University of Leicester
Affiliated Teaching Hospital

Kettering General Hospital NHS
NHS Foundation Trust

Index No: M40

Feedback Policy: Guidance on the Management of Complaints, Concerns, Comments and Compliments and other Feedback

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Ratified by: (Name of Committee)	Patient Experience Steering Group
Name of originator/author, job title and department:	James Gillespie-Allan Head of Patient Experience and Involvement
Director Lead (Trust-wide policies) Director of Nursing & Quality (local Policies)	Leanne Hackshall Director of Nursing and Quality
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Equality impact assessed by: (name, job title and department)	James Gillespie-Allan Head of Patient Experience and Involvement
Date impact assessed:	Currently working with Chaman Verma to complete this.
CQC standards CARE Values	Safe, well led, caring and responsive Compassionate – Demonstrating to our patients/cares and family members that the Trust is dedicated to improving from experience. Accountable – To be open and honest when something has gone wrong and implementing learning from this. Respectful – Take into account the person circumstance of those engaging with patient experience. Engaging – Making feedback accessible and ensuring communication meets the needs of those using our services.

CONTRIBUTION LIST

Individuals involved in developing the document

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Approval and Authorisation
Completion of the following signature blocks signifies the review and approval of this process**.**

Name	Job Title	Signature	Date
Leanne Hackshall	Deputy Director of Nursing and Quality.		31.10.2018

Local Committee approval (where applicable)

Name of Committee	Name of Chairperson	Date of Approval
Patient Experience and Involvement Steering Group	Leanne Hackshall	30.06.2016

Change History

Version	Date	Author	Reason
1.6	June 2006	Emma Payne, Patient Experience Manager	Policy reviewed and amended.
2	August 2009	Emma Payne, Patient Experience Manager	Policy reviewed and amended in light of changes in legislation relating to complaint handling and changes in local process.
4	February 2012	Jason Ellis, Project Lead, Quality Governance	Policy rewritten and amended in light of changes in local processes.
5	August 2012	Maureen Walton Complaints & Litigation Facilitator	Policy reviewed in light of departmental/staff and minor changes to internal process
6	June 2013	Sarah Thomas Complaints & Claims Manager	Policy reviewed in line with change to process
7	May 2016	Tracey Sharp CBU Complaints manager	Policy rewritten in light of changes in local process.
8	May 2017	James Allan Patient Experience Manager	Minor updates relating to changed roles and local process.
9	October 2018	Graham Thornley Interim Complaints Manager	Minor updates relating to changed roles and local process.

Impact Assessment

Undertaken by	Date
James Gillespie-Allan Head of Patient Experience and Involvement	18 October 2018

A translation service is available for this policy. The Interpretation/Translation Policy, Guidance for Staff (I55) is located on the library intranet under Trust wide policies.

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1. Introduction

1.1 Kettering General Hospital NHS Foundation Trust (the Trust) is committed to listening and responding to patients and encouraging a culture that seeks and uses people's experiences to improve our services. The Trust recognises the need for a clear and accessible process for patients, their families and carers to provide feedback about their experiences.

1.2 The Local Authority Social Care and National Health Service Complaints [England] Regulations 2009 came into force on 1 April 2009. Every patient, their relative, carer or friend has the right to bring any aspects of a patient's care and treatment, about which they are dissatisfied, to the Trust. All staff must be aware of an individual's right to comment on the standards and quality of services provided by the organisation. Staff must aim to resolve all concerns and issues brought to their attention immediately to avoid escalation and undue distress for patients, their relatives, carers and friends. Patients, their relatives, carers and friends must be encouraged by staff to speak openly about any concerns they have or if they wish to make a complaint.

1.3 This policy provides a guide to all staff who may receive feedback for improvement from patients or the public. It does not include complaints from staff about employment issues or relating to HR issues.

1.4 The Trust aims to ensure that staff, visitors, patients, their families and/or carers are not discriminated against or treated any differently through raising concerns or making a complaint and as such no future or current care will be compromised as a result.

1.5 As the Trust serves a diverse patient population, we are committed to providing a responsive resolution service for all in line with the Equality Act (2010).

1.6 Throughout this policy we will refer to concerns/complaints as concerns. Guidance will cover how to deal with informal and formal responses and resolution.

2. Procedural Statement

2.1 A key objective of the organisation is the willingness to listen, change, improve and evolve in response to concerns. The lessons learned and trends identified through concerns play a key role in improving the quality of care received by patients and is a priority for the Trust. This policy sets out the Trust's processes for handling, responding to and learning from concerns, both formal and informal. This policy is relevant to all Trust staff who must know what to do if a patient, relative, carer or member of the public raises a concern with them. The organisation welcomes all forms of feedback and uses this information to improve the service provided to the local community.

2.2 Compliments, comments, complaints and concerns from patients, carers and the public are encouraged and welcomed. Should patients, their relatives, carers or friends be dissatisfied with the care provided by this Trust they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously. Under no circumstances should patients, relatives or carers be treated adversely as a result of making a complaint.

3. Scope

3.1 This document explains the process by which the Trust manages concerns and complaints reported to the Patient Experience Team and how it receives and acts on feedback

received. This policy is intended for use by all those employed by and working on behalf of the Trust (eg agency, bank, contractors, honorary contracts, etc).

4. Aim

4.1 This policy replaces the Trust's Complaints Policy and Procedure document issued in July 2016

4.2 The purpose of this concerns policy is to enable all staff to deal with complaints and concerns in a speedy and efficient manner that is open, accessible, fair, flexible, conciliatory and without blame or discrimination, in line with the Local Authority Social Care and National Health Service Complaints [England] Regulations (2009) and reflects the recommendations from the NHS Hospital Complaint System Review (Clywd/Hart 2013), which was commissioned by the Department of Health following the Francis Report (2013).

4.3 The principles that underpin the policy are:

- To increase people's confidence that their complaints will be taken seriously and that services will improve as a result of their experiences
- To have a flexible approach to resolving people's complaints, which includes effective support
- To provide a seamless approach to complaints investigations
- To ensure that the organisation is open and fair when dealing with complaints
- To place the emphasis on early and effective resolution of complaints
- To provide excellent local leadership and accountability that supports the resolution of complaints
- To be supportive and flexible when handling complaints

4.4 The 2009 Regulations state that complaints that can be resolved to the complainant's satisfaction not later than the next working day should not be categorised as a complaint. The Trust will, however, seek to learn from these matters and will record these as concerns in order that it can capture and learn from identified risks, quality issues and learn lessons where necessary.

4.5 When someone expresses dissatisfaction with the service of the Trust with a request that the issue(s) are looked into, all such matters will be handled under this policy and this includes complaints and concerns. The Patient Experience Team, incorporating the Patient Advice and Liaison Service (PALS) and the Complaints Team and will work together to resolve concerns.

4.6 This policy enacts all the commitments and requirements of the 2009 Regulations ensuring that:

- The policy will be easily accessible to everyone.
- Investigations will be fair, thorough, responsive, open and honest.
- The Trust will listen to the complainant to understand the concerns and will work with the complainant to rectify the problem.
- The Trust will respect an individual's right to confidentiality
- The Trust will learn from complaints and use them to improve services
- The Trust will answer complaints in a timely manner and in a timescale agreed with the complainant at the outset of the investigation
- Staff will respond positively to complaints and will endeavour to resolve issues quickly
- The Trust will aim to conduct a thorough investigation of its complaints in order to satisfy the complainant
- Complainants are told the outcome of the investigation of their complaint, and;

- Action is taken if necessary in the light of the outcome of a complaint
- The Trust will ensure that patients, relatives and their carers are not treated any differently as a result of raising a complaint.
- Complainants should receive, so far as is reasonably practicable, assistance to understand the complaints procedure and where to obtain assistance if required.

5. Responsibilities

5.1 Every member of staff within the Trust is responsible for ensuring that all complaints are responded to efficiently and appropriately and to ensure that any learning from complaints is embedded within their work practices.

5.2 **The Chief Executive (CEO)** has overall responsibility and is accountable for ensuring compliance with the arrangements made under the Social Services and National Health Service Complaints (England) Regulations 2009 and in particular ensuring that action is taken, if necessary, in light of the outcome of a complaint. The CEO or his/her designated director will sign off all formal written responses. The Chief Executive may delegate responsibilities to other designated Executive Directors as appropriate.

5.3 **Executive Directors** are responsible to the Trust Board in relation to complaints handling. They may also meet with complainants to assist in the resolution of complaints and to understand the views of patients/patients.

5.4 **The Director of Nursing and Quality** has executive responsibility for overseeing the systems for recording, investigating, responding and learning from complaints.

5.5 **The Deputy Director of Integrated Governance**, in conjunction with the Head of Patient Experience and Involvement, has responsibility for the strategic management of the Trust's complaints handling and systems and oversees the work of the Quality Governance Department (the Patient Experience Team).

5.6 Head of Patient Experience and Involvement is responsible for managing the Patient Experience Team and will:

- Instigate investigation reports, vigorously critique completed investigation reports and quality assure final response letters for review and approval by the Chief Executive.
- Monitor complaint progress as required by the Patient Experience Team and PALS, supporting the Divisions to develop and implement the learning from all complaints, concerns and comments.
- Prepare reports.
- Work closely with advocates and any patient and public involvement forums.
- Ensure consent processes are followed by investigators.
- Ensure all monitoring requirements by Department of Health are complied with and reported. Including completion and submission of KO41(a) quarterly data returns.
- Continuously audit the complaints handling process.
- Be accessible to complainants and staff, facilitating meetings where appropriate and provide the required training to staff.
- Manage the recording and monitoring of complaints in line with agreed timescales.

5.7 **The Complaints Manager** is the Trust's named complaints manager and has delegated responsibility from the Chief Executive to initiate appropriate investigations and manage the complaints process within the Trust in line with The Local Authority Social Services and NHS Complaints (England) Regulations 2009, As part of their duties, the Complaints Manager will:

- Triage complaints into either Simple or Complex using the matrix (Appendix 2). Where there is possible harm caused, link with Patient Safety to assess for Serious Incident investigation.
- Ensure that all formal complaints are logged on the risk management database (Datix)
- Manage the complaints schedule, which is informed by Datix, to monitor compliance with deadlines.
- Identify the Key Lines of Enquiry (KLOE) from the complaint letter and in consultation with the complainant, either in writing or by telephone
- Agree and confirm with the complainant how long the investigation is anticipated to take.
- Ensure that all complainants receive an acknowledgement within three working days of receipt of their complaint which outlines which issues will be covered by the investigation
- Offer complainants the opportunity to add any additional or missing issues to the investigation
- Ensure the complaint is shared with the appropriate Division (either Surgery, Medicine, or Family Health) in a timely and professional manner requesting they appoint an investigating officer and respond within the given timeframe. The Trust's complaints email address will be used for this purpose.
- Ensure that the complainant is kept informed of any delays with the investigation and agree a revised timeframe in those circumstances, in line with the extension criteria set out in this policy.
- In the event of delays, and where appropriate, this contact may be made by the relevant member of the Division and a file note placed on Datix outlining the conversation and new timeframe agreed in line with the extension criteria set out in this policy.
- The Patient Experience Team will present the final response letter to the Chief Executive, or nominated deputy, for approval and signature
- Ensure the complainant receives a final response letter from the Trust's Chief Executive (or deputy) within the timeframe specified
- Support the Divisions to establish systems to investigate and monitor their action plans, and perform trend analysis review by way of contributing to lessons learnt. (see Appendix 7)
- Provide training through the induction programme, mandatory training, together with any identified ad hoc training.
- Be the Trust contact for the Parliamentary and Health Service Ombudsman (PHSO) and other external agencies as delegated by the Chief Executive.
- Complete and submit KO41(a) quarterly data returns.

5.8 **The Patient Advice and Liaison Service (PALS)** will ensure that any concerns or issues raised about any aspect of service provided by the Trust which does not require a formal response is to be investigated and resolved on an informal basis. Members of the PALS team will liaise with and obtain advice from the wider Patient Experience Team where necessary. The PALS team will:

- Work to resolve concerns and be accessible and responsive to people raising concerns and staff.
- Ensure all processes relating to the administration of concerns are efficiently managed.
- Ensure that all concerns are logged on the risk management database (Datix)
- In consultation with the person raising the concern agree the preferred method of contact, either writing, by telephone or a face to face meeting.
- Confirm with the person raising the concern how long the investigation is anticipated to take.

- Through ongoing dialogue the person raising a concern will be offered the opportunity to add any additional or missing issues to the investigation
- Ensure the concerns are shared with the appropriate Divisions in a timely and professional manner requesting they respond within the given timeframe. The Trust's generic PALS inbox will be used for this purpose.
- Ensure that the person raising a concern is kept informed of any delays with the investigation and agree a revised timeframe for response in those circumstances.
- Produce written responses for the Chief Executive as required.
- Support the Divisions to establish systems to monitor concerns, and perform trend analysis review by way of contributing to lessons learnt.
- Continuously audit concerns to identify trends and themes.
- To provide training and support as required. To collect and collate feedback, sharing across the Trust as required.

5.9 The Divisional Directors, Surgery, Medicine, and Family Health

The designated Divisional Director Leads are responsible for nominating an investigating officer for complaints, ensuring the provision of effective investigation reports into concerns in their areas. The key areas of responsibility for the Divisional Director leads are to:

- Ensure that the complaints investigation process in their Division is robust, effective and patient centred in conjunction with support from the Patient Experience Team.
- Ensure that all complaints are thoroughly and objectively investigated by named members of staff.
- Ensure that all relevant staff are given the appropriate training, with support from the Patient Experience Team.
- Investigate all concerns and complaints.
- Ensure that formal complaints relating to their department are appropriately investigated within the agreed timescales and guidelines specified in this document.
- Inform members of staff where complaints are received about them and provide appropriate support throughout the investigation.
- Ensure that the outcomes of investigations are conveyed clearly and promptly to the Patient Experience Team within the agreed timeframes.
- Develop action plans/lessons learnt which should be disseminated and monitored via their Divisional governance meetings, with assurance given to the Quality Governance Steering Group via their monthly exception reports.
- Ensure that all lessons learnt and action plans are developed and fully implemented, resulting in improvements and better outcomes to service delivery which should be shared with all staff and patients.
- Report progress on the implementation of recommendations made following investigation by the Parliamentary and Health Service Ombudsman (PHSO) through their local governance arrangements and to the Quality Governance Steering Group.
- Provide leadership by example according to the following key principles:
  - Decisions to be taken in the patient/public interest
  - Accountable for decisions/actions
  - Gives reason for decisions/actions
  - Patient and staff safety is paramount in all things

5.10 **Governors** are required to report complaints received to the Patient Experience Manager so that the Trust ensures that all issues can be addressed, resolved and monitored.

5.11 **All staff** within the Trust have a responsibility to ensure they are aware of the contents of this policy and have undertaken appropriate training. Staff must follow this policy and fully participate in the resolution of complaints and concerns by listening to views and acting appropriately to resolve and learn from the issues raised. Staff must contribute to learning

and improvements as a result of concerns and complaints and will ensure that patients, their relatives and carers are not treated differently as a result of the issues raised.

All staff have a responsibility to ensure that:

- They try their utmost to resolve concerns where possible.
- They take immediate action where failures have been identified to reduce the likelihood that further harm to other patients/carers will occur in the future.
- They should notify the Patient Experience Manager as soon as possible if they have been involved in any event likely to give rise to a concern.
- They assist with any investigation and provide statements, comments and reports as required.
- They escalate concerns, comments or complaints to the Patient Experience Manager in a timely and professional manner.

Staff, visitors, patients and patients are not discriminated against or treated any differently through raising concerns or making a complaint and as such no future or current care will be compromised as a result.

5.12 **Local Counter Fraud Specialist** will receive all suspected fraud, bribery and/or corruption allegations and will carry out an investigation that may lead to a criminal prosecution being commenced.

6. Definitions

6.1 **Feedback** is any form of feedback received by a member of staff relating to the services provided by the organisation. This can be a compliment, a comment, a concern or a complaint. Feedback can be verbal or written. Feedback is sought through patient engagement through methods such as the Friends and Family Test and local resources such is the Listening Booth and attendance at local engagement events.

6.2 A **complaint** is an expression of dissatisfaction from anyone who accesses the Trust's services or a third party requiring a response and where the issue(s) is not resolved within one day.

6.3 A **concern** is an issue raised which has the potential to become a complaint, but which the person requests is dealt with outside of the complaints regulations and for those issues that are resolved within one day by staff.

6.4 **Formal complaint** - a complaint where the complainant has requested to receive a written response from the Chief Executive or from a named individual.

6.5 **Informal complaint** - a complaint that is resolved by staff local to the area, is resolved by a meeting, and does not require a written response from the Chief Executive.

6.6 **Local resolution** is the action of resolving concerns and complaints as soon as they are reported to any member of staff, at any time, and as agreed with the complainant.

6.7 **Third Party** - concerns and complaints brought to the attention of the Trust by a person acting on behalf of a patient (with the patient's consent).

6.8 **Parliamentary and Health Service Ombudsman (PHSO**) - the Parliamentary and Health Service Ombudsman (the Ombudsman) is the second stage of the complaints process.

The Ombudsman's role is to investigate complaints whereby individuals feel they have been treated unfairly or have received poor service from government departments and other public organisations:

The PHSO standards are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right (including financial redress)
- Seeking continuous improvement

6.9 **Care Quality Commission (CQC)** - monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety within health and social care and publish what is found including performance ratings to help people choose care. Patients can approach the CQC to complain about an NHS organisation.

6.10 **Advocacy** - An advocacy service is provided by an advocate who is independent of the NHS. An advocate will represent the wishes of the complainant. An advocate can help complainants to access information, provide support at meetings, write letters or speak for a complainant on their behalf.

6.11 **Joint complaint resolution** - complaint investigated and responded to as a result of more than one organisation investigating.

6.12 **Mental Capacity Act (MCA) (2005)** - The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- by allowing people to plan ahead for a time in the future when they might lack the capacity, for any number of reasons.

6.13 **Action Plan** is the document used to describe what needs to improve, how, by when and the date this needs to be done by and how the Trust will be assured that learning has taken place.

7. Concerns and Complaints Procedure

7.1 NHS Complaints Procedure

There are two stages within the complaints process NHS Complaints Procedure, (2009):

- Stage 1: Local Resolution
- Stage 2: Parliamentary Health Service Ombudsman (PHSO)

Complaints may be made about any matter reasonably connected with the exercise of the functions of the Trust, including any matter reasonably connected with its provision of health care or any other services.

Matters excluded from consideration under the arrangements are:

- A complaint made by an NHS body, which relates to the exercise of its functions by the Trust.
- A complaint made by a primary care provider which relates either to the exercise of its functions by the Trust or to the contract or arrangements under which it provides primary care services.

- A complaint made by an employee of the Trust about any matter relating to his/her contract of employment.
- A complaint which is being or has been investigated by the PHSO.
- A complaint arising out of the Trust's alleged failure to comply with a Data Subject Request under the Data Protection Act 1998 or a request for information under the Freedom of Information Act 2000.
- A complaint regarding alleged fraud, bribery and/or corruption that will be reported to, and investigated by, the Local Counter Fraud Specialist.
- HR issues. Staff grievances are handled separately. The Trust has local procedures for handling staff concerns about health care issues and established grievance and openness procedures.

7.2 Who can complain?

7.2.1 Anyone who uses the Trust's services may complain, including:

- The patient.
- Someone acting on behalf of the patient, and with their written consent. (eg an advocate, a relative, or a Member of Parliament acting on behalf of their constituent).
- Parents or legal guardians of children. (For definition a child is someone who has not attained the age of 18).
- Someone acting on behalf of a patient who is unable to represent his or her own interests, by reason of physical disability or mental incapacity, provided this does not conflict with the patient's right to confidentiality or a previously expressed wish of the patient.

7.2.2 Where a patient or person affected has died or is unable to raise a concern due to capacity under the MCA (2005), the representative must be a relative or other person who, in the opinion of the Complaints Manager, had or has a sufficient interest in his/her welfare and is a suitable person to act as their representative. The need to respect the confidentiality of the patient is a guiding principle.

7.2.3 If, in any case, the Trust is of the opinion that a representative does not or did not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, that person is notified of this in writing and given reasons for the decision. This will be managed by the Complaints Manager.

7.2.4 In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child and where they are in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

7.3 Confidentiality and Consent

7.3.1 Information about concerns and complaints and anyone involved is strictly confidential and is only disclosed to those with a demonstrable need to know and/or a legal right to access those records under the Data Protection Act 1998.

7.3.2 Complaint records are kept separate from clinical records, subject to the need to record information which is strictly relevant to their health in the patients clinical records.

7.3.3 Correspondence about complaints is not included in patients' clinical records. Informal discussions about concerns relating to their health can be documented in the clinical records.

7.3.4 If the complainant is the patient it is not necessary to obtain their express consent to use personal information when investigating a complaint. It is good practice to explain that information from health records may need to be disclosed to those involved.

7.3.5 Where a concern is raised on behalf of an existing or former patient, consent must be obtained from the patient to disclose personal health information and the results of any investigation in order to uphold the duty of confidentiality to the patient. The complainant will be asked to return a Consent Form (Appendix 1) to the Patient Experience Team.

7.3.6 If the patient is deceased then the personal representative appointed under the 'Will' should give consent for the complainant to receive the personal health information.

7.3.7 If, once consent has been requested, there is a delay in obtaining the consent the investigation will be put on hold until the appropriate consent is received.

7.3.8 Where a concern is raised on behalf of an existing or former patient who has not authorised the complainant to act on their behalf care must be taken not to disclose personal health information without the patient's express consent. Matters of a non-personal or non-clinical nature may be investigated and a response provided to the complainant.

7.3.9 Where a concern has been raised on behalf of a patient by a Member of Parliament (MP) it will be assumed that implied consent has been given by that patient. If, however, the MP concern relates to a third party, consent will need to be obtained from the patient prior to the release of personal information.

7.3.10 Where a concern has been raised by someone acting on behalf of a patient who is unable to represent his or her own interests due to capacity under the MCA (2005) the representative must be a relative or other person who, in the opinion of the Trust, had or has a sufficient interest in his/her welfare and is a suitable person to act as their representative. The need to respect the confidentiality of the patient is a guiding principle.

7.3.11 Where it is known that the concern involves a vulnerable adult or vulnerable child, the Adult Safeguarding Lead or the Lead Nurse for Safeguarding Children will be informed.

7.3.12 All letters regarding the complaint will be marked 'Private and Confidential'. All internal emails regarding the complaint must not contain patient identifiable information in the email heading. Where possible, the email contents should be anonymised and any attachments should be password protected.

7.3.13 By ensuring that all complaints are dealt with in the strictest of confidence the scope for patients, relatives or carers being treated differently as a result of the complaint will be minimised.

7.4 Accessibility and Publicity

7.4.1 The guide to providing feedback Compliments, Comments, Concerns and Complaints leaflet provides information about the Trust's approach to handling issues raised and explains the options available in order to resolve their concern in

a self-determined way. This leaflet is also available in an easy read format and can be downloaded from the Trust's website. Hard copy leaflets are located in all wards and departments and are available from the PALS and Patient Experience Team.

7.5 Time Limits

7.5.1 A complaint should be made within twelve months of the date on which the matter occurred (the subject of the complaint), or when the matter which is the subject of the complaint came to the notice of the complainant.

7.5.2 Where a complaint is made after twelve months the Complaints Manager following discussions with the appropriate Division, may investigate it if they are of the opinion that the complainant had good reasons for not making the complaint within that period and it is still possible to investigate the complaint effectively and efficiently.

7.5.3 In accordance with the 'For the Record' guidance (Department of Health 1999/053), complaint files are kept for 10 years. Complaints files about babies and children where there is the possibility of future legal proceedings are kept until their 25th birthday. If the baby or child has died, the complaint file is kept for 10 years.

7.6 Identification of Learning and Assurances from Complaints

7.6.1 All complaints and concerns offer an opportunity for the Trust to learn and improve. When the investigation of a complaint identifies that local changes in practice are required a Learning Action Plan (Appendix 7) will be completed and the Divisional Lead Nurses or Clinical Directors will be determined by who is investigating and responding to the concern. They will ensure these are disseminated to the relevant areas and implemented as soon as is practically possible and shared across the Trust as appropriate.

7.6.2 Action plans will be maintained by the Divisional Leads and evidence will be obtained in order to validate that the learning has been implemented and evidenced. This will be scanned into Datix as evidence of learning and how learning has been assured.

7.6.3 The Complaints Manager will produce learning actions and themes within complaints reporting and this information will be utilised by the Quality and Assurance Manager when undertaking assurance visits across the Trust. The Quality and Assurance Manager will seek assurance that learning has continued to be embedded and that there is good staff awareness of learning and what lead to the learning.

7.6.4 Divisional Governance Managers will include learning information in the quarterly Divisional governance assurance reports considered at CBU Governance Meetings, held monthly.

7.6.5 Where learning is identified that may pose a risk until implemented, the Complaints Manager will liaise with the Divisional lead and facilitate a risk assessment and inclusion in the relevant risk register until the action is completed.

7.6.6 Patient Experience newsletters must include details of learning from feedback.

7.6.7 The Quality Governance Team Newsletter will include learning information so that learning can be shared across the organisation.

7.6.8 The Patient Safety Lessons Learnt Forum, Leadership Forum and Daily Safety Huddles will be utilised by the Patient Experience Manager, Divisonal Managers or

clinical staff when key learning messages are required to be shared across multi-disciplinary teams.

7.6.9 Learning assurances will be detailed in quarterly and annual patient experience/complaints reports.

7.6.2 All trends and themes that result from concerns and complaints are reported through Patient Experience reports to the Patient Experience Steering Group, the Quality Governance Steering Group, the Integrated Governance Committee and to the Trust Board. As well as learning from individual complaints, the Trust has a process for aggregating information about complaints, incidents and claims to enable learning.

7.6.3 The Trust is committed to listening to the views of all patients and the public about the care we provide and values the experiences of our patients. Questionnaires are sent to complainants so that learning can be identified for the Trust's processes.

7.7 Reporting into Committees

7.7.1 Concerns, complaints and PALS performance, outcome themes, learning implemented and improvements required, together with status updates on complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) are reported on a quarterly basis to the Patient Experience Steering Group and the Quality Governance Steering Group as part of the Patient Experience quarterly report. An annual Patient Experience Report is produced for the Information Governance Committee and the Trust Board.

7.8 Data returns to the Department of Health

7.8.1 All NHS organisations and those delivering NHS services are required to submit Quarterly returns to the Health and Social Care Information Centre (HSCIC).

7.8.2 The information obtained from the KO41a collection monitors written hospital and community health service complaints received by the NHS. It also supports the commitment given in Equity and Excellence to improve the patient experience by listening to the public voice. The data required for this collection is as follows:

- Summary of the overall numbers of complaints
- Age of complainant
- Status of complainant
- Service area complained about
- Subject area of clinical treatment with sub-categories
- Profession of staff involved

7.9 Local Resolution

7.9.1 When a complaint is made directly to a member of staff:

- The first responsibility on receipt of a complaint is to ensure that the patient's immediate health care needs are being met. This may require urgent action before any matters relating to the complaint are dealt with.
- Show empathy with the person and listen carefully to their concerns.
- Apologise for how their experience has made them feel and provide assurance that the matter will be taken seriously.
- Advise the person what further enquiries are appropriate and give them reasonable opportunity to be involved as much as they wish to be in the progress of any enquiries.

- Ask the person what they wish to see as an outcome to the matter and, where possible, work to achieve this.
- Take action to rectify the matter if it is within your remit of responsibility, or refer to a manager who can attempt to immediately resolve.
- Ascertain how the person wants to receive feedback, i.e. verbally, through a Local Resolution Meeting (LRM) or in a letter.
- Provide assurance that the patient, their relative or carer will not be treated differently as a result of raising a concern or complaint.
- Contact the Patient Experience Team for support.

7.10 Procedure for Handling Complaints

7.10.1 The first responsibility on receipt of a complaint is to ensure that the patient's immediate health care needs are being met. This may require urgent action before any matters relating to the complaint are dealt with.

7.10.2 The Patient Experience Team will be available to provide information to complainants on the options available to them on how to raise their concerns or complaint and advise on the process. Close collaboration between PALS and the Complaints Team is essential to ensure a coherent and seamless approach to resolving people's concerns. These teams will work closely together to establish to most effective means of resolution of patients concerns and complaints.

7.10.3 In situations where complaints and concerns might be dealt with in a more timely way outside the complaints procedure these will be handled by PALS in agreement with the complainant.

7.10.4 Formal complaints can be made by any means of communication that suits the person raising the concern, such as in writing, by email, by telephone or face to face. Where an individual is not able to make their concerns known they can contact the Patient Experience Team for assistance who may direct them to Healthwatch or an advocacy service who provide support to people who wish to make a complaint.

7.10.5 When a complaint is received it is important to assess the severity through a risk assessment. Complaints received directly by the Patient Experience Team will be risk assessed by Complaints Manager

7.10.6 On receipt of a complaint:

- The Complaints Manager will complete a risk assessment.
- It will be triaged as either simple or complex by the Patient Experience Team.
- The complaint will be acknowledged within 3 working days, either by telephone or letter as appropriate to the complaint. The acknowledgement will advise of the deadline.
- The acknowledgement will offer a resolution meeting.
- Where necessary consent will be sought.
- The complaint will then be forwarded to the appropriate Divisional Director who is responsible for nominating an investigating officer within the Division.
- The nominated Divisonal investigating officer lead will complete the investigation response and send to the Patient Experience Team as soon as possible, but no later than 15 days from the date of acknowledgement.
- The response will identify areas of learning and actions/improvements taken as a result of the complaint.
- Learning and actions will be followed up by the Divisonal Managers through the Divisional Governance meetings and monitored by the Patient Experience Team.

7.11 Risk Level Examples

7.11.1 All complaints received are risk assessed using the following table. Once the investigation is complete the outcome of the investigation and the complaint will again be risk assessed.

Risk Levels	Examples
Level 1 LOW	Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care. Usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Level 2 MEDIUM	Service or experience below reasonable expectations in several ways but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
Level 3 HIGH	Significant issues of standards, quality of care, or denial of rights. Possibility of litigation OR A matter that is categorised as a Serious Incident (SI) requiring a Root Cause Analysis Investigation Report. Issues regarding long term damage, grossly substandard care, professional misconduct or death. Serious patient safety issues. Probability of litigation is high.

7.11.2 The flow chart at Appendix 3 should be referred to for guidance on the management of complaints.

7.11.3 Where the risk level is scored as Level 3 (High) the case will be referred to the Serious Incident Review Group (SIRG) to agree the level of investigation. One single investigation process will be established with the complainant being clearly advised of the process.

7.12 Timescales

7.12.1 The timescale the Trust will seek to respond to complaints will be within 35 working days, or within the timescale agreed with the complainant depending on the nature and complexity of the complaint.

7.12.2 The timescale given to the investigating officer must be adhered to. If for any reason the investigating officer is unable to complete their investigations in the time given they must contact the Patient Experience Team as soon as possible with their reasons. The Patient Experience Team must contact the complainant to advise of the delay and agree a new timescale.

7.13 Producing written responses

7.13.1 The complaint response must include:

- All issues raised have been addressed.
- Accurate information.
- A full and honest explanation.
- Apology (apologies).
- Explain the actions that have/will be taken to improve the situation.
- The investigator must also determine whether a complaint is upheld, partly upheld or not upheld. To find a complaint upheld, partly upheld or not upheld, the investigator needs to consider and decide if the complaint was made on reasonable grounds and information.

7.13.2 The Patient Experience Team will review the complaint and the investigation to ensure that it has been thorough and addresses all the issues raised by the complainant. This process will act as a quality check for the complaint investigation.

7.13.3 A complete documentary record of the handling and consideration of each complaint is kept by the Patient Experience Team. Complaint records are kept separate from health records, subject to the need to record information which is strictly relevant to their health in the patients/patient's health records.

7.13.4 Any form of record, email, report or statements prepared during the course of the investigation must be filed in the complainants file held in the Patient Experience Team. Such documents must be factual, accurate and avoid expressions of opinion.

7.13.5 The Patient Experience Team will ensure that all information relevant to the investigation of the complaint is recorded on Datix and is available without unnecessary delay to the Parliamentary Health Service Ombudsman (PHSO) if requested.

7.13.6 All final responses will inform the complainant that if they have any outstanding or further concerns or feel that the complaint has not been satisfactorily resolved, they may contact the Patient Experience Team for further review.

7.13.7 Divisonal Managers are responsible for ensuring that all complaints are shared through appropriate means (e.g. team meetings, supervision) and that Learning Action Plans (Appendix 7) are implemented within the agreed timescale.

7.13.6 Progress on learning action plans should be reported to the Patient Experience Team and, where agreed, the complainant should be kept informed on the progress of the actions.

7.14 Duty of Candour (being open)

7.14.1 Candour is defined in Robert Francis' report as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'

'Prompt apologies and explanations, with a reassurance they will not reoccur, may prevent a claim being brought at all'

7.14.2 Duty of Candour is a statutory duty for health service bodies under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 regulated by the Care Quality Commission (CQC).

7.14.3 To meet the requirements of Regulation 20, a registered provider has to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident.
- Provide an account of the incident which, to the best of the providers' knowledge, is true of all the facts the body knows about the incident as at the date of notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.

- Offer an apology
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

7.14.4 Full guidance can be found in the Trust's Duty of Candour Policy.

7.15 Redress

7.15.1 In accordance with HM Treasury's advice to public organisations, the Trust will consider compensation when maladministration has been identified and will consider:

- A loss that has been caused by failure to pay an entitlement.
- When someone has faced additional costs as a result of the action or inaction of the Trust.
- Whether the process of making the complaint has imposed costs on the person complaining, e.g. lost earnings, or cost of pursuing the complaint.
- The circumstances of the person complaining, e.g. whether the action or inaction of the Trust has caused knock on effects or hardship.
- Whether the damage is likely to persist for some time.
- Whether any financial remedy would be taxable when paid to the person complaining.

7.15.2 Any payments made through this policy will be ex-gratia payments and are not intended to cover allegations of clinical negligence. Claims of clinical negligence will be handled by the Claims and Inquest Manager in conjunction with the NHS Litigation Authority and in accordance with the Trust's Claims Management and Legal Advice Policy.

7.16 Advocacy

7.16.1 The Trust supports and encourages the use of advocates within all services and all staff are required to actively promote this. Details of advocacy agencies are provided in the Trust's Compliments, Comments, Concerns and Complaints leaflet and publicity material. All services are required to display the publicity materials on accessing PALS and the complaints process.

7.17 Legal Implications

7.17.1 If a complaint reveals a likelihood of legal action, the Patient Experience Team should inform the Claims and Inquest Manager and provide a complete copy of the file. However, it should not be assumed that a complainant who has used a legal representative to make a complaint has decided to pursue litigation. The Patient Experience Team will continue to investigate and respond to the concerns raised in line with this policy.

7.18 Serious Allegations and Disciplinary Investigations

7.18.1 The complaints procedure is concerned only with resolving complaints and not with investigating staff regulation of conduct. The purpose of the complaints procedure is to thoroughly investigate complaints with the aim of satisfying complainants, whilst being fair to members of staff.

7.18.2 Where serious allegations regarding staff performance and behaviour arise through the complaints procedure, they will be investigated and managed through the appropriate HR policies.

7.18.3 The Trust has a duty to maintain staff confidentiality and must not share information regarding any action against staff with the complainant.

7.18.4 Investigation under the complaints procedure will only take place if it does not compromise or prejudice other on-going investigations i.e. police investigations.

7.19 Staff Grievances

7.19.1 Staff grievances are handled separately. The Trust has local procedures for handling staff concerns about health care issues and established grievance and openness procedures including:

- Grievance Policy and Procedure
- Staff Raising Concerns in the Workplace (Whistleblowing) Policy

7.19.2 Staff can use the NHS Complaints Procedure if their complaint relates to their own health care or if they are acting on behalf of a third party.

7.20 Fraud, Bribery and/or Corruption

7.20.1 Any complaint concerning possible allegations of fraud, bribery and/or corruption should be passed immediately to the Local Counter Fraud Specialist or the Director of Finance for action. This may lead to an investigation being carried out and a criminal prosecution being commenced by the Local Counter Fraud Specialist.

7.21 Complaints about services provided by other organisations/Joint organisational working

7.21.1 If the Trust receives a written complaint that is solely concerned with areas dealt with by another health body or by a body outside the NHS, with the complainant's agreement the complaint will be forwarded to the correct body. If there are any doubts over which body is responsible for handling the complaint, this is resolved before the complaint is dispatched.

7.21.2 Where a complaint involves more than one NHS provider or one or more other bodies such as a local authority or a purchaser, there will be full co-operation in seeking to resolve the complaint through each body's local complaints procedure. It will be agreed between each organisation which NHS body is going to take the lead and will co-ordinate the responses from the other Trusts to form one response back to the complainant.

7.21.3 Where the Trust receives a complaint which is mainly concerned with services provided by the Trust, but includes issues regarding an external agency, the Patient Experience Team will forward a copy of the complaint as appropriate for investigation and a response. The Patient Experience Team will incorporate the response from the external agency into the Trust's final response to the complainant.

7.21.4 Where the Trust makes arrangements for the provision of services with independent providers, it ensures that the independent providers have arrangements in place for the handling and consideration of complaints about any matter connected with its provision of services as if the Local Authority Social Services and NHS Complaints (England) Regulations 2009 applied to it.

7.22 Complaints about the Data Protection Act 1998 and the Freedom of Information Act 2000

7.22.1 The Information Commissioner will contact the Data Controller regarding complaints arising out of an alleged failure to comply with a Data Subject Request under the Data Protection Act 1998.

7.22.2 The Information Commissioner will contact the Freedom of Information Officer regarding complaints arising out of an alleged failure to comply with a Data Subject Request under the Freedom of Information 2000.

7.22.3 The Trust will consult with the Information Commissioner about complaints arising out of an alleged failure to comply with a Data Subject Request under the Data Protection Act 1998 and the Freedom of Information Act 2000.

Further information is available at http://www.informationcommissioner.gov.uk/

7.23 Freedom of Information Act (2000)

7.23.1 All written records of the complaint and the Trust's investigation are subject to requests made under the Freedom of Information Act (2000), unless it can be demonstrated that exclusion clauses apply.

7.24 Media Interest

7.24.1 Staff should refer any media interest in a complaint to the Media and Communications Manager and copy in the Director of Nursing and Quality, Patient Experience Manager and other senior staff members as appropriate.

7.25 Procedure for Handling Habitual and/or Vexatious Complainants

7.25.1 Complainants (and or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where previous or current contact with them shows that they meet two or more of the criteria outlined in Appendix 6.

7.25.2 Where complainants have been identified as unreasonably persistent in accordance with the above criteria, the Chief Executive (or appropriate deputy in his/her absence) will determine what action to take. The Chief Executive (or his/her deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as unreasonably persistent complainants and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. practitioners, conciliators, Healthwatch and MPs. A record must be kept in the complainant's complaint file for future reference of the reasons why the complainant has been classified as unreasonably persistent. This will not form part of their health care record.

7.25.3 The Chief Executive (or his/her deputy) may decide to deal with such complaints in one of the following ways as found in Appendix 6.

7.25.4 If a complainant has been determined as 'unreasonably persistent' there is an on-going approach to constantly review this status. There is discretion for withdrawing this status if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for something that is not connected to the original complaint.

7.26 Involvement of the Clinical Commissioning Groups (CCGs)

7.26.1 Complainants may raise concerns about the Trust to the local Clinical Commissioning Group (CCG). The CCGs are overseen by NHS England. The CCG

will seek to agree with the complainant how they wish the matter to be investigated and responded to. The CCG will contact the Patient Experience Team with details of the complaint and arrange for the investigation and response, as determined by the complainant. In all cases, the response will be copied to the CCG.

7.27 Reinvestigation of a Complaint

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

7.27.2 The complaint will be reassessed and if appropriate reinvestigated. The issues that remain unresolved for the complainant will need to be clarified and a new timeframe agreed.

7.27.3 Independent advice or a second opinion may be considered to review the complaint.

7.27.4 Meeting with the complainant is encouraged, to aid resolution. In some circumstances and in agreement with all parties, conciliation or mediation could also be considered.

7.27.5 If local resolution has been completely exhausted and the complainant still remains dissatisfied, the complainant will be reminded of their right to go to the PHSO.

7.28 Dissatisfied Complainants – Route to the Parliamentary Health Service Ombudsman (PHSO)

7.28.1 Complainants should be encouraged to let the Trust know if they are dissatisfied with the response to their complaint so that the Trust may attempt to try again to resolve the concerns raised.

7.28.2 Complainants have the right to ask the PHSO to review and investigate their complaint.

7.28.3 The PHSO will also consider information from the Trust on how it has attempted to resolve the complaint.

7.28.4 The Trust will comply with all requests for information from the PHSO to assist with its investigation and this will be co-ordinated by the Complaints Manager. On occasions where the PHSO believes more can be done at a local level to resolve the matter, it will advise the Trust and complainant with the request for this to be implemented. In such cases, the Complaints Manager will co-ordinate this with the relevant Divisional investigating manager and will keep the Chief Executive and Director of Nursing and Quality informed of all PHSO decisions.

7.28.5 Decisions reached by the PHSO will be shared by them with the complainant and the Trust and any recommendations made to the Trust will be addressed and assurances provided on this to both the PHSO and the complainant. This will be co-ordinated by the CBU Complaints Managers.

7.28.6 Decisions on PHSO upheld complaints will be covered in the quarterly and annual Complaints Reports and in the Trust's Annual Report.

8. Process for Implementation and Dissemination

8.1 The Divisional investigating manager should possess the necessary skills to investigate and deal with complaints. If the proposed person does not have the capacity or is on annual leave/sick then an alternative investigating manager needs to be appointed.

8.1.1 Training

8.1.1.1 The Patient Experience Team will provide training sessions to all Trust staff including the Trust induction and induction programmes for Nurses, Healthcare Assistants, junior doctors and Allied Health Professionals, mandatory training as well as individual training as required.

8.1.1.2 Root Cause Analysis Training is a recognised method with which to investigate a complaint and is recommended training for investigating managers.

8.1.2 Monitoring Effectiveness

8.1.2.1 The Patient Experience Team will monitor the quality of investigations and complaint responses and will highlight additional training needs to the relevant Divisonal Director, General Manager, Head of Nursing and Lead Nurse.

What will be monitored and/or standard to be achieved	Document	Method	Frequency	Lead	Report to	Responsibility
Current complaints and timeframes	Complaints Schedule	Schedule	Weekly	Complaints Manager	Divisional Leads	Head of Patient Experience and Involvement
Actions and learning from complaints	Complaints Action Plan	Action Plan	Weekly	Divisional Manager	Divisional Governance meetings	Head of Patient Experience and Involvement
Number of complaints/ concerns received	Patient Experience Report	Report	Quarterly	Complaints Manager	Patient Experience Steering Group Quality Governance Steering Group	Head of Patient Experience and Involvement
			Annually		Information Governance Committee Trust Board	
Emerging themes and trends	Patient Experience Report	Report	Quarterly	Complaints Manager	Patient Experience Steering Group Quality Governance Steering Group	Head of Patient Experience and Involvement
			Annually		Information Governance Committee Trust Board	
Learning from complaints	Patient Experience Report	Report	Quarterly	Complaints Manager	Patient Experience Steering Group Quality	Head of Patient Experience and Involvement

					Governance Steering Group	
			Annually		Information Governance Committee Trust Board	

9. Review

9.1 The policy will be reviewed on an annual basis or at any stage when changes are made to the governing legislation, national guidance or the Trust's internal process. The outcome of these reviews will be noted in the Version Control Sheet at the front of the document and version numbers amended accordingly.

9.2 Any changes to this policy will be ratified by the Patient Experience and Involvement Steering Group.

10. References and Associated Trust Policies

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, No. 39

The Francis Report (2013)

Clywd/Hart Report (2013)

Principles for Remedy (Parliamentary and Health Service Ombudsman 2009)

Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman 2009)

Data Protection Act (1988)

Freedom of Information Act (2000)

Equality Act (2010)

Mental Capacity Act (MCA) (2005)

National Patient Safety Association

Maintaining Standards at Work (Whistleblowing)

Incident Reporting Policy R30

Risk Management Policy R32

Patient Experience and Involvement Strategy

Incident Reporting Policy R30

Supporting Staff Involved in Incidents Complaints and Claims

11. Equality Impact Assessment

11.1 As part of its development, this policy and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation or religious belief. No detriment was identified.

Appendix 1 – Patient Consent Form

Complaint Ref: (To be Completed by QGD)	
Patient's Name:	
Patient's Date of Birth:	
Patient's Address:	
Name of Representative:	
Relationship to Patient*:	
Patient's Signature:	
Date:	

*** If Next of Kin/legal representative, please see overleaf for list of documentation accepted as proof.**

- I hereby authorise you to release to my representative any information which may be relevant to the concerns raised.
- I hereby authorise you to carry out an investigation into the concerns raised in this complaint.
- I hereby authorise you to have access to my medical records

PLEASE RETURN THE SIGNED CONSENT FORM TO:

Quality Governance Department
1st floor, Thorpe House
Kettering General Hospital NHS Foundation Trust
Rothwell Road
Kettering
Northants, NN16 8UZ

The Department of Health require us to record your ethnic origin, therefore, it would be helpful if you could tick the following as appropriate: ✓as appropriate		
1	White British	☐
2	White Irish	☐
3	White - any other white background	☐
4	Mixed white and Black Caribbean	☐
5	Mixed white and Black African	☐
6	Mixed white and Asian	☐
7	Mixed - any other mixed background	☐
8	Asian or Asian British Indian	☐
9	Asian or Asian British Pakistani	☐
10	Asian or Asian British Bangladeshi	☐
11	Asian or Asian British - any other Asian Background	☐
12	Black or Black British Caribbean	☐
13	Black or Black British African	☐
14	Black or Black British - any other Black background	☐
15	Other ethnic group - Chinese	☐
16	Other ethnic group	☐
17	Prefer not to state	☐

List of Acceptable documentation

	Type of Applicant	Type of documentation
A	Complaint on behalf of a patient without capacity	One item showing proof of the patient's identity **and** one item showing proof of the representative's identity
B	Next of Kin/Representative applying on behalf of a patient	Power of Attorney **plus** proof of the patient's identity

Appendix 2 – Triage criteria for complex/simple complaints

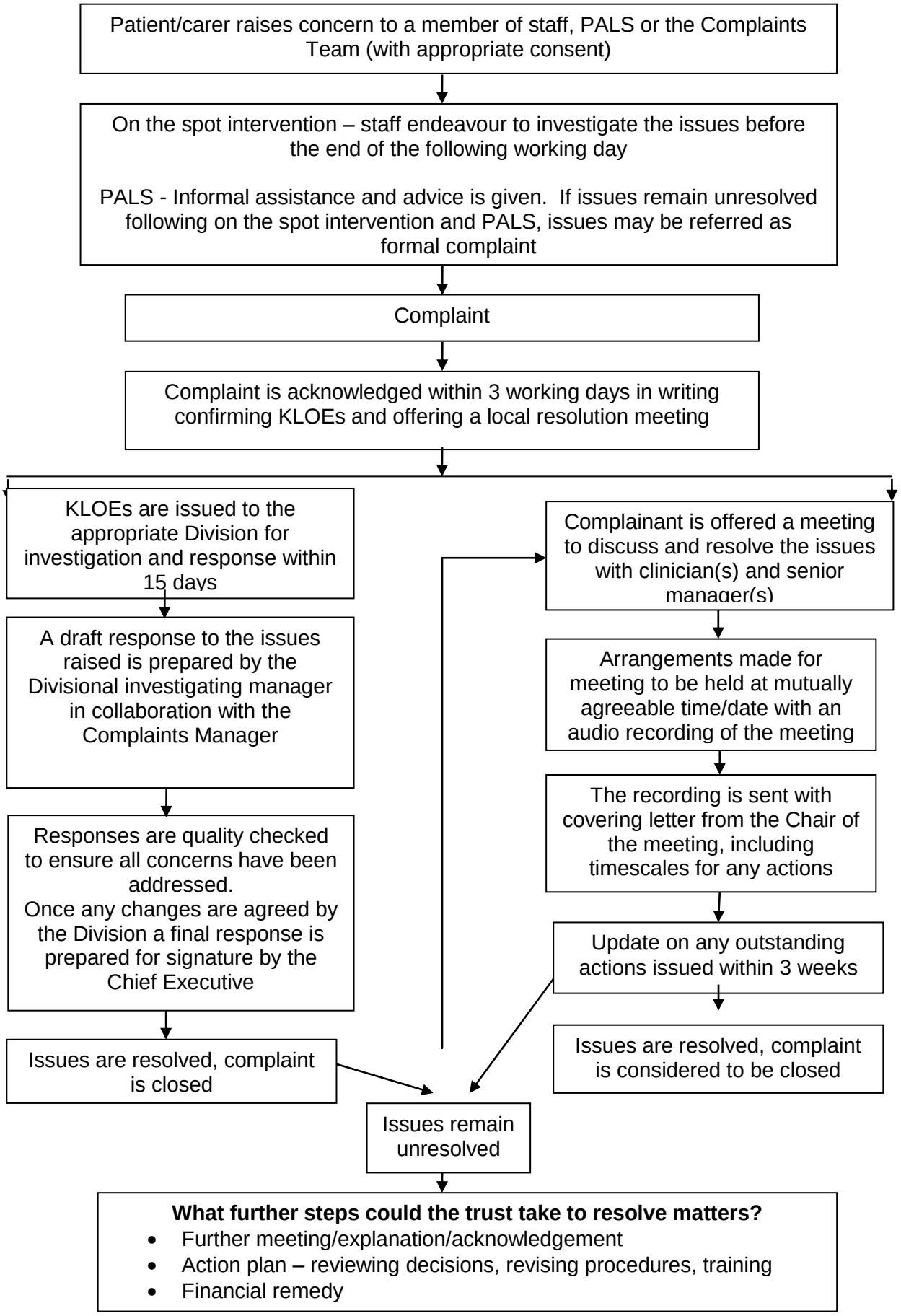
SIMPLE

- Delayed and cancelled appointments
- Resulted in no or minor harm
- Single failure of care needs

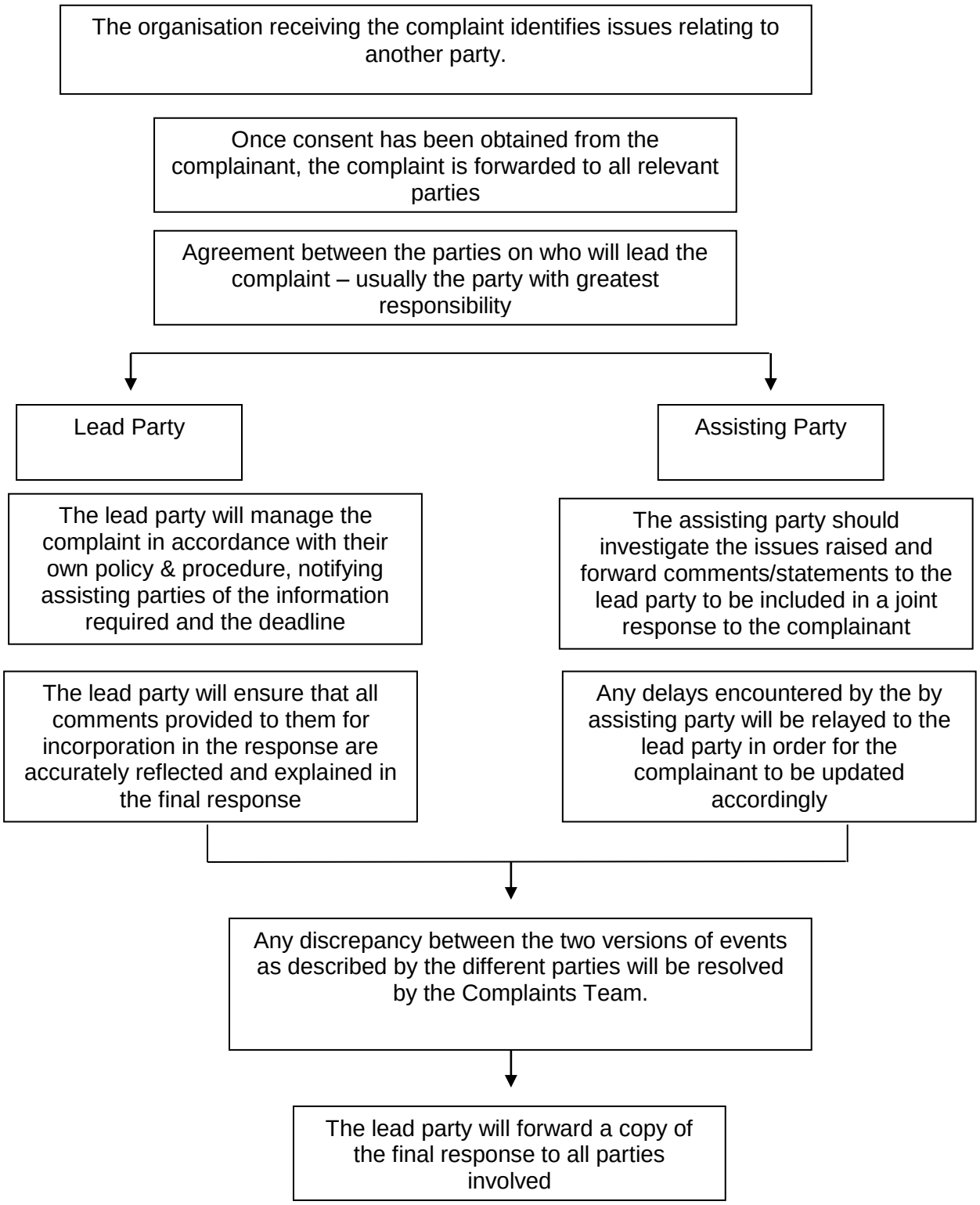
COMPLEX

- More than one area / service
- More than one area of failure
- A number of concerns raised across MDT
- Resulted in moderate or significant harm
- Incorrect treatment and/or medical errors

Appendix 3 – Complaints Flow Chart



Appendix 4 – Joint Complaints Flow Chart



Appendix 5 – Guidance on Complaint Outcomes

NHS providers are legally required to publish data on complaints handling performance, which must include the number of complaints that are considered to be 'well founded'. The Trust publishes this information in the complaints reports.

When assessing the outcome it is important to apply the following rules to determine an overall outcome:

- If the majority of issues raised are well founded then, overall, the complaint should be recorded as 'well founded'.
- If the main and most serious issue is well founded, then the complaint should be recorded as 'well founded'.
- If the majority of the main issues raised in the complaint are unfounded, then the complaint should be recorded as 'not founded'.

Appendix 6 – Managing Habitual/Vexatious Complaints

In determining arrangements for managing fixated complaints staff must ensure that the complaints procedure has been correctly implemented so far as possible, and that no material element of a complaint is overlooked or inadequately addressed, and to appreciate that even fixated complainants may have issues which contain genuine substance.

Definition of a fixated Complaint

Complaints may be deemed to be fixated where previous or current contact with them shows that they meet one or more of the following criteria (this is not an exhaustive list, and other factors may be considered by the Director of Nursing and Quality)

Where complaints:-

- Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted or where implementation of the NHS complaints procedure is inappropriate for the issue raised (e.g. where investigation is “out of time” and cannot be investigated fairly and effectively, or where the issue of concern arises from care as a private patient).

- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).

- Are unwilling to accept documented evidence of treatment as being factual, (e.g. drug records, medical or nursing records) or deny receipt of an adequate response in spite of correspondence specifically answering their questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Trust staff and, where appropriate, advocacy support to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

- Repeatedly focus on specific issues which have been appropriately and fully considered and responded to.

- Have threatened or used actual physical violence towards staff or their families or associates at any time – (this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented). The matter should be reported to, and involve, the Local Security Management Specialist.

- Have, in the course of addressing a registered complaint, had an excessive number of contacts with the Trust, placing unreasonable demands on staff. (A contact may be in person, by telephone, letter or fax. Discretion must be used in determining the precise number of “excessive contacts” applicable under this section, using judgement based on the specific circumstances of each individual case).

- Are known to have recorded meetings or face-to-face/telephone conversations without the prior knowledge and consent of other parties involved.
- Display unreasonable demands or patient/complainant expectations, and fail to accept that these may be unreasonable (e.g. insist on responses to enquires being provided more urgently than is set out in the national guidance on complaints handling).

You should take account of the context and history of the complaint when considering the questions above. An individual complaint may not be fixated in isolation, but in context it may form part of a wider pattern of vexatious behaviour.

However, you should not automatically refuse a request simply because it is made in the context of a dispute or forms part of a series of requests. You must still ask whether the request falls as fixated by considering the questions listed above.

An important point is that it is the complaint, not the complainant, which must be deemed to be fixated. You should not automatically refuse to deal with a complaint just because the individual has caused problems in the past. You must look at the complaint itself.

Considerations prior to taking action

You must make sure that the details of a complaint are not lost because of the presentation of that complaint. There are a number of things to bear in mind when considering the imposition of restrictions on a complaint.

These may include:

- Ensuring that the complaint case is being, or has been, dealt with appropriately, and that reasonable actions will follow, or have followed the final response.

- Confidence that the complainant has been kept up to date and that communication has been adequate with the complainant prior to their behaviour becoming unreasonable or fixated.

- Checking that the complainant is not raising any new or significant concerns that need to be considered that will affect the organisation's view on the existing case.

- Applying criteria with care, fairness and due consideration for the complainant's circumstances – bearing in mind any known physical or mental health conditions that may explain the reason for their difficult behaviour. This should also include consideration of the impact of any bereavement, loss or significant/sudden changes to the complainant's lifestyle, quality of life or life expectancy.

- Considering the proportionality and appropriateness of the proposed restriction in comparison with the level of unreasonableness of the behaviour and impact on staff.

- Ensuring that the complainant has been advised of the existence and purpose of the policy and has been warned about, and given a chance to amend their behaviour or actions.

- Considering whether there are further actions to take before designating the complaint as fixated or unreasonable.

Actions prior to designating complaint as 'unreasonable or fixated'

Consideration should be given as to whether any further action can be taken prior to designating the complainant as 'unreasonable' or 'unreasonably fixated'. This might include:

- Where no meeting with staff has been held, consider offering this as a means to dispel misunderstandings and move matters forward – this option will only be appropriate where risks have been assessed, and a suitably senior member of staff can be present.

- Where multiple departments are being contacted by the complainant, consider setting up a strategy to agree a cross-departmental approach.

- Issue a warning letter explaining that if the complainant's actions continue, the organisation may decide to treat him or her as an unreasonably fixated complainant and explain why.

- Consider if providing a copy of records, or setting a meeting to talk through records may help to dispel misunderstandings or misconceptions – this option will only be appropriate where staff are unaware of any circumstances where this would not be advisable and consent is appropriately obtained.

Options for dealing with Fixated Complaints

Where complaints have been identified as fixated in accordance with the above criteria, the Director of Nursing and Quality (or appropriate deputy in their absence) will determine what action to take.

The Director of Nursing and Quality (or deputy) will implement such action and will notify complainants in writing of the reason why they have been classified as fixated complainants and the action to be taken, and how long the restrictions will remain in place. The complainant should be provided with a copy of this Policy.

This notification may be copied for the information of others already involved in the complaint, e.g. clinicians, Advocacy support, Member of Parliament. A record must be kept for future reference of the reasons why a complaint has been classified as fixated.

The Director of Nursing and Quality may decide to deal with complainants in one or more of the following ways:

- Place time limits on telephone conversations and personal contacts.

- Decline contact with the complainants either in person, by telephone, by fax, by letter or any combinations of these, provided that one form of contact is maintained, (if staff members are to withdraw from telephone conversations with a complainant it may be helpful for them to have an agreed statement available to be used should the complainant persist in ringing).

- Restrict contact liaison through a third party (such as an advocate).

- Refuse to register and process further concerns or complaints about the same matter - notify the complainant in writing that the Trust has responded fully to the points raised and has tried to resolve the complaint but has nothing more to add and continuing contact on the matter will serve no benefit. The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered. Complainants should be reminded of their right to pursue their complaint via the Health Service Ombudsman.

- State that the organisation does not deal with correspondence that is abusive or contains allegations that lack substantive evidence, request that a revised version of the correspondence be provided.

- Inform the complainant that any personal contact will take place in the presence of a witness.

- Drawing up a signed “agreement” with the complainant which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other actions as indicated in this section.

- Inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable or fixated complaints to its solicitors.

- Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice, or guidance from the Health Service Ombudsman.

Reviewing and Withdrawing ‘Complainant’ Status

Once complainants have been determined as ‘fixated’ there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach, or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should have used discretion in recommending the initial ‘fixated’ status and discretion should similarly be used in recommending that the status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Director of Nursing and Quality (or nominated deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

Record Keeping

Ensure that adequate and accurate records are kept of all contact with fixated complainants. This should include circumstances when:

- The decision to use this policy is invoked.

- Where a deputy is used to make the decision, the reason for the non-availability of the Director of Nursing and Quality should be recorded on the file.

- A decision is taken not to apply the policy when a member of staff asks for this to be done, or make exception to the policy once it has been applied.

Appendix 7 – Learning Action Plan

Responsible lead for action plan……. Division……. Date……

Root cause/ contributing factor	Level of risk (in line with complaints policy)	Agreed action	Level (Individual, Team, specific Division.)	By Whom	By when	Evidence of completion	Sign off

As investigators we have liaised with all the people in the Action Plan and there is agreement to undertake the actions: