York Teaching Hospital NHS
NHS Foundation Trust

Policy for Handling Complaints and Concerns

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Links to Organisational/Service Objectives, business plans or strategies	Our Shared Commitment 2016: Quality & Safety Ambitions Patient Experience Strategy 2015

Executive Summary

The purpose of this policy is to:

1. Set out the principles via which York Teaching Hospitals Foundation Trust (YTHFT) handles complaints and concerns

2. Define the roles and responsibilities for handling complaints and concerns within the Trust and across organisational boundaries

3. Promote early resolution and a person-centred approach, which focuses on the outcome sought by the person making contact

4. Define the linkage between the processes for handling complaints and concerns and other formal investigations, including safeguarding, serious incidents and professional standards

5. Reduce the risk of repeated failures by ensuring that necessary improvements are appropriately identified and acted upon as a result of feedback.

6. Ensure that the Trust carries out all duties required under the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009* (the Complaint Regulations); and the *Care Quality Commission Regulation 16: Receiving and Acting on Complaints*.

7. Ensure that the Trust acts in accordance with the Parliamentary and Health Service Ombudsman's Principles of Remedy.

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Version History Log

Version	Date Approved	Version Author	Status and location	Details of significant changes
4	29/09/04	P Goff		Incorporates The NHS (Complaints) Regulations 2004
5	29/09/04 Reviewed November 2006	P Goff		Reviewed in the light of The NHS (Complaints) Amendment Regulations 2006
6		P Goff		Incorporates the Trust Policy Template issued in October 2007
7		P Goff		Although compliant with RM standards, the assessor requested more explicit info on how the Trust ensures that patients, relatives and carers are not treated differently as a result of a complaint.
8		M Thirlway	Horizon	Incorporates The NHS (Complaints) Regulations 2009 and aims to comply with RMSAT Standards
9		M Thirlway	Horizon	Incorporates Regulation 19 of the Health & Social Care Act 2010, changes to RMSAT standards and CQC outcomes, and updates to the Trust management structure and commissioning arrangements.
10	March 2015	K Gamble	Intranet	Incorporates overview of Being Open (Duty of Candour) requirements
11	July 2016	H Rowell	Staff Room	Full revision.

Contents

1. Introduction

Welcoming and listening to feedback from patients, their families, carer and members of the public is an essential part of the Trust's quality governance system.

Patients need to be confident that their complaints or concerns are acted upon in a consistent, fair and timely manner. Where failures occur they will be openly acknowledged, an appropriate and timely apology given and any necessary remedy offered for any injustice or hardship that may have been caused.

The purpose of this policy is to:

- Set out the principles via which York Teaching Hospitals Foundation Trust (YTHFT) handles complaints and concerns
- Define the roles and responsibilities for handling complaints and concerns within the Trust and across organisational boundaries
- Promote early resolution and a person-centred approach, which focuses on the outcome sought by the person making contact
- Define the linkage between the processes for handling complaints and concerns and other formal investigations, including safeguarding, serious incidents and professional standards
- Reduce the risk of repeated failures by ensuring that necessary improvements are appropriately identified and acted upon as a result of feedback.
- Ensure that the Trust carries out all duties required under the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009* (the Complaint Regulations); and the *Care Quality Commission Regulation 16: Receiving and Acting on Complaints*.
- Ensure that the Trust acts in accordance with the Parliamentary and Health Service Ombudsman's Principles of Remedy.

2. Scope

This policy covers complaints and concerns made by patients, their representatives or members of the public about care or services provided by York Teaching Hospitals NHS Trust. This includes all care at all sites and within all community services provided by the Trust.

The policy covers the handling of complaints across organisational boundaries and the responsibilities for handling complaints where services are sub-contracted to independent providers.

The policy does not include feedback about staff that is not related to their duties within the Trust and issues regarding Human Resources and recruitment.

3. Definitions /terms used in policy

Complaint: an expression of dissatisfaction with any aspect of the service provided to a patient, their carer or family member or a member of the public which requires the Trust to provide a formal response in line with the NHS Complaints Regulations 2009.

Concern: where a patient, their carer or family member or a member of the public wishes to make the Trust aware of an issue, event or incident and receive a response, but where the issues raised do not require a formal investigation under the complaint regulations.

Consent: permission from the patient for another person to act on the behalf and for their personal information to be disclosed in the response to that concern or complaint. A patient may also be asked to give their permission for their medical records to be shared between NHS and Social Care organisations to enable their complaint to be considered.

Advocate: a person acting on behalf of a patient or their family member, carer or friend to assist and support them in the process of raising a concern or a complaint. Advocacy services for complaints against the NHS are funded by local authorities and are available in all areas where the Trust provides services.

4. Policy Statement

The Trust will handle complaints and concerns using the principles set out by the Parliamentary and Health Service Ombudsman:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

Considering raising a concern or making a complaint

Listening to patient, carer, family and public concerns is the responsibility of every member of staff and volunteer and linked to the Trust values. In the first instance, the Trust expects all staff to try to help the individual putting forward their concerns as close as possible to the

time that the issues arise and to seek to achieve resolution without the need to access the concerns or complaints process.

Information about how to raise concerns or make a complaint will be accessible for patients and the public. This will include information displayed in hospitals and on the Trust website and ensuring that staff and volunteers are able to provide advice and assistance with raising complaints or concerns if asked. Information will be available in accessible formats as required, including, easy read and British Sign Language.

People considering raising complaints or concerns will be reassured that their care/the patient's care will not be adversely affected in any way if they choose to do so.

Raising a concern or making a complaint

The Trust will enable patients and the public to raise concerns or complaints in the way in which they feel most comfortable. This may be email, via social media, telephone or face-to-face.

The Trust will recognise and engage with an advocate where the person raising the concern or complaint wishes to have this support. Patients making a complaint or raising a concern will be given information about how to access advocacy services, so they are aware of the support available.

The procedure for handling concerns and complaints is shown in the diagram at appendix 3 and roles and responsibilities are detailed at appendix 2. The process will be person-centred in that the member of Trust staff receiving the concern or complaint will seek, from the outset, to ascertain the outcome sought and tailor the resolution process accordingly.

Where the person raising the concern or complaint is not the patient, consent will be obtained from the patient to share details of their care with that person.

The Trust is committed to listening to anyone who wishes to make a complaint or raise concerns about the quality of their care regardless of personal characteristics including: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. The Trust will make reasonable efforts to ensure that peoples' individual requirements are taken into account and that there are no barriers to particular groups' making their voices heard.

The Trust will work in accordance with *The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*, which state that the time limit for making a complaint is 12 months after the date on which the matter which is the subject of the complaint occurred; or the date on which the matter which is the subject of the complaint came to the notice of the complainant. This will not apply if the complainant had good reasons for not making the complaint within that time limit; and, notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

Staying informed

The person raising a concern or making a complaint will have a named contact who will provide updates and ongoing communications throughout the process.

Receiving outcomes

Every complaint or concern will receive a response. This will include details of the evidence considered, who has been involved, a response to each element of the concern or complaint and details of what changes or remedies have/will take place as a result of the complaint. Responses to concerns will be provided in the format preferred by the person involved. This may be face-to-face, by telephone, email or letter.

All formal complaints will receive a response from the investigating officer with a covering letter signed by the Chief Executive. This will usually be a letter, but the format may be tailored to the wishes and needs of the person making the complaint. Wherever possible (and wished by the person making the complaint) this will be supported by a face-to-face meeting and engagement between the investigating officer, those responsible for the services which are the subject of the complaint, and the person making the complaint.

Responses will include advice about what to do if the person raising the concern or complaint is not satisfied.

Learning and improving

Reports of concerns and complaints are an essential part of the Trust's clinical governance system. Reports on numbers, supported by narrative details of issues raised, will be presented monthly to the Board of Directors. Quarterly reports will be presented to the Patient Experience Steering Group. These reports will be shared with directorates.

Information on the numbers of concerns and complaints; their subjects; and the learning and action will be made available to the public. This will

include publication of Board of Directors papers, information in Quality Accounts, the Trust Annual Report and the publication of a Complaints Annual Report.

Reports will show any themes and trends by subject and/or directorate. Narrative comments and commentary will give an insight into the issues raised and the learning. Where themes and trends are evident, the Board and Patient Experience Steering Group will seek assurance that appropriate improvement actions are in place.

The quarterly KO41 return will be submitted to the Health and Social Care Information Centre as required.

Individual members of staff are encouraged to keep copies of their statements and the outcomes of complaints or concerns related to their own practice. Reflective practice will support nurse and medical revalidation and personal development.

Keeping records

For each concern or complaint a case will be created, at the point of receipt, on the Datix information management system.

The Datix record will be updated with details of all contacts with the person making the complaint or concern. This will include a summary of any verbal contact as well as copies of written correspondence.

The Datix record will include coding for directorate, ward, subject and profession to allow meaningful quantitative reports to be produced.

Records of complaint cases will not be held in medical records to ensure that patient care is not influenced, in any way, by the fact that a concern or complaint has been raised.

Complaints and concerns involving multiple organisations

All NHS and Local Authority Social Care Services are required to work together to provide a single response to complaints made about their services where the complaint has raised issues relating to multiple organisations in their complaint.

Where it is necessary to share details of the complaint or concern with another organisation, consent will first be sought from the patient. Once consent is received, contact will be made with the other organisation(s) concerned and a joint approach to resolving the complaint or concern will be agreed.

The Trust will always seek to collaborate to achieve a single, coordinated resolution process.

Complaints and concerns involving sub-contractors

Complaints and concerns made about services provided by other organisations on behalf of YTHFT will be logged and investigated by the Trust.

All sub-contractors are expected to comply with this policy and to contribute openly, honestly and fully with investigations and resolution.

Complaints raised by MPs and Elected Members of Local Authorities

Where a complaint or concern is raised by an MP or a Local Authority Elected Member and relates to services provided to an individual, the MP's statement that they are acting for their constituent satisfies the requirement for consent where the person is also the patient to whom the concern or complaint relates. Where this is not the case, consent will be sought as per section 5.5. This is in line with the Information Commissioner's Office guidance.

5. Links with other policies and procedures

Being Open With Patients Policy

Being open involves:

- Acknowledging, apologising and explaining when things go wrong
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring
- Providing support for those patients, their families/carers and staff involved, to cope with the physical and psychological consequences of what happened.

Saying sorry is not an admission of liability and is the right thing to do.

The Duty of Candour is a statutory obligation since November 2014 and reinforces the fundamental obligation to be open and honest in the event of an incident where patient harm has occurred.

Serious Incident Policy

If an existing complaint is declared an SI then the investigation will cease in the complaints process and all issues relating to the harm that occurred and the questions/concerns raised by the person making the complaint will become part of the SI investigation. The person making the complaint will be contacted by the existing investigating officer to explain the situation and what will happen next. If there is a change of investigating officer the person making the complaint will be given an

opportunity to speak with the new investigator, who will then take over as the single point of contact.

The person making the complaint will receive a single response, managed under the SI process, which gives the outcome of the SI and addresses the issues raised in the original complaint.

Safeguarding Adults and Children

All members of the Patient Experience Team will complete safeguarding training at Level 1, ensuring that they understand how to identify potential abuse and how to notify the safeguarding team.

Complaints or concerns which, at the point of initial assessment by the Patient Experience Team have clear safeguarding issues will be highlighted to the Safeguarding Team for review.

Complaints and concerns where safeguarding issues are raised will be notified to the Chief Nurse for assurance that the safeguarding adults or children team are involved where necessary.

The Safeguarding Team will receive a copy of the weekly complaints report to provide an additional check that all safeguarding issues are identified and taken forward.

Claims

If the person making the complaint or concerns indicates that they have already instigated legal proceedings/made a claim for compensation, or are likely to do so, the Patient Experience Team will notify the Legal Services Team. The Legal Services Team will review the draft response before it is signed off.

NHS England has clarified the position where a complaint is made and a claim is likely or ongoing:

- where the complainant is taking, or plans to take, legal proceedings, a complaint may only be put on hold where there are exceptional reasons to justify it, or the complainant has requested that investigation be delayed
- exceptional circumstances for putting a complaint on hold may include formal requests to do so by the police, a coroner or a judge.
- any concerns about continuing with the investigation of a complaint should be raised during the discussion with the complainant of how the complaint is be handled in order to allow the complainant's views to be heard.
- if, exceptionally, an NHS body decides to put a complaint on hold against the wishes of the complainant, the complainant should be

informed of this as soon as is practicable and provided with a full explanation (in writing, unless requested not to) of the reasons for this.

- Any decision to put the complaint on hold in these circumstances would be expected to be made with the involvement of the NHS body's 'responsible person'.

Coroners' Investigation

If a complaint is made into circumstances which are also the subject of a coroners' investigation similar principles will be followed as for claims. In most circumstances there is no reason to delay a complaint investigation unless requested by the person making the complaint. It can be helpful to provide explanations, and where necessary apologise, to relatives ahead of the inquest, which can take some time to conclude. The investigating officer will keep in touch with the Legal Services Team and share copies of all statements and reports.

Disciplinary Policy

Where an investigation finds that misconduct by a member of staff has occurred, this will be handled under the Trust Disciplinary Policy. The action plan for the complaint will give assurance to the person complaining that action has been taken, but without breaching the confidentiality of the individual concerned.

6. Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 5.

7. Accountability

Operational implementation, delivery and monitoring of the policy resides with:

- All healthcare professionals and volunteers are responsible and accountable to the Chief Executive for the correct implementation of this policy.
- Professional staff are accountable according to their professional code of conduct. The General Medical Council for doctors, the Nursing and Midwifery Council for nurses and midwives and the Health Professions Council for allied health professionals.

Appendix 1 Categorisation and grading for concerns and complaints

Determining whether an issue raised is a complaint or concern

York Teaching Hospitals Foundation Trust (YTHFT) is committed to ensuring that lessons are learned and actions delivered to minimise the risk of issues recurring and improve the quality of our services for the future.

In practice, this means guiding the person making contact with YTHFT through the process to help them achieve the outcome they want in a timely manner and to ensure that the issues raised are managed at the appropriate level in the Trust.

There is no absolute definition given by the current complaint regulations or Department of Health guidance. The table below sets out the considerations used by YTHFT in making the classification decision.

Complaint	- Patient wishes to receive a formal (usually written) response – regardless of the seriousness of the issues raised. When discussing with people how they wish to take forward their concerns, this route will usually be suggested if: - The issues raised are likely to result in medium or high categorisation. - The issues raised are complex and an investigation will be required and/or written staff statements are necessary.
Concern	- Patient does not want a formal investigation and states that they are happy with an informal response (most likely to be verbal or email) When discussing with people how they wish to take forward their concerns, this route will usually be suggested if: - The issues raised are likely to result in low categorisation. - Formal staff statements are not required. - It is anticipated that the case can be resolved swiftly.

Grading

There are four levels: low, medium, high and extreme. Identifying the correct grade is vital to ensuring that the complaint/concern is resolved appropriately and that all the necessary people are aware of the issues raised. This will help ensure that any risks to this patient's care and to other patients in future are effectively managed.

Seriousness	If any one factor in the medium or high categories fits the complaint/concern then it should be placed into this category.
Low	Patient received an unsatisfactory service but issue not directly related to their clinical care or safety. No harm to patient. No impact on the patient's overall NHS care. No/minimal impact on patient/complainant's dignity and respect. Issue can be rapidly resolved directly between the Trust and the complainant. No real risk of litigation. No media or MP interest.
Medium	Patient received an unsatisfactory service in several ways. One or more issue relates to the patient's clinical care or safety. Minor injury to patient but with no long-lasting problems. or Risk of minor harm to patient or low risk of more serious harm. Issue led to detrimental impact on patient's overall NHS care. Patient/complainant perceived a significant breach of their/the patient's dignity and respect. Issue can be resolved directly between the Trust and the complainant but it may take time to achieve this. Some potential for litigation. Some local media interest. MP involved. The issue has occurred more than once for this complainant leading to repeated negative impact on care.
High	Patient received a significantly sub-standard service which highlights clear quality assurance or risk management issues. Serious injury to patient or patient death. or Significant risk of serious injury or death. Issues while in the Trust's care led to a significant impact on the patient's overall NHS care which highlights clear quality assurance or risk management issues. Serious safeguarding or professional misconduct issues involved. Patient/complainant was subject to a serious breach of their dignity, respect or human rights Litigation a strong possibility. Widespread media interest.
Extreme	Issue is registered and being investigated as a serious incident. Issue is not registered as a serious incident, but the seriousness of the issues raised requires a senior clinical owner for the investigation and oversight by the Chief Nurse or Medical Director.

Appendix 2 Roles and Responsibilities

Chief Executive

The Chief Executive is the responsible person for ensuring compliance with the Complaint Regulations and the CQC standards. The Chief Executive may delegate this function to another person authorised to act on his/her behalf.

They will sign all final complaint response letters to the complainant or the Parliamentary and Health Service Ombudsman.

Chief Nurse

The Chief Nurse has overall responsibility for the Trust's Patient Experience Strategy and for ensuring that there is an effective and patient-centred system in place for welcoming feedback and responding to and learning from concerns and complaints.

The Chief Nurse will review all complaints each week. Any complaints which may require an extreme risk rating, raise serious safeguarding or professional conduct issues will be escalated immediately to the Chief Nurse as they are received. The Chief Nurse will identify those requiring escalation to Risk and Safety Group for consideration as serious incidents and confirm that any necessary safeguarding review or investigation is underway.

The Chief Nurse and Deputy Chief Nurse are responsible for the quality of complaint responses and must give approval for every written response before it is signed by the Chief Executive. They will check that an appropriate investigation has been carried out, that the questions asked receive a clear response, that the response is appropriately empathetic and that, where failures have occurred, that an appropriate apology and remedy are offered and learning is identified.

Lead for Patient Experience

The Lead for Patient Experience is responsible for the function of the 'complaints manager' as required by the Complaint Regulations. The Lead for Patient Experience may delegate actions to the Patient Experience Team staff.

They are responsible for ensuring that the Policy and Procedure for Handling Concerns and Complaints is up to date and is implemented effectively across the Trust.

They will ensure that appropriate measures are in place for staff training and to monitor compliance.

They will ensure that the necessary monthly, quarterly and annual reports are submitted to the Board, the Health and Social Care Information Centre, Patient Experience Steering Group and that these are shared with directorates.

Ensures that themes, trends and learning from complaints is triangulated with other sources of patient experience information to support risk management, performance management and service improvement.

Complaints Team

The Complaints Team includes the Patient Experience Team Leader, the Complaints Officers and the Complaints Administrator.

The Complaints Team will:

- Receive the complaint (or high risk concern). This may be in writing (email or letter); or notes of a face-to-face meeting with Trust staff or a telephone call.
- Assess whether the complaint is regarding care provided by YTHFT.
- Acknowledge complaint in writing via preferred method (email, letter). Explain that the investigating officer will be in touch within 3 working days. If the complaint is not about care provided by YTHFT, the team member will explain the correct organisation to contact and offer to forward on the complaint.
- Give a timescale (30 or 50 days), which will be confirmed when the investigating officer makes contact.
- If contact is from a third party, seek the patient's consent to share information with the person making the complaint or concern. If necessary, also to seek consent to share information with other organisations involved in the complaint or concern. When consent is required, the complaints process timeline will start on the day consent is received.
- Escalate complaints identified as meeting the criteria for extreme risk, with serious safeguarding or professional conduct issues immediately to the Chief Nurse. Escalate other issues requiring immediate attention to the appropriate people, eg Lead for Patient Experience, safeguarding team, information governance team, professional standards team.
- Identify the directorate or directorates responsible for leading and contributing to the investigation. Log the complaint on Datix, creating a separate subject for each main issue raised. Upload a

copy of the complaint, acknowledgement and any other relevant documents.

- Notify the directorate manager (copy to nominated deputies and matron) of the complaint by sending a link to the Datix record.
- Support the nominated investigating officer, as required, to discuss the issues raised, agree the resolution plan and provide any required guidance on planning and carrying out the investigation.
- Support the investigating officer with meeting the complainant if required. This is not a note-taking function, which should be provided by the directorate. Criteria for Patient Experience Team Support include: requested by the complainant; supporting investigating officer if new in post or previous meetings/dialogue have been difficult.
- Maintain oversight of the timescale for response and seek to resolve and/or escalate any delays. Send weekly status updates to investigating officers, copied to assistant directors of nursing.
- For written responses, receive the draft report from the directorate manager. Ensure that the draft has been copied to or reviewed by the appropriate assistant director of nursing.
- Pass final draft, with a record of the agreed scope of the investigation and a copy of the complaint, to the Chief Nurse/Deputy Chief Nurse for final approval.
- When approval received, arrange signature by the Chief Executive, scan a copy and send out to the person who made the complaint. (First checking that consent has been received). Send copies to any advocates involved.
- Close the Datix record, recording the outcome and any learning.
- Complete regular audits of compliance with Trust policy and agreed improvement actions to monitor completion.
- Contribute to training sessions for Trust staff to develop the skills of investigating officers in investigation and complaint response writing.

Directorate Manager

The directorate manager is responsible for ensuring that each complaint or concern allocated to their directorate for investigation is subject to a timely investigation which is proportionate to the issues raised and focused on the outcome sought by the person raising the issues.

They are responsible for both the quality and timeliness of investigations. For formal complaints this means:

- Allocating an investigating officer and agreeing with them the scope of the investigation and the resolution plan.
- Ensuring that there is appropriate nursing and medical oversight of the complaint, findings of the investigation and response by engaging with the relevant matron and/or clinical director.
- Receiving the investigation findings and, where the person involved requests a written response, the draft response letter from the investigating officer. They will ensure that it responds to all the questions/issues raised in the complaint; is written in a clear and empathetic style and with a level of detail which is appropriate for the person making the complaint. If the complaint is partially upheld or upheld, learning points and improvement actions should be clearly identified.

Where the investigating officer is <u>not</u> a matron: the investigating officer will send the draft report to the directorate manager, copied to the assistant director of nursing (York, Scarborough or Children & Community) or head of midwifery for quality review.

If the outcome of the investigation has been communicated face-to-face, a letter should be sent summarising, in brief, key points covered in the meeting. The expectation for what will be included in the letter should be set during the meeting. It will not be verbatim minutes of the meeting.

The directorate manager will engage with the assistant director of nursing or head of midwifery as required regarding any comments or queries on the draft response and agree a final draft.

The directorate manager will send the final draft to the Patient Experience Team.

Where the investigating officer <u>is a matron</u>: the investigating officer will send the draft report to the assistant director of nursing (York, Scarborough or Children & Community) or head of midwifery for quality review, copied to the directorate manager. As at 1.15 if the outcome of the investigation has been communicated face-to-face, a letter should be sent summarising, in brief, key points covered in the meeting. The expectation for what will be included in the letter should be set during the meeting. It will not be verbatim minutes of the meeting.

The assistant director of nursing or head of midwifery will engage with the directorate manager as required regarding any comments or queries on the draft response and agree a final draft.

The assistant director of nursing or head of midwifery will send the final draft to the Patient Experience Team.

The directorate manager is responsible for ensuring that the response is completed in a timely manner and that the person making the complaint is kept informed if there are any delays.

For concerns, where the person involved does not wish to make a formal complaint, the directorate manager is responsible for ensuring that a timely and proportionate response is provided in the format requested by the person involved. They will keep records of any discussions, investigation and correspondence with the person involved and ensure that these are recorded on the Datix system.

The directorate manager will ensure that a system is in place within the directorate to review themes from complaints, concerns and improvement actions and ensure that actions are completed.

Investigating Officer

Reviews the complaint in detail. Seeks early advice as appropriate from colleagues and/or the Patient Experience Team regarding the issues raised.

Contacts the person complaining via telephone, face-to-face or email to introduce themselves within three working days. This is to discuss the issues raised and the outcome sought. Confirms with the person complaining the key issues for investigation, the timescale for response and method via which they would like to receive the outcome: ie a letter or face-to-face meeting. Logs the contact on Datix.

For medium or low risk complaints, it may be possible to conclude and close the complaint at this stage by giving an explanation and apology. (In any conversation at this stage the investigating officer must be mindful of the need for patient consent before disclosing any information about their health or care.) If the person complaining agrees that no further resolution is required, the conversation and outcome of the complaint must be fully documented on the Datix record before advising the directorate manager and the Patient Experience Team that the case can be closed. If necessary a follow up letter may be sent to confirm the telephone discussion and complete resolution.

Engages directorate manager (with support from the complaints officer if required) to confirm the scope of the investigation and resolution plan.

Assembles evidence, which may include medical records, appointment letters, staff statements polices/procedures/protocols, notes from interviews with staff etc.

Obtains a senior nursing and/or medical opinion when required.

Uses the evidence gathered to complete the investigation. This may require the use of tools such as: a timeline and/or root cause analysis to identify what happened and what caused the problems that occurred.

Where possible draws conclusions about whether each aspect of the complaint is upheld on the basis of the evidence. Where it is not possible to conclude 'beyond reasonable doubt', a conclusion based on 'balance of probability' will be made. Sometimes it may not be possible to draw a conclusion, even to the level of balance of probability. In such cases it is acceptable for the investigation to be inconclusive.

Identifies any errors, gaps in care or other failings and ensure that an appropriate improvement action is identified for each one**.**

Documents the findings of the investigation. Where a full written response is required, completes a draft letter to the person complaining. Where the person complaining wishes to receive the outcome in a meeting, completes an internal investigation report in an appropriate format to support this meeting.

When the investigating officer is a matron they will send the completed draft response to the assistant director of nursing or head of midwifery, copied to the directorate manager.

When the investigating officer is not a matron they will send the completed draft response to the directorate manager, copied to the assistant director of nursing or head of midwifery.

Assistant Directors of Nursing (York, Scarborough, Children & Community) and Head of Midwifery

Receives weekly notification of all complaints and high risk concerns relating to their areas.

Receives immediate notification of any extreme risk complaints relating to their areas.

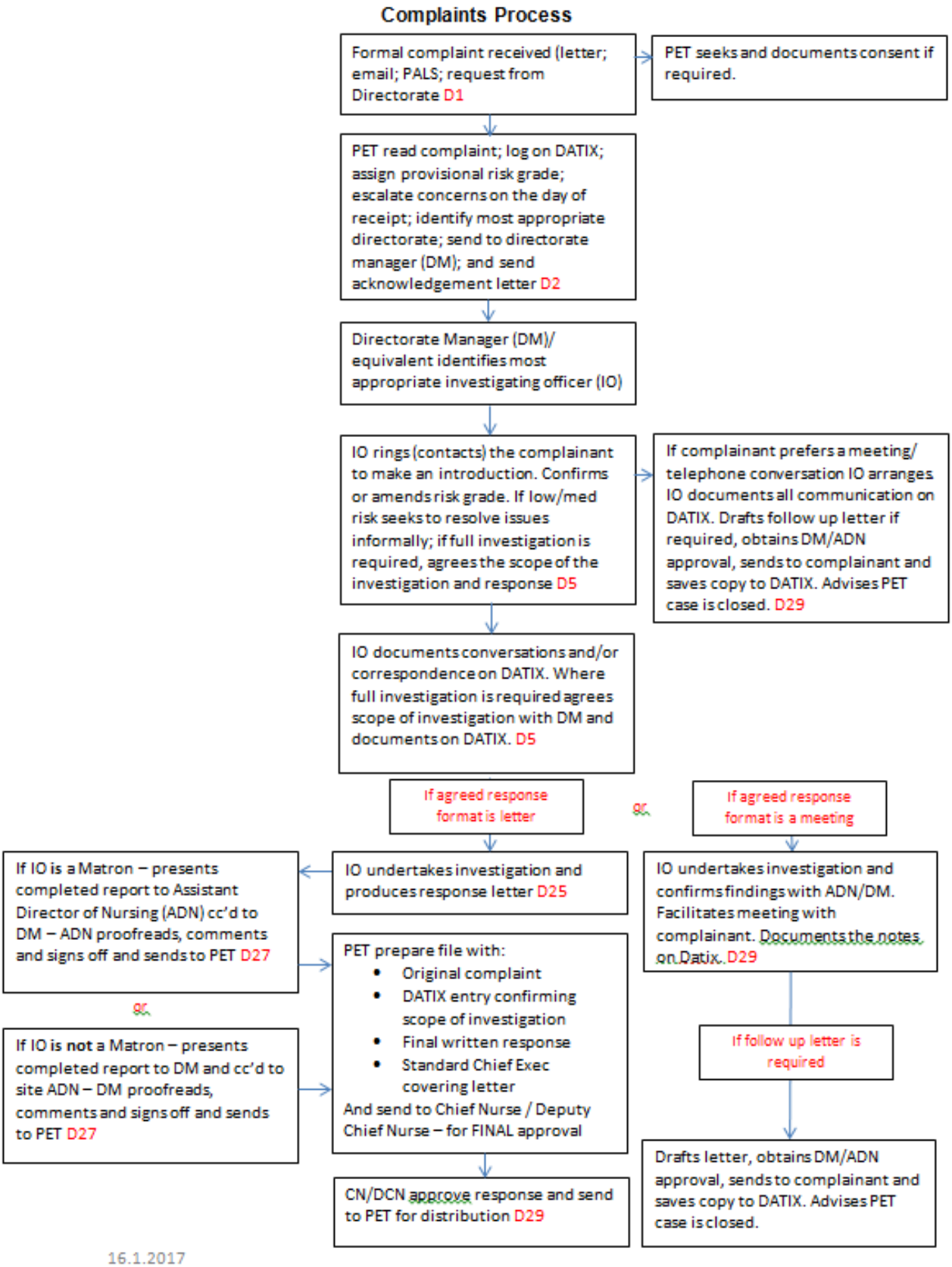
Receives draft response letters from matrons for quality checking. This means confirming that the requirements of 1.14 have been fully met. If further work is required, works with the matron to complete a final draft and sends it to the Patient Experience Team.

Is copied into draft response letters from other investigating officers and provides comments on their content to the relevant directorate manager as required.

Receives status updates from the Patient Experience Team on outstanding cases relevant to their area. Engages with directorate managers, where necessary, to discuss the outstanding cases and agree necessary actions to complete the investigation in a timely manner.

Seeks assurance from matrons and directorate managers that improvement actions have been delivered.

Appendix 3: Process Flow for Complaint Handling



Appendix 4 Procedure for managing repeat or unreasonable complainants

1. Introduction

The Trust is committed to dealing with all complainants fairly and we do not normally limit the contact complainants have with the Trust. However, we do not expect our staff to tolerate behaviour by complainants which is, for example, offensive or threatening, or which because of frequency of contact, hinders the work of the Trust. In these circumstances the Trust will take action to manage this behaviour.

The formal procedure should be used only as a last resort and after all reasonable measures have been taken to try to resolve complaints through the Trust concerns and complaints policy and procedure.

Judgement and discretion must be used in applying the criteria to identify potential serial or unreasonable complainants and in ensuring that the action to be taken in each specific case is proportionate to the actions of the person concerned.

This procedure covers both people who have made formal complaints and those whose issues have been addressed as concerns.

2. Purpose of this procedure

This procedure is designed to ensure that people making regular contact with the Trust are treated fairly and compassionately.

It also is designed to ensure that staff are protected from unreasonable demands made by serial or unreasonable complainants.

3. Definition of a repeat or unreasonable complainant

A complainant or anyone acting on their behalf might be deemed to be a repeat or unreasonable complainant where previous or current contact with them shows that they meet two more of the following criteria:

- Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.
- 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 disregard new issues, which are significantly different from the original complaint. These might be new health issues for which the person requires support or new concerns which need to be addressed as separate complaints.
- Are unwilling to accept documented evidence of treatment given.

- Deny receipt of an adequate response despite 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 services, to help them specify their concerns, and/or where the issues identified are not within the remit of the Trust to investigate.
- Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. It is recognised that determining what is a trivial matter is subjective and careful judgement must be used in applying this criterion.
- Have threatened or used actual physical violence towards staff or their families or associates at any time. This will cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will then be pursued through written communication. All such incidents should be documented as Datix incidents.
- 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 might be in person or by telephone, letter, email 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.
- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. Staff must recognise that complainants might act out of character at times of stress, anxiety or distress and should make reasonable allowances for this. They should document all incidents of harassment as Datix incidents.
- Are known to have recorded meetings or face-to-face or telephone conversations without the prior knowledge and consent of other parties involved.
- Display unreasonable demands or expectations, and fail to accept that these might be unreasonable, e.g. insist on responses to complaints or enquiries being provided more quickly than is reasonable.

4. When to start the repeat/unreasonable process

The first step is to ensure that the usual complaints or concerns resolution process has been correctly and fully implemented so far as possible and that no material elements of the person's concerns are overlooked or inadequately addressed. Staff should appreciate that repeat or unreasonable complainants might have issues which contain genuine substance. The need to ensure a fair approach is essential.

If all reasonable efforts have been made to resolve the person's concerns and their contact (regularity and/or content) remains unreasonable the following step-wise procedure will be followed. If written correspondence is not appropriate for the person concerned, appropriate adjustments will be made.

Process

Informally notifying the person concerned that we consider that their contact is becoming unreasonable and explaining the reasons for this. If appropriate, providing a copy of this procedure to explain what will happen if the behaviour persists. If appropriate, explaining what change is required for their behaviour to be considered reasonable.

Formally writing to the person concerned to set out the concerns about their behaviour, that it has been classified as repeat or unreasonable, and the reasons why. Ask them to agree to a set of clearly stated measures to limit their contact or modify their behaviour. These may include:

- Limiting contact to a single person (deputies and out of hours arrangements to be stated as necessary)
- Requirements for standard of behaviour eg to cease threatening, abusive or inappropriate language
- Limiting contact to a certain type eg written only
- Being clear about issues that the Trust can no longer respond to and that the Trust will not enter into further correspondence about these
- Being clear about the circumstances in which new issues will be considered, how to raise these, and the timescale for receiving a response.

The consequences of not complying with these measures should be clearly stated. These may include:

- Further limitations on the methods and or timing of contact via which the Trust will communicate
- Involvement of other agencies, eg the police or solicitors.

A timeframe should be given after which the arrangements will be reviewed and, if appropriate the restrictions removed.

This letter should be signed be the Chief Executive or nominated deputy.

If the person concerned does not comply with the requirements set out in the letter sent at step 2, the consequences described should be acted upon.

5. Withdrawing repeat status

Any restrictions on contact with the Trust should be reviewed after the agreed time period. If the complainant has demonstrated a more reasonable approach to contacts with the Trust the restrictions should be removed. A letter will be sent to the person involved to confirm this action.

Roles and responsibilities

Any member of staff concerned about the behaviour of a complainant should seek advice from the Patient Experience Team.

The Lead for Patient Experience (or deputy) should be made aware and the situation escalated to senior management as required.

The Patient Experience Team will engage with the relevant colleagues to agree a handling plan. The Chief Nurse and Deputy Chief Nurse will be made aware of the handling plan.

The Patient Experience Team will check that handling plans are implemented in full. Other colleagues will complete the actions allocated to them and notify the Patient Experience Team.

The Patient Experience Team will ensure that cases are reviewed at the appropriate time.

The Chief Executive (or deputy) is responsible for signing letters under this procedure.

The Chief Nurse and Deputy Chief Nurse are responsible for ensuring that this process is fit for purpose and implemented appropriately by the Patient Experience Team.

Appendix 5 Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	Handling Concerns and Complaints
1.	**What are the intended outcomes of this work?** For anyone affected by the work of the Trust to be able to raise a concern or a formal complaint and to receive an open, timely response which addresses the issues which matter to them.
2	**Who will be affected?** Patients, carers, members of the public, hospital staff
3	**What evidence have you considered?** Feedback from people who have raised complaints or concerns in the past about the process. Feedback from Healthwatch York about the complaints process. Feedback from investigating officers about delivering the complaints procedure. Feedback from groups representing deaf and blind/partially sighted service-users about access to the complaints/concerns procedure.
a	**Disability –** in implementing the policy information about how to raise complaints/concerns must be made available in different formats, including British Sign Language, audio description and easy read. Members of staff delivering the policy will be required to make early contact with those raising complaints/concerns through their preferred method, ensure that any relevant disabilities are identified at this stage and put reasonable adjustments in place to ensure the person complaining can fully engage with the process and receive a full response.
b	**Sex –** this characteristic will not impact on the ability to raise a complaint or concern
c	**Race –** this characteristic will not impact on the ability to raise a complaint or concern
d	**Age –** If a child (under 16) wishes to raise a complaint or concern they will be supported to do so using the same principles as giving consent to treatment
e	**Gender Reassignment –** this characteristic will not impact on the ability to raise a complaint or concern
f	**Sexual Orientation –** this characteristic will not impact on the ability to raise a complaint or concern
g	**Religion or Belief –** this characteristic will not impact on the ability to raise a complaint or concern

h	**Pregnancy and Maternity -** this characteristic will not impact on the ability to raise a complaint or concern	
i	**Carers/relatives –** this characteristic will not impact on the ability to raise a complaint or concern.	
j	**Other Identified Groups –** no other groups have been identified	
4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	Feedback from patients, Healthwatch and staff has been received during the period September 2015 – September 2016
		• Listening to individual experiences of making complaints/concerns • Listening to feedback about delivering the previous policy • Piloting new approaches to complaints handling with individual teams • Feedback from Patient Experience Steering Group
5.	**Consultation Outcome**	
a	Eliminate discrimination, harassment and victimisation	Positive impact through promoting openness and good communication
b	Advance Equality of Opportunity	No impact
c	Promote Good Relations Between Groups	Positive impact
d	What is the overall impact?	Positive
	Name of the Person who carried out this assessment: Hester Rowell, Lead for Patient	
	Date Assessment Completed: 19 September 2016	
	Name of responsible Director: Beverley Geary, Chief Nurse	

Appendix 6: Policy Management

1. Consultation Process

This policy has been developed based on feedback given at Patient Experience Steering Group, feedback from individual experiences of making complaints/concerns (including via Healthwatch), the outcome of pilot exercises with individual teams and feedback from staff.

2. Quality Assurance Process

The Trust Policy Manager will check that the policy includes all mandatory information and follow's the Trust's format and style.

3. Approval Process

Patient Experience Steering Group will oversee the development of this policy and be the first point of approval. When they are satisfied that it meets the needs of patients, the public and staff they will recommend it to Quality & Safety Committee for approval.

4. Review and Revision Arrangements

This policy will be reviewed by the Lead for Patient Experience should there be any change to the NHS Complaint Regulations or other NHS quality standards relating to complaints or concerns. Otherwise it will be reviewed every two years.

5. Dissemination & Implementation

See appendix 7.

6. Document Control including Archiving Arrangements

Register/Library of Policies

This policy will be stored in the policies and procedures section of the Trust's electronic portal, Staff Room. It will be displayed in an alphabetical list as well as being accessible through the portal's search facility.

Archiving Arrangements

On review of this policy, archived copies of previous versions will be held on the Trust's document management system.

Process for Retrieving Archived Policies

To retrieve a former version of this policy, the Policy Manager should be contacted.

7. Standards/Key Performance Indicators

Please see section 11.

8. Training

The Lead for Patient Experience is responsible for ensuring that adequate training is provided for staff regarding this policy. Members of the Patient Experience Team will support with delivery of this training through ongoing support to individuals and more formal team training session.

9. Trust Associated Documentation

See Section 5.

10. External References

- Statutory Instrument 2009 No. 309, The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- The NHS Constitution, the NHS belongs to us all (for England, 21 January 2009), Department of Health, January 2009
- Listening, Responding, Improving – A guide to better customer care, Department of Health, 26 February 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 - Good Governance
- The Parliamentary & Health Service Ombudsman vision for NHS complaints and concerns: My Expectations for Raising Complaints and Concerns (November 2014) http://www.ombudsman.org.uk/__data/assets/pdf_file/0010/28774/Vision_report.pdf
- The Patients' Association Good Practice Standards for NHS Complaints Handling (September 2013) which were commissioned following the failures in complaints management at Mid-Staffordshire Hospitals. http://www.patients-association.org.uk/wp-content/uploads/2014/06/Good-Practice-standards-for-NHS-Complaints-HandlingSept-2013.pdf

11 Process for Monitoring Compliance and Effectiveness

The policy will be monitored against the following key performance indicators:

Minimum requirement to be monitored	**Process for monitoring**	**Responsible Individual / committee/ group**	**Frequency of monitoring**	**Responsible individual / committee/ group for review of results**	**Responsible individual / committee/ group for developing an action plan**	**Responsible individual / committee/ group for monitoring of action plan**
All complaints acknowledged within three working days	Weekly performance reports Monthly Complaints and PALS report	Lead for Patient Experience Patient Experience Steering Group	Weekly Quarterly	Patient Experience Steering Group	Lead for Patient Experience	Patient Experience Steering Group
Complainants to receive a response within the timescale agreed at the outset	Weekly performance reports Monthly Complaints and PALS report Escalation reports to Performance Assurance Meeting	Matrons Directorate Managers	Weekly Monthly Monthly	Patient Experience Steering Group	Matrons Directorate Managers (Working with Assistant Director of Nursing)	Patient Experience Steering Group Performance Assurance Meetings Assistant Directors of Nursing
Number of complainants dissatisfied with their first response	Weekly performance reports Monthly Complaints and PALS report	Matrons Directorate Managers	Weekly Monthly	Patient Experience Steering Group	Matrons Directorate Managers	Assistant Directors of Nursing Patient Experience Steering Group

Number of complaints referred to the Parliamentary & Health Service Ombudsman which are partially upheld or upheld	Monthly Complaints and PALS report	Patient Experience Steering Group	Monthly	Patient Experience Steering Group		
All agreed improvement actions to be delivered.	Audits of action completion – results	Patient Experience Team Leader	TBC	Assistant Directors of Nursing Directorate Managers	Matrons Directorate Managers	Assistant Directors of Nursing Patient Experience Steering Group

Appendix 7 Dissemination and Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Complaints and Concerns Policy & Procedure
Date finalised:	
Previous document in use?	
Dissemination lead	Lead for Patient Experience
Which Strategy does it relate to?	Patient Experience Strategy 2015-2018
If yes, in what format and where?	**Intranet**
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**
To be disseminated to:	**All Staff**
Method of dissemination	Patient Experience intranet page, intranet document library, notification of new policy by weekly staff bulletin. Emailed directly by Lead for Patient Experience to all directorate managers, deputy directorate managers and matrons to be cascaded to anyone in their teams involved in the complaint process
who will do it?	Lead for Patient Experience
and when?	Once ratified
Format (i.e. paper or electronic)	Electronic

Dissemination Record

Date put on register / library	
Review date	December 2019
Disseminated to	All Staff
Format (i.e. paper or electronic)	Electronic
Date Disseminated	As above
No. of Copies Sent	N/A
Contact Details / Comments	