.

1.2a. Sufficient attempts are made to contact the complainant verbally.

Unless explicitly asked not to, it is good practice to try and establish verbal communication even if just at the outset. This is typically carried out by phone. We would define ‘sufficient’ as a minimum of three attempts.

1.2b. If there is verbal contact, the person making the call should accurately establish the aspects of the complaint and the solutions the complainant wants in order to resolve the complaint.

If a complainant is contacted verbally, whoever speaks to them should record the details of their complaint and the outcome they are seeking to achieve.
1.3. The complainant’s preferred method of communication should be established at the earliest opportunity.

The legislation requires that the complainants preferred method of communication be established (Regulation 13 (1) – complaints may be made orally, in writing or electronically). Complainants may wish to communicate in writing, over the phone, by email or through face to face meetings. At the point of initial contact the preferred method of communication should be established. It may be that the complainant states at the outset how they wish to communicate e.g. stating in a complaint letter that they wish to communicate by writing.

1.4 An explanation of how the complaints process at the organisation works should be provided.

Explaining how the complaints process works is the first step in ensuring the complainant is well informed about what to expect and how typically complaints are handled.

1.5 The complainant should be offered a face to face meeting to discuss the issues raised early on in the process.

It is good practice to offer face to face meetings, especially when complaints relate to more serious issues or complex circumstances. It may be that it was explicitly raised by the complainant that they would not like a face to face meeting, in which case select ‘not applicable’. In addition, you may judge that, for some reason, offering a meeting was inappropriate.

1.6 Third party consent should be obtained, where the complaint was made on behalf of the patient.

Consent is required when communicating to the complainant about the details of a third party and the Trust should have a written record from the third party giving their consent. This includes MPs writing on behalf of constituents.
1.7 Where the complainant is communicating through a third party (e.g. an independent advocacy service provider, Member of Parliament or a solicitor), the organisation establishes the boundaries of communication e.g. does the complainant wish to be copied into correspondence? Would they still be interested in a face to face meeting? What amount of clinical information can be released to the third party?

* A letter from a solicitor does not prevent an organisation from attempting to establish good relationships with a complainant, including offering to meet still and copy in correspondence.

1.8 A written acknowledgement is sent to the complainant in the three day time frame.

* Written acknowledgement within three days of receipt is one of the few specific requirements of the law regarding complaints handling (Regulation 13 (3)). Unless explicitly asked not to, this should be a hard copy letter posted to the complainant.

1.9 The complainant is informed of the availability of third party support to help them during the complaint process.

* The legislation requires that complainants are informed of the existence of third party support to help them make their complaint (Regulation 3 (2) (d)), namely the Department of Health funded Independent Complaints Advocacy Service - ICAS. This should be done in either writing or verbally at the outset of the complaints process i.e. first conversation with the complainant or in the acknowledgement letter.

1.10 The outcome the complainant is seeking should be clearly established.

* Complainants may be seeking information, an apology, a second opinion on their treatment, the retraining or disciplining of staff and changes to practice amongst other things. The organisation should be clear what outcome is expected.
1.11 The manner in which the complaint is to be handled should be discussed with the complainant.

The legislation requires that the manner in which the complaint is to be handled is discussed with the complainant (Regulation 13 (7) (a)). This is in addition to a general explanation of the process covered earlier and might include who will investigate the complaint, how they propose to do it and what evidence they might be considering. There should be evidence of a record of a call or meeting with the complainant or through reference to a conversation in a letter to a complainant.

1.12a A timeframe for responding should be discussed with the complainant.

The legislation requires the organisation to discuss the timeframe for handling a complaint. Where such an offer is refused, the complainant should be informed of the organisation’s decisions on both these issues (Regulation 13 (7) (b)).

1.12b The complainant should be informed if the investigation may be taking more time than originally planned.

After setting a timeframe, the organisation should try its up most to stick to it. Where this proves difficult, the complainant should be informed in good time (Regulation 14 (1) (b) keep the complainant informed ......as to the progress of the investigation).

1.13 If yes, a new date for a response should be agreed with the complainant.

Whilst not required by legislation, it is good practice to agree a new timeframe when there is a delay.
**Standard 2.** The complaint undergoes initial assessment and any necessary immediate action is taken. A lead investigator is identified.

The complexity and seriousness of the complaint should influence the extent of any investigations. The level of seniority of the person leading any investigation must match the level of severity of the complaint i.e. the more serious the complaint, the more senior the investigating officer. Where conflict of interest issues arise, it is good practice to engage the services of a person who is external to the Organisation.

2.1 The complaint is recorded and initially assessed and categorised as low, moderate, high or extreme.

The organisation must make a record of the complaint ([Regulation 13 (2) (a)]). The organisation should have a risk rating scheme that looks at both severity of impact and the likelihood of repetition. Typically these classify complaints as low, moderate, high or extreme.

2.2 Categorisation is appropriate.

Correct grading of a complaint is important as it often determines the nature and quality of an investigation. It may be that the complaint has different distinct aspects of different severity, but the grading must relate to the highest area e.g. if any aspect could be rated as extreme, the complaint as a whole is rated as extreme.

2.3 Complaints relating to clinical care are risk assessed by a clinician of appropriate seniority.

Whilst non-clinical staff may provide an initial risk assessment, where the complaint is about clinical care, clinical staff must be involved in reviewing this risk assessment if not involved in the initial assessment.

2.4 Members of the executive team are alerted to a serious complaint.

In most instances when a complaint is major and always when extreme, there should be evidence of this being communicated to a Board level executive.
(e.g. Director of Nursing, Medical director, Chief Executive). Use your judgement as to whether an executive should be informed based on the detail of the complaint.

2.5 The complaint is communicated to external Organisations e.g. the Police, Care Quality Commission, Strategic Health Authority as appropriate.

In exceptional circumstances, the issues raised in a complaint may warrant communication to an external organisation. For example, the police may be contacted when a criminal offence is suspected.

2.6 Where serious misconduct is suspected, the individual(s) is suspended, pending further investigation.

Suspension is warranted when the content of a complaint suggests an individual(s) poses a significant risk to others at the time the complaint is made. Suspending that individual reduces that risk while the organisation investigates further.

2.7 A lead investigator is identified.

The lead investigator is responsible for planning the investigation and gathering all the evidence together and its conclusion. Complaints that cross departments may have a number of ‘investigators’ but a lead investigator should have oversight. Coordination and administration does not constitute investigation. The person might be identified on a complaint case file or in the response letter to the complainant but you must be satisfied that this individual played an investigative role - not that they were simply a senior member of staff in the relevant area who is associated with responsibility for the response.
**Standard 3.** Investigations are thorough (Regulation 3 (2) (b) and Regulation 14 (1)), where appropriate obtain independent evidence and opinion, and are carried out in accordance with local procedures, national guidance and within legal frameworks.

After the initial assessment, the nature and scope of the investigation is determined and the approach to it planned. Statements, interviews, reviews of notes and site visits will usually constitute the bulk of an investigation but third party sources of independent evidence to evaluate findings against will also be obtained. If the investigation should be based solely on a review of entries into the health record, this is usually inadequate. The investigator is chosen and sufficient evidence should be gathered.

3.1 There is evidence of a clear management plan for the investigation.

It is critical that one person be responsible for the conduct of the investigation and thus for establishing the framework for the investigation. This is particularly important where the complaint spans more than one division or even more than one health care facility. Ensuring that the planning stage is performed well will have a major influence on the ultimate success of the investigation. Has the investigator identified what questions need to be answered? What information is required to answer those questions and the best way to obtain that information? It is not best practice simply to have one individual dividing up the complaint and requesting responses from the relevant departments or individuals (for example through internal emails or proforma).

3.2 There is sufficient evidence to show, where necessary, patient records (e.g. clinical notes, booking system records, lab results) were reviewed.

Reviewing the records of a patient’s treatment will often form the starting point of an investigation and will be a key (though not infallible) source of evidence. Frequently, reference to the notes being reviewed is made in a letter to the complainant, or internal communication or proforma. Records held at another Trust can be accessed in cooperation with the complainant and so this is not a viable reason for not being able to review all relevant parts of the record.
3.3a There is sufficient evidence to show that statements were obtained from relevant members of staff involved with (or witnessing) the complaint.

Statements will form a key part of an investigation and are relatively easy to obtain in comparison to interviews. They may include accounts of events but also opinions on the appropriateness of treatment provided or conduct of an individual. Collecting statements from those involved or able to act as witnesses is particularly important where there is an apparent dispute over events. Accounts may be provided on behalf of a junior (e.g. Consultant giving a view on behalf their registrar who gave treatment) but only when the statement is complete and comprehensive and has no apparent need for further clarification. If the investigator was unable to obtain a statement from a key member of staff, this should be recorded with reasons why. A staff member being on night duty is not an acceptable reason for not obtaining a statement. Where they are a crucial witness, the organisation should evidence they have made efforts to contact ex-employees. Where they are regulated professionals (e.g. nurses and doctors) they have a duty to cooperate.

3.3b There is sufficient evidence to show that statements were obtained from other individuals involved with (or witnessing) the complaint (e.g. friends, relatives, the complainant).

If there is an important third party witness, for example a relative or carer, the organisation should seek permission from the complainant to obtain a statement from them. In some cases it may be that a detailed separate statement is sought from the complainant if there is a specific issue for which a detailed account is required. These will obviously have a weight of credibility ascribed to a biased witness but each statement should be assessed on its merits rather than not being collected at all.

3.4 Where necessary, there is sufficient evidence to show that relevant members of staff involved with (or witnessing) the complaint were interviewed.

In certain circumstances, an interview may be warranted. This may be because of a serious complaint with conflicting accounts being provided by
3.5 Where necessary, there is sufficient evidence to show that other individuals (e.g. friends, relatives, the complainant) were interviewed.

As described in relation to staff, in certain circumstances statements are insufficient. Other people beside organisation staff may be useful witnesses who can be interviewed with the complainants consent.

3.6 The organisation uses a standardised template for recording interview notes.

A good practice point. A well designed template document ensures a standardised approach to conducting investigations is taken throughout the organisation; it should prompt the investigator to collect the relevant information/evidence. A standardised approach makes it easier for staff to review the information.

3.7 The date, time, venue and duration of any interview are recorded.

This is to ensure that a full and transparent record of the investigation process is made.

3.8 The notes identify the name(s) and job title of those who conducted the interview.

Recording the names(s) of the interviewers shows who was accountable for conducting the interviews; it will also help panel members determine whether the interviewer was a person of sufficient seniority.

3.9 The interview notes give a clear and concise account of the interview.

A clear and concise account will make it easier for the decision maker to draw their conclusions.
3.10 A “site visit” to areas concerned is conducted.

A site visit may be appropriate in order to examine the scene of a complaint (where the condition of the site, or something at the site, is an issue), possibly taking photographs to refer to at a later date.

3.11 Relevant copies of any organisation policies/protocols are obtained along with other documentary evidence e.g. NICE guidelines to support judgements on clinical practice.

*If the decision was made on the basis of hospital policy and/or professional/NICE guidelines, this should be referred to and available on file, ideally, with the specific part of the guidance highlighted.*

3.12 Appropriate further independent opinion is secured on complaints relating to clinical issues

*This sub standard relates specifically to independent opinion from those divorced from the handling of the complaint and the issues complained about. In most cases seeking only the opinion of clinical staff actually complained about would does not constitute best practice unless the issue is minor or clear cut and easily verified e.g. guidelines/records reviewed. The degree of involvement will depend on the severity of the complaint. For lower level concerns, a simple review may suffice. For others, detailed opinions may be required. Where the complaint relates to serious harm or death, opinions from clinicians from outside the Trust (e.g. another Trust, a medico legal review, a Royal College review) will likely be required.*
**Standard 4. The investigator reviews, organises and evaluates the investigative findings.**

The role of the investigator is also to gather and analyse all the relevant facts and opinions pertaining to the complaint and at the end of the fact finding exercise, report back and, if appropriate, make relevant recommendations. Their role is to provisionally prove or disprove any matter of fact raised by the complainant and to highlight key points for the decision maker to consider.

4.1a The investigator identifies any dispute of facts (e.g. different accounts of events).

The points of agreement and disagreement should be clearly laid out as the response to the complainant will need to highlight what facts are in dispute (if any). Examples of disputed facts include what was said by a healthcare professional to a patient before, during or after treatment (for example if risks of an operation and chances of success were explained), whether a healthcare professional did something (e.g. ignored a patient asking for help on a ward), whether a treatment was or was not given (e.g. given medicine to take home at discharge) or when a letter for an appointment was or wasn’t posted. There may be different views of what happened but there must be a right or wrong answer. There is some degree of overlap with disputes of opinion, for example whether a healthcare professional’s tone was rude rather than complaining about what they actually said.

4.1b Where there is a dispute of facts, the investigator identifies any evidence which indicates the more likely version of events.

This might include highlighting the relevant aspects of the health record (e.g. the consent form or record of an outpatient appointment in notes) or highlighting corroborating elements from different statements of interviews which indicate a more likely version of events. It may also include highlighting the credibility of witnesses (e.g. a healthcare professional about whom there have been a number of previous complaints or a complainant who has complained frequently and no grounds for the complaint have been found).

4.2a The investigator identifies any difference of opinion (e.g. views
from different clinicians on appropriateness of patient treatment).

Differences of opinion will typically be over whether a treatment was appropriate as there may not be an exact or clear answer. It might also be over something like a waiting time for an appointment where a department or member of staff has given an appointment date they consider reasonable but the complainant does not. As mentioned above, there can be some overlap where the complaint is about how somebody said something, rather than what they said.

4.2b Where there is a difference of opinion, the investigator highlights any evidence which suggest one opinion to be more reasonable.

For disputed clinical care issues, the investigator should highlight key aspects of best practice guidance or independent opinion that has been obtained. There might be other sources of evidence to support, on balance, whose opinion is more reasonable, for example NHS Constitution rights for patients waiting times or organisation policies. As with matters of fact, credibility of witnesses, particularly in relation to complaints about the manner/attitude of staff, will be important to highlight.

4.3 The investigator indicates the preliminary conclusion(s) they have reached on each key complaint aspect.

For the key complaint aspects, the investigator will detail their conclusions. This is best thought of as the prosecution in court; the prosecution is pressing the case for guilty but they don't decide, the judge does. In this instance, they are not attempting to prove guilt or innocence, rather reviewing the evidence and pressing the case for the version of events they support in light of their investigation.

4.4 The investigation report clearly and concisely summarises the investigation, evidence and preliminary conclusions reached.

There should be a succinct but comprehensive report or proforma highlighting the key aspects of the above to enable the decision maker to make good quality well informed decisions without needing to go back through the entire investigation in detail.
Standard 5. The judgement reached by the decision maker is transparent, reasonable and based on the evidence available.

Ideally the investigator and decision maker should not be the same person. The quality of any decision will depend on the decision maker’s knowledge, experience and integrity. After evaluating the findings, the decision maker will exercise their discretion in deciding whether the complaint can be upheld or not. This decision will be based on the civil standard (proof on the balance of probabilities).

5.1 An identifiable individual with appropriate seniority has reviewed the findings of the investigation and the provisional recommendations.

Typically, a divisional lead will authorise the response which has been drafted for them. It is insufficient to simply review a draft letter; it must evidence (for example through a proforma) that the person has properly considered the underlying issues of a complaint.

5.2 The decision maker decides which aspects of the complaint are justified and which are not, detailing why they have reached their view.

After reviewing the investigation or draft letter, the decision maker must decide whether or not they uphold the complaint. There must be evidence of the decision maker highlighting the key aspects they took into account when making their decision.

5.3 The decision maker decides which (if any) issues could not be resolved in the investigation and records why.

When there is an issue that cannot be resolved, it is particularly important for the decision maker to explain why they have been unable to reach a conclusion. A typical example will be a dispute between a complainant and a member of staff about what was said during a consultation or a complainant reporting inappropriate behaviour of staff on a ward. The explanation is particularly important as, very often, complainants perceive that when a conclusion is not reached in their favour, the organisation is denying their version of events is true. In fact, they are stating there is no clear evidence that they are right or wrong.
5.4 Any decisions reached are correct on the balance of probabilities.

It should be clear that information is collected and thoroughly evaluated; and that the right policies, procedures and clinical guidelines were followed. It should be clear that the decision maker reached his or her decision based on the balance of probabilities.

5.5 The decision maker classified the complaint as fully, partly or not upheld.

An essential stage when finalising a complaint is to determine whether it is upheld or not. This provides clarity for the complainant and for the person complained about. This should complement the narrative findings. A complaint should be upheld where the findings show that the service provided did not reach the appropriate standard. Any facts on which the judgement to uphold the complaint is based must be proven on the balance of probabilities. A complaint should not be upheld where the facts are clearly established and it is determined that what the complainant claims happened did not occur or their views on what they should expect are unreasonable. A complaint will also not be upheld where there is insufficient evidence to conclude, on the balance of probabilities, that the complainant’s allegation is true. Commonly, this will arise where there is a conflict of accounts that cannot be reconciled on the evidence available and the investigator cannot establish the facts.

**Standard 6. The complaint documentation is accurate and complete. The investigation is formally recorded, the level of detail appropriate to the nature and seriousness of the complaint.**

Good documentation is fundamental to effective complaints handling. All information should be maintained centrally as there are risks to effective record keeping and decision making if statements and other material pertinent to the complaint are kept in a number of different locations. Documentation should be such that it permits evaluation of the conduct of an investigation and would enable an independent observer to draw the same conclusion as the decision maker.
6.1 The file should include all relevant documents. This should include:

- The initial complaint correspondence;
- The initial assessment of the complaint severity and the details of the person making the assessment;
- Dates, identities and positions of all parties involved in the investigation;
- Copies of all correspondence (patients, staff and other opinions sought);
- Interview notes and emails in relation to the investigation;
- Extracts from the patient record where appropriate;
- Records of oral communications – face to face and telephone conversations;
- Photographic evidence where appropriate - a hard copy should be available which is signed on the back “as taken and not modified”. A copy of the original digital photograph should be stored on CD;
- Copies of organisation policies or protocols that have been referred to or at least a reference made to it in the file;
- Cleaning schedules if there are infection controls concerns;
- Staffing rotas may be included to determine interviewees or possible staff shortages;
- Any previous complaints about the same persons or situation or process;
- Any previous complaints from the complainant, where appropriate;
- Other supporting information obtained to help formulate a judgement;
- The final investigation report should be included, detailing the author, the decision making process, conclusions and recommendations i.e. a summary of the key facts relied upon in reaching the final decision;
- The response letter to the complainant;
- Evidence of support offered to staff involved in the complaint;
- A chronology of the investigation process.

Good record keeping assists in improving accountability and provides for transparent decision-making. Care Quality Commission Essential Standards of Quality and Safety also state “A documented audit trail of the steps taken and the decisions reached is kept – 17A(4)”.

6.2 The documentation should be clear, legible and non erasable.

Internal documentation must be legible, clear and in a format where it cannot be altered (e.g. not written in pencil).
6.3 The documentation should be professional and non-judgemental.

*Internal documentation must be professional; it shouldn’t contain off hand derogatory remarks or indicate prejudice to the outcome of the complaint (outside of the formal process of reaching a conclusion).*

### Standard 7. Both the complainant and those complained about are responded to adequately. (Regulation 14, investigation and response).

*Many complaints are resolved through the provision of an explanation, detailed information and an apology where needed. Responses to complainants are often incomplete and do not offer adequate explanation. Some letters contain factual errors; others make no acknowledgement of a mistake being made. It is important that the response letter addresses all the matters arising from the complaint.*

7.1 The response letter is sent from the Chief Executive.

*The Complaints Regulations (Regulation 14 (2)) state that the organisation must send the complainant in writing a response, signed by the responsible person. This is the CEO of the organisation although the functions of the responsible person may be performed by any person authorised by the responsible body to act on behalf of the responsible person. It is widely recognised as good practice that letters come from the Chief Executive. A cover letter from the Chief Executive explaining they have read and reviewed an enclosed letter or report from another member of staff would be acceptable.*

7.2 The response letter is sent within the planned time.

*The timeframe for the investigation should have been communicated to the complainant, ideally after discussion as highlighted earlier in the scorecard.*
7.3 The timeframe is reasonable.

25-28 days has been the historical target for delivering responses and for some Clinical Commissioning Groups, remains a contractual requirement. This should be used as a starting point but complex complaints will reasonably take longer. Also, some simpler complaints could be answered much more quickly. You should take into account the urgency of the issues raised, the complexity of the case and the reasonable expectations of the complainant.

7.4 The response letter is personalised and the tone courteous.

Complaints Regulations state that “complainants are treated with respect and courtesy” paragraph 3c (2). The letter should demonstrate sincerity and where appropriate, compassion. It should never contain any rude or dismissive comments. Importantly, the tone should match the seriousness of the complaint. The letter should not contain effusive apologies for a minor complaint or a lack of appreciation of the gravity of the situation in a major one.

7.5 The style and language of the response letter is appropriate.

The letter should be written in a style that can be easily understood by the person receiving it so that they understand the reasons for the decision and why the decision was made. The language should not be overly formal or overly casual and again should indicate some consideration of the style and language used by the complainant.

7.6 Technical or specialist terminology is explained.

Plain English is the key here. The organisation should take care if using technical language; that it is explained unless used by the complainant first. Specialist terminology and hospital speak (e.g. consultant on take, hospital on red alert, winter pressures, discharge plan etc.) should be avoided where possible if the words are not likely to be understood by the complainant.

7.7 There is a summary or statement of the complaint that mirrored the complainant’s original complaint in the letter.

This assumes that all key aspects of the complaint have been correctly
identified at the outset.

7.8 The response letter could reasonably be considered by the organisation to constitute a full and honest account of events.

Answers should be forthcoming and not skirt around the issues. There should be no unsatisfactory events or findings uncovered in the investigation that are deliberately not shared with the complainant e.g. inadequate staffing levels not communicated to the complainant. In extreme cases, a wholly inadequate investigation might impair the organisation’s ability to argue that their response is full and honest as well as adequate/sufficient.

7.9 The letter contains a response to each of the specific issues raised by the complainant.

All too often, key issues raised by the complainant are not discussed in the final response letter.

7.10 The letter contained an explanation of the findings in a level of detail that the complainant wanted.

Clear and relevant reasons should be given for the decisions. The 2009 Complaint Regulations state that:
“clear and relevant reasons should be given for the decisions…..must send a response which includes the following matters:

- an explanation of how the complaint has been considered; and
- the conclusions reached in relation to the complaint, including any matters for which the complaint specifies, or the responsible body considers, that remedial action is needed.”

7.11 An acknowledgment of responsibility and an apology is given where appropriate.

If errors have occurred, then the response should first admit fault i.e. accept responsibility. This is a necessary precondition for a sincere apology. It is not good practice to include apologies which are non-specific or an apology but no acceptance of responsibility.
7.12 The complainant is notified if a firm conclusion could not be drawn and an explanation given as to why.

If the decision maker could not make a firm conclusion based on the available evidence, then he or she should say so and give the reasons why not. These reasons should be explained clearly and be objectively sound.

7.13 Appropriate remedies are given including financial compensation where appropriate.

An organisation that values openness and accountability should be willing to admit and make good its errors. Redress should be proportional to the detriment suffered. Generally, when a person suffers a detriment wholly or partly as a result of the inappropriate actions of an organisation, that person should, wherever possible, be restored to their original position. When this is not possible, fair and reasonable alternatives should be offered. As examples, the PHSO often secures awards of around £250-£500 for patients that have experienced particularly poor complaints handling about a serious matter. A further appointment and a refund of car parking charges might be other examples.

7.14 A sufficient explanation of next steps, including any remedial action, changes in policy or clinical practice is given (Regulation 3(2) (g)).

Did the response letter say how the hospital was going to rectify the issue(s)? Was a promise made to take certain actions to ensure that the problem will not be allowed to happen again? The more specific, personalised and timed the plans for improvement, the more credible they will be. General promises to talk to staff are often not seen as credible by complainants. Action plans may be included to detail timescales and lead individuals for thorough responses.

7.15 The complainant is offered the opportunity to discuss the outcome of the hospital’s findings.

The letter should make it clear who the complainant should contact if they would like to discuss the matter further. A specific offer means a named individual with their contact details e.g. a divisional manager or the Consultant in charge of a person’s care. A general offer could be “please contact the
7.16 The complainant is advised in writing of their right to ask for an independent review by the Parliamentary and Health Service Ombudsman.

Care Quality Commission Essential Standards 17e(10) state that the people using the services:

“...know the steps they can take if they are not satisfied with the findings or outcome once the complaint has been responded to, and are advised of their right to refer the matter to the next stage of the complaints system, including the Health Service Ombudsman.”

7.17 Staff members involved in the complaint are informed of the outcome.

It is important that staff are made aware of the conclusions of the investigation. They are entitled to know the outcome (for example whether the complaint was upheld and/or it was accepted that the care they delivered was inadequate). This also allows staff to be informed about the reasons being given by their organisation for things going wrong. For example a complainant might have been told short staffing on a ward was a one off when the staff themselves know that short staffing is in fact a repeated occurrence. This gives staff the opportunity to raise this issue with their managers and/or union representatives.
Standard 8. The investigation of the complaint is complete, impartial and fair.

Complaints need to be examined in a fair, impartial and objective manner. Investigators should approach people and issues with tolerance and an open mind, listening to and taking account of what they say. They should respect people as individuals and ensure that anti-discrimination, fairness and equity principles are applied throughout the process. All the relevant evidence should be gathered as the investigator has a fundamental obligation to ascertain all the facts. The investigation must be conducted by someone who has not been involved in the events giving rise to the complaint. They must not have, or be perceive to have any conflict of interests. Unbiased decisions should be made based upon sufficient evidence.

8.1 As a whole, the investigation strategy and process is planned thoroughly and well executed.
As a whole, you must ensure that reasonable effort is made to conduct a sufficient investigation; records checked, witnesses interviewed, statements critically reviewed and independent evidence gathered. It can be difficult to consider an investigation as impartial or fair if evidence gathering was so minimal as to be unable to provide the necessary information to make a judgement.

8.2 The complaint process is managed fairly for the complainant.
Was procedural fairness followed? Was a fair and proper procedure followed when reaching a decision? In particular you should ensure that information is not held back from the complainant and that there were no witnesses that were not interviewed who might have corroborated a complainant’s version of events.

8.3 The complaint process is managed fairly for the complained about.
Any decision affecting an individual must make sure that the rules of procedural fairness are followed. Fairness demands that a person be told the case to be met and given the chance to reply before any decision is made. In other words, hearing the other side of the story is critical. In particular if apologies for misconduct are given on behalf of staff that they are aware this is being done and have been given an opportunity to comment.
8.4 The organisation should be able to successfully defend the quality and fairness of its investigative process for the complaint. Was the right information collected and thoroughly evaluated? Were the right policies, procedures and clinical guidelines followed? Did the decision maker reach their decision based on the balance of probabilities?

Organisational Standards

In addition to ensuring that each complaint is handled according to best practice, we would recommend that NHS organisations adopt the following organisation wide standards.

Standard 9
The organisation records, analyses and reports complaints information throughout the organisation and to external audiences.

Standard 10
Learning lessons from complaints occurs throughout the organisation.

Standard 11
Governance arrangements regarding complaints handling are robust.

Standard 12
Individuals assigned to play a part in a complaint investigation have the necessary competencies.
The PALS Service strives to meet the following standards:

- To be available on the phone between 9am – 5pm.
- To respond to telephone messages within four working hours.
- To respond to emails within four working hours.
- To respond to letters within five working days.
- To resolve concerns within five working days.
- To visit each hospital and mental health ward on an agreed rolling schedule.
- To acknowledge all patient comments placed on national websites such as NHS Choices and Patient Opinion within two working days.
- To strive to be accessible to all our patients, carers and everyone who uses our services.
HOW WE HANDLE COMPLAINTS

When a complaint is received:

If a complaint is resolved verbally or in person, a letter summarising the resolution and learning should be sent to the patient or carer.

The patient or carer’s preferred approach should be established at the beginning of the process.

All formal complaints received (written or verbal) should be passed to the Complaints Manager.

If possible, the Complaints Manager will telephone the patient or carer to agree what will be investigated, agree a summary of the complaint and ask if there are is anything in particular that the patient or carer is seeking as an outcome.

All formal complaints will be acknowledged in writing within three working days.

The target response time for resolution of complaints is 25 working days from receipt to final written response. Extended timescales may be negotiated with the patient or carer where required, for example if cases are complicated, records are held by another organisation or if it is a complaint about several organisations but we will always seek to complete these investigations within 40 days.

Complaint Investigation:

The acknowledgement letter and the original complaint are sent to the Decision Maker asking them to investigate.

The Decision Maker decides who is to investigate (this is usually the Service Manager) and sends the complaint to them. This person is the Lead Investigator.

The Lead Investigator undertakes the investigation. This may take the form of reviewing the complaint, taking statements where required, reviewing patient records, liaising with other services or HR if needed and preparing a draft response.

The Lead Investigator sends a draft response, in the form of a letter from the Chief Executive and a Complaint Action Plan to the Decision Maker. The Decision Maker signs off the response and sends this, alongside the supporting evidence, to the Complaints Team. The Complaints Manager reviews the response and passes to the Director of Governance to review on behalf of the Board.

The Complaint File is passed to the Chief Executive for review and final sign off.

The letter is then sent to the patient or carer, with the offer of a meeting or further response if they feel that their concerns have not been fully addressed.
PROCEDURE FOR DEALING WITH UNREASONABLY PERSISTENT COMPLAINANTS

If the above criteria are fulfilled, and after agreement with the Chief Executive, the Complaints Manager or other assigned senior manager should proceed as follows:

(i) inform the patient or carer in writing of the actions already taken and the fact that local resolution has been exhausted;

(ii) identify one person in the organisation to be the point of contact and inform the patient or carer of this;

(iii) inform the patient or carer that no further telephone calls or personal visits will be accepted and letters will be filed but not acknowledged;

(iv) notify the patient or carer that the Trust reserves the right to pass all correspondence to the Trust’s solicitors.

Care should be taken that new issues of concern raised by the patient or carer are not overlooked.

Withdrawing ‘unreasonably persistent’ status

Once patient or carers have been determined ‘unreasonably persistent’ there needs to be a mechanism for withdrawing this status, if, for example, patient or carers subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedures would appear appropriate.

Staff should use discretion in recommending that unreasonably persistent status should be withdrawn when appropriate. This will be agreed with the Chief Executive; Subject to this approval, normal contact with the patient or carer and the Trust’s complaints procedure will then be resumed.
My Expectations for raising a complaint

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

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

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

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

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