Liverpool Women's NHS Foundation Trust

Management of Concerns and Complaints Policy

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Designation of Policy Author(s)	Deputy Head of Patient Experience
Policy Development Contributor(s)	Deputy Director of Nursing & Midwifery Independent Complaints Consultant Head of Patient Experience
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Summary of Changes	Simplification of document. Added in specific references from NHS Complaints Standards 2022, including guidance on the "complained about"

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

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1 Executive Summary

1.1 Policy Scope

i. The policy applies to all staff of Liverpool Women's Hospital NHS Foundation Trust (the 'Trust') and its appointed agents.

2 Introduction

i. Complaints are part of everyday life and shape our experiences and relationships. At some point we all find ourselves having to make a complaint or being complained about. Complaining and being complained about raise challenges, concerns and opportunities in equal measure. Our own expectations are therefore invaluable in understanding what constitutes a good complaints process.

ii. This policy therefore promotes an approach that requires the staff of Liverpool Women's NHS Foundation Trust (the 'Trust') to reflect on their own personal experience of complaint handling and to place themselves in the shoes of the patient at all times. Furthermore, by applying current best practice in the field of complaint handling we can go the extra mile and make the process of complaining easier and more solution focused. A creative and flexible approach supported by a positive culture is central to the objectives outlined in this policy.

iii. An effective and efficient complaints process that provides for both organisational learning and interpersonal conflict resolution for patients is integral to the policy. Information from complaints can help improve the Trust's operational service delivery and provide invaluable feedback to the Trust Board. However, it is crucially important that we also do not lose sight of the complainant's desire for a resolution of their personal concerns. Our complaint handling must be focused on people and their experiences, not unduly on statistical data however valuable that may be.

iv. The policy also promotes the benefit of early intervention, informal problem solving, and where appropriate conciliation and mediation. Not every complaint requires an investigation, and these alternatives to a forensic detailed enquiry can provide many complainants with a speedier outcome to their concerns. The Trust is committed to making best use of the considerable flexibilities provided by the NHS Complaints Procedure and ensuring the delivery of a patient focused experience. Not all complaints are the same and a 'one size fits all' approach to complaint handling is contrary to this aspiration.

2.1 Background

i. This policy complies with the statutory requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

issued under the Health and Social Care (Community Health and Standards) Act 2003 , and with Regulation 16 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

ii. The policy also responds to the national strategic drivers for change in NHS complaint handling contained in the 'My Expectations' report jointly published in 2014 by the PHSO, the Local Government Ombudsman (LGO) and Healthwatch. 'My Expectations' represents the formal response of the Department of Health Complaints Programme Board to the findings, conclusions and recommendations of the 2013 Francis Inquiry and Clwyd/Hart 'Putting Patients Back In The Picture' review, and the Government's 'Hard Truths' report.

3 Policy Objectives

i. The policy aim is to ensure that our staff are informed and aware of the action to be taken when a patient or other eligible person shares a concern or wishes to make a complaint concerning any aspect of the patient experience.

ii. The complaints handling policy describes how the core expectations given in the NHS Complaint Standards will be put into practice. This policy sets out how we handle complaints and the standards we will follow. This procedure follows the relevant requirements as given in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations).

iii. It should be read in conjunction with the more detailed guidance modules available on the Parliamentary and Health Service Ombudsman website.

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

v. The aim of this policy is to ensure that we comply with the Parliamentary and Health Service Ombudsman (PHSO) principles of good complaint handling including ensuring that:

- the complaints procedure is accessible and well publicised.
- complaints are responded to in a rapid and sensitive manner.
- complaint responses are open and transparent.
- the complaints procedure is supportive of those who may find it difficult to complain.
- the Trust seeks continuous improvement arising from feedback.
- patients and carers are able to complain without fear of discrimination.

vi. The Executive Summary sets out the overarching strategic vision for the Trust's complaint handling policy, this can be summarised by the following key objectives: the Trust will:

- Comply with its legal obligations for complaint handling as set out in the relevant statutory regulations.

- Promote best practice in complaint handling consistent with the national strategic objectives of 'My Expectations'.

- Provide a non-discriminatory and accessible complaints process that addresses the needs of people with legally protected characteristics.

- Encourage the early resolution of patient concerns before the need to make a complaint arises.

- Encourage early intervention when complaints arise and promote their local and informal resolution wherever possible.

- Provide a quality complaint handling service when patient dissatisfaction is referred to the Patient Experience Team

- Ensure that all correspondence is subject to robust triage to ensure the best use of finite complaint handling resources.

- Develop the use of mediation as an alternative to investigation.

- Where necessary undertake best practice evidence-based investigations

- Produce investigation reports that clearly set out relevant findings, conclusions and recommendations.

- Provide decision (adjudication) letters to complainants that clearly explain the outcome (upheld or not) and action being taken to address identified failings.

- Use information from complaints ('lessons learnt') to inform and help shape future service delivery.

vii. Our staff will:

- View complaints as an opportunity to repair relationships and learn from our mistakes.

- Use their own experience of making complaints to understand, appreciate and address the expectations of our patients.

- Place themselves in the shoes of the patient at all times.

- Use initiative in their interactions with patients who express concerns about their care and treatment in order to prevent complaints occurring.

- Take ownership for complaints when they do arise and use their best endeavours to resolve them locally and informally.

- Work closely with the Patient Experience Team to deliver a holistic and collaborative complaint handling experience when matters escalate.

- Contribute to the delivery of quality outcomes for our patients through investigations and other resolution initiatives.

- Be mindful at all times of their legal obligations under the ‘duty of candour’ to engage honestly and transparently with the complaint process.

4 Duties / Responsibilities

i. The following describes the core responsibilities of committees and key individuals in ensuring that the policy is correctly applied:

4.1 The Patient Involvement and Experience Subcommittee (PIESC)

- Ratification and review of the policy
- Monitoring implementation of the policy and associated actions plans
- Receiving quarterly and annual complaints reports detailing complaint themes, recommendations, actions taken and lessons learned

4.2 Chief Executive (CEO)

- The 'Responsible Person’ with accountability for ensuring compliance with the statutory requirements of the NHS complaints procedure.
- Ensures the fitness for purpose of the Trust's complaints procedure and has strategic responsibility for its performance
- Executive level ownership for the quality of responses sent to complainants

4.3 Chief Nurse

- Senior level scrutiny and oversight of the quality of investigation reports
- Adjudicates on the outcome of complaints enquiries and investigations (final decisions concerning the substantive reply to complainants)
- Senior level scrutiny and oversight of the quality of decision letters to complainants

4.4 Head of Patient Involvement and Experience/Deputy Head of Experience

- Operational management of the policy
- Performance of the Patient Experience Team in line with statutory requirements, business plan objectives and KPI's
- Scrutiny of the quality of investigation reports and associated draft letters of adjudication (decision) to complainants
- Production of quarterly, annual and other reports as required
- Undertaking complaints audit activities

4.5 Patient Experience Team

- Operational delivery of the policy and its day to day application
- The effective and efficient administration of the Trust’s complaints procedure
- Day to day liaison with patients and staff in matters of concern or complaint
- Management of the complaints process and commissioned investigations
- Drafting of adjudication (decision) letters to a required standard
- The full duties and responsibilities of the Patient Experience Team are set out in any supporting Standard Operating Procedure/ Processes and Job Descriptions (See appendix 1)

4.6 Clinical/Service/Operational Managers (Senior Leadership Team)

- Ensuring all staff have access to the policy and understand the process for dealing with complaints
- Providing necessary assistance to the Patient Experience Team in all aspects of the operation and delivery of the Trust complaints procedure
- Ensuring the participation and cooperation of all staff with complaints enquiries and investigations
- Nominating appropriate staff to undertake investigations as required.
- The full duties and responsibilities of Clinical/Service/Operational Managers are set out in any supporting Standard Operating Procedure/ Processes and Job Descriptions
- With Maternity/Midwifery complaints, the SLT should also include the Director Of Midwifery (DOM) for sign off.

4.7 Investigating Officers

- Undertake investigations in a manner consistent with the requirements set out in this policy, associated guidance and included in their training
- Produce investigation reports and action plans (if required) of an acceptable quality in a format that complies with policy requirements
- The full duties and responsibilities of Investigating Officers are set out in any supporting Standard Operating Procedure/ Processes and Job Descriptions

4.8 Medical Records

- Sourcing and making available the health care records on request

4.9 All Staff

- Ensuring their familiarity with and adherence to the policy at all times
- Proactively engaging with patients where concerns and complaints arise and endeavour to find practical solutions and prevent their escalation
- Support the work of the Patient Experience Team through participation and assistance with general enquiries and investigations
- Undertake investigations where required
- Attend training as required

5 Main Body of Policy

5.1 Policy Guidance (Regulations)

5.1.1 Regulatory Context

i. The Trust must comply with the statutory framework for the handling of complaints. This includes the duty to have a complaints process and to operate it in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, and Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

ii. The policy guidance addresses our obligations under the 2009 Regulations as these are used by the PHSO in their determinations concerning individual patient complaints where maladministration causing injustice is alleged. Regulation 16 is used by the Care Quality Commission (the healthcare regulator) to determine the fitness of the Trust's systems and processes for complaint handling.

5.1.2 Complaint Definition

i. The Regulations provide no statutory definition of a complaint. The following is therefore based upon a variant of the best practice definition used commonly by UK public service agencies and recognised by the public service ombudsmen.

ii. A complaint is an expression of dissatisfaction about a Trust service or member of staff, whether made orally or in writing, and which requires a response.

iii. The 2009 Regulations removed the historical custom and practice of categorising complaints as either 'informal' or 'formal' in response to the way in which they were made by the complainant (i.e. orally or in writing). The NHS Complaints Procedure now promotes a seamless single process with the next step being referral to the PHSO. Consequently, the Trust's amended definition reflects the statutory framework whereby it is the substance of the complaint that determines the manner of its handling, and not how the complaint was made. This will be reflected most commonly in decisions as to whether early intervention and problem solving or a forensic investigation will be needed to resolve the complainant's concerns.

5.1.3 Eligibility

i. Regulations prescribe who can complain under the NHS Complaints Procedure. This will most commonly be a patient, but may include those with a sufficient interest in the patient's health and wellbeing (such as family representatives), appointed advocates and others demonstrably affected by any act or omission on the part of the Trust. In the event that there is any doubt about the eligibility of an individual or organisation to be making a complaint, the 2009 Regulations should be consulted and a decision reached by the Head of Patient Involvement and Experience/Deputy Head of Patient Experience.

5.1.4 Complaints outside the Policy

i. The following fall outside the scope of the policy, complaints:

- Made by another NHS body
- Made by an employee of a NHS body relating to that employment
- The subject matter of which is the same as that of a complaint that has previously been made by the same complainant and resolved in accordance with the 2009 Regulations

- The subject matter of which is being or has been investigated by the PHSO
- Arising out of a failure to comply with a request under the Freedom of Information Act 2000.

5.1.5 Time Limit on Making A Complaint

i. A complaint should be made within twelve months of the matter that gave rise to dissatisfaction or within twelve months of the complainant becoming aware of the substantive matter. Where a complaint is made outside of these time limits the following criteria will determine whether the Trust will accept the complaint:

- That good reason can be provided for the delay in complaining and supporting evidence made available to the Trust.
- That the delay does not compromise the ability of the Trust to effectively conduct enquiries into the matter complained about
- That the resources required to consider such a complaint are not disproportionate to the substantive matter complained about
- That a reasonable prospect of achieving an outcome of value exists

ii. The Head of Patient Experience (Deputy) will consider requests on a case-by-case basis, and a discretionary decision taken according to their respective merits. Complainants will be advised of their right to refer the matter to the PHSO in the event that a decision to exclude is made.

5.1.6 Duty to Co-operate (Complaints Involving Other Bodies)

i. The Trust is under a statutory 'duty to co-operate'. Where a complaint includes issues relating to both the Trust and another NHS body or local authority, the respective organisations are obliged (where possible) to work together to coordinate a joint response. It is usual practice for the organisation to which the majority of the issues relate, to take the lead in communicating with the complainant and coordinating the investigation and response. Where there is agreement that the Trust will act as the lead party, the complaint will be managed in accordance with this policy and the Patient Experience Team will be responsible for liaising with the complainant and other relevant bodies. Decisions concerning the application of Regulation 9 will be considered by the Head of Patient Involvement and Experience/Deputy Head of Patient Experience on a case-by-case basis.

5.1.7 Complaint Handling Timescales

i. Matters referred to the Trust under this policy and supporting procedures must be acknowledged within **three working days** after the day of receipt, and a final response provided no later than **six months** from the date of receipt (or a longer period where agreed with the complainant). The Regulations enable the Trust to reach decisions about the timeframe for handling and responding to complaints on a case-by-case basis. The substance of the complaint, the required depth of enquiry or investigation, and the impact on Trust resources will inform decisions concerning the target date for responding to each complainant

5.1.8 Response to Complainant

The Regulations set out the minimum requirements concerning the nature and form of the response to be sent to the complainant at the conclusion of the Trust's consideration of the complaint. This includes:

- A written response signed by the Chief Executive as the 'Responsible Person'. This is the adjudication (decision) letter that sets out the Trust's reply to the complaint and which addresses the outcome of the enquiry or investigation into the matter.
- A report that explains how the complaint has been considered, and which includes relevant findings, conclusions and recommendations.
- The response must provide information on the complainant's right to refer their complaint to the PHSO .

5.1.9 Referral to the PHSO

i. Complainants who are dissatisfied with the Trust's response can refer the matter to the PHSO. This right should be exercised within 12 months of the Trust's reply. The Ombudsman will normally expect a complainant to have used the Trust's procedure before accepting the complaint for consideration, but has discretion in exceptional circumstances. The PHSO also has powers to access Trust documents and (where required) interview staff in order to reach a decision. This policy requires all Trust staff to co-operate with any investigation undertaken by the Ombudsman.

5.1.10 Publicity

i. The Trust must make information available to the public concerning its arrangements for dealing with complaints. This includes information about the right to complain, how to use the complaint procedure, and the further help available from Trust staff, Liverpool Advocacy Hub, the PHSO and other sources.

5.1.11 Monitoring & Reporting

i. The trust is required to maintain records of all complaints handled under the Regulations and must publish an annual report providing non-personal detail on the nature and volume of all complaints activity for the reporting period in question.

5.1.12 Regulatory Oversight

i. The Care Quality Commission (CQC) is the healthcare sector regulator with responsibility for assessing the Trust's compliance with its statutory obligations as a registered provider. CQC has a memorandum of understanding with the PHSO and the two agencies share information to aid both the effective consideration of individual complaints, and the assessment of Trust systems and processes for complaint handling. This policy emphasises the need for staff co-operation with our regulators and other external agencies (e.g. the Information Commissioner).

5.1.13 Supplemental Note

i. The Local Authority Social Services and National Health Service Complaints (England) Regulations came into effect on the 1st April 2009 and replaced The National Health Service (Complaints) Regulations 2004. The 2004 Regulations required responses to complainants to be sent within 20 working days of the date of complaint. The 2009 Regulations removed this timescale and NHS bodies now have six months in which to respond

ii. This policy also provides guidance on the limited circumstances in which the Trust will review its decision on a complaint.

5.2 Policy Guidance (Trust)

5.2.1 Introduction

i. This section explains the Trust's policy approach to the handling of concerns and complaints and requires all staff to observe:

- Our statutory obligations
- Recognised national best practice; and
- Local initiatives that address the particular needs of the Trust as a specialist provider of NHS services

ii. The 2009 Regulations provide all NHS providers with a broad outline of what a local complaints process should contain by way of a minimum requirement. This includes a 'procedure before investigation' and arrangements for 'investigation and response'. However, the Regulations also acknowledge the need for flexibility in the application of the national standards. As a specialist NHS Trust providing Maternity, Neo-Natal Gynaecology and other services to women and their families, this policy therefore addresses the particular needs of our patients. This includes:

- Requests for general information about clinical procedures and best practice
- A desire for answers to questions concerning personal care and treatment
- The opportunity to express concerns about the patient experience
- The making of a complaint

iii. How each individual issue is dealt with is critical to the overall handling of a patient's concerns. Therefore, it is of the upmost importance that staff can clearly distinguish matters that are explicitly complaints and those which are questions or statements of opinion.

iv. A complaints investigation should only be undertaken where there is absolute clarity about the specific matters to be investigated. The following sub-section of this policy explains how staff should approach the handling of patient concerns in order to ensure a proportionate, effective and efficient response to the individual issues raised. The same methodology is to be applied by all Trust staff including the Patient Experience Team.

5.2.2 Complaints, Questions and Opinions

i. The policy guidance below provides a simple illustration of the quite different nature of a complaint, a question and a statement of opinion. The contents of the table also explain why questions and statements of opinion cannot be 'investigated'.

Issue Raised	An Example	The Explanation
Complaint	*"I had an appointment booked for 2pm on the 14th of June and when I arrived your receptionist told me all surgery for that day had been cancelled. I am very unhappy about his as I am self-employed and lost a day's money as result."*	• This is clearly a complaint as **dissatisfaction** is expressed • It concerns a matter of **fact** (an appointment for the day and time in question).

		• An **investigation** of this issue is possible (access to relevant records etc.) • Dependant on the findings and conclusions of the investigation, it will be possible to either **uphold** or **not uphold** the complaint
Question	*"I wasn't given an epidural. Nobody explained why it was refused. I've read somewhere that I should have been given a choice. Is this right?"*	• The patient is **unclear** about epidural policy and practice issues • The **facts** are absent • She wants **information** • Once she has the information, she will be in a position to **decide** whether to make a complaint • **You cannot investigate a question**! Unlike a complaint, it does not assert a position on a factual matter
Opinion	*"I think you should train your staff properly. You should take a long hard look in the mirror. I will never use your hospital again!"*	• Here the patient shares their **personal view** • No **facts** are provided • **You cannot investigate an opinion!**

5.2.3 Handling Patient Concerns (All Staff)

i. It is often the case that a patient's concerns will include a combination of complaints, questions and opinions. By applying the policy guidance staff can speedily focus attention on the factual matters where a clear dissatisfaction is expressed. This can be achieved by using the following three-step guidance:

- Step 1, answer any questions. By providing the requested information, it is often possible to resolve a patient's concerns. Many questions will raise matters that are commonly asked by patients and for which there is a readily available answer. Where the answer is not immediately available, agree a timeline with the patient for providing the answer. Once an answer has been given, it is for the patient to decide whether they feel a basis for complaint exists (see Step 3).

- Step 2, where a patient offers an opinion, acknowledge their right to hold personal views on the subject raised. Where appropriate, offer an apology for any negative experience.

- Step 3, address any remaining complaints. Where a patient raises a complaint orally, responsibility for providing a reply rests with the staff member to whom the complaint was directed (unless an alternative arrangement has been agreed; i.e. onward referral to a service manager or the Patient Experience Team).

ii. Many complaints/concerns do not require a full investigation. It is often the case that simple enquiries will be sufficient to determine the outcome of a complaint (whether it can be upheld or not). Where it is not possible to resolve a complaint informally and locally within the service area complained about, patients must be advised of the right to escalate their complaint to the Patient Experience Team.

5.2.4 The Role of the Patient Experience Team

i. Complaints and concerns are the responsibility of everyone working for the Trust. Good complaint handling by staff will often prevent the need for patient concerns to be escalated to the Patient Experience Team (PET). Effective complaint/concern handling is all about ownership, collaboration and teamwork. Simply directing a patient to the PET compromises the objectives of this policy.

5.2.4.1 Intervention by the PET

i. However, where the concerns require a more formal consideration (perhaps due to the substance of the issues or because the initial response of staff has not been accepted) referral to the PET will be wholly appropriate. Where the Trust is contacted through written correspondence (including email and other electronic media) the PET will lead on communication with the person or organisation. In both cases, the PET will use the same policy guidance. In answering any questions raised by the patient or other eligible person, the PET may require the assistance of relevant Trust staff. This may simply be the provision of information to the PET, or possibly a need for the staff in question to be involved in a meeting or telephone conversation designed to answer questions and narrow the likely areas of complaint.

5.2.4.2 Handling Concerns

i. All concerns and associated resolution and actions are logged and recorded on the Trust Ulysses risk system for monitoring and reporting purposes, regardless of whichever resolution process is utilised.

ii. The table below reflects a problem solving and early resolution focused approach to handling concerns. This is referred to as the PALS+ model.

Undertakes Triage	Gathers Information	Communicates
PET uses the policy guidance to identify questions, opinions and concerns.	PET gathers/requests the required information from relevant Managerial/senior Trust	Contact is made with patient / eligible person in line with their agreed wishes to problem solve their concerns:

PET agrees how the patient/eligible person wishes to receive feedback about their concern.	sources to answer questions /concern	1) Correspondence 2) Phone conference 3) Conciliation meeting

iii. Where the proportion of questions is significantly higher than the number of complaints, a phone conference or conciliation meeting under a PALS+ model is advisable (this is because answers to questions may elicit further lines of questioning requiring a 'real time' response). Furthermore, where the questions concern a specific topic or service, it is advisable to ensure the presence of a staff member with sufficient knowledge of the subject area.

iv. Correspondence (hard copy or electronic media) may be more appropriate where the answers to questions address largely non-contentious matters of general policy and service delivery (for which the Trust has a 'fixed position') rather than patient specific care and treatment.

v. A PALS + problem solving, and resolution focused 'right first time' approach will in many instances enable the PET to secure the speedy closure of concerns (including both questions and complaints) through effective early intervention. Further detail relating to PALS+ are in 5.2.4.9.

5.2.4.3 Handling Complaints

i. The PET/Patient Experience Officer assigned the complaint will engage with the person raising the complaint (preferably in a face-to-face meeting or by telephone) to make sure they fully understand and agree:

- the key issues to be considered (Heads of Complaint)
- how the person has been affected
- the outcomes they seek (outcomes)
- signpost the person to support and advice services, including independent advocacy services, at an early stage
- agree a suitable timescale for how long the investigation will take with the person raising the complaint, depending on the complexity of the complaint and the work that is likely to be involved
- keep the person regularly informed and engaged throughout

ii. The basis of the enquiries to be undertaken by the PET or investigation to be conducted by the appointed staff member (or externally commissioned investigator) will be the Heads of Complaint. These will have been agreed with the patient or eligible person, but the Trust reserves the right to define the complaints in such a way as to make the required enquiries or investigation both proportionate in scope and focused in objectives.

iii. Detailed guidance about the investigation processes of complaints is provided in separate guidance document.

5.2.4.4 Defining Complaints (Heads of complaint)

i. Complainants often highlight a number of individual issues that require consideration by the Trust. Therefore, it can often be misleading to talk about a 'complaint' in the

singular. To address such a situation, any individual issues raised in a complaint should be referred to as the 'Heads of Complaint'.

ii. Complainants may raise several examples of a particular dissatisfaction, e.g. instances of poor communication on the part of different staff members. A complaint may also contain what the complainant perceives as multiple issues of dissatisfaction, when in reality only a small number of issues are actually raised.

5.2.4.5 Desired Outcomes

i. It is equally important that the PET seek to establish the nature of the complainant's desired outcomes (i.e. what they would like to see happen). Whilst an enquiry or investigation can identify on the basis of the evidence available whether a complaint should be upheld or not, the outcome will be of limited value if the complainant's expectations have not been managed from the outset. The following are examples of what the complaints process cannot deliver:

- A financial remedy, such as compensation
- Any claims for an alleged detriment experienced (e.g. personal injury and clinical negligence) must be directed to the Trust's legal services team
- The termination of a member of staff's employment
- Should the complaints process identify a serious failing on the part of a member of staff, this will be referred to the Trust's Human Resources procedures for further consideration

ii. However, the following are all examples of outcomes that the complaints process is able to deliver:

- An explanation for events complained about
- An apology
- An indication of steps taken by the Trust to remedy any failings
- Where possible, an assurance concerning future patient experience
- Where merited, changes to Trust policy, procedure and practice

5.2.4.6 Case Management Functions

i. The PET is responsible for ensuring the timely, effective and efficient consideration of complaints made under the scope of this policy and supporting procedures. This includes (but not exclusively):

- Guidance and advice on the operation of the policy and procedure
- Proactive liaison with patients, eligible persons and staff as necessary
- Receipt and acknowledgement of escalated concerns and complaints
- Formal registration of concerns and complaints
- Defining complaints for the purposes of enquiry and investigation
- Undertaking enquiries into concerns and complaints as necessary
- Adherence to statutory timescales for complaint handling (see 6.4.20)
- Monitoring of investigations to ensure compliance with this policy
- Quality assurance of investigation reports in conjunction with Clinical/ Service Managers
- Drafting of adjudication (decision) letters for the Chief Executive
- Monitoring of recommendations and action plans
- Decisions concerning patient complaint review requests (see 6.4.21)

- Responding to PHSO enquiries and investigations

5.2.4.7 Complaint Handling Timescales

i. The policy guidance details the regulatory requirements relating to the timescales for acknowledging (3 working days) and responding (within 6 months) to complainants. The PET is responsible for ensuring a consistent approach to target dates for response. The rationale for such decisions should be recorded on the relevant complaint file.

5.2.4.8 Complaints Review Requests (Closed Complaint)

i. Where a complainant requests a review of the Trust's decision in their complaint, the following criteria (enabled by Regulation) will apply:

Review Rejected

- A substantive challenge. Dissatisfaction with the Trust's decision in a matter of complaint does not constitute reasonable grounds for granting a review

- A procedural challenge. Where the Trust takes the view that its consideration of the complaint has complied with the requirements of this policy, no grounds will exist for the matter to be reviewed

Review Agreed

- A factual inaccuracy of significance affecting the reliability of the decision. Where a complainant identifies such an error, a review should be conducted.

- New evidence not previously available is identified. Where a complainant brings new evidence to the attention of the Trust that is relevant to its decision in the complaint, a review should be conducted.

ii. Note: Any factual inaccuracy and previously unavailable new evidence must have a material relevance to the Trust's decision (i.e. not all factual inaccuracies or previously unavailable new evidence will necessarily have a bearing on the reliability of the Trust's decision in the complaint). The PET is responsible for undertaking an objective assessment of the complainant's request, and for the Head of Patient Involvement and Experience/Deputy Head of Patient Experience agree whether or not a review should be conducted.

iii. Any review should be proportionate to the matters raised. Most commonly it will simply require the executive adjudication (decision) to be revisited. A fresh enquiry or investigation should only be undertaken in exceptional circumstances (where the matter raised is of such a fundamental nature it is justified to do so). **Where a review is rejected, a complainant should be informed of their right to refer the complaint to the PHSO**.

5.2.4.9 Early Resolution (PALS +)

i. Current best practice stresses the value of early resolution in complaint/concern handling. The PALs and complaints functions of the PET are therefore organisationally aligned and work in close collaboration with wider Trust staff to promote practice that is (wherever possible) consistent with this strategic objective for complaint handling as advocated by the Department of Health and PHSO. A swift

settlement is the principle focus of early resolution and it is an ideal approach for general concerns and non-complex complaints. This will be recorded as a PALS+ case. The PALS+ model puts patients, with concerns and queries, in touch with senior members of the department who can listen, discuss and address these issues in a positive and dynamic way. This provides timely and personal resolutions for patients and strengthens the relationships with the Trust. This option is offered to patient were it is deemed that is would be a helpful avenue for resolution by the PET. It is the patient's choice to pursue this process. However, there will be circumstances where the issues raised can only be addressed through a forensic investigation focused on establishing facts and attributing accountability.

ii. The use of PALS + is positively encouraged by the Trust and can be used at any stage in the consideration of a concern, although most commonly it will be used at the outset when a person first brings a matter to the Trust's attention.

iii. We aim do either complete or have an agreed plan in place to complete PALS+ cases in around 10 working days. However, this can take longer if the additional time means the concern is more likely to be resolved successfully for the individual.

iv. The individual has the right to escalate a PALS+ case to a formal complaint at any stage.

v. If all questions have been answered and the patient or eligible person has been provided with all the relevant information, they are then in a position of being able to decide whether they feel a basis for complaint in these matters exists. Any new complaints arising from the Trust's answers to the patient or eligible person's questions can then be added to any original complaints that still remain unresolved.

vi. If the person raising the concern is satisfied that this resolves the issues, the staff providing the resolution have the authority to provide a response on behalf of the Trust. This will often be done in person, over the telephone, or in writing (by email or letter) in line with the individual circumstances.

vii. We will capture a summary of the concern and how we resolved it and we will share that with the person raising the concern if requested. This will make sure we build up a detailed picture of how each of the services we provide is doing and what people experience when they use these services. We will use this data to help us improve our services for others.

5.3 Investigation

5.3.1 Introduction

i. Interpersonal conflict resolution (repairing relationships) is the primary focus of complaint handling. An investigation is concerned with establishing the facts in order to reach a judgment in the matter of complaint. A complaints investigation is unlike a Root Cause Analysis (RCA) investigation in that organisational learning is a by-product of the activity, not the objective of the activity. This is reflected in an investigative approach that is directed and informed by the complainant's issues of dissatisfaction.

ii. A complaint investigation must be objective and impartial to have any credibility. Simply obtaining an account of events from staff that refutes those of the complainant and using this as a basis for a response does not amount to a credible investigation. The role of the investigator is to gather relevant evidence from both parties and to evaluate the strength of that evidence on a balance of probability (i.e. what is more likely or not to have happened). The oral and written accounts of both staff and the complainant can be 'triangulated' (verified) by checking a range of potential evidence such as patient notes, policy documents, witness statements etc. It is the investigator

who must reach a judgment on the merits of the complaint, not the staff or manager of the service complained about.

iii. It is the responsibility of the Clinical/Service/Operational Manager to ensure that any staff member commissioned to investigate a complaint has (a) been appropriately trained to undertake the role, and (b) that no conflict of interest exists which argues against their appointment (e.g. they are themselves a named subject of complaint or were responsible for the substantive action or inaction complained about).

5.3.2 Investigation Scope

i. The PET will provide the investigator with a clear understanding of the defined complaints and these will inform the scope of the investigation (it is helpful to agree an investigation plan at this point). A proportionate approach is required (i.e. sufficient to identify and obtain directly relevant evidence) and an investigator must seek the agreement of the PET and the Clinical/Service/Operational Manager for any widening of investigative scope. The PET will also advise the Division of the agreed timescale for the investigation and agree any extensions if required. The Division / investigator must keep the PET informed of progress and bring any delays to its attention.

ii. Staff who carry out investigations (Investigating Officer) will give a clear, balanced explanation of what happened and what should have happened. They will reference relevant standards, policies and guidance to identify clearly if something has gone wrong.

iii. The Investigating Officer will make sure the investigation clearly addresses all the issues raised. This includes reviewing evidence from the person raising the complaint and from any staff involved in the investigation.

iv. If the complaint raises clinical issues the Investigating Officer will obtain a clinical view from someone who is suitably qualified. Ideally they should not have been directly involved in providing the care or service about which the complaint was made.

5.3.3 Evaluating Evidence

i. Investigators must understand the basic premise for reaching their conclusion on a complaint: 1) ‘what should have happened?’ and 2) ‘what did happen?’. 3) ‘if what happened is not what should have happened, then why?’

5.3.4 Triangulation

i. In simple terms, triangulation is the process by which the investigator arrives at a conclusion on a particular complaint by comparing all the available evidence (both oral and direct). Some evidence may be corroborative (i.e. a written record that supports the oral testimony of an interviewee) and some evidence may carry greater weight (i.e. CCTV footage as opposed to human memory). The investigator must carefully consider the findings (established facts) of the investigation and then triangulate this evidence to arrive at a balanced conclusion.

5.3.5 The Investigation Report

i. On completion of the investigation, the investigator is required to submit a report to the Clinical/Service/Operational Manager for review. Once this review has been completed it will then be sent to the PET. The report must comply with the Trust template and clearly address the following matters:

- **Findings:** The facts established in relation to each head of complaint

- **Conclusions:** A 'balance of probability' decision whereby the investigator comes to a view on the merits of the complaint in the light of the facts established. The investigator's decision must be founded on 1) an objective consideration of the facts (what any reasonable person would conclude) and 2) a subjective element in which any special knowledge, skills and experience are applied to the facts.

  In reaching a conclusion, the investigator must clearly state whether the particular complaint is **upheld or not upheld**. Individual heads of complaint cannot be partially upheld (i.e. there is either evidence to support the complaint or not; this policy does not provide for a 'not proven' outcome).

- **Recommendations:** A proposed course of action suggested by the investigator to the Trust that may remedy any substantive failings identified by the investigation. Recommendations should be both proportionate and realistic. Where there has been a failure to comply with policy, the investigator should highlight the need to remind staff of their obligations. Recommendations suggesting changes to policy should only be made where the investigator has established a business case to do so.

5.4 Adjudication/ CEO Letter

5.4.1 Introduction

i. Adjudication is the process by which the Trust takes a final decision concerning its response to a patient or other eligible person's complaint. This will follow enquiries conducted by the PET or subsequent to an investigation conducted by an appointed investigator. In both instances, the findings and conclusions will form the overall outcome upon which the final decision must be made. In particular, the conclusions on each Head of Complaint will clearly indicate whether it is upheld or not upheld, and these judgments will be founded upon the evidence contained in the relevant findings for each head of complaint.

ii. Where relevant, the outcome of the enquiries or investigation conducted may also contain specific recommendations to remedy any identified failings. Any recommendations should be carefully considered alongside the conclusions, and where agreed by the adjudicator (decision maker) an action plan for implementing the recommendations should be included in the response to the complainant.

5.4.2 Trust Adjudicator

i. The Chief Executive is the Trust's 'Responsible Person'. However, a number of functions are delegated to appropriate Trust officers for the purposes of the effective operation of the complaints procedure. The Chief Nurse is therefore responsible for the adjudication of final responses to complainants on behalf of the Chief Executive.

ii. The Chief Nurse must carefully consider the outcome of all enquiries and investigations, and either accept the conclusions and any recommendations, or (exceptionally) reject them with a clearly recorded explanation. Where the latter is the case, a review of the complaint should be undertaken with a view to determining an appropriate course of action (e.g. a new enquiry or investigation if the concern is founded on the quality of the forensic work completed, or a meeting with the PET or investigator to explain the rationale for departing from the outcome reached).

5.4.3 Adjudication (Decision) Letter

i. The PET is responsible for drafting the decision letter in a format consistent with a LWH template developed for this purpose. The letter must be appropriate in tone, contain apologies where appropriate, and clearly explain the decision reached on the complaint and the steps being taken to address any identified failings. The letter must also inform the complainant of their right to request a review and refer the matter to the PHSO.

ii. Where there is a mix of upheld and not upheld judgments (in whatever percentage differential) concerning the individual Heads of Complaint, the overall decision should be partially upheld.

5.5 Support for Staff

i. We will ensure all staff who are appointed to investigate complaints have the appropriate training, resources, support and protected time to respond to and investigate complaints effectively.

ii. The Divisional Senior Leadership Team / Investigating Officer will make sure staff being complained about are made aware and will give them advice on how they can get support from within our organisation, and external representation if required.

iii. We will make sure staff who are complained about have the opportunity to give their views on the events and respond to emerging information. Our staff will act openly and transparently and with empathy when discussing these issues.

iv. The Divisional Senior Leadership Team / Investigating Officer will keep any staff complained about updated. These staff have the opportunity to ask to see how their comments are used before the final report is submitted.

v. The PET will contact all staff who have been "complained about" in a reasonable time period (usually between 3 and 6 months) after the complaint investigation has been completed to survey their experience of being involved in the complaint process. Feedback from this can be used to improve the associated procedures and guidance.

5.6 Supplementary Guidance

5.6.1 Duty of Candour

i. Registered healthcare organisations are obliged by law to acknowledge when a patient is harmed or has died as a result of a patient safety incident, and to apologise and provide explanations for such failings. It is a requirement for Trust clinicians to be candid with patients about avoidable harm and for safety concerns to be reported openly and truthfully. The Trust must not provide misleading information to the public, regulators and commissioners. Everyone working for the Trust must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest open and truthful. Where serious harm or death has been or may have been caused to a patient by an act or omission of the Trust, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.

- Openness: enabling concerns and complaints to be raised freely without fear, and with questions asked being answered. Being open involves:

  - Acknowledging, apologising and explaining when things go wrong;
  - Enquiries or investigations into concerns or complaints;

- Reassuring patients, their families and carers that lessons learnt will help prevent incidents occurring, and providing support for those involved to cope with physical and psychological consequences;

- A willingness to learn from and change behaviours and practice in light of concerns and complaints;

- Transparency - accurate information about performance and outcomes to be shared with staff, patients, the public and regulators;

- Candour - any patient harmed by a Healthcare Service is informed of the fact and an appropriate remedy offered (regardless of any complaint being made)

5.6.2 Patient Confidentiality

i. The provisions of the Data Protection Act (DPA) 2018 apply to all personally identifiable data and information held by the Trust. Detailed guidance and advice on the application of the DPA 2018 can be found at the official website of the Information Commissioner's Office. Any consideration of a patient concern (including the investigation of a complaint) must observe statutory requirements for the processing of personal data and comply with Trust patient confidentiality policy. Patients should be informed that information from their health records might need to be disclosed to the investigator, but reassured that their information will be accessed and used on a strict 'need to know' basis. If the patient objects, then the effect of this will need to be explained to them (i.e. it may not be possible to provide them with a full response to their concerns). The patient's wishes should always be respected, unless there is an overriding public interest to the contrary. Complaints related documentation must be kept completely separately from a patient's clinical records (both electronic and paper).

5.6.3 Third Party Representation

i. Where a complaint is made by a person authorised to act on behalf of a patient, the PET will ask the patient to complete a form giving authority to the Trust to disclose relevant information to the patient's representative. Care must be taken by staff not to disclose personal health information unless the patient expressly consents to disclosure. If the patient in question is deceased, then the Trust will only deal with an immediate Next of Kin or person with Power of Attorney (evidence demonstrating such capacity will need to be provided).

ii. In situations where consent is delayed or refused by a patient for a third party to conduct the complaint on their behalf, the third party must be advised in writing that the Trust is unable to disclose any confidential information about the patient, and will be unable to continue any investigation into the complaint. Where the consent is delayed the complaints process will be held in abeyance until valid consent is received. The timescale on which any complaints must be responded to, will also be suspended accordingly.

iii. Where only verbal consent can be obtained from the patient, a written record of the discussion must be documented and included within the complainant's file. Care must be taken by Trust staff in all circumstances to properly identify they are speaking to the right person. This guidance equally applies to situations where patients are pursuing a complaint in their own right.

5.6.4 Members Of Parliament & Elected Representatives

i. Correspondence from MPs and other elected representatives that raise matters of complaint on behalf of a constituent will normally be directed to the Trust Chief Executive. Where this is the case, the Chief Executive will send an acknowledgment that the complaint has been received, and will pass the referral to the PET for action. Contact should be made with the person concerned and consent obtained for relevant correspondence to be copied to the MP.

5.6.5 Adults Lacking Capacity

i. In circumstances where a patient aged 18 years or over is deemed not to have capacity (as defined by the Mental Capacity Act 2005) a check must be made to ascertain whether a Lasting Power of Attorney (LPA) for the patient's health and welfare is in place. Where an LPA has been appointed, any consent must be sought from the attorney who will make decisions on behalf of the patient. If there is no LPA in place, liaison between the PET and the Safeguarding Team will take place to review matters of capacity and consent on a case-by-case basis. There may be circumstances whereby serious concerns are raised through the complaints process relating to a safeguarding concern. In such situations, liaison must take place between the Chief Nurse, Head of Patient Involvement and Experience/Deputy Head of Experience and the Safeguarding Lead to establish which procedures to instigate (which must be in the best interests of the patient involved).

5.6.6 Children and Young People

i. Children and young people under 18 should be assessed to establish whether they have the necessary competence and understanding to give consent. Where this is not the case, those with parental responsibility (or those deemed to have the best interests of the child in mind) may pursue the matter. Where such an eligible person does not wish to pursue a complaint on behalf of the child, the child may (if appropriate) be referred to an advocacy service.

ii. Where the complainant is between 16 and 17 years of age, and where there is evidence to suggest that they lack capacity to consent, a check must be made to ascertain whether a Lasting Power of Attorney (LPA) for the patient's personal welfare is in place. If so, consent must be sought from the attorney who will make a decision on behalf of the patient. If there is no LPA in place, liaison between the PET and the Safeguarding Team will take place to review matters of capacity and consent on a case-by-case basis.

iii. Where a patient is under 18 years old, the Trust have a duty to ensure that they are satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child. If there is no LPA and the complainant lacks capacity, consent must be sought from the next of kin. Where there are concerns that a next of kin is not acting in the best interests of the patient, liaison will take place between the Head of Patient Involvement and Experience/Deputy Head of Experience, Chief Nurse and the Safeguarding Team to establish whether the complaint should proceed.

5.6.7 Serious Incidents (SI)

i. Complaints which identify an event that constitutes a serious incident must be communicated to the Risk and Patient Safety Manager (Deputy) and (if not already identified) should be escalated (via the Deputy Director of Nursing and Midwifery)

and reported to the commissioners via Patient Safety Incident Response Framework (PSIRF)

ii. Complaint investigations should be placed on hold until the SI investigation is complete and the results shared with the relevant parties. Any concerns not addressed in this information should then be taken forward and addressed under this policy, but only on the confirmation of the person raising the original concerns.

5.6.8 Coroner's Inquests

i. The fact that a death has been referred to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. The Trust must initiate proper investigations regardless of the involvement of a Coroner, and where necessary extend these investigations if the Coroner so requests.

5.6.9 Criminal Offences

i. Where it is alleged that a criminal offence has been committed, the matter should be immediately reported to the appropriate Clinical Director/Directorate Manager who will decide whether or not the Police should be informed. Every effort should be made not to prejudice Police enquiries and consultation with the Trust's legal advisor is necessary before proceeding.

5.6.10 NHS / Fee Paying Patients

i. This policy covers any complaint made about the Trust's staff or facilities relating to care whilst in the Trust's private pay beds. Discretion will be applied to complaints concerning private medical care provided by a consultant outside the NHS contract. If such care was provided on NHS premises, the Trust will assume the same levels of care and risk management.

5.6.11 Vexatious & Persistent Complaints

i. The Trust is committed to treating all complainants equitably and acknowledges the right of individuals to pursue a complaint. However, where the Trust identifies a pattern of complaint making that is vexatious in nature (i.e. the raising of the same or similar issues on a repeated basis despite having had a full response from the Trust) the Head of Patient Involvement and Experience/Deputy Head of Experience will, in agreement with the Chief Executive, follow the relevant procedure for 'Handling Vexatious & Persistent Complaints'.

5.6.12 Collecting Patient Feedback

i. The Trust will dispatch questionnaires to all patients who have used the complaints process requesting feedback provided through these forms (which will protect patient anonymity). Any feedback received will be used in the annual complaints report prepared by the PET.

5.6.13 A Complaint Does Not Affect Clinical Care

i. The patient must be assured in the acknowledgement letter that raising a concern or making a complaint will not affect the care and treatment provided by the Trust.

5.6.14 Provision of Additional Support

i. Some complainants may need additional support in making a complaint, for example:

- Their first language is not English
- The complainant has an impairment or disability (physical or mental) which makes it difficult for them to complain without additional assistance, or

- Has a low level of literacy

ii. The PET will work with Trust staff on a case-by-case basis to respond appropriately to the needs of patients presenting particular needs. Provision is available to enable people from particular groups who may need additional support to make a complaint if required. This includes:

- The use of interpreters
- The provision of information in alternative formats
- Securing suitable accommodation for any meetings to meet the needs of any person(s) with mobility issues
- Referral to Liverpool Advocacy Hub locally to support any person unable to formulate their complaint themselves (either verbally or in writing) to participate in this process.

5.6.15 Complaint Action Plans

i. The relevant Clinical/Service/Operational Manager, investigator and PET will agree any action to be taken as a result of the investigation. The action plan will be developed within an agreed timescale, with updates on progress until all actions are completed. The ongoing action plan must be presented by the investigator or Clinical/ Service/Operational Manager at an appropriate meeting within the area to ensure that progress is being made. Evidence of implementation and updated action plans must be updated on Ulysses to ensure a central record is held.

ii. The PET will keep the complainant updated on the progress of the action plan if requested to do so by the complainant. Any delay in action plans not being completed must go to the relevant Divisional meeting and reported by the Division to the Patient Involvement and Experience Sub Committee for discussion and assurance. The Risk Register must be updated by the Division if there are any actions that cannot be achieved, or any actions that pose a risk.

5.6.16 Reporting

i. Quarterly reports must be submitted by the PET to the Patient Involvement and Experience Sub Committee. Divisional Managers, Clinical Directors and Clinical Governance Leads receive these papers for monitoring and further distribution within their divisions. The information will form part of the Integrated Governance Report.

ii. In addition to Quarterly complaints/concerns data, the Trust Board will receive an annual report on complaints. This will also be placed on the Trust internet and intranet site.

iii. The NHS Executive will be provided with statistics on the number and type of complaints made via the statutory quarterly 'Hospital and Community Health Services Complaints Collection' return (KO41)

6 Key Reference

1. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
2. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations).
3. NHS Complaints Standards 2022 NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)
4. https://ico.org.uk

7 Associated Documents

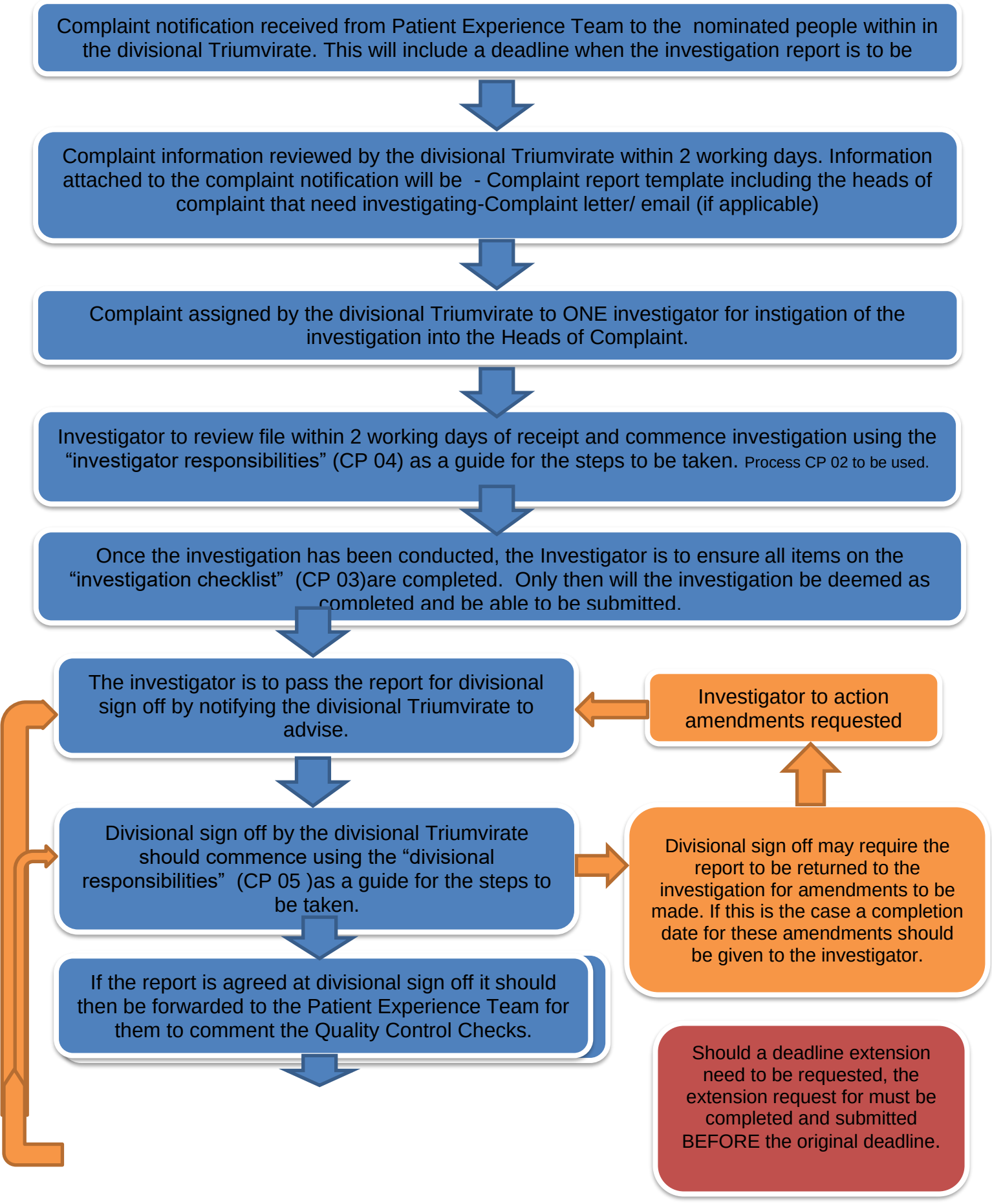
1. Being Open and Duty of Candour Policy and Procedure'
2. Women, Babies and Families Strategy

8 Training

i. The Head of Patient Involvement and Experience/Deputy Head of Experience and the Divisional Senior Leadership Team (SLT) are responsible for identifying learning and development needs related to the operation of the Trust's complaints process, and for commissioning appropriate training to address those needs.

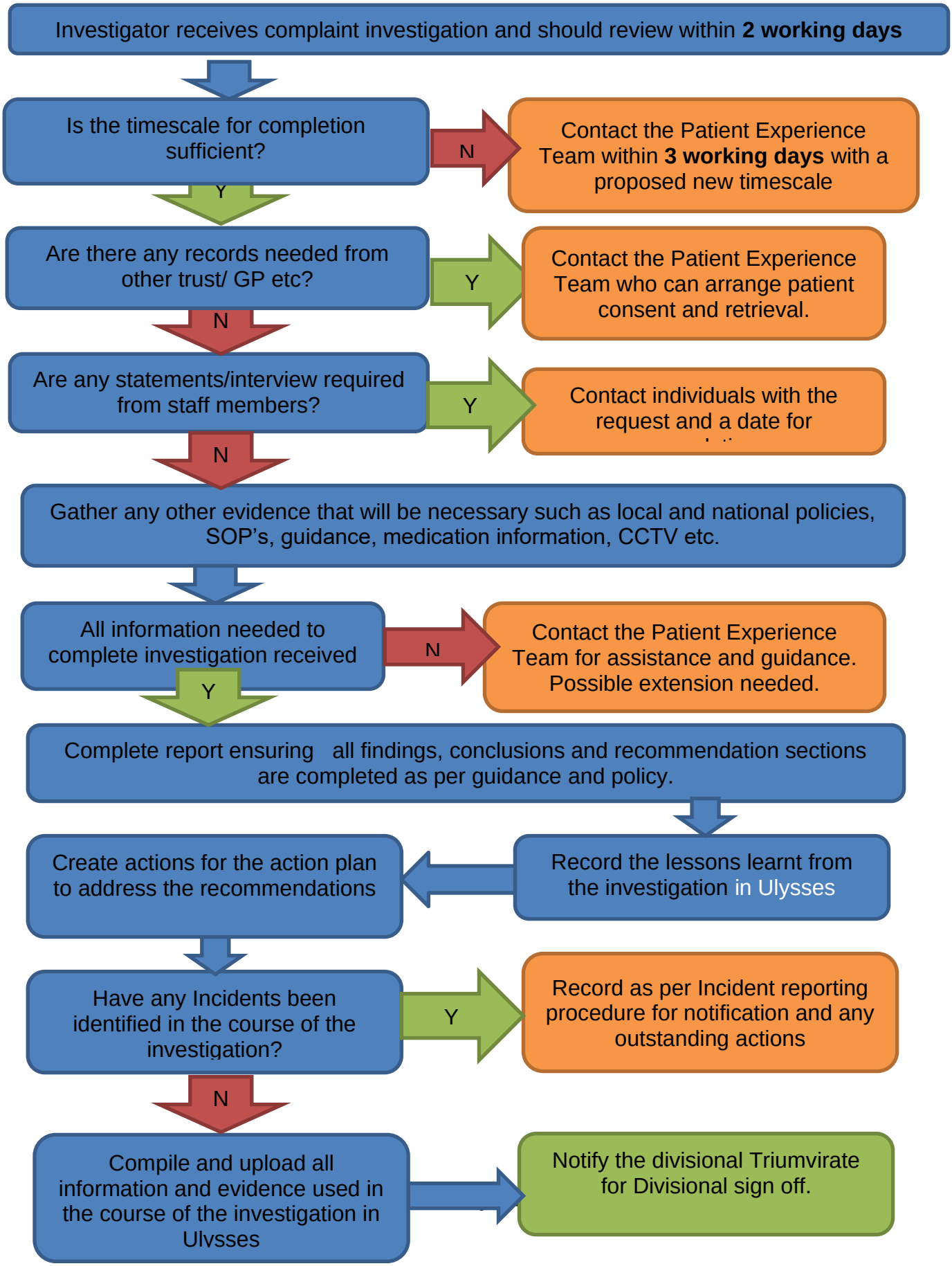
Appendices – Associated process maps

Divisional Complaint Investigation Process CP- 01



Investigation flow chart – CPO2

*To be used in conjunction with the **Investigator responsibilities** document CP 04*



Task	Completed Y/N/NA
All heads of complaint have been addressed	
All Heads of Complaint have a defined findings and conclusion sections completed	
All relevant reflections/evidence/ statements have been obtained of events to inform the investigation	
All heads of complaint are recorded as either UPHELD or NOT UPHELD in the conclusion sections of the report	
All recommendations have been added to the report.	
Created SMART actions in the action plan to address all recommendations.	
Any applicable timeline has been added to Annex 1	
Any applicable supporting information has been added to Annex 2	
All relevant reflections/evidence/ statements used in the investigation are logged and stored against the complaint in Ulysses?	
Lessons learnt from the investigation have been recorded in Ulysses?	
Any incidents that have been identified by the investigation have been recorded via the Trust incident reporting procedures	

Investigator responsibilities and guidance – CP04

The investigator must complete their initial review the complaint within **2 working days** of allocation to plan the scope of the investigation and the information needed to complete this.

An investigator cannot investigate a concern they are involved in. If an investigator identifies they are a material part of the complaint they must advise the person in their division who allocated the report of this and request this be reassigned.

The investigator is responsible for the production of the report within the defined timescales. If during the initial review the timescales for completion are deemed unsuitable the investigator must inform the Patient Experience Team **immediately** regarding their proposed new timescales. This will then be agreed with the Complainant.

The investigator is responsible for **all areas** of the report, even if they are not in the same speciality, area or division. Investigators should speak to, and gather expertise from any area they need assistance from in addressing the concern.

The role of the investigator is to gather relevant evidence from all parties and to evaluate the strength of that evidence on a balance of probability

Investigators should plan their investigations at the start and ensure they are gathering all the necessary information from an early stage to prevent any delays. The typical types of information investigators need are (but not limited to)

- Interviews/statements from people involved in the concerns
- Patient Notes
- Related policies, processes and procedures

For any timescale extensions requests, other than during the initial review, an **Extension Request Form** must be completed and submitted to the Patient Experience Team for approval.

All heads of complaint in the completed report must have a **findings and conclusion** section for each concern noted.

Findings. This is where the investigator will note the facts obtained in their investigation. This should include clear information on

- What should have happed, (preferably linking this back to any policies procedures guidelines etc.)
- What did happened in this instances (either in support of the complainants alleged facts or showing what did happen)

Conclusions: A 'balance of probability' decision whereby the investigator comes to a view on the merits of the complaint in the light of the facts established in the findings. The investigator's decision must be founded on 1) an objective consideration of the facts (what any reasonable person would conclude) and 2) a subjective element in which any special knowledge, skills and experience are applied to the facts. In reaching a conclusion, the investigator must clearly state whether the particular complaint is **upheld** or **not upheld.**

Investigators must ensure that the **recommendations** section is completed in the report. Any head of complaint that has been upheld should generate a recommendation to address the issue identified.

Investigators are responsible for creating the actions in the action plan to address the recommendations.

Investigators must ensure any individual "special instructions" in relation to a specific report from the Patient Experience Team are adhered to during the production of the report. (These will be clearly identified in the report Patient Experience Team can provide further clarity as and when these arise).

Investigators are responsible for compiling and uploading to the Ulysses complaint record, all information and evidence used in the course of their investigation. This includes any statements obtained.

Investigators are responsible for updating the Ulysses complaint record with any necessary updates during the course of the investigation.

The investigator is responsible for recording the lessons learnt from each complaint on the Ulysses complaint record when the investigation has been completed.

Any Incidents identified during the investigation process should be reported via the relevant incident reporting processes for notification.

The investigator is responsible for submitting the completed report to the divisional Triumvirate for sign off. (A report completion checklist has been created to assist in ensuring all areas have been completed prior to submission)

REMEMBER: THE COMPLAINANT WILL RECIVE A COPY OF THE REPORT THAT HAS BEEN SUBMITTED.

The Patient Experience Team can be contacted at any stage by the investigator for help and support in completing the investigation.

Divisional sign off responsibilities – CP 05

Triumvirate (Clinical Leads & Divisional Manager)

At Divisional sign off you must ensure that all "Heads of Complaint" have been sufficiently addressed in line with the policy and guidance available.

Any areas of the report that need amending or further information should be returned to the investigator with a timescale for completion or a response.

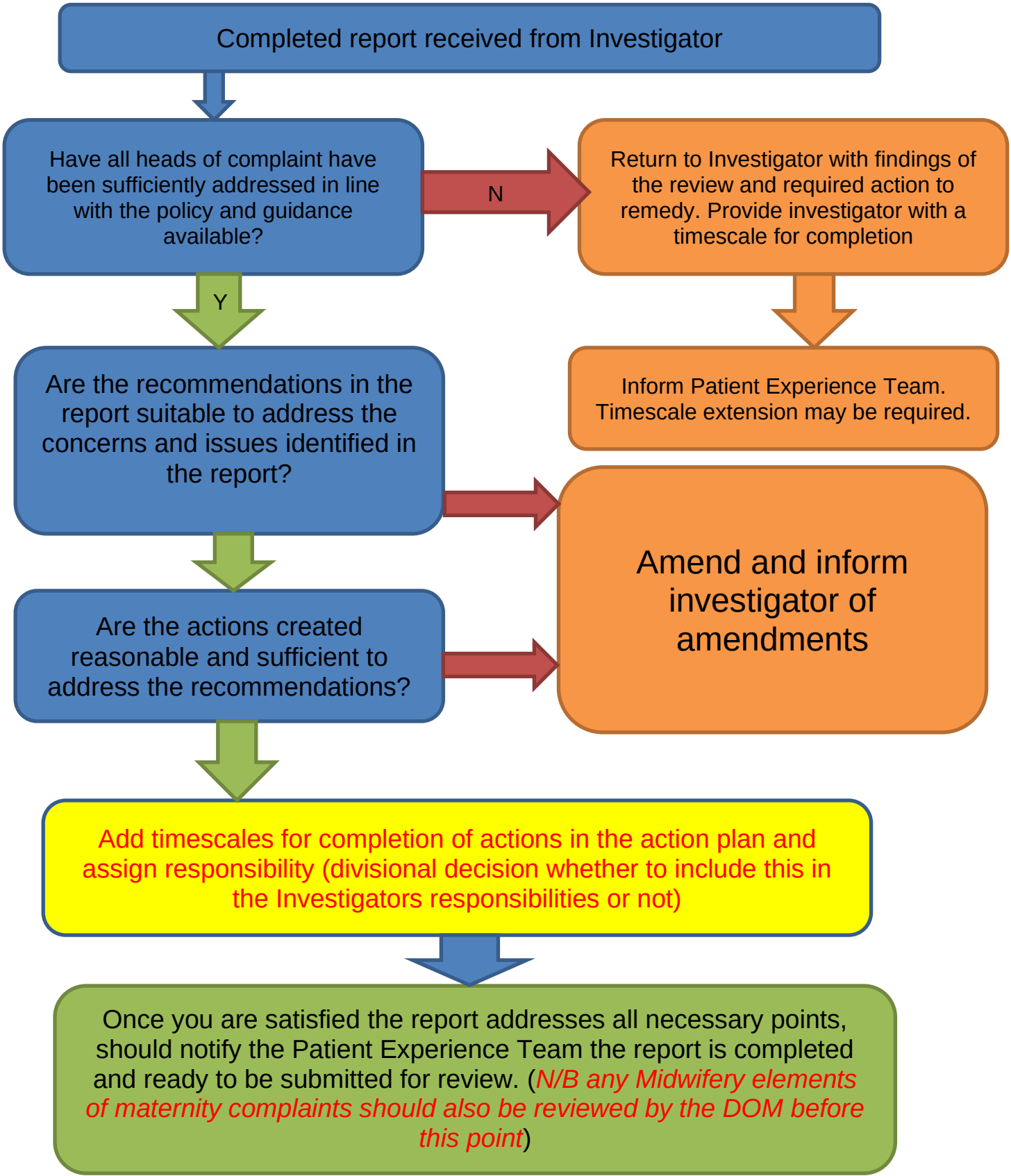
The relevant member of the Triumvirate is responsible for agreeing to the recommendations included in the report only if they are suitable to address the concern.

The relevant member of the Triumvirate is responsible for reviewing and agreeing to the required actions in the action plan to meet the recommendations. *(Timescales*

and responsibilities for each of these actions should ideally be assigned at this stage but can be assigned by the investigator – This is a divisional decision)

Once the relevant member of the Triumvirate are satisfied the report addresses all necessary points, they should notify the Patient Experience Team the report is completed and ready to be submitted for review.

Relevant member of the Triumvirate - Divisional sign off flow chart



9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment			
GDPR			
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	Yes		
External Stakeholders	Cheshire Mersey ICB		
Trust Staff Consultation via Intranet	Start date:		End Date:

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
Policy will be uploaded to the staff Intranet and communicated via Staff Track and the Meditech Bulletin Board	Policy Officer

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
May 2017	1	Deputy Director of Nursing and Midwifery	Policy creation
April 2019	1.1	Policy Officer	New automated template
April 2020	1.2	Deputy Head of Patient Experience	Specific reference made to the PALS + (conciliation) model. Trust reports and specific job titles updated.
May 2023	1.3	Policy officer	Document extended as per fast track request for 6 months
Oct 2023	1.4	Deputy Head of Patient Experience	Simplification of document. Added in specific references from NHS Complaints Standards 2022, including guidance on the "complained about"

9.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Response times for complaints	100%	Performance Report	Patient Involvement and Experience Sub Committee	Monthly	Head of Patient Experience
Action Plans for all complaints	100%	Performance Report	Patient Involvement and Experience Sub Committee	Monthly	Head of Patient Experience

9.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Head of Patient Experience	Patient Involvement and Experience Sub Committee	Quarterly

10 Initial Equality Impact Assessment Screening Tool

Name of policy/ business or strategic plans/CIP programme: **Complaints Policy**	**Details of policy/service/business or strategic plan/CIP programme, etc:** The objectives of this policy are to offer a fair and equitable system, which is non discriminatory and accessible to people of all backgrounds, by which people who are dissatisfied with the service they receive from the Trust have the opportunity to raise their concerns or complaints both formally and informally, and details the steps the Trust will take when investigating any complaints raised, and how and within what timescales the complainant will receive a response.	
Does the policy/service/CIP/strategic plan etc affect (please tick) **Patients** ☐ **Staff** ☐ **Both** ✔		
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	No	The policy applies to any person wishing to make a complaint or raise a concern about the service they have received from the Trust. This policy applies to all protected groups equally, with provision available to enable people from particular groups who may need additional support to make a complaint if required, including the use of interpreters, the provision of information in alternative formats, securing suitable accommodation for any meetings to meet the needs of any person(s) with mobility issues and referral to HealthWatch locally to support any person unable to formulate their complaint themselves (either verbally or in writing) to participate in this process.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	No	Confidentiality around patient information and the complaints process are paramount throughout this policy. Documentation regarding any complaint a patient may have raised is stored separately from their health records, and raising a concern or complaint will not have any
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	Yes	
Any other of the human rights?	No	

		adverse impact on the treatment or care a patient receives. There is provision in this policy for third parties (patient, carer's, next of kin or a Lasting Power of Attorney) to raise a complaint on behalf of a patient who is deemed to lack capacity or is deceased. Having a complaints procedure in place which includes the right for a complainant to be present at some stage during the process, an investigation where needed and includes the right to appeal upholds the 'Right to a Fair Trial' which covers procedures such as this one.
EIA carried out by: Michelle Morgan Quality assured by:	Date 21.05.2020	Contact details of person carrying out assessment Head of Audit, Effectiveness and Experience ext 4230