COMPLAINTS and CONCERNS POLICY

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Applies to:	All Trust staff and members of the public

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead for the Trust on 01278 432000

DOCUMENT CONTROL

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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.

2. POLICY STATEMENT

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

2.2 We encourage all patients and their families to feedback to staff members, nursing staff, ward and service managers, the PALS service and the complaints manager.

2.3 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.

2.4 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.

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

3 PURPOSE AND RATIONALE

3.1 The purpose of this policy is to provide a framework for listening and responding to patient and family enquiries, concerns and complaints.

3.2 The aim of this policy is to ensure that we comply with the user-led 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.

4. DEFINITIONS

4.1 Informal Concerns: these are usually verbal requiring immediate and swift resolution. Matters raised verbally which are of a serious nature or cannot be resolved swiftly must be escalated for advice and further action.

4.2 Complaint: A complaint can be defined as 'an expression of dissatisfaction, grievance and/or injustice requiring a response'.

5 DUTIES AND RESPONSIBLITIES

5.1 **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.

5.2 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.

5.3 **The Chief Executive (or delegated Executive Director)** is the responsible officer for complaints and oversees and agrees all final response letters in reply to all formal complaints received by the Trust.

The **Trust Board** agrees the policy and receives regular reports on complaints and PALS.

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

5.5 The **Chief Nurse** is the executive lead for this policy and will ensure policy development and review takes place at least every three years. They will review all complaint responses to ensure they have been managed with the appropriate clinical input and answered appropriately.

5.6 **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 (or delegated Executive Director). In the complaints procedure they are considered the "Decision Makers".

5.7 **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.

5.8 **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.

5.9 **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.

5.10 The **Complaints Manager** is responsible for:

- Reviewing new complaints and completing initial risk assessment, seeking clinical and managerial input where necessary. To ensure complaint is processed within timeframes set and the quality of the response before sharing with the Chief Executive (or delegated Executive Director) for final sign off.
- To ensure that resolution meetings are offered and where required to facilitate those meetings to ensure the best outcome for the patient and the staff involved
  - 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:

5.11 The **Patient and Carer Involvement Group** is responsible for reviewing trends data in relation to complaints received. Oversight and approval of policy and any changes.

5.12 The **Quality and Performance Committee** receives quarterly performance and risk reports from the **Patient and Carer Involvement Group**.

5.13 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).

5.14 The **Quality Assurance 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.

6 PATIENT ADVICE AND LIAISON SERVICE (PALS)

6.1 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.

6.2 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.

6.3 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.

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

6.5 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.

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

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

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

7 CONCERNS

7.1 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.

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

7.3 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.

7.4 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 meetings by taking notes and facilitating the meeting arrangements if availability allows.

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

7.6 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.

7.7 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.

7.8 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.

8 FORMAL COMPLAINTS

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

8.2 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 () 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.

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

8.4 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.

8.5 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.

8.6 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.

8.7 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.

8.8 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.

8.9 The Trust will aim to respond to all complaints within 25 working days and this will be communicated with the complainant but depending on complexity it may be agreed with the complainant that the response will be within 40 working days.

9 WHO MAY COMPLAIN

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

9.2 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.

9.3 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.

9.4 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.

9.5 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.

9.6 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).

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

9.8 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:

9.9 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.

10 WHO CANNOT COMPLAIN?

10.1 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.

10.2 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.

10.3 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.

11 TIME LIMITS

11.1 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.

12 COMPLAINTS PROCEDURE: LOCAL RESOLUTION

12.1 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).

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

12.3 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.

12.4 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.

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

13 COMPLAINTS PROCEDURE: INDEPENDENT REVIEW

Parliamentary and Health Service Ombudsman (PHSO)

13.1 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.

13.2 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.

13.3 This is the last stage of the complaints process and the Ombudsman's decision is final.

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

14 ROLES IN THE COMPLAINTS PROCESS

Complaints Team:

14.1 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:

14.2 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:

14.3 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 (or Delegated Executive Director) and the Complaints Action Plan.

Complaints involving other health or social care providers or commissioners:

14.4 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.

15 SERIOUS INCIDENTS AND SAFEGUARDING CONCERNS

15.1 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. If at this point a serious incident is identified the investigation of the incident will be overseen by Governance support and the complainant informed. The incident investigation process can take longer than the usual target response time of 25-40 working days normally allocated under local guidance for the complaints process to complete, and in line with national guidance this may not be fully completed for 60 working days. At this point the complainant will be provided with a Trust main point of contact i.e. the SI appointed liaison. The incident investigation terms of reference may include some of the complaint concerns and this will be agreed with the complainant. The complaints team will respond to any concerns that are raised that are not covered in the terms of reference for the SI investigation. If the complaint is not resolved through the incident investigation and not able to be resolved by any additional complaints management the complainant will be informed of the usual escalation route.

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

16 COMPLAINTS AND DISCIPLINARY ACTION

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

16.2 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.

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

16.4 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).

17 SECURITY OF PATIENT INFORMATION

17.1 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.

17.2 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).

17.3 Correspondence relating to formal complaints will not be filed in the patient's notes or uploaded to any electronic patient notes system.

17.4 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.

18 UNREASONABLY PERSISTENT COMPLAINANTS

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.

19 TRAINING REQUIREMENTS

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

19.2 Team awareness sessions will be provided on request.

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

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

Complaints relating to Transgender issues

19.5 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.

20 MONITORING LEARNING AND EFFECTIVENESS

20.1 Monthly reports are produced by the Complaints Manager and submitted to the Quality Assurance 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 Quality Assurance 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 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

22 REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

22.1 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

22.2 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.

23 APPENDICES (need checking these do not line up with appendix content)

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
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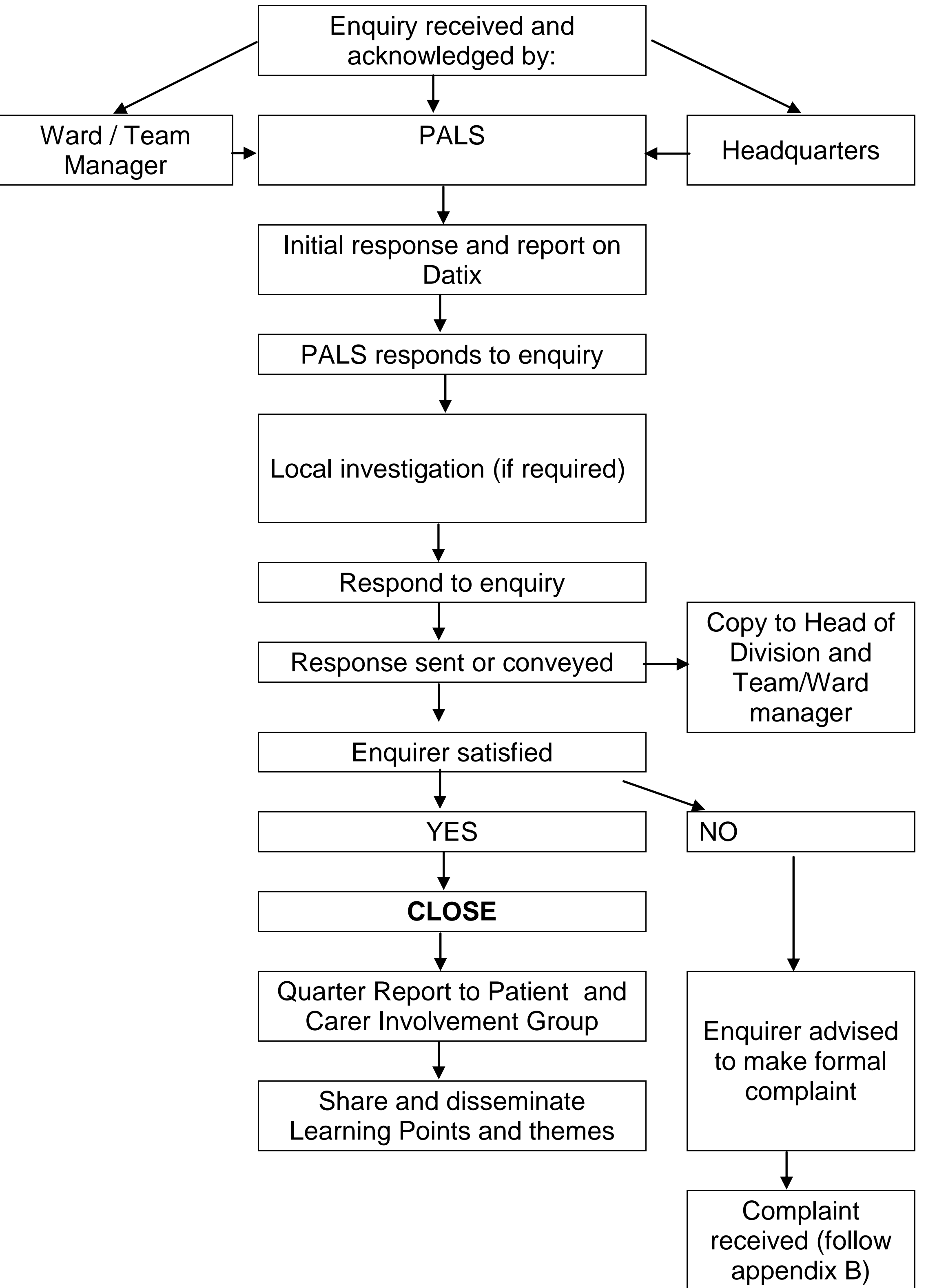
APPENDIX A

PATIENT ADVICE AND LIAISON SERVICE PROCESS DIAGRAM



APPENDIX B

COMPLAINTS PROCESS DIAGRAM

Working Days	Stage	What happens?	Who is responsible?	What should be on the Complaints file?
0	**Complaint received and triaged**	Complaint received (written or verbal) and passed to Complaints Manager	Complaints Manager	• Complaint
		Complaints Manager, or the Complaints Officer telephones the patient or carer to agree what will be investigated and if there is anything in particular that the patient or carer is seeking (e.g. an apology / a new appointment etc). At this stage, and if appropriate a local resolution meeting will be offered.	Complaints Manager	• Telephone Note
		Acknowledgement letter sent confirming the above.	Complaints Manager	• Acknowledge-ment Letter
3	**Investigation stage**	Email sent to Lead Decision Maker asking them to investigate.	Complaints Manager	• Email
		Decision Maker decides who is to investigate (e.g. manager) and sends complaint to them. This person is the Lead Investigator.	Decision Maker	
		Lead Investigator reviews case, takes statements where required, reviews patient records etc. and prepares draft response.	Lead Investigator	• Documentation e.g.: Patient records / statements
	Draft response stage	Lead investigator sends draft response and Action Plan to Decision Maker.	Lead Investigator	
15		Decision Maker signs off response and sends to Complaints Team.	Decision Maker	
		Complaints Manager reviews response and sends to Director.	Complaints Manager	
		Director signs off letter.	Director of Governance	
25-40	**Final response**	Complaint care file taken to Chief Executive **(or delegated executive Director)** for final sign off and sending.	Chief Executive	• Final letter

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.

APPENDIX D

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

APPENDIX E

PALS AND COMPLAINTS CONSENT FORM

CONSENT FORM

Name:	
Address:	
Date of Birth:	

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)*

……………………………………………… ……………......................................
Patient's signature *Patient's name*

……………………………………
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

JOINT PROTOCOL FOR PALS AND COMPLAINTS HANDLING

PROTOCOL FOR JOINT WORKING ON PALS/COMPLAINTS

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 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.

APPENDIX G

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

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.

APPENDIX H

APPENDIX I

PALS STANDARDS

The PALS Service strives to meet the following standards:

- To be available on the phone Monday to Friday between 9am – 5pm.
- To respond to telephone messages within twenty-four hours wherever possible.
- To respond to emails within twenty-four hours wherever possible.
- To respond to letters within five working days or within a timescale agreed with the patient/family if more complex.

- To resolve concerns within five working days.
- To visit each hospital and mental health ward on an agreed rolling schedule.
- To strive to be accessible to all our patients, carers and everyone who uses our services.

APPENDIX J

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. For any that are part of a Serious Incident investigation the timeframe is for completion within 60 working days in line with National Guidance.

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.

APPENDIX K

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:

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

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

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

19.5.1.1.1.4 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.

APPENDIX L

My Expectations for raising a complaint