East Kent Hospitals University
NHS Foundation Trust

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POLICY DOCUMENT

Complaints Management

Version:	1
Author:	Sue Holland – Head of Patient Experience
Approving committee:	Patient Experience Committee
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Director responsible for implementation:	Chief Nurse and Director of Patient Experience and Quality
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Applies to (include subsidiary companies):	All Trust staff and 2gether Support Solutions

We care

Version Control Schedule

Version	Date	Author	Status	Comment
1	26.02.2020	Sue Holland	Ratified	New policy – replacing previous Policy for Management of Complaints, Concerns, Comments and Compliments

Policy Reviewers

Name and Title of Individual	Date Consulted
Amanda Hallums, Chief Nurse and Director of Patient Experience and Quality	10 January 2020
Deputy Chief Nurses	10 January 2020
Care Group Heads of Nursing	10 January 2020
Care Group Governance Matrons	10 January 2020
Phil Elliott, Head of Information Governance	10 January 2020
Patient Experience team	10 January 2020

Name of Committee	Date Reviewed
Complaints and Feedback Steering Group - attendees	10 January 2020
Patient Experience Committee	21 February 2020

Summary of Key Changes from Last Approved Version

Complete re-write to separate complaints and PALS, which also reflects the changes to the complaints process effective 01 January 2020.

Associated Documentation

PALS Policy and Procedure

Risk Management Policy

Raising Concerns (Whistleblowing) Policy

Contents

1. Policy Description

1.1. This document sets out the policy for managing complaints at East Kent Hospitals University NHS Foundation Trust (the Trust) and applies to all staff, volunteers, students, contractors, locums and those on honorary contracts. All staff must adhere to the terms of the Complaints policy.

1.2. The spirit of the Complaints Policy is that all staff are empowered to resolve minor comments, concerns and problems immediately. A key objective of the organisation is the willingness to listen, to change, improve and evolve in response to complaints. The lessons learned and trends identified through complaints play a key role in improving the quality of care received by patients and are a priority for the Trust.

2. Introduction

2.1. It is the objective of the Trust to ensure issues raised by service users are managed promptly, fairly and justly.

2.2. The Trust will ensure the views of patients, relatives and carers are heard and acted upon; this reflects the Trust's values: we want our patients and their families to feel safe, cared for and confident in their treatment. The policy will help support service users who wish to provide feedback or raise concerns. It is the personal responsibility of all Trust staff to act when a complaint, formal or informal, is made to them.

2.3. The Trust recognises complaints as being a valuable tool for learning, improving the quality of health services and a chance to apologise at for any mistakes. Careful handling of complaints is an essential requirement for the Trust; the emphasis should always be on resolution. Complaints are one way of identifying users' perspectives of the service provided; complaints can be an early indicator a service is not functioning effectively. Appropriate trend analysis of the factors which prompted the complaint can provide valuable insight into where improvements may be required. Complaints are intrinsically linked with incidents and claims.

2.4. This policy will demonstrate the expectations complaints will be managed in accordance with changes and lessons learnt as a result of the Francis Report and the Clwyd-Hart review. More recently: *Learning from Mistakes* and *My Expectations* by the PHSO and *Assurance of Good Complaints Handling for Acute and Community Care – a toolkit for commissioners*, by NHS England.

2.5. The Trust will act in accordance with the Care Quality Commission standards and legislation in its management of complaints, with particular reference to:

2.5.1. Regulation 16 – Receiving and Acting on Complaints;

2.5.2. Regulation 20 – Duty of Candour.

3. Definitions

3.1. **Formal complaint:** An expression of dissatisfaction by a patient or their representative which the patient or representative wishes to be investigated in accordance with the Local Authority Social Services and National Health Service Complaints Regulations (2009). A complaint requires a formal investigation and written reply. Complaints can be made verbally or in writing.

3.2. **Patient Advice and Liaison Service (PALS):** This is a service provided by the Trust looking into informal concerns or feedback which can be answered within a short timeframe, all feedback/concerns/actions carried out by this service are known as “PALS”. Use of the word “complaint” should not automatically mean someone expressing dissatisfaction enters the formal complaints process. It may be more appropriate for concerns to be dealt with and resolved in a more immediate and timely manner either by local resolution or through the PALS service. As long as this is agreed with the person raising the complaint, this approach is appropriate.

3.3. **Complainant:** The patient, person, or representative making the complaint.

3.4. **Datix:** The Trust’s database to assist with managing complaints, producing reports and storing complaint information.

3.5. **Gillick Competency:** a young person under 16 who has the legal competence to consent to medical examination and treatment if they have sufficient maturity and intelligence to understand the nature and implications of that treatment.

4. Purpose and Scope

4.1. The purpose of this policy is to explain how the Trust implements the statutory framework for the Local Authority and National Health Service Complaints (England) Regulations 2009.

4.2. Compliance with this policy will ensure the Trust is listening to, learning from and impartially investigating complaints in line with the Regulations and the PHSO’s Principles of Remedy.

4.3. The Trust has a commitment to ensure complainants are treated equally and will not be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation; nor placed at a disadvantage by making a complaint. The Trust aims for all users of its services to have their complaints dealt with

empathetically, respectfully, promptly, confidentially, impartially and with courtesy.

4.4. The Trust will ensure all complaints are understood, investigated thoroughly and in liaison with the complainant, use a method of resolution agreed with the complainant: either a meeting and /or a written response.

4.5. The way we respond to our service users is important in indicating to them how seriously their comments are taken. Good complaints handling and resolution is seen by the Trust as an integral part of its quality work to ensure the highest standard services for local people.

4.6. This policy will:

4.6.1. Ensure appropriate complaints management in line with the Regulations and also the PHSO's Six Principles of Good Complaint Handling;

4.6.2. Act as a reference guide for both staff and service users;

4.6.3. Mandate complaints are acknowledged within three working days;

4.6.4. Ensure the Trust is responding to complaints in line with internal and external performance targets;

4.6.5. Ensure actions are being implemented and monitored arising from complaints;

4.6.6. Ensure any themes from complaints are recognised, learning is undertaken, with appropriate actions being implemented.

4.7. The process for this policy is included in Appendix A.

5. Duties

5.1. Every member of staff has a responsibility for handling complaints whatever their position in the Trust.

5.2. **The Board of Directors** will receive assurance on compliance with this policy and designate one of its members to take responsibility for ensuring compliance with the policy.

5.3. **The Trust's Quality Committee** is responsible for monitoring and reviewing the risk, control and governance processes in the organisation to manage complaints. This is in order to assure the Board of Directors the most efficient, effective, economic risk, control and governance processes are in place and the associated assurance processes are appropriate.

5.3.1. The Quality Committee, which is a sub-committee of the Board, ensures the Trust Board is kept informed on a monthly basis via the approved monthly Integrated Performance Report.

5.4. **The Patient Experience Committee** has responsibility for ensuring the effective communication of complaints themes and trends, actions and learning are shared across the Trust care groups.

5.5. **The Complaints and Feedback Steering Group** has responsibility for monitoring the complaints process, trends, response rates and learning outcomes and reporting to the Patient Experience Committee.

5.6. **Chief Executive Officer (CEO)** is the designated Responsible Officer under Regulation 4 (1) (a) and is ultimately accountable for the quality of care within the Trust. The CEO is responsible for ensuring the implementation of this policy, maintaining an overview of complaints and, in particular, ensuring action is taken in light of the outcome of complaints. The CEO delegates the responsibility for complaints to the Chief Nurse and Director of Patient Experience and Quality in order to ensure patient safety and quality of services are maintained.

5.7. **Chief Nurse and Director of Patient Experience and Quality o**n a day to day basis, the Chief Nurse and Director of Patient Experience and Quality, will take a lead role in ensuring the regulations and process is followed and for the integration between the Trust's complaints function, internal and external governance and assurance processes.

5.8. **Head of Complaints, PALS and Bereavement Services (HCPBS)** will be the designated Responsible Officer under regulation 4 (1) (b) and will routinely manage the complaints process under the guidance of the Chief Nurse and Director of Patient Experience and Quality. The HCPBS is responsible for liaison and co-ordination of the Complaints function, Bereavement Services, as well as the Patient Advice and Liaison Service (PALS). The HCPBS is also responsible for:

5.8.1.1. Compiling regular analytical reports covering themes and trends in complaints received;

5.8.1.2. Board reporting monthly, quarterly and annually;

5.8.1.3. Ensuring that complaints training is available to staff Trust wide;

5.8.1.4. Ensuring the Trust facilitates PHSO investigations;

5.8.1.5. Quality assurance of final complaint responses prior to executive sign off.

5.9. **Care group triumvirate** (senior leadership team) and their Governance teams must ensure the systems and processes outlined in this policy and supporting procedure are in place to manage complaints within their area of responsibility. The care group triumvirate and Governance team is responsible for all complaints involving their area. After the complaint has been investigated and a response made, the care group triumvirate and Governance team will also be

responsible for ensuring any learning and associated action plans arising from the investigation are implemented, and risks identified as a result of complaints are assessed and added to the risk register, if appropriate, in line with the Trust Risk Management Policy.

5.10. **Deputy Head of Complaints, PALS and Bereavement Services (DHCPBS)** is responsible for the day to day operational management of the Complaints team including, quality assurance of responses, manage / oversee complex non-standard complaints. He/she will provide advice and support to the care group Governance teams. The DHCPBS will also be responsible for the monitoring of complaint Key Performance Indicators and reporting on these (via the HCPBS) to the Chief Nurse and Director of Patient Experience and Quality.

5.11. **Complaints Managers** are the first point of contact and support for complainants and the care group Governance teams. They are responsible for day to day case management of complaints, including acknowledging all complaints, production of complaints information and data on to Datix, the Trust's complaints database. They are responsible for daily monitoring, reviewing/amending and chasing of complaint responses.

5.12. **Care Group Governance team** are responsible for investigating a complaint, for arranging any local resolution meetings for the complainant and for ensuring a draft response is written and approved by the Head of Nursing for the care group. They would also become the single point of contact, providing a named individual responsible for liaising with the complainant and the Complaints Managers.

6. Complaints covered by the policy

6.1. A complainant can be a person who receives or has received services from the Trust; or a person who is affected by or likely to be affected by the action, omission or decision of the Trust. A complaint can also be made by a person acting on behalf of someone who:

6.1.1. has died

6.1.2. is unable to complain

6.1.3. has asked someone else to act on their behalf

6.1.4. is a child.

7. Complaints not covered by this policy

7.1. A complaint made by a responsible body (i.e. another health or social care organisation).

7.2. Complaints for patients not associated with the complainant and from whom there has been no signed consent received.

7.3. The complaints procedure is not to investigate matters of a serious criminal nature e.g. accusations of sexual or physical abuse. In such circumstances the Complaints team will immediately highlight the matter with the Safeguarding team, Deputy Chief Nurse or HCPBS to determine the correct course of action, which may involve consideration of a safeguarding investigation and/or direct referral to the Police or appropriate other authority.

7.4. A complaint made by a current or previous employee about any matter relating to their employment.

7.5. A complaint which is made orally and is resolved to the complainant's satisfaction (PALS), see appendix B for the PALS process .

7.6. Complaints about private medical treatment provided in an NHS setting. However, if the patient is using the Trust's staff or facilities, as an NHS patient, they can use the complaints procedure to investigate such specific issues

7.7. A complaint previously investigated and resolved. This includes if the complaint has been investigated by the PHSO or its successor previously.

7.8. A complaint which is being, or has been investigated by a local commissioner under the Local Government Act 1974, or a health service commissioner under the 1993 Act.

7.9. A complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000 or a complaint about out of the Trust's alleged failure to comply with a data subject request under the Data Protection Act 1998.

7.10. A complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services etc. or section 24 (compensation for loss of office etc.,) of the Superannuation Act 1972 or to the administration of those schemes.

8. The different ways a complaint can be made

8.1. Complaints may be made by:

8.1.1. Letter to:

The Complaints team
The Trust Offices
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG

8.1.2. By email to ekhuft-tr.pals@nhs.net;

8.1.3. Via the Trust website using the on-line form;

8.1.4. Verbally, either in person or by telephone; or

8.1.5. To a member of Trust staff outside of the Complaints team - expressions of dissatisfaction may be sent to staff across the organisation for a variety of reasons. Staff should review the issues raised by the patient. These should be resolved at a local level if possible or, if an investigation is warranted as a result of these comments, the communication should be passed to the Complaints team to be appropriately logged as a formal complaint. If staff are in any doubt of the correct action to take, they should contact the Complaints team for advice.

9. Time limit for making a complaint

9.1. Complaints should be made as soon as possible after the event to which they relate. The Trust will investigate complaints made within 12 months of the event or made within 12 months of knowledge of the event/incident complained about. It is important service users feel able to raise issues of concern and every opportunity is taken to respond where it is possible to investigate the facts of the case. The Regulations state complaints outside this time limit can still be investigated if there is a legitimate reason why the complaint was not made earlier and where it is still possible to investigate. The Trust may endeavour to do so, although this may, in some cases, be by addressing the complaint informally (where notes are available).

9.2. Where it has been decided an effective and fair investigation is not possible, the DHCPBS or HCPBS will provide a written explanation of this decision to the complainant.

9.3. All complaints received by the Trust will be acknowledged within three working days.

9.4. The Trust's aim is to investigate and respond to all complaints as speedily and efficiently as possible; the timescale varies depending on the complexity of the issues raised and the time required to investigate.

10. Managing informal complaints

10.1. Complaints may be received by the Complaints team that can be resolved quickly and efficiently, in cases such as these the PALS policy/procedure should be followed. PALS staff and the care group staff should work together quickly to resolve the concerns (see Appendix B).

10.2. When it is agreed to appropriately resolve issues informally, the PALS and/or Complaints team reserve the right to escalate a complaint to a formal complaint if issues are not resolved quickly and efficiently in line with Department of Health guidance.

11. Consent to investigate a complaint

11.1. In cases where a patient representative makes a complaint on behalf of a patient, consent will be obtained from the patient for permission to access/investigate their health records and to release the details of the investigation to the representative.

11.2. Only when consent is received will an investigation into a complaint will be formally actioned. Complaints without consent will be shared with the care group for learning and for them to take any actions as deemed appropriate. These details will not be shared with the complainant without the patient's consent.

11.3. If a patient has died, or is unable to act for themselves (e.g. dementia diagnosis where the clinical team corroborate) the Complaints team must escalate these cases to the DHCPBS, HCPBS or Information Governance team for advice.

11.4. If a patient is unable to consent due to capacity issues, support and advice will be sought from the HCPBS/DHCPBS, Information Governance team and Adult Safeguarding team in conjunction with the clinical team to ensure patient concerns are appropriately investigated.

11.5. If concerns are raised by a care home/supported living, advice will be sought from HCPBS/DHCPBS to ensure concerns are appropriately investigated. These may be raised outside the Complaints Regulations; however, appropriate staff from the care group will be contacted and/or Information Governance team/ Adult Safeguarding team to seek advice on how to proceed.

11.6. Consent will, unless it is not possible be required from a patient with learning disabilities if a complaint is made on their behalf by a relative or friend. In cases such as these where patient is unable to consent, advice from the DHCPBS, HCPBS or Information Governance team must be sought to assess if the complaint has been made in the best interests of the patient and to ensure an appropriate investigation is undertaken.

11.7. When a complaint is made or concerns raised by a patient who has capacity, but who may need additional support through the complaints process, the Complaints team will assist the individual and recommend an advocacy support if appropriate.

11.8. Where a complaint has been made on behalf of a child or young person (CYP), consideration should be given to their age, Gillick competency and whether they meet the Fraser guidelines.

11.9. For young people aged 16 or 17, it is likely the young person can make the complaint themselves if they have the understanding to do so. If the person with parental responsibility raises the complaint on behalf of the young person, consent should be sought from the young person. We will be guided by the Gillick Competence principle.

11.10. MPs may complain on behalf of their constituents without written consent, where the patient has directly contacted the MP. If a third party has approached the MP then written consent is required from the patient.

11.11. It is very important to obtain the patient's or their representative's consent before sharing confidential information with another body or organisation. Consent should be obtained in writing wherever possible. If this is not possible, verbal consent should be logged on Datix by the person receiving it. See consent process Appendix C.

12. Timescales for responding to complaints

12.1. Complaints received by the Trust will be acknowledged within three working days. Written responses to complaints will be provided within:

12.1.1. Thirty (30) days for a complaint which is about one service, clinic or ward within the Trust;

12.1.2. Forty-five (45) days for a complaint which is about two or more services, clinics or wards and/or may require the Trust to obtain information from a body or organisation outside of the Trust, e.g. a GP or community-based service. If a complaint consists of more than ten questions, this would also be given the longer time frame.

13. Complaints involving other NHS bodies

13.1. Complaints about other NHS Bodies and/or social care should be managed by one organisation with the final result being a single response to the complaint involving all parties. This is following the guidance set down by the Kent and Medway Health and Social Care Partnership.

13.2. Normally, the Trust with the most serious or key complaint will take the lead and co-ordinate the response from all parties to the complainant.

13.3. The care group Governance team will identify if any other organisations are required to input into a complaint e.g. GP, South East Coast Ambulance Service or other NHS trust and agree who should lead on the complaint with the other organisations.

13.4. Agreement should be reached early regarding the Trust's responsibilities. Consent must be obtained from the patient to share the complaint and to ensure the complainant agrees to outside organisations to be contacted.

13.5. Details of other NHS bodies requiring input should be shared between the care group and Complaint Manager involved so they have full overview of the plan for the complaint and can accurately respond.

13.6. If the complainant requests a meeting, the care group Governance team will ensure that all other bodies are contacted to be represented at the meeting.

14. Expectations

14.1. Complainants will be provided with a local resolution meeting and/or full written response in order to provide the information to respond or answer the concerns raised. When the Trust concludes information is unavailable, this will be explained in order that all responses are open, clear and transparent.

14.2. All communication with complainants, including written responses, will be explained without clinical or technical jargon.

14.3. If any complainants who need any support to access and help them achieve the best experience of their complaints will be offered appropriate assistance, e.g. translation services.

14.4. All care groups will adhere to the response timeframes and keep complainants informed at all times.

15. Risk assessment grading of complaints

15.1. On receipt of a letter of complaint, the Complaint team will grade each complaint on Datix. This is a risk grading of either low, medium or high in accordance with the Risk Management Policy (which follows the NPSA severity grading). This will help determine the level or nature of investigation required by the care group and will be recorded on Datix. It is the responsibility of the care group's Governance team investigating the complaint to adjust the grading if necessary following the investigation. This assessment will be reviewed by the care group Governance team and/or the Complaints team after the complaint investigation is complete.

16. Investigations

16.1. During an investigation the care groups Governance teams or lead investigator will ask for verbal or written statement from staff involved in the patient's care, they will also access the patient's healthcare records and any Trust electronic systems which may assist.

16.2. If an independent review of a complaint is required, a clinician within the same or corresponding speciality, who is not involved/named in the complaint, will be asked to review the investigation. If it is appropriate or possible the clinician should be based at a different hospital to where the complaint is focussed. If any complainant would like a review carried out by an external expert or clinician to the Trust, this will need to be agreed by all Trust staff involved in the complaint and the expense of this external review met solely by the complainant.

16.3. Staff who are named in a complaint will be given an opportunity to comment on the complaint. Best practice is as follows:

16.3.1. Staff should be made aware a complaint has been made about them. They should be supported by their manager or a senior member of the team, it is recognised personal complaints can be difficult and distressing to staff;

16.3.2. Staff should be given a copy of the complaint to review and consider whilst drafting their response;

16.3.3. Staff should be given access to all documentation required, such as healthcare records and all electronic systems;

16.3.4. The contents of the response should be shared with the staff member at the end of the process and any learning, action/reflections discussed and documented;

16.3.5. Staff should, in line with their professional registration, use the complaint for reflection and as part of revalidation/appraisal processes.

17. Local resolution meetings (LRM)

17.1. Complainants have the right to request a meeting and, in some cases, it may be pertinent to offer a meeting in the first instance. There are some considerations to be made when a meeting is being considered:

17.1.1. Complainants preference for a face to face meeting; the Complaints team will flag if a meeting is considered more appropriate, or has been requested, when they send the complaint to the care group. The care group should consider the request fairly, considering the individual's requirements.

17.1.2. Complainants may request a meeting due to a disability: these requests must be given due consideration and generally the meeting should be agreed by the care group.

17.2. When a meeting is agreed, the care group should make sure the Complaints team are aware of the plan and any associated information. Details of the meeting this should be relayed to the complainant via the care group Governance team, with any agenda items agreed before the meeting. Guidance for LRM is noted in Appendix D.

17.3. If the meeting is likely to be contentious, staff from the care group Governance team or an appropriate senior staff member from the care group will attend to help facilitate, chair or to assist resolution.

17.4. Meetings may be recorded, if agreed by all parties. These recordings are used to help staff formulate their written responses and at times may, with permission, be used by the care groups for training purposes or highlighting concerns for consideration. Recordings will be saved to the electronic complaint file. CDs of recordings may be provided for complainants to collect from one of the Trust's PALS offices by prior arrangement. It is not acceptable for any attendee at the meeting to covertly record the meeting.

17.5. In the cases of bereavements or complex cases, a meeting should be considered if this will offer a more compassionate forum, for example to outline the history of the patient, particularly when dealing with bereaved families. This may not always be accepted or be preferable but it is good practice in cases such as these to consider the best way to share the outcome of the investigation.

17.6. Complainants may ask for a written response and then make it clear early on in the process they also expect a meeting to follow.

17.7. The Trust has a duty to its staff and takes this very seriously. If a meeting is requested that may put staff at risk of abuse or harassment under any guise, then the requests for the meeting can be refused. An explanation to the complainant will be provided in writing by the Chief Nurse and Director of Patient Experience

and Quality. This decision will be final and will not be taken without consultation with the Complaints team or the care group's Governance team.

17.8. If a particular staff member is complained about and the complainant requests that person to be present it is generally inadvisable to meet this request. The hierarchy of staff should be considered and the staff member's line manager should attend. This can help to diffuse difficult or challenging meetings and can help during discussions with a focus on resolution for the Trust, rather than one person being the focal point.

17.9. Following the meeting, a letter must be sent to the complainant within 20 working days. Care groups are expected to produce a written overview of the discussions and actions to share with the complainant. This response should be an outline of the meeting and discussion overview, rather than a full transcription or 'minutes' of the meeting. This will act as both a record the meeting took place and also to allow the complainant to go on to the second stage of the process, to refer their concerns to the PHSO, if required. It is also is required to formally close the complaint. The PHSO mandates a recording of the meeting, with a covering letter to the complainant, is not a sufficient record of the meeting.

18. Responses

18.1. All draft responses must include the following items, as required in Regulation 14 - Responding to a Complaint section:

18.1.1. An apology for having to make a complaint

18.1.2. An explanation of how the complaint has been considered and investigated

18.1.3. The lead investigator (must not be involved in the complaint and relevant in terms of position, e.g. Clinician, Head of Nursing, Deputy General Manager etc)

18.1.4. Full answers to specific questions raised; an explanation of events and if applicable information from the staff involved.

18.1.5. Appropriate and quantified apologies for any errors or wrong doings by the Trust services or staff.

18.1.6. Details of actions or remedial action as appropriate, which may include reviewing or changing a decision on the service given to an individual complainant; revising published material; revising procedures to prevent the same thing happening again; training or supervising staff.

18.1.7. Details of any pending or work in progress improvements to services.

18.1.8. Confirmation any outstanding treatment complained about has been considered as part of complaint

18.1.9. Advice on redress for direct or indirect financial loss, loss of opportunity, inconvenience, distress or any combination of these. (Redress process)

18.1.10. Details about the role of the PHSO and their contact details.

18.2. Where actions are identified from an investigation these will be logged on to Datix by the care group Governance team. If actions are pending, the care group will provide the Complaints team with updates on Datix as an audit trail of changes made as a result of complaint to evidence learning.

18.3. The outcome of a complaint will be recorded on Datix, as determined by the Regulations: upheld, partially upheld or not upheld.

18.4. A quality assurance process will be followed by the Complaints team. Appendix E.

19. Learning from complaints

19.1. An inherent part of complaints management is ensuring lessons are learnt and action is taken to improve services. The Trust will use any comments, compliments, PALS and complaints received to:

19.1.1. Identify what is working well through compliment trends through shared good practice.

19.1.2. Help identify potential service problems through trends in concerns raised as an early warning system.

19.1.3. Highlight potential system failures and/or human error to identify a need for improvement.

19.1.4. Provide the information required to review services and procedures effectively, to respond to requests for patient experience data for service reviews/evaluations.

19.2. By listening to feedback, the Trust can identify ways to improve the way in which things are done. The Trust records whether or not the complaint has been upheld, partially or in full, so learning can be focused on where there have been service failures of any kind.

19.3. Following the closure of a complaint, actions arising from it will be reported within the care group responsible for ensuring actions are completed through their governance reviews. The Complaints team will report on actions and outcomes within the quarterly report.

19.4. The care group Governance teams will also monitor any action plans provided to ensure they are carried out, showing learning through the Complaints and Feedback Steering Group.

19.5. Key issues identified from any investigations carried out by the PHSO are shared in the quarterly report and provided to the Quality Committee, Patient Experience Committee and the Complaints and Feedback Steering Group.

19.6. An annual report will be prepared for circulation within the Trust and is publicised on the Trust's website. The report will specify:

19.6.1. The number of complaints received by the Trust in the period;

19.6.2. The number of complaints acknowledged in three working days;

19.6.3. The timescales complaints were responded to within agreed timescales;

19.6.4. The number of complaints the Trust considered were well founded;

19.6.5. The number referred to the PHSO;

19.6.6. The subject matter of the complaints received;

19.6.7. Any matters of general importance arising out of those complaints or the way in which they were handled;

19.6.8. Action taken to improve services as a consequence of those complaints.

20. Confidentiality and record keeping

20.1. Staff must comply with the Trust's Information Governance policies in all matters relating to the handling of complaints.

20.2. Records of formal complaints will not be held in any patient's healthcare records. Complaints will be stored electronically within Datix and the Trust's servers, accessed by the Complaints, PALS and Bereavement Service Department and the care group Governance teams.

20.3. Staff must not discuss complaints with patients or their carers during clinic appointments or inpatient stays.

20.4. Complaint details will not be held in staff personal files unless in relation to a disciplinary matter.

21. Staff support

21.1. Receiving and investigating complaints can be stressful for staff to deal with. Complaints that involve whole teams or services can impact greatly on those

involved. There are services available to help and support staff; in the first instance advice and support should be sought from the staff member's line manager. It is the expectation that the Lead Investigator will identify when a complaint may impact on staff and to advice appropriately on support available.

21.2. The health and well-being pages on Staff Zone detail support available to staff. The Occupational Health department can also offer support and outline resources available: Tel: 01227 864206 or email occupationalhealth.kch@nhs.net

21.3. Staff may also wish to obtain support from the professional organisation or trade union.

22. When complaints cross other processes

22.1. Complaints are a key part of the overall governance framework and as such work with and alongside other governance processes. Complaints can be part of an existing:

22.1.1. Claim

22.1.2. Inquest

22.1.3. Incident/RCA/Serious Incident

22.1.4. Police investigation

22.1.5. Social services investigation

22.1.6. Human Resources investigation

22.1.7. Safeguarding investigation

22.1.8. Allegation

22.2. It is key when logging a complaint, to check on Datix to see if the complaint is linked to any other investigation (Datix will allow links to claims/incidents/PALS). If a dual process is identified, a link should be made on Datix.

22.3. The complaint may form part of an existing investigation or as a result of a complaint, an incident may be logged. It is important to triangulate with the Patient Safety and Safeguarding teams to link issues covering more than one area and agree a way forward. These links may extend to outside the care group but are key in the management of such cases.

22.4. Multiple investigations are not required, linking one process with another is key to manage this appropriately with staff and to minimise duplication.

22.5. If a complaint is made and part of that complaint is an incident, subject to an SI (Serious Incident) or AAR (After Action Review) or RCA (Root Cause Analysis)

investigation, then the Complaints team will inform the complainant of this and the complainant may proceed to remove this item from the complaints process. A note should be made of this on the file and then to proceed to investigate as a complaint all other issues not covered in the SI/AAR/RCA investigation. By managing the complaint this way, duplication and errors can be minimised, with the patient being the focus throughout.

22.6. The Complaints Manager and Head of Patient Safety should keep one another informed of progress to ensure a joint approach with the complainant being properly updated throughout.

23. Managing difficult/challenging complaints

23.1. The Trust is committed to dealing with all complainants fairly and impartially and to providing a high-quality service. However, we do not expect our staff to tolerate abusive, offensive or threatening behaviour, or which makes it difficult for us to consider complaints. This policy explains how we will manage such behaviour.

23.2. It is important we are able to communicate with someone bringing a complaint to us so we can make sure we fully understand it. We therefore do not normally limit the contact that people have with us.

23.3. We do not expect our staff to tolerate any form of behaviour considered abusive, offensive or threatening, or that becomes so frequent it makes it more difficult for staff to complete their work or help other people. We will act under this policy to manage this type of behaviour and this applies to all contact made with us, including the use of any social media platform.

23.4. We will make reasonable adjustments to ensure our service is accessible to everyone. It is important we provide a safe environment for our staff to work in, which may mean we decide to restrict how someone can contact us.

23.5. At all times, if the complainant is a patient, their health care needs will continue to be addressed. Any complainants who are patients will not be discriminated against in any way. It is important, however, to identify the stage at which a complainant has become unreasonable/disproportionate and for action to be taken accordingly.

23.6. We will usually only act to restrict someone's contact with us after we have considered whether there are any other adjustments we could make to prevent unreasonable behaviour from occurring. Any restrictions imposed will be appropriate and proportionate. The options we are most likely to consider are:

23.6.1. asking for contact in a particular form (for example, email only);

23.6.2. only allowing contact with a specific members of staff or at specific times;

23.6.3. asking the person to enter into an agreement about their future behaviour; and/or

23.6.4. actions designed to specifically meet the needs of the person.

23.7. In all cases we will write to tell the person why we believe their behaviour is unreasonable, what action we are taking and how long that action will last. We will also tell them how they can challenge the decision if they disagree with it. If, despite any adjustments we have made, a person continues to behave in a way which is unreasonable, or disproportionate, we may decide to end contact with that person.

23.8. There will be occasions where we decide that a person's behaviour is so extreme that it threatens the immediate safety and welfare of our staff or others. In these instances, we will stop all contact immediately, reporting what has happened to the Police or taking legal action. In such cases, we may not warn the person before we do this.

23.9. We may consider behaviour to be unreasonable or disproportionate if a complainant:

23.9.1. Continues pursuing a complaint when the Trust's complaints procedure has been fully exhausted.

23.9.2. When new issues are constantly raised and/or added to prolong contact or when the substance of a complaint is changed significantly. This can include raising further concerns when the investigation is still ongoing, or raising further issues on receipt of a complaint response. This behaviour must be evidenced as outside the normal part of the process and must be seen as disproportionate to consider this policy.

23.9.3. Complainants who display unreasonable demands or expectations or fail to accept these may be unreasonable when a clear explanation is provided, which may include documented evidence. This can include when complainants continue to question minutia taking up a disproportionate amount of time.

23.9.4. Complainants who do not identify clearly the specific issues they wish to be investigated. This can include failure to agree a scope despite reasonable efforts by the Complaints team.

23.9.5. Complainants who dictate how the investigation will be carried out disregarding current practice or regulations.

23.9.6. Complainants who have harassed or bullied staff.

23.9.7. Where physical violence has been used or threatened towards staff.

23.9.8. Complainants have, in the course of registering their complaint made an excessive number of contacts to the Trust in person, telephone, letter or email.

23.10. At all times if the Trust consider a person's behaviour is unreasonable the Trust will tell them why and will ask them to change it. If this behaviour continues, the Trust will act including deciding whether to restrict the person's contact with the Complaints team. This decision will be taken by a Deputy Chief Nurse and Head of Patient Experience.

24. Redress

24.1. Redress is very important in resolving complaints and should be considered early on the complaints investigation. The concept behind redress is to financially reimburse the patient back to the point before any costs were incurred due to the reasons behind the formal complaint. In these cases, refer to the Redress Procedure appendix F.

25. Withdrawal of a complaint

25.1. If a complainant withdraws a complaint at any stage of the procedure, the staff member of service complained about should be informed immediately. The complainant should also be sent a letter by the HCPBS / DHCPBS confirming the decision to withdraw the complaint. Any identified issues should still be followed up within the care group and any learning cascaded to staff.

26. Unresolved complaints

26.1. Once a response letter has been sent from the CEO, or delegated signatory, the complaint is closed.

26.2. It may not be possible to resolve a complaint with a first response. Complaints can be re-opened if there is evidence the original issues raised have not been addressed. Any further investigation and letter should follow the process flow as for the original complaint. If the complainant makes comments on the Trust's final response, requests further information, access to health records or makes other enquiries without additional complaints, it will be regarded as a continuation of the previous complaint.

26.3. The Complaints team will re-open the complaint and ask the relevant care group for a further investigation. At this stage, a face-to-face meeting may be more helpful, if the complainant agrees.

26.4. If, after a second letter or meeting, a complainant remains dissatisfied options available are:

26.4.1. If further investigation will provide any new information, this should be provided in writing.

26.4.2. If there is no further information or anything to add to previous meetings or letters, the complainant should be advised. If the complainant remains unhappy, they should approach the PHSO.

26.4.3. If an independent view of a complaint is required, a clinician within the same speciality, not involved in the complaint, from another of the Trust's sites will be asked to review the investigation.

26.5. The commissioning of an external for exceptional or complex cases can be considered. This would be at the sole expense of the complainant.

27. Parliamentary and Health Services Ombudsman (PHSO)

27.1. The PHSO independently reviews NHS complaints. They can only review the complaint if it has already been raised with the organisation or practitioner concerned and if the complainant is dissatisfied with the resolution process. The PHSO is completely independent of the NHS. The PHSO will only consider complaints, which have been through the NHS complaints procedure. There is no appeal against a decision made by the PHSO.

27.2. Before the PHSO accepts a complaint for review, they will wish to be satisfied all reasonable attempts have been made to resolve the complaint at a local level. Further information can be found at: www.ombudsman.org.uk

28. Media and press

28.1. Complaints must be dealt on a strictly confidential basis. However, some may come to the attention of the media through the actions of complainants, staff or unconnected third parties. The communications team should handle all media communications.

28.2. In all cases where a complainant or third party advises they will be seeking attention from the media, the communications team should be alerted immediately. This should also include any action to, or if staff are aware social media has been used to share details of the complaint.

29. Policy Development, Approval and Authorisation

29.1. Head of Patient Experience has written the policy it has been approved by Patient Experience Committee.

29.2. This policy will be ratified by the Policy Authorisation Group.

30. Review and Revision Arrangements

30.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

30.2. It will be ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with section 9.3 of the policy for the Development and Management of Trust Policies (and other Procedural Documents).

31. Policy Implementation

31.1. Refer to Appendix H.

32. Document Control including Archiving Arrangements

32.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

32.2. This policy will be uploaded to the Trust's policy management system.

32.3. The Policy for Management of Complaints, Concerns, Comments and Compliments, which this document supersedes, will be retained within the Trust's policy management system for future reference.

33. Monitoring and Assurance

33.1. The following table outlines the monitoring arrangements in place for the management of complaints:

Policy Objectives	Monitoring methods	Assurance
Compliance with the complaints regulations	Annual report/Quarterly report	Monitoring outcomes Monitor reopen complaints Monitoring PHSO referrals and findings combined with actions
Complaints managed in line with the complaints process; notably: • Initial acknowledgement sent within three working days • Methods of response will be agreed with the complainant • Timescales for response to formal complaints are set and adhered to • Levels of investigation appropriate to complexity of complaint • Investigations competed within the agreed timescales • Internal and external communication and collaboration with other organisations will occur	Reported monthly to Quality Committee	Quarterly reporting Annual report Weekly report monitoring numbers of incoming complaints, closures and response times.
The Trust has a process by which it aims to make changes as a result of formal complaints	Learning from complaints, Actions log, feedback.	Actions reviewed in quarterly report.
Cases referred to the ombudsman will be reviewed to learn lessons about how to manage the process better	Final reports to be discussed in the Complaints and Feedback Steering Group.	Review numbers, outcomes, share reports with care groups, monitor action plans.
All complaints risk graded “orange” or “red” on Datix and where the subject of complaint has experienced moderate to severe harm have had an RCA carried out and a report produced	Triangulate with patient safety team and work collaboratively across Quality and Assurance	Ensure complaints, incidents, claims are linked on Datix to demonstrate collaborative working

Policy Objectives	Monitoring methods	Assurance
Where necessary, initial and on-going support is offered to staff involved in/with a complaint	Liaise with care groups over complex, sensitive or contentious complaints	Follow up with care groups if concerns raised regarding specific departments and/or staff
There will be addition of appropriate risks identified from complaints to the relevant risk registers to enable the implementation of risk reduction measures where necessary.	Risks to be escalated to the Chief Nurse and Director of Quality	Advice sought from Chief Nurse and Director of Quality if added to risk register
Complaint reports, according to minimum requirements, including learning the lessons from complaints.	Monthly report to Quality Committee	Chief Nurse and Director of Quality/Quality Committee oversight
The Trust communicates lessons between healthcare organisations	Oversight of joint cases by DHCPBS/HCPBS NHS and Social Care Complaints Manager Forum	DHCPBS/HCPBS to review
Complaints Handling in the NHS training	Training programme to be set up and monitoring of care group attendance	Attendance records

34. References

2009 Complaints Regulations

CQC KLOEs

PHSO Principles of Remedy

PHSO Unreasonable Behaviour Policy

PHSO Redress policy

Learning from mistakes

My Expectations

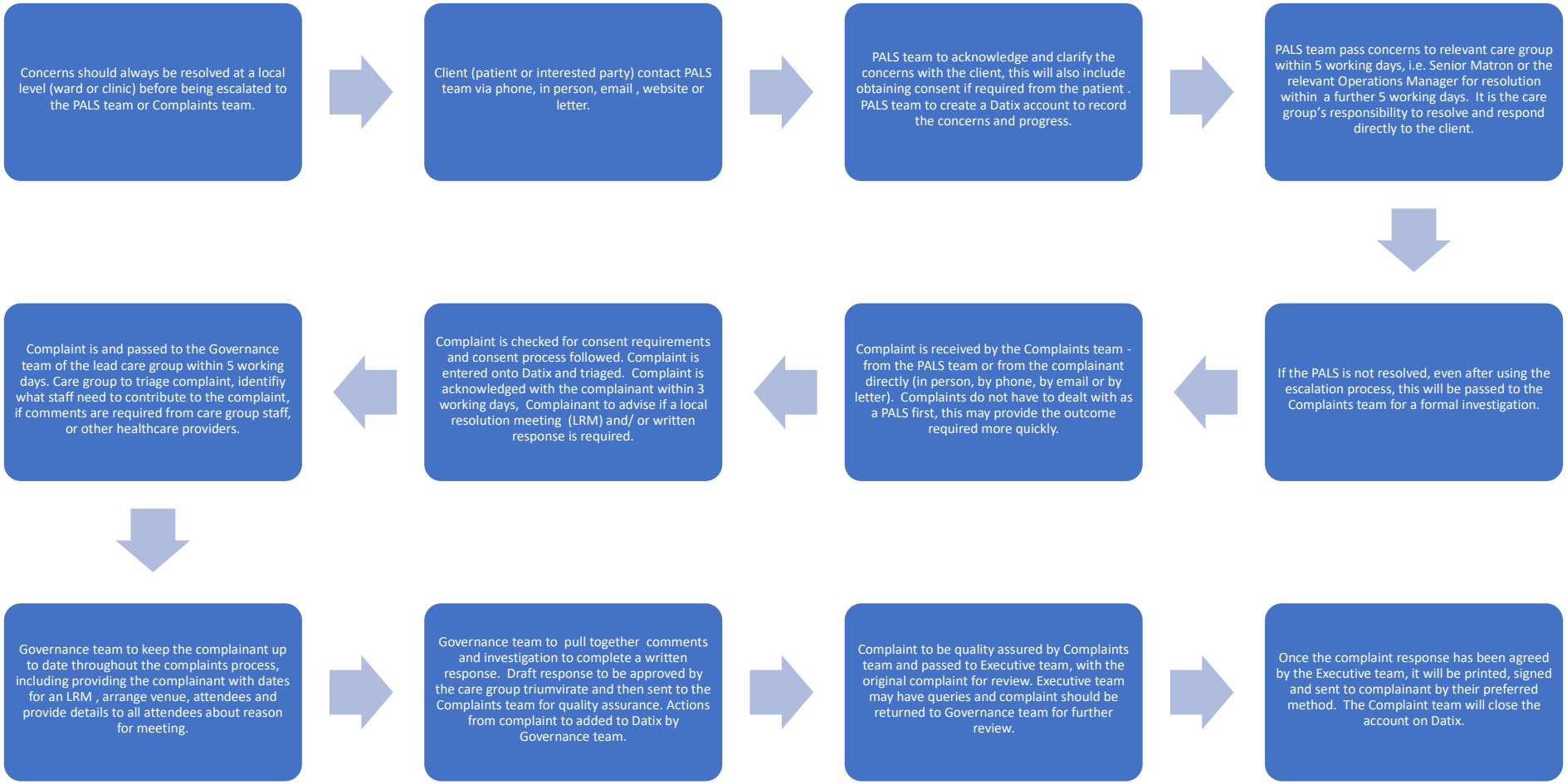
Assurance of Good Complaints Handling for Acute and Community Care – a toolkit for commissioners, NHS England

35. Appendices

NHS
East Kent
Hospitals University
NHS Foundation Trust

Appendix A – Complaint process

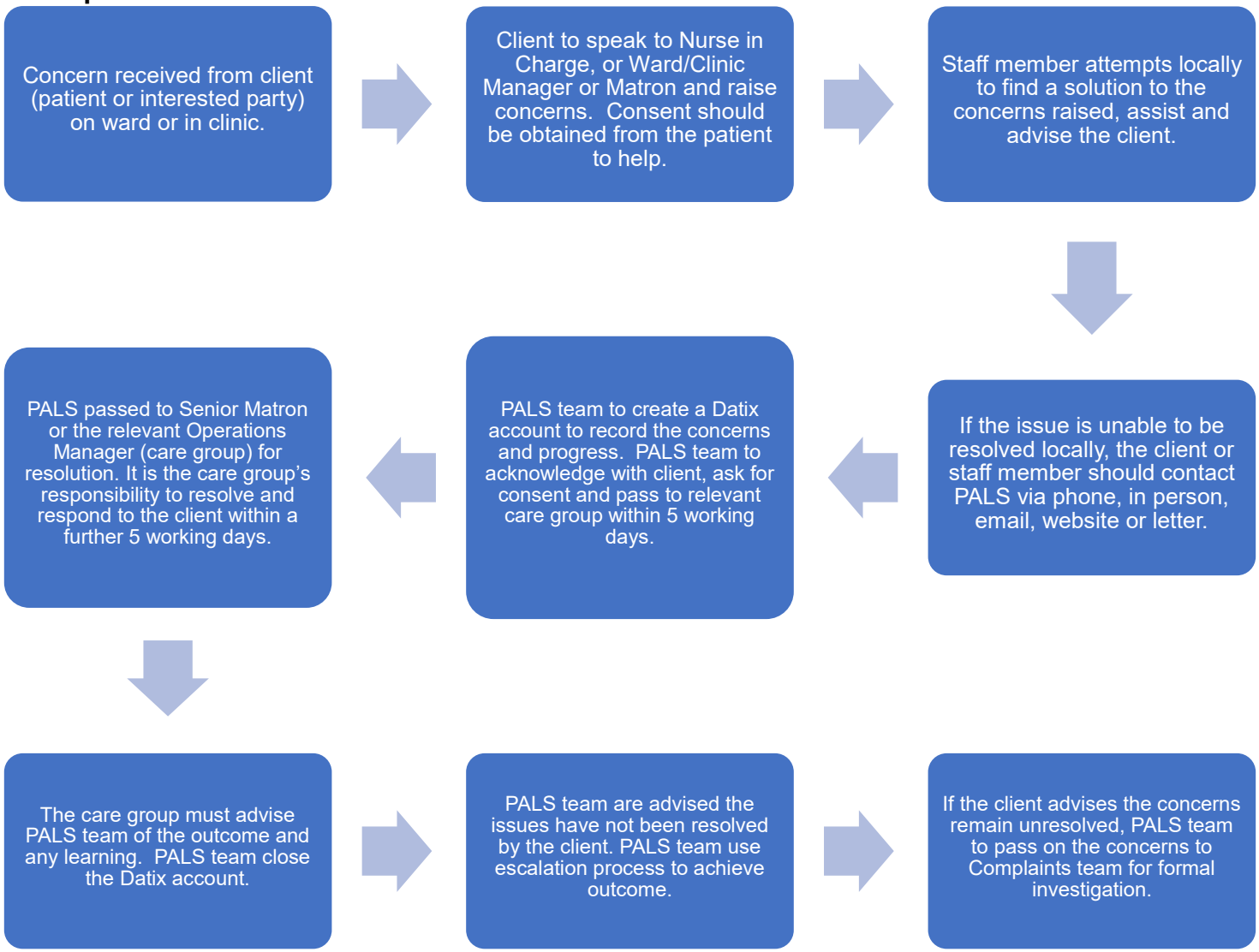
Complaints Process



We care

Appendix B – PALS process

PALS process on ward or on clinic



Appendix C – Consent process

In order to be able to respond to complaints the Trust may need consent of the patient, if the complaint is from another person than the patient, or information will be required from another Trust or healthcare provider.

In order for the Trust to investigate a complaint the Trust will need to access the patient's health records and share this information, reassurance must be obtained that the person asking for the information has a right to receive it and evidenced that if they are not the patient they have the authority of the patient to act on their behalf.

For patients who are deceased 'consent' from the Personal Representative (PR) of the deceased must be obtained; this will be a person or solicitors named in the Grant of Probate or Letters of Administration. Alternatively information limited to that already within the knowledge of the complainant can be shared with the complainant.

Responses to complaints can be provided without patient consent if there is no patient information being shared, such as details about care and treatment. As an example, generic information about the process for triaging patients can be shared, but not how a particular patient was triaged or what the outcome was for them.

In complaints where consent is required the 'clock' on the complaint will not start ticking until the date 'consent' is received. Complaints will be sent to the care groups as a 'heads up' only. Draft responses cannot be finalised by the care groups until consent has been received.

For audit purposes it is ideal to obtain written consent from the patient, however, there may be circumstances where this is not practical and then a decision should be made by the Head or Deputy Head of Complaints, PALS and Bereavement Services and that decision will be updated on Datix

Consent is required if:

- The complainant is not the patient. If the patient is able to sign a consent form this should be obtained, if the client is unable to sign, but is able to give verbal consent this should be taken.

- If the complainant does not have capacity and there is no Power of Attorney for Health and Welfare, then we will take an individual view. In this case the Head or Deputy Head of PET must be asked for advice.

- If the complaint has come from an MP there is implied consent, unless the complainant is not the patient. In this case patient consent must be obtained, unless the patient is unable to provide consent – see above.

- If the patient is deceased, the situation must be handed sensitively. In most cases consent will be required. For difficult or sensitive situations the Head or Deputy Head of PET must be asked for advice.

- If the patient is 13 years old and over consent should be obtained, unless they do not have capacity, or their health needs mean this is unachievable (advice from clinicians will be taken)

In all cases, if it is going to be difficult to obtain written consent and verbal consent can be obtained. Please note the time and date this was given and to whom on Datix.

Outline:

Consent is asked for at the start of the complaint; if, after four weeks has elapsed and consent of the patient has not been provided, we will ask again in writing for consent and allow a further four weeks. If, after this, no consent has been provided a further letter/email is sent to advise the complainant if consent is not received within ten working days, the complaint will be closed (it can be re-opened once consent is received).

Process when consent received:

- On receipt of consent, check all parts of the forms are completed and all information has been provided.
- On Datix web, select the patient and go into the consent tab.
- Fill in the date consent received box and save.
- Select complaint / PALS / Compliment ref and key dates tab
- Remove the acknowledged and action done dates (but remember what dates they were) and change the date received date to the date consent was received and click save.
- The dates should have changed and then re-input the done dates back in. Check the response date is correct – if this is 45 days, change to that date.
- Change current stage to Local Resolution and save.
- Email care group to confirm consent has been received and advise of timescales.
- If external comments are needed, email to them with the full complaint details and a copy of the consent and give timescales.
- Confirm with client that consent has been received and that we will respond in the 30/45 day timescale.
- Save documents to word and Datix web.
- Click Progress / Notes (Complaints and PALS)
- Change Reminder from AWAITING CONSENT to DRAFT
- Change reminder date to the date the draft is due in and add a new note with the update and timescales.

Appendix D – Local Resolution Meeting guidance

Under the Complaints Regulations complainants can ask to have a meeting to discuss their concerns; this is a Local Resolution Meeting (LRM).

A local resolution meeting could be held at different stages of the complaints process, more often meetings would be recommended in complex complaints, or if a complainant is unhappy with the first response received from the Trust. The focus for a local resolution meeting is on the outcome for the complainant in terms of resolving the complaint. These meetings are sometimes the last opportunity to resolve a complaint before it may progress to the Parliamentary and Health Service Ombudsman (PHSO). It is also an opportunity to win back the trust and confidence of the complainant, as well as repair the Trust's reputation and to provide assurance and transparency in the Trust's complaints management.

Good practice in relation to the outcomes from a local resolution meeting should focus on:

- the complainant felt the complaint hand been handled fairly;
- the complainant feeling the meeting and written response directly addressed the elements in their complaint and any systemic concerns raised;
- the complainant being reassured matters will be put right and prevented from reoccurring in future;
- the Trust understanding how they might be able to improve their complaints processes in future;
- the complainant had confidence in the complaint handling procedure and the outcomes produced;
- the complainant was made aware of any improvements or changes in practice as a result of their complaint;
- the Trust providing an open and transparent account of the complaint investigation;
- the Trust to understand how the investigation had not met the needs of the complainant and to take further action that may be agreed.

Well managed local resolution meetings are chaired by a member of the Governance team or a senior member of staff from the care group. Staff attending should prepare in advance of the meeting. Pre-meetings should also be arranged with the staff in attendance.

It should not be underestimated how intimidating and daunting it can be for a complainant to attend such a meeting. With this in mind a number of considerations must be made prior to the meeting and during the set up for the meeting, including:

<u>Chair of the meeting:</u>

- The chair of the meeting should ask for permission for an audio recording to take place. Minutes are not verbatim; staff are unable to bear witness to what has been said in a meeting.

- Meetings should be recorded on Trust recording equipment only. If a recording device is unavailable a member of staff attending the meeting should take notes, which should be verified by all in attendance after the meeting.
- Attendees should be asked to introduce themselves.
- If the meeting is likely to be contentious the chair should ask all attendees to allow each participant the chance to speak and for one person to speak at a time. This is especially important for the recording.
- The chair of the meeting should advise how long the meeting has been convened from and watch time keeping.
- Listen carefully. Confirm the complainant's concerns and the issues to be investigated.
- Ask the complainant what they want to achieve. Can it be resolved straight away?
- If appropriate, manage expectations and explain what is possible.
- The chair should advise the complainant and staff that they can ask for clarification on points raised.

<u>Staff attending the meeting:</u>

- Come prepared for the meeting, understand the concerns and the patient's history.
- Listen carefully.
- Avoid medical or technical jargon – explain any phrases or words if they have to be used.
- Answer the complainant's concerns you are able to and the issues you will need to further investigate after the meeting.

<u>During the meeting:</u>

- People in the meeting will introduce themselves.
- If any attendees feel over whelmed at any stage, a short break should be provided.
- The complainant should be informed of any actions agreed and what happens after the meeting, including timescales.
- The complainant should be asked if they would like a copy of the meeting recording, which can be picked up from their local Trust PALS office by prior appointment only.
- Attendees should be open about the right of the complainant to approach the PHSO if they remain dissatisfied

<u>After the meeting:</u>

- A letter from the chair of the meeting should be written to reflect the meetings and discussions, along with any identified actions. Anything that needed to be confirmed, or further investigated should be included. This should be ready and provided to the client within 20 working days of the meeting. The care group letter should be sent to the Complaints team for quality assurance and approval from the Executive. This letter will be sent with a covering letter from one of the executive team.
- Once the letters are sent to the complainant the complaint will be closed.

LRM checklist for staff organising an LRM

Before meeting:

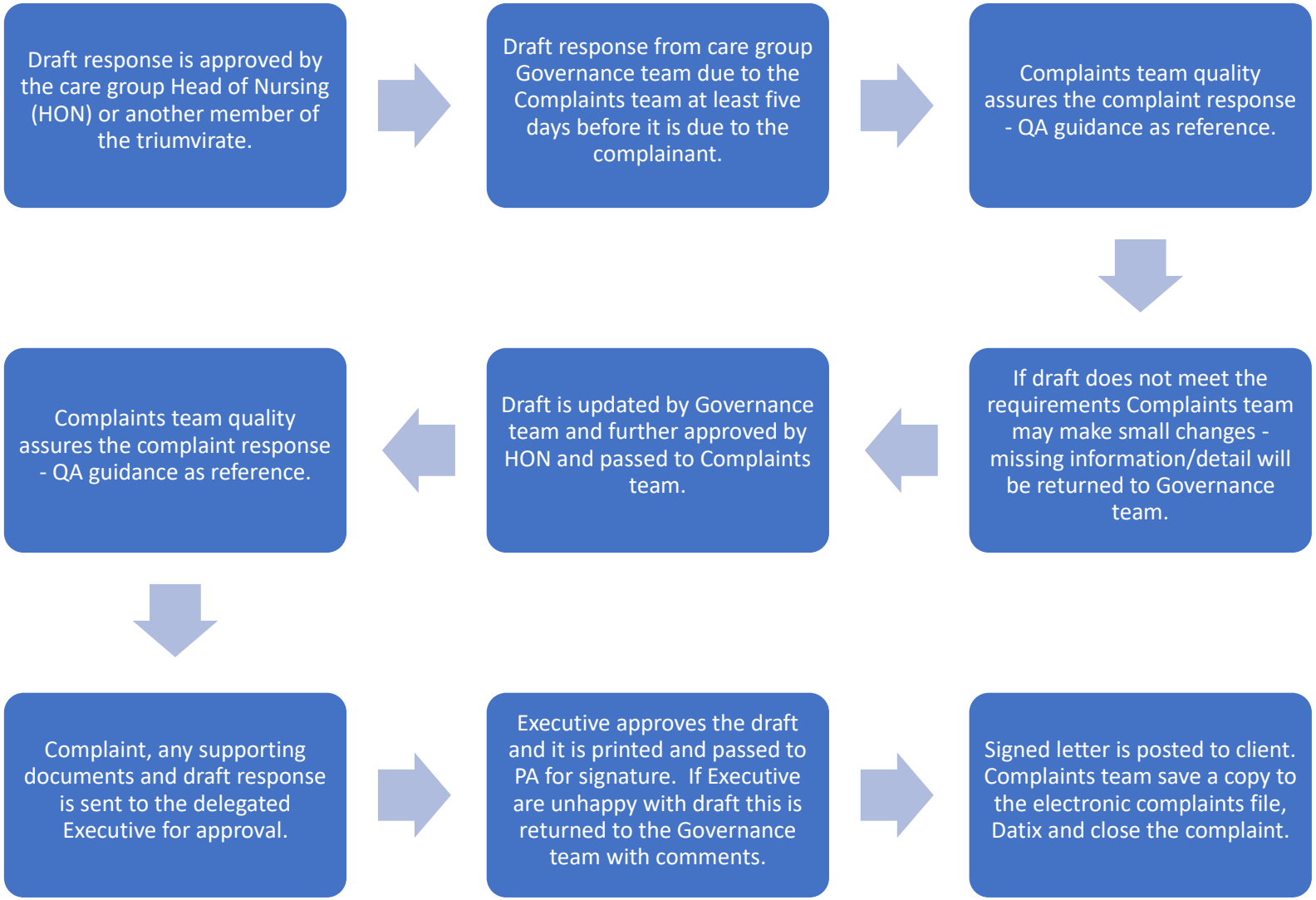
- Obtain the complaint and print out any information pertinent to the meeting.
- Obtain medical records.
- List and check the people who need to attend (staff and complainants).
- By phone/email obtain several dates/times when complainant and staff can attend.
- By phone/email ask complainant to provide a clear agenda outlining specific issues (ideally a week in advance of meeting).
- Are any additional family members attending?
- Does the complainant have/need a seAp Advocate, if not then provide details to complainant again.
- Does the complainant have access/travel issues?
- Agree a venue suitable to both complainant and staff – usually the hospital site the complaint concerns.
- Does any equipment need to be booked e.g. digital recorder/laptop?
- Confirm in writing meeting details to complainant (include attendees and titles, venue, time and duration).
- Confirm in writing to staff - including relevant previous correspondence (include attendees, venue, time and duration).
- Arrange pre meet with staff – ideally with agenda and allocate agenda points to staff attending.

After the meeting

- Confirm actions and their ownership – ensure staff who need to follow up concerns know the timescales they are working to.
- Write response letter confirming any actions being taken and send to the Complaints team.
- Update Datix with actions arising from the meeting.
- Seek feedback from staff who attended in terms of management of meeting – also provide feedback to staff in terms of their contribution.

Appendix E - Quality Assurance process

Quality assurance process



Appendix F – Managing Claims for Financial Redress Process

Glossary of terms

Term	Definition
Deciding on the balance of probabilities	Determining whether it is more likely or not that an alleged event or incident occurred
Ex gratia payments	Sum of money paid voluntarily, without any legal requirement to do so
Extra-statutory payments	Sum of money paid over and above that covered by statute (but within the scope of the legislation's broad intent)
Financial Redress	Money paid as part of redress. This may include sums to recompense for extra costs incurred and/or sums to recognise the impact of poor service on the customer.
Maladministration	The term used to describe when our actions or inactions result in a Patient experiencing a service which does not match our aims or commitments
Redress	Remedy for a wrong or a grievance, which can include any combination of an apology, an explanation, putting things right and a financial payment

1. Introduction

1.1 When dealing with complaints or the findings of other related investigations, the main purpose of East Kent Hospitals University NHS Foundation Trust (Trust) is to remedy the situation as soon as possible and wherever possible, to ensure the individual is satisfied with the response and feels that they have been fairly treated.

1.2 However, the Trust accepts that there may be occasions when mistakes will cause additional expense, financial loss, inconvenience or distress to the individual service user and/or their carer. This policy is concerned with the circumstances in which financial remedy may be considered, and the related governance processes.

1.3 Some services are now commissioned on behalf of the Trust from independent and third sector providers. In these cases, the Trust still has an organisational responsibility for the service being provided[1] (see Sections 9 and 10).

1.4 Redress relates to financial redress as a result of maladministration only and not clinical negligence cases which will be dealt with through the NHS Litigation Authority.

1.5 The annex to this document gives some guidance on the range of amounts that can be

[1] Local Government Ombudsman's Report, http://www.lgo.org.uk/pdf/partnerships-sr.pdf *Local Partnerships and Citizen Redress,* July 2007

considered

2. Context

2.1 The context of this policy is the Parliamentary and Health Service Ombudsman's document *Principles for Remedy*[2]*.* The Ombudsman's commitment to the inclusion of financial remedy as a means of remedy has been illustrated in the recommendations made following consideration of cases as reported in *Remedy in the NHS – Summaries of Recent Cases*[3]*.* The policy also draws on the principles set out in the Local Government Ombudsman's report *Remedies, Guidance on Good Practice* [4].

2.2 The NHS Finance Manual[5] provides guidance for NHS bodies on such "special payments", including ex-gratia payments. This guidance enables an NHS body to make such ex-gratia payments, generally where the complainant has incurred financial loss following the actions or omissions of the relevant NHS body. However, it also makes provision for payments where there has been no financial loss but clarifies that such payments should only be made in exceptional circumstances. The guidance also allows for NHS bodies to make ex-gratia payments in discovered cases of maladministration where no complaint has [yet] been made.

2.3 The other context is the changes in the complaints procedure with effect from April 2009 when the Healthcare Commission was removed as the second stage of the process, complaints going directly from Local Resolution to the Ombudsman. The Ombudsman expects Trusts and those who provide NHS services under contract, to demonstrate good practice in financial redress and to be in a strong position to influence this practice. In addition the 2009 complaints' procedures provide a common process for both health and social care. The principles for the payment of financial remedies, already adopted by Local Authorities, are replicated within health to ensure equality and consistency.

3. Purpose of the procedure

3.1 The purpose of the procedure is to set out when the Trust, or its providers, should consider a financial remedy to a complaint or other investigation, the governance procedures that should be followed in such consideration, and the factors to consider in deciding on the amount (if any) to be paid.

3.2 The aim of the procedure is to ensure:

a) A consistent approach is applied to evaluate the proper amount of the financial remedy having regard to the particular circumstances of individual cases.
b) Complaints are dealt with fairly and effectively with, where appropriate, any financial remedy being offered at an early stage.
c) The number of complaints to the Ombudsman is minimised, and
d) Payments of financial remedy are properly monitored and controlled.

4. Applicability

4.1 This procedure applies to complaints dealt with at the Local Resolution stage of the

[2] PHSO *Principles for Remedy* http://www.ombudsman.org.uk/improving_services/remedy/
[3] PHSO *Remedy in the NHS – Summaries of Recent Cases,* June 2008, http://www.ombudsman.org.uk/improving_services/special_reports/hsc/nhs_remedy/index.html

[4] LGO *Remedies, Guidance on Good Practice 6,* www.lgo.org.uk/remedies.pdf

[5] NHS *Finance Manual,* http://www.info.doh.gov.uk/doh/finman.nsf

complaints procedure and to complaints being considered by the Parliamentary and Health Service Ombudsman. In order for a financial remedy to be considered any complaint under Local Resolution should have been committed to writing.

4.2 The Trust may equally become aware of the need to provide some redress to an individual following other channels of investigation for example an incident or issues relating to safeguarding adults or children.

4.3 The procedure does not apply to matters that are the subject of current legal action or any settlement of court proceedings or matters that can be taken to statutory appeal e.g. eligibility for continuing care.

5. Maladministration with injustice

5.1 If THE TRUST is causing, or has caused, injustice to the complainant it should consider a remedy if, after an investigation it appears that there has been maladministration. Maladministration includes, for example, neglect or unjustified delay in service provision; failure to follow policies; providing inaccurate or misleading advice, bias or unfair discrimination.

5.2 Not all maladministration causes injustice:

a) The complainant may not have suffered any disadvantage.
b) If the complainant has been disadvantaged, this may not be as a direct consequence of the Trust's failure. The disadvantage may have been caused by a third party or by the actions of the complainant themselves.

5.3 For a remedy to be considered it must be clear, on balance, that the injustice occurred as a result of the Trust's actions or non-actions.

6. General principles of remedy

6.1 The PHSO *Principles for Remedy*[6] sets out the general principles for remedy. Remedies can include one or more of the following:

- An apology
- Service improvement to reduce the risk of further occurrence
- Changing a decision on service provision
- Training for staff

6.2 The Ombudsman's overriding principle is that the organisation should, as far as possible, put the individual back into the position that s/he would have been in if the maladministration had not occurred. However, there will be circumstances where this cannot be achieved because of the passage of time or events that have occurred. In such cases, a financial remedy may be appropriate.

7. View of complainants

7.1 It is good practice to seek the view of the complainant at the outset about the remedy he or she is seeking. Sometimes an apology is all that is required or taking some specific action such as arranging an appointment or providing a second opinion. However, while taking account of the complainant's views, THE TRUST must come to its own decision on what is a reasonable, proportionate, remedy. This may include providing a financial

[6] PHSO *Principles for Remedy,* http://www.ombudsman.org.uk/improving_services/remedy/

remedy even though this has not been sought by the claimant.

8. When financial remedy will be considered

8.1 Financial remedy may be appropriate, for example, if the complainant has suffered as a result of a delay by the Trust in taking some action; or if there is no practical action that would provide a full and appropriate remedy; or if the complainant has sustained loss or suffering. Financial remedy, and more than one may apply, needs to take account of all the facts of the case.

8.2 These include:

a) **The effects of the complainant's own actions:** for example, not attending an appointment.

b) **Quantifiable loss**

Costs that would not have been necessary but for the Trust's maladministration.

For example:

- A patient paying for treatment from elsewhere because of an error on the part of the service provider. This will need to be assessed with care, on the basis that it was reasonable for the complainant to incur costs and they were as a consequence of the maladministration.
- Loss of possessions. In such cases the individual should be reimbursed reasonable replacement value.
- Where possible copies of receipts should form part of the claim.
- Loss of value: for example, damage to possessions.
- Lost opportunity: for example, the complainant may have been deprived of the right to appeal against a funding decision because he or she was not told of that right.

c) **Distress**

This will include perceived pain and suffering, stress, anxiety, inconvenience, frustration, worry and uncertainty. The amount will need to take account of all the circumstances including the severity of the distress, the length of time involved, the vulnerability of the individual and the number of people affected.

d) **Professional fees**

It may sometimes be appropriate to recognise the nature of the complainant's difficulty was such that expenditure on professional fees in pursuing the dispute was justified. For example, paying an advocate because one had not been offered by the Trust. However, this will need to be assessed with care. The Trust will need to be satisfied that it was reasonable for the complainant to incur these costs, and that it was a consequence of maladministration. It may sometimes be appropriate to reimburse only part of the expenditure, from the point when the professional advice became appropriate.

e) **Time and trouble in pursuing the complaint**

This should only be paid when the time and trouble in pursuing the complaint are more than the minor costs that would routinely be expected. It is not the same as distress

caused by the Trust's actions. In assessing whether payment is appropriate, relevant factors to consider could include the passage of time in resolving the matter; the effort required from the complainant; the degree of inadequacy of the Trust's responses, the vulnerability of the individual and whether there has been any element of wilful action of THE TRUST as opposed to poor administration.

9. When financial redress will not be considered

9.1 When the complaint relates to current legal action or any settlement of court proceedings or matters that can be taken to statutory appeal e.g. eligibility for continuing care.

9.2 Where there it has been proved on the balance of probabilities that the Trust have not been responsible for maladministration.

9.3 Complaints that relate to clinical negligence. In these circumstances complaints will be advised to seek legal address. However, complainants may seek financial redress from the Trust for maladministration and also pursue legal redress.

10. Joint liability

Where maladministration involves more than one organisation or division, agreement should be reached as to how the financial remedy will be divided. This may need to take into account the proportionate level of failure by each organisation or division involved.

11. Agreement on amount of financial remedy payable

11.1 To ensure consistency and equality in the level of payments made for non- quantifiable loss, the case should be considered by a Complaints Redress Panel is established.

11.2 The redress panel can only consider financial remedy up to £5,000, beyond this amount complainants are advised to seek legal redress.

11.3 The Panel should include:

a) A clinical executive Director or nominated deputy who will be the Chairman of this Panel
b) Head of Nursing from each care group or their nominated deputy. There should be a representative from each care group for which there is a request letter to be considered.
c) Head of Complaints, PALS and Bereavement Services or nominated deputy.

It will be quorate when there are at least three members plus a member of the Complaints or PALS team.

11.4 None of the above should have had any involvement in the complaint/incident being considered and the Panel could call on other expertise when necessary. To ensure consistency and equality, national guidance and local and national precedence will be taken into account and records of each decision, with reasons, will be documented, keeping a centralised register.

11.5 The Redress panel will meet at least every six weeks. In the interim, if an urgent decision is required, a 'virtual' panel can be convened, using tele-conferencing or video-conferencing.

11.6 The Redress Panel will require the Complaints team to prepare a brief redress summary for the complainant (see annex 2)

12. Making an offer of financial remedy

12.1 When an offer of financial remedy is made it should include the words “without prejudice” at the top of the first page. Any offer should always be without prejudice and as a goodwill gesture “in full and final settlement” of the complaint. This means that, if the offer is accepted, the matter is effectively closed. Confirmation of acceptance of the offer should be obtained in writing before payment is made.

12.2 Where there is any uncertainty about whether it is appropriate to pay financial compensation, the Trust will take advice from its legal adviser before making any offer.

12.3 Guidance from the Ombudsman explicitly states that public bodies should apply an appropriate interest rate to payments for financial loss and explain the reasons for the chosen rate. Unless there is a good reason to use another rate, the Trust will use the interest used by the courts.

13. Monitoring and authorisation or payments

13.1 A record of any financial remedy paid must be made on the record of the complaint/incident. All payments will be made using an appropriate cost code for the department where the maladministration occurred and authorised by the relevant care group director. The Finance Department will be asked to send one cheque to the recipient, amalgamating the contributions from the various divisions.

13.2 The complaints manager and risk manager, as appropriate, will be responsible for maintaining the information on the level of financial remedy paid and details will be included in the quarterly reports to the Board. The record will detail the reason why the financial remedy has been paid, and how the amount has been assessed.

Annex 1

GUIDANCE ON AMOUNTS TO BE CONSIDERED WHEN DECIDING ON FINANCIAL REMEDY FOR NON-QUANTIFIABLE LOSS.

The amounts have been based on national guidance and precedence:

Local Government Ombudsman’s report *Remedies, Guidance on Good Practice 6.* (LGO report)

Parliamentary and Health Service Ombudsman, Remedy *in the NHS – Summaries of Recent Cases.* (PHSO Report)

NB These will only apply where maladministration has been proved. Where the actions of the complainant are shown to be a significant contributory factor, no payment will be made.

Circumstances	**Amount £**
Moderate time and trouble	50 – 100
Unhelpful, negative and defensive response to a complainant with threat of counterclaim and lack of apology. Disregard for procedures and good practice	Up to 250
Distress: perceived pain and suffering, stress, anxiety, inconvenience, frustration, worry and uncertainty	Up to 500

Exceptional time and trouble. For example, where the investigation and review of a complaint has taken many months in excess of the relevant timescale agreed with the complainant and the complainant has been put to considerable inconvenience in pursuing a complaint.	Up to 500
Delay in complaint handling and failure of Trust to adequately respond to recommendations made by the Parliamentary and Health Service Ombudsman	Up to 500
Care of a child. No adequate systems in place for care planning, communication, risk assessment and risk management. This resulted in moderate to high level of risk for patient and high parental concern.	Up to 500

All decisions regarding cases examined will be recorded on an Excel sheet. This will be available to members at each meeting so that they can refer back to it to review any similar cases in order to ensure consistency.

Annex 2 – Redress Panel proforma, to be used in conjunction with the procedure.

Client name:	Case reference:
Date complaint first received:	
Name of person completing this form:	
Brief summary of the complaint:	
The amount the complainant is seeking	
Has the complainants own actions adversely affected either the maladministration or the outcome? *For example did the complainant fail to attend an appointment?*	
What is the **quantifiable loss** for which the complainant is claiming?	
Is the complainant claiming for **distress**? *If so consider the number of points of maladministration, the impact of the maladministration and the severity of the maladministration*	
Has the complainant incurred any **professional fees** in pursuit of his/her complaint?	

Has the complainant endured **additional time and trouble** in pursuing the complaint?
Recommendation to the Redress panel

Appendix G – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	**Sue Holland**	
Job title	Head of Patient Experience	
Care Group/Department	Corporate	
Date completed		
Who will be impacted by this policy	[x] Staff (Trust) [x] Staff (Other) [x] Service Users	[x] Carers [x] Patients [x] Relatives

Assess the impact of the policy on people with different protected characteristics. When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**Yes**	**Neutral**
Disability	**Yes**	**Neutral**
Gender reassignment	**Yes**	**Neutral**
Marriage and civil partnership	**Yes**	**Neutral**
Pregnancy and maternity	**Yes**	**Neutral**
Race	**Yes**	**Neutral**
Religion or belief	**Yes**	**Neutral**
Sex	**Yes**	**Neutral**

Sexual orientation	**Yes**	**Neutral**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	No
Did the consultation analysis reveal any difference in views across the protected characteristics?	N/A

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	No

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	This policy does not impact on any of the protected characteristic groups.

Appendix H – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

Policy Title:	Complaints Management
Version Number:	1
Director Responsible for Implementation:	Amanda Hallums – Chief Nurse and Director of Patient Safety and Quality
Implementation Lead:	Sue Holland – Head of Patient Experience

Staff Groups affected by policy:	All staff groups.
Subsidiary Companies affected by policy:	2gether Solutions – they must follow the Trust policy. The policy has been shared with 2gether Solutions.
Detail changes to current processes or practice:	Changes to individual responsibilities have been consulted and communicated prior to the process implementation of 01 January 2020.
Specify any training requirements:	None
How will policy changes be communicated to staff groups/ subsidiary companies?	Trust News Head of Patient Experience will share with the Governance Matrons to disseminate to the care groups.