

### COMPLAINTS HANDLING POLICY

|                               |   |                           |  |
|-------------------------------|---|---------------------------|--|
| <b>Document Reference:</b>    | Automatically allocated on Sharepoint                       | <b>Version:</b>           | <b>8</b>                                       |
| <b>Document Owner:</b>        | Director of Nursing   | <b>Document Author:</b>   | Debra Fairley<br>Deputy Director of Nursing    |
| <b>Accountable Committee:</b> | Patient and Public Experience and Engagement Steering Group | <b>Date Approved</b>      | 4.11.14  |
| <b>Ratified by:</b>           | Procedural Documents Approval Group                         | <b>Date Ratified:</b>     | 10.11.14                                       |
| <b>Date issued:</b>           | 10.11.14  | <b>Review date:</b>       | 31.10.2016 extension approved until 28.02.2017 |
| <b>Target audience:</b>       | All staff and people working at ANHSFT premises             | <b>Equality Analysis:</b> | Yes  |

#### Key points

- Sets out responsibilities of staff when dealing with a complaint or concern during the course of their duties.
- Implementation of this policy is underpinned by procedural standards and guidance for the management and investigation of a formal complaint.

**The most recent version of this document is held on the Sharepoint Policies page.**

**Uncontrolled if Printed**

## Contents Page

|      |  |    |
|------|--|----|
| 1.0  | Associated Documents   | 3  |
| 2.0  | Introduction   | 3  |
| 2.1  | Statement of Intent  | 3  |
| 2.2  | Sustainable Development – EcoAwaire  | 4  |
| 2.3  | Purpose  | 4  |
| 2.4  | Scope  | 4  |
| 3.0  | Definition of terms used within this document  | 4  |
| 4.0  | Making a complaint   | 5  |
| 5.0  | Time limit for making a complaint  | 5  |
| 6.0  | Complaints, Patient Advice and Liaison Service   | 5  |
| 7.0  | Duties   | 6  |
| 8.0  | Principles underpinning the effective management and investigation of a formal complaint | 8  |
| 9.0  | Risk assessment  | 8  |
| 10.0 | Putting things right   | 9  |
| 11.0 | Learning from complaints   | 9  |
| 12.0 | Parliamentary and Health Service Ombudsman (PHSO)  | 9  |
| 13.0 | Consultation   | 10 |
| 14.0 | Approval   | 10 |
| 15.0 | Ratification Process   | 10 |
| 16.0 | Dissemination and implementation   | 10 |
| 17.0 | Process for monitoring effective compliance  | 11 |
| 18.0 | Record keeping   | 12 |
| 19.0 | Equality Analysis  | 12 |
| 20.0 | References   | 12 |
| 21.0 | Version control  | 13 |
| 22.0 | Document control   | 13 |

## 1.0 ASSOCIATED DOCUMENTS

- *Being Open Policy* (current version)
- *Claims Handling Policy* (current version)
- *Essential Standards of Caring for People with Dignity and Respect* (current version)
- *Safeguarding Children and Young People Policy* (current version)
- *Safeguarding Adults Policy* (current version)
- *Risk Management Policy* (current version)
- *Serious Incidents Requiring Investigation (SIRI) Policy* (current version)
- *Reporting Concerns and Whistleblowing Policy* (current version)
- *Disciplinary Procedures Policy* (current version)

In addition, a number of recent, national reviews are relevant to this policy. These include:

- *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* published in October 2013 by the Right Honourable Ann Clwyd and Professor Tricia Hart.
- *Good Practice Standards for NHS Complaints Handling* published in September 2013 by the Patients Association.
- Professor Don Berwick's *Review of Patient Safety in the NHS*, which was reported on 6.8.13.
- *Hard Truths: the Journey to Putting Patients First* published by the Department of Health in January 2014.
- *Interim Complaints Policy* published by NHS England in August 2013<sup>1</sup>.

## 2.0 INTRODUCTION

### 2.1 Statement of Intent

Airedale NHS Foundation Trust (ANHSFT) has adopted the Parliamentary and Health Service Ombudsman's (PHSO) principles for good complaints handling. All complaints and concerns investigations, therefore, will:

- focus on outcomes,
- be undertaken in a fair and proportionate manner; and
- be sensitive to an individual's needs.

The process has been developed to be as straightforward as possible as well as being accessible to patients and their relatives and carers. The Trust will also abide fully with the Duty of Candour<sup>2</sup> where complainants allege or report incidents that may result, or have resulted, in moderate/significant harm.

---

<sup>1</sup> This policy was due for review in January 2014 – the final policy has yet to be published.

<sup>2</sup> The Department of Health introduced the statutory duty of candour for NHS bodies from 1<sup>st</sup> October 2014 and will be extended to all CQC registered providers from April 2015.

## 2.2 Sustainable Development - EcoAwaire

As part of its development, this policy was reviewed in line with the Trust's sustainability ideals. As a result, the document is designed to be used electronically in order to reduce any associated printing costs.

## 2.3 Purpose

The purpose of this policy is to ensure that people who have cause for concern or wish to make a complaint about care and services are supported and helped to do so and, that they are treated as individuals without prejudice or discrimination and with dignity, compassion and respect. The Trust will seek to respond to all complaints and concerns in an open, fair, transparent and impartial manner. It will seek to ensure that decisions are taken quickly; measures are introduced to put things right where it is necessary to do so; and lessons are learnt to improve care, services and behaviours where a complaint or concern is upheld.

## 2.4 Scope

This policy applies to all areas of the Trust and all individuals employed by the Trust, including those working on behalf of the Trust such as volunteers.

## 3.0 DEFINITION OF TERMS USED WITHIN THIS DOCUMENT

| Term   | Meaning   |
|--|---|
| Care Quality Commission  | A non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England.   |
| Complainant  | A person who makes a formal complaint or reports a concern to the Trust about care and services. This may be the patient and/or a family member/carer.  |
| Concerns   | Are issues that are of interest or importance affecting the person raising them.  |
| Feedback   | Feedback is information/suggestions about care or services that ANHSFT provides, which may be complimentary or critical.  |
| Final letter of response   | The final response to a formal complaint, which has been signed by the Chief Executive. This may be in the form of a letter, report, or formal meeting notes according to the nature of the investigation and a complainant's wishes.   |
| Complaint File   | All relevant information material to the investigation of a formal complaint. This may include, for example, e-mail copies, letters of correspondence, staff statements, and reports/reviews of care etc. This will be stored in the Complaints Office after the investigation has concluded and the final letter of response has been dispatched.  |
| Line managers  | For the purpose of this policy, the term line manager is used to refer to anyone in the Trust who is responsible for managing other staff members.  |
| Formal complaint   | A complaint is deemed to be formal when the complainant (or their representative) states he/she wishes to make a formal complaint and puts this in writing either by letter or e-mail.  |
| Parliamentary and Health Service Ombudsman (the Ombudsman) <b>PHSO</b> | The Parliamentary and Health Service Ombudsman (the Ombudsman) combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman) and Health Service Commissioner for England (Health Service Ombudsman) whose powers are set out in Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993 respectively.<br><br>Her role is to investigate complaints when individuals have been treated unfairly or have received poor service from the NHS in England. |

## 4.0 MAKING A COMPLAINT

A complaint may be made by:

- A patient
- Any person who is affected by, or likely to be affected by, the action, omission or decision of the Trust.

A person acting on behalf of a child, a person who has died, a patient who is unable by reason of physical or mental capacity to make the complaint, or a person who has been asked to represent the complainant on his/her behalf. Usually, this person is the next of kin.

If, in any case a representative does not, or did not, have sufficient interest in the person's welfare or, is unsuitable to act as a representative, after due diligence, he/she will be informed of this in writing stating the reasons why.

In the case of a child, the representative must be a parent, guardian or other adult person who has responsibility for the care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by them accordingly.

## 5.0 TIME LIMIT FOR MAKING A COMPLAINT

A complaint must be made within 12 months of the occurrence of an incident/event.

Where a complaint is made after the expiry period of 12 months, the Complaints Manager may decide to waive the time limit, providing that it is still possible to investigate the complaint effectively and efficiently.

## 6.0 COMPLAINTS, PATIENT ADVICE AND LIAISON SERVICE

A team of staff deals with both formal complaints and concerns to operate a Complaints, Patient Advice and Liaison Service (known as C-PALS). There are clear and discrete processes for handling formal complaints and concerns.

**PALS:** The Trust operates a Patient Advice and Liaison Service (known as PALS) which seeks to provide information, advice and support to help patients, families and their carers. This may be at the point of care or at any time during their 'journey' of care and treatment. PALS offers an independent point of contact for patients, families and their carers if they wish to express a concern or are seeking help, advice, guidance and support. PALS will then liaise with the appropriate service/ward manager if this is required to seek early resolution to a concern.

**Complaints Team:** The Complaints team deals with formal complaints. Formal complaints are handled separately from PALS and the Complaints Team provides an independent contact from hospital/community services for patients, families and carers seeking to make a formal complaint.

Wards and departments will display information, advising patients and service users of how to raise a concern/complaint.

Further information about contacting PALS and how to make a complaint is provided in the Trust's information leaflet.

Contact details for C-PALS for patients, users and their representatives are available on the Trust's web site, ward/department/hospital notice boards.

## **7.0 DUTIES**

### **7.1 Chief Executive**

The Chief Executive signs the final letter of response. The Board receives assurance on complaints and concerns via the Trust's governance reporting arrangements.

### **7.2 Director of Nursing**

The Director of Nursing is the executive board member who is accountable for complaints handling in the Trust. The Director of Nursing is also responsible for reviewing complaints concerning the professional conduct of nurses, midwives and allied health professionals in accordance with processes set out in this policy.

### **7.3 Deputy Director of Nursing**

The Deputy Director of Nursing is responsible for the overall leadership of C-PALS in order to support the Director of Nursing to develop associated strategy, policy and operational delivery in line with national guidance/frameworks.

### **7.4 Executive Medical Director**

The Medical Director is responsible for reviewing complaints concerning the professional conduct of medical staff in accordance with processes set out in this policy.

### **7.5 Complaints Manager**

The Complaints Manager is responsible for the day to day line management of C-PALS and for ensuring that complaints/concerns are dealt with in accordance with this Policy.

### **7.6 Director of Operations, Clinical Directors, General Managers, Line Managers**

The Director of Operations, clinical directors, general managers and line managers are responsible for ensuring that they, and their staff, comply with this policy. General managers should (1) consider the need for financial redress upon completion of each investigation of a formal complaint concerning their Group; (2) ensure that any risks/learning arising from complaints are integrated into the Trust's risk management systems and (3) review the complaint for professional conduct concerning all other staff from those set out above.

### **7.7 Assistant Director of Healthcare Governance - legal advice**

The Assistant Director of Healthcare Governance is responsible for supporting and advising staff in the event that legal advice may be required and must always be consulted when a complaint has the potential for litigation. A decision will be taken upon initial discussion as to whether or not to consult the Trust's legal team/solicitor and at what stage this might be required. To note, all information, supportive documents, clinical records and personal statements used as investigative evidence may be subject to full disclosure: for example, if a complainant refers their complaint to the PHSO or a solicitor.

## 7.8 Trust Governors

Trust Governors should, when approached by patients and their families/carers seeking to make a complaint or report a concern, encourage them to contact C-PALS so that their complaint/concern can be handled in accordance with this Policy.

## 7.9 Investigators

For the purpose of this policy, an investigator is someone who has been appointed to undertake an investigation of a complaint/concern. An investigator must investigate a formal complaint in accordance with the approved procedural standard set out in **(XX)**. In addition, investigators must:

- Address all issues and concerns within the complaint.
- Remain impartial, confidential, objective, accountable, fair and responsive when investigating a complaint or concern.
- Escalate any new concerns or issues as soon as they come to light (including those that arise during the course of an investigation) so that they can be assessed for previously unforeseen risks and instigate any remedial or mitigating action.
- Undertake the necessary training in order to carry out robust, thorough and quality investigations and, to provide adequate explanations.
- Be aware of a complainant's fear of retribution and take every step to support and reassure them throughout the complaints management process.
- Keep complainants up to date and informed, in accordance with their individual wishes, of how the investigation is progressing, seeking advice and support from the Complaints Team as required.

## 7.10 All staff

*All staff* that have cause to deal with a complaint or a concern during the course of their duties, are responsible for ensuring that they comply with this Policy and that they:

- Focus on people's individual needs and wishes, encouraging them to come forward with their concerns.
- Respect patient confidentiality at all times.
- Treat people with courtesy, understanding, sensitivity and without prejudice.
- Handle concerns and complaints in accordance with all relevant Trust policies set out in (1.0).
- Work towards achieving a complainant's preferred outcome as far as practicably possible.

- Encourage complainants to raise their complaint in a way that is acceptable and appropriate for them, this may be by including using a language interpreter or other means such as sign language or Braille.
- Resolve verbal complaints/concerns locally at the point of care and to provide honest explanations without the need to go through more formal complaints handling arrangements/PALS in order to achieve swift, local resolution.
- Help people where they lack confidence or capacity to make a complaint, and direct them to a means they find most supportive. This may involve referring them directly to PALS or a matron/service manager.
- Learn from mistakes and strive to resolve matters quickly when things go wrong.
- Make a declaration of interest where the complainant is personally known to them. This must be documented in the Complaint or PALS File wherever it is appropriate to do so.
- Deal with formal complaints in accordance with the procedural standards set out in this Policy.

## 8.0 PRINCIPLES UNDERPINNING THE EFFECTIVE MANAGEMENT AND INVESTIGATION OF A FORMAL COMPLAINT

Clear procedures and additional guidance are available to enable staff to investigate and respond to a formal complaint and concern. These procedures must be followed when working in accordance with this policy and are set out in the following documents<sup>3</sup>:

- Patient Advice and Liaison Service: Information Leaflet. **Link here**
- *Procedural Standard (1) Managing, Processing and Investigating a Formal Complaint.* **Link here.**
- *Guidance for Managing Habitual and Vexatious Complainants.* **Link here**
- *Guidance for Managing Complaints Concerning Individual Staff.* **Link here**
- *Guidance for staff writing a statement.* **Link here**

## 9.0 RISK ASSESSMENT

All formal complaints will be subject to a *risk assessment* where there are allegations concerned with:

- Neglect and harm – the Trust’s safeguarding policies will be strictly applied.
- Serious incidents and critical events – the Trust’s risk management policies will be strictly applied.
- Professional misconduct – the Trust’s disciplinary policies will be strictly applied.
- Litigation - so that early and appropriate legal advice can be sought.
- Any matter that might require immediate intervention/action: for example allegations concerning cancelled surgery or delayed treatment – so that timely and appropriate remedial action can be taken.

---

<sup>3</sup> Procedural standards will continue to be added as they are developed.



- Any matter that might require escalation to the Care Quality Commission, Monitor and local Clinical Commissioning Groups (CCG).
- Any matter that might result in adverse publicity/media attention for the Trust, requiring escalation to the Executive Team.

Following a risk assessment of the complaint and in accordance with associated Trust policies to assist with good complaints handling (for example: there may be an urgent requirement to refer to the Trust's safeguarding policies) and, in the event there are immediate risks (or perceived risks) it will be escalated immediately by C-PALS to the relevant line manager/specialist team (for example: the safeguarding team) so that appropriate action can be taken in a timely manner. The risk assessment will be forwarded to key staff as set out in *Procedural Standard (1) Managing, Processing and Investigating a Formal Complaint*.

## **10.0 PUTTING THINGS RIGHT**

The PHSO has stated that where complaints maladministration or poor service has led to injustice for a complainant, remedies should be offered, where appropriate, to compensate for this. There are no automatic remedies for injustice – financial or non-financial - and each case should be considered individually. An apology; full explanation of events; acknowledgment of errors and poor care/service; and remedial actions (including any learning) must be included in the final letter of response.

Financial compensation, if appropriate, will be agreed with the Director of Finance, following consultation with the relevant executive directors and general managers and in accordance with NHSLA guidance. Financial remedy must be considered for each formal complaint by the General Manager upon completion of the investigation.

Further information about financial remedy can be found at <http://www.ombudsman.org.uk/home>.

## **11.0 LEARNING FROM COMPLAINTS**

The Trust is committed to learning from complaints, concerns and all other means of feedback including that from the Friends and Family Test, CQC annual surveys and real time inpatient surveys. It will seek to make continuous improvements following all incidents, complaints and concerns that make a difference to the care and services received by patients, users and their representatives. This will be achieved in accordance with the Trust's risk management, clinical governance, and quality, safety and operational systems and processes in order to:

- Highlight the risks from incidents raised by complaints/concerns;
- Undertake analysis of incidents of complaints/concerns aimed at encouraging learning and promoting improvements in practice;
- Share information about complaints/concerns at a local and organisational level to encourage learning; and
- Ensure that patients, users and their representatives are involved and kept informed of changes that are to be/being implemented as a result of raising their complaint/concern.

## **12.0 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)**

Complainants who are dissatisfied with the Trust's response may ask the PHSO for an independent review of their complaint. All complainants will be informed of how to refer their complaint to the PHSO.

## **13.0 CONSULTATION**

The previous policy was subject to extensive consultation and review following the publication of several important national documents cited previously. The following were consulted on this policy: executive directors, clinical directors, matrons, line managers, senior nurses, members of C-PALS, the Trust's Quality and Safety Team and the public.

Members of the Patient and Carer Panel were consulted on the previous version, procedures in this revised version, upon review, remain relatively unchanged – key changes relate to strengthening staff responsibility and accountability and streamlining /clarifying processes. Fundamental principles remain unchanged.

## **14.0 APPROVAL**

The content of the original policy was ratified by the Quality and Safety Operational Group (QSOG). This version was approved by the Procedural Documents Approval Group<sup>4</sup>.

## **15.0 RATIFICATION PROCESS**

This policy has been approved by the PPEE Steering Group and ratified by the Procedural Documents Approval Group.

## **16.0 DISSEMINATION AND IMPLEMENTATION**

### **16.1 Dissemination**

This policy will be available on Sharepoint and staff will be informed of its ratification via the Trust's weekly staff brief.

### **16.2 Implementation**

Clinical directors, general managers and senior matrons will be informed in writing by the Deputy Director of Nursing upon ratification of the policy so that they can alert their staff to work in accordance with it. It will be available to staff via the Trust policies page on Sharepoint.

The Deputy Director of Nursing and Complaints Manager will compile an action plan to commence implementation of the policy six months after its ratification.

### **16.3 Training/Awareness**

Roles designated to have the appropriate level of responsibility to undertake an investigation of a complaint is Band 7 and above for a clinical and non-clinical investigation. For admin/clerical investigations this is deemed to be a Band 5 role. For predominantly medical investigations this is deemed to be clinical leads, clinical directors, governance leads and consultants.

---

<sup>4</sup> Replaces QSOG as being accountable for the ratification of Trust policies, guidelines and other formal documents

Managers will identify staff within their teams who are required to undertake this role. Nominated staff who are required to investigate complaints will be expected to undertake training. This will be organised by the Complaints Team and HR.

## 17.0 PROCESS FOR MONITORING EFFECTIVE COMPLIANCE

| Standard to be monitored  | Process for monitoring  | Frequency            | Person responsible for: undertaking monitoring & developing action plans | Committee accountable for: review of results, monitoring action plan & implementation | Frequency of monitoring  |
|---|---|----------------------|--|---|--------------------------|
| <b>(1) A formal complaint is handled in accordance with approved procedural standards set out in this Policy</b>                  | Audit of the management, processing and investigation of a formal complaint.<br><br>Reported in the Annual Report.  | Annual               | Complaints Manager   | Quality and Safety Operational Group  | Annually                 |
| <b>(2) Concerns reported to PALS are dealt with in accordance with an individual patient's (or their representative's) wishes</b> | Audit of the outcome of the PALS concern using the PALS records.<br><br>Reported in the Annual Report   | Annual               | Complaints Manager   | Quality and Safety Operational Group  | Annually                 |
| <b>(3) Effective complaints handling</b>  | Written report  | Annual               | Complaints Manager   | Trust Board CCG   | Annually                 |
| <b>(4) Learning from complaints and concerns</b>  | (1) Formal complaints are discussed at local service delivery groups.<br><br>(2) Necessary actions and learning are monitored by the Deliver Assurance Groups (DAG) | At each meeting      | General Manager, Clinical Director and Senior Matron                     | DAG   | Monthly                  |
| <b>(5) Compliance with national standards associated with complaints management</b>   | (1) Submission of the <i>Hospital and Community Health Services Written Complaints Return</i> known as 'KO41' data.<br><br>(2) Assessment of CQC Outcome 17         | Annual<br><br>Annual | Complaints Manager<br><br>Complaints Manager                             | Department of Health<br><br>Trust Board   | Annually<br><br>Annually |

## 18.0 RECORD KEEPING

This policy will result in the following classes of records being created, which will observe the following retention regimes:

|  | Retention period                     | Disposal method |
|--|--------------------------------------|-----------------|
| PPEE Steering Group Minutes            | Duration of associated Group minutes | Destruction     |
| Procedural Document ratification Group | Duration of associated Group minutes | Destruction     |
| Annual Report                          | 24 months                            | Destruction     |

## 19.0 EQUALITY ANALYSIS

ANHSFT is committed to the overarching principles of equality and diversity. As such the organisation values and supports its entire staff. We are committed to ensuring all forms of prejudicial, unfair bias and/or actions which result in discriminatory practices are eliminated. The Trust makes this stand based not only on meeting its legislative duties but also a moral basis of ensuring equitable outcomes for all of its staff and patients.

The Trust is continually working towards eradicating all forms of harassment and discrimination, exclusion, victimisation, harassment and bullying and working to ensure it meets its legal duties by ensuring that:

- Unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 are eliminated.
- Equality of opportunity between people from different groups is advanced and good relations between people from different groups are fostered.

The Trust treats any complaints it receives very seriously and as such any complaint received in respect of this policy or associated policies (in terms of application or adherence) will be investigated by Trust staff. The process undertaken will also ensure that complainants, patients, relatives and carers are not discriminated against on the grounds of disability, gender, marital status, sexuality, colour, race, nationality, ethnic origin, religion, belief or age. Additionally the Trust will ensure that no individual is treated in a detrimental manner as a result of having made a complaint about this policy.

The policy will be continually reviewed to ensure that there are no elements within the policy, practice or procedures that are prejudicial on any grounds in respect of the protected equality characteristics mentioned above. Using the guidance produced under the auspices of equality legislation, this document has also been equality impact assessed.

## 20.0 REFERENCES

Berwick, D. (2013) *Review of Patient Safety in the NHS*.

Care Quality Commission (2010) *The Essential Standards of Quality and Safety*

Clwyd, A. and Hart, T. (2013) *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*. Crown Copyright.

Department of Health (2014) *Hard Truths: the Journey to Putting Patients*.

Patients Association (2013) *Good Practice Standards for NHS Complaints Handling*.

## 20.1 Supporting documents

Procedural Standard (1) Managing, Processing and Investigating a Formal Complaint. [Link here](#).

Guidance for Managing Habitual and Vexatious Complainants. [Link here](#)

Guidance for Managing Complaints Concerning Individual Staff. [Link here](#)

Guidance for staff writing a statement. [Link here](#)

Equality and Diversity Impact Assessment. [Link here](#)

## 21.0 VERSION CONTROL

| Version | Date | Author | Status | Comment |
|---------|------|--------|--------|---------|
|         |      |        |        |         |
|         |      |        |        |         |
|         |      |        |        |         |
|         |      |        |        |         |
|         |      |        |        |         |
|         |      |        |        |         |

## 22.0 DOCUMENT CONTROL

### 22.1 Procedural Document Register

### 22.2 Archiving Arrangements

Electronic copies of current and previous versions of procedural documents will be retained in line with best practice outlined in the Department of Health, Records Management: NHS Code of Practice Part 1 (2006) and Part 2 (2009).

Archived electronic documents form part of the Trusts database, which is maintained by the Health Information Specialist on a shared drive on the intranet. This person and key members of the quality and safety team are the only individuals approved to access this drive. The documents will be archived using SharePoint version control.

### 22.3 Process for Retrieving Archived Documents

Archived documents can be retrieved by contacting the Health Information Specialist.