East Kent Hospitals University NHS Foundation Trust

Policy for Management of Complaints, Concerns, Comments and Compliments

Version:	10.00
Ratified by:	Patient Experience Team
Date ratified:	15 March 2018
Name of originator/author:	Sue Holland, Head of PET
Name of responsible committee/individual:	Patient Experience Group Sally Smith, Chief Nurse and Director of Quality and Operations
Date issued:	15 March 2018
Review date:	1 March 2019
Target audience:	All Trust Staff and staff of contracted outside organisations

We care

Version Control Schedule

Version	Date	Author	Status	Comment
1.0	February 06	Complaints Manager	Final	
1.1	September 06	Complaints Manager	Final	Minor re-draft to allow for changes in legislation, including extending normal response deadline to 25 days and introducing principle of agreeing extensions
2.0	February 09	Head of Patient Experience	Draft	Major changes in legislation relating to complaint handling requires re-draft of the procedure
3.0	October 2011	Head of PET	Draft	Review sent to Deputy Chief Nurse and Head of Quality and Leads for comment
3.1	November 2011	Head of PET	Draft	Minor redraft – sent to all Divisions Leads for comment.
3.2	January 2012	Head of PET	Draft	For Ratification at RMGG
4	February 2012	Head of PET	Draft	Agreed at RMGG minor changes to be made and agreed with chair of RMGG
5	April 2012	Head of PET	Final agreed copy	Minor changes agreed with Chair of RMGG
6	October 2012	Head of PET	Amended copy	Minor Changes
7	November 2013	Interim Head of PET	Draft	Reviewed following publication of “A review of the NHS hospital complaints system: putting patients back in the picture”
8	December 2013	Interim Head of PET Plus Head of PET	Draft	Revised to incorporate comments received from RMGG members, Divisional Medical Directors and Divisional Complaints Leads
9	January 2015	Head of PET	Draft	Major review post CQC report
10	March 2015	Head of PET	Final agreed copy	Agreed at QAB
11	March 2018	Head of PET	Reviewed and agreed – no amendments	Agreed at Patient Experience Group

Contents

1 Introduction

1.1 The purpose of this document is to provide staff of the East Kent Hospitals NHS University Foundation Trust (the Trust) with a framework of the Trust's complaints policy in meeting the requirements of:

- The Local Authority Social Services and National Health Service Complaint (England) Regulations 2009.
- The guidance of the Care Quality Commission: http://www.cqc.org.uk/content/hospital-community-mental-health-providers
- The Parliamentary and Health Service Ombudsman (PHSO): http://www.ombudsman.org.uk
- Duty of Candour: http://www.ekhuft.nhs.uk/staff/clinical/duty-of-candour/

1.2 The policy describes how the Trust manages, responds to, and learns from complaints made about its services and the way in which they are commissioned.

1.3 The policy includes the fundamental requirements of good complaint and concerns handling used by the Trust to deliver arrangements in an easily accessible, equitable, sensitive and open manner.

1.4 A glossary of terms and abbreviations used in this document is to be found at Appendix A

2 Background

2.1 The Trust is committed to high quality care for all as a core principal of our vision and purpose. This includes the provision for any user of the organisation, their family, carers, or members of the public, with the opportunity to seek advice, raise concerns or make a complaint, about any of the services it supplies.

2.2 The Trust recognises that staff work very hard to get it right first time. However, there may be occasions when people will be dissatisfied with the service received, or decisions made and wish to make a complaint or raise a concern.

2.3 The Trust will endeavour to respond as quickly and effectively as possible to resolve complaints and respond to enquiries and to use the information to improve the quality of patient services; learning from complaints is at the heart of the complaints policy.

2.4 At the core of the above commitments are the Trust's 'We Care' values and behaviours:

We care so that:

- People feel cared for as individuals;
- People feel safe, reassured and involved;
- People feel confident we are making a difference.

3 Application

3.1 This policy applies to all staff employed by East Kent Hospitals University NHS Foundation Trust (EKHUFT), either directly or indirectly. It is also relevant to outside organisations which are contracted to provide clinical services to the NHS.

4 Aims of the Policy

4.1 The aims of the policy are to ensure that the complaints process is flexible and responsive to the needs of individual complainants. In addition, it emphasises the need to communicated effectively with complainants and involve them in the decisions concerning the handling of their complaint. The policy seeks to ensure that:

- Users who complain are listened to and treated with courtesy and empathy.
- Users who complain are not disadvantaged as a result of making a complaint.
- Complaints are investigated promptly, thoroughly, honestly and openly.
- Complaints are answered with transparency and candour.
- Complainants are kept informed of the progress and outcome of the investigation.
- Apologies are given as appropriate.
- Action to rectify the cause of the complaint is identified, implemented and evaluated.
- Complaining can make a difference.
- Learning from complaints demonstrably informs service development and improvement.
- The Trust is accountable when things have gone wrong.
- Complaints handling complies with confidentiality and data protection policies and is transparent.
- Complaints, concerns, comments and compliments are reported to the relevant Trust committees and to the Board and to ensure the importance of narrative as well as numbers contained within the data.
- Staff involved in complaints, at all levels are given support.

a. All staff must be familiar with the Trust's complaints handling processes. This includes being able to provide accurate advice to complainants as to how they can make a complaint.

b. Complaints may also include requests for information under the Freedom of Information Act (2000), the Data Protection Act (1998) and the Access to Health Records Act 1990. Staff must also be familiar with these processes.

5 Complainants' Rights

The policy is informed by the NHS Constitution which includes a number of recommendations relating to patients' rights. They have a right to:

- Have their complaint acknowledged and properly investigated.
- Discuss the manner in which the complaint is to be handled.
- Know the period in which the complaint response will be sent.
- Be kept informed of the progress of their complaint.
- To know the outcome, including an explanation of the conclusions.
- Confirmation that any action needed has been taken.

- Take a complaint about to the PHSO if they are not satisfied with the way the Trust has handled their complaint.
- Receive compensation if they have been harmed by medical negligence.
- Make a claim for judicial review if they feel that they have been directly affected by an unlawful act or decision of the Trust.
- Seek redress for any out of pocket expense or distress caused as a consequence of seeking treatment about the matter they are complaining about.

6 Who can make a complaint?

6.1 Any person who is affected by, is likely to be affected by, or is aware of an action, omission or decision of the Trust, for the purposes of delivering health care to its users.

a. A complaint or concern may be made by a person acting on behalf of a patient in any case where that person:

- Is a child. The representative must be a parent, guardian or other adult person who has care of the child. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the Kent County Council Children's Services. The competency of a young person from the age of 16 must be considered and the patient must be consulted to ensure that they are happy for the complaint to be taken up on their behalf.

- Has died. In the case of patient or person affected who has died, the client must be a relative or other person who had sufficient interest in their welfare and is a suitable person to act as a representative. More details are provided on the 'deceased consent' form.

- Has physical or mental incapacity. In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, the representative must be a relative or other person, who has sufficient interest in their welfare and is a suitable person to act as a representative.

- Has given consent to a third party acting on their behalf. In all cases we will need a consent form to be completed and signed. Without this being documented and filed the complaint will not proceed. Unless there are exceptional circumstances complaint will be closed within two weeks of the consent being requested and not received.

- Has delegated interests via a Lasting Power of Attorney, but even in this case, we will endeavour to ensure the patient is happy for the complaint to be made on their behalf.

- Is an MP acting on behalf of, and by instruction of, a constituent. Consent will be implied if the constituent has written or emailed the MP about a Trust issue.

b. There may be circumstances in which information disclosure is in the best interests for the patient, or the protection, safety or wellbeing of a child or vulnerable adult. In these circumstances PET will escalate as necessary in line with safeguarding policies and procedures.

c. Investigation and response to a complaint can take place even if it becomes apparent that the client has also taken legal proceedings, but both processes must take place independently of each other (concurrent management). The only exception is where the Police have requested us not to investigate until they have completed all their enquiries.

7 Complaints that cannot be dealt with under this policy

7.1 The following complaints will not be dealt with under the NHS Complaints Regulations 2009:

- A complaint made by one NHS organisation about another NHS organisation, including contract arrangements.
- A complaint made by an employee of the Trust relating to their employment.
- A complaint relating to any scheme established under Section 10 (superannuation of persons engaged in health services) or Section 24 (compensation for loss of office) of the Superannuation Act 1972 or to the administration of those schemes.
- A complaint, the subject matter of which has been previously investigated under these or previous regulations.
- A complaint made orally via PALS which is resolved to the complainant's satisfaction by PALS within 24 hours.
- A complaint which is currently being, or has been, investigated by the PHSO
- A complaint arising out of the Trust's alleged failure to comply with a request for information under the Freedom of Information Act 2000.
- A complaint which is entirely about another NHS organisation. Where minor aspects concern the Trust, our response to that part will be forwarded to the lead organisation or separately to the client if so requested.
- A complaint being made about a private health facility where the treatment was not commissioned by the Trust.

8 How to make a complaint

8.1 A person who is unhappy with something the Trust has done or is doing may well approach a member of the front line staff. Where it is appropriate, the Trust empowers its staff, through Customer Service training, to resolve the complaint or concern quickly by the member or members of staff involved.

8.2 If it has not been possible to resolve the client's complaint, comment or concern, the member of staff will advise the client of his/her options.

- To contact PALS for further advice and assistance, directing the client to the PALS office within the hospital (K&CH, WHH or QEQM) or providing the telephone number or email.
- To write to the Chief Executive or the Patient Experience Team (as the client prefers) outlining their complaint and how they wish the issues to be resolved. This can be done by post or by email, but not any forms of social media unless through the Trust's website or own social media.

- To contact SEAP (Support Empower Advocate Promote) which is an independent complaints advocacy and support organisation which will help the client to formulate the complaint.

- To request a complaints form from the main reception desk at the hospital. The form can either be completed at the time and handed back to the receptionist (who will put it in an envelope and ensure that the PET office on site receive it without any delay), scanned and then emailed, or put in the post.

- To complete the relevant on-line form and submit it electronically.

8.3 Where a client has difficulties expressing himself/herself, for instance, because they are hard of hearing, where English is not their first language or they have communication difficulties as a consequence of illness or trauma, every endeavour will be made to facilitate communication as soon as possible, for instance, by appointing an interpreter, or a 'signer' or providing information in an 'easy read' format. However, it is recognised that there may be a delay in providing this level of communication.

8.4 A complaint can be made twelve months from the date on which the matter that is the subject of the complaint came to the notice of the complainant.

8.4 If there are good reasons for not having made the complaint within the twelve months, then the Trust may still consider the complaint if they feel that it can be properly investigated and responded to. In doing so, the Trust will take into account the fact that members of staff involved may have left the Trust and that memories will have faded; the investigation may have to depend on the notes and the protocols existing at the time alone.

Further details concerning the mechanisms for making a complaint can be found in 'Talk to Us', the Trust's complaints leaflet, or through the website http://www.ekhuft.nhs.uk/patients-and-visitors/

9 Principles for responding to concerns, complaints, comments and compliments; the investigation and organisational response

9.1 The Trust will acknowledge and supply thanks for any compliment made about the Trust and/or its employees and will ensure that individuals mentioned are informed. The Trust collates and reports all compliment information.

9.2 The Trust follows the Parliamentary and Health Service Ombudsman's Principles of Good Complaint Handling as set out below:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

9.3 The Trust will investigate a complaint, comment or concern in an appropriate manner to resolve it as efficiently as possible, proportionate to the seriousness of the complaint.

9.4 A key consideration will be to make the arrangements for resolving the complaint as flexible as possible, treating each case according to its individual nature with a focus on satisfactory outcomes, organisational learning and that those lessons should lead to service improvement.

9.5 The client will be consulted as to how they would like to correspond with the Trust; while some people prefer a meeting, others will always elect for a formal written response. If a meeting is requested, only two cancellations on behalf of the client will be permitted.

9.6 The Trust aims to respond to comments and concerns within ten working days or less and to more complex complaints which need a higher level of investigation, within thirty working days. If a comment or concern cannot be resolved quickly and to the satisfaction of the complainant, it becomes a formal complaint.

9.7 If it becomes apparent that it is impossible to resolve a complaint within thirty working days, the client will be contacted with an explanation and to request and extension to the agreed time. Up to three requests for extensions may be made, but the third request must be done by a senior member of staff in the Division, for instance, the Head of Nursing.

9.8 All complaints, comments and concerns ('complaint') will be acknowledged no later than three working days after the day the complaint is received, either by telephone, email or letter. The preference is by telephone as this enables the PET officer to make a personal contact and to quickly seek clarity on any points raised.

9.9 The acknowledgement will provide or request:

- An action plan for handling the complaint.
- Timescales for responding.
- The client's expectations and desired outcome.
- Information with regard to SEAP, the complaints advocacy service.
- Patient or deceased patient consent as appropriate including consent to involve another organisation if necessary.

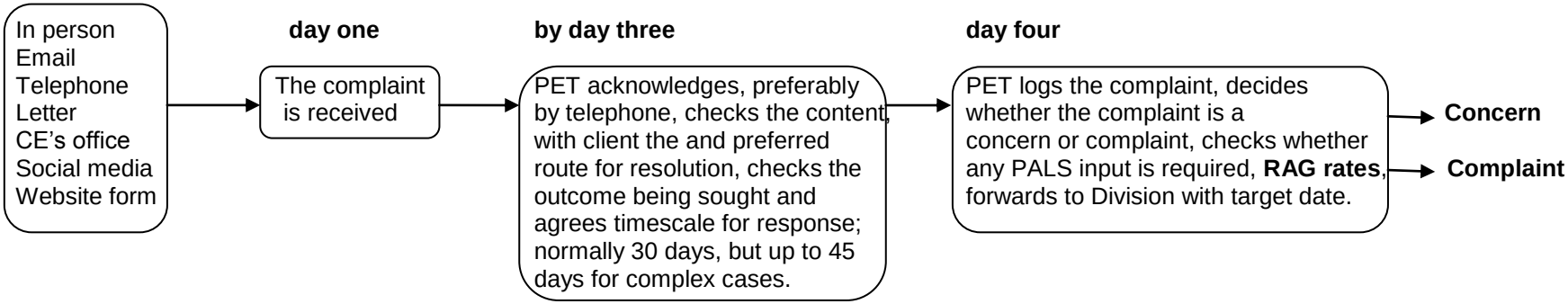
9.10 The client can expect that:

- They will be kept up to date with the progress of their complaint.
- They will be assured that their complaint will be investigated and, where appropriate, they will receive an explanation based on facts.
- They will be assured that action has been taken to prevent an occurrence, if appropriate.
- They will be informed of any learning for the Trust.
- A remedy will be made where appropriate.
- They will be informed of the next option open to them if they are dissatisfied with the way the Trust has handled their complaint. Information will be supplied about the PHSO.
- Should they wish, they can receive all correspondence and papers generated in the course of a complaint investigation, including staff statements, as these would have to be disclosed to a claimant should they later pursue a claim for negligence through the courts. The Data Protection Act 1998 enables this.

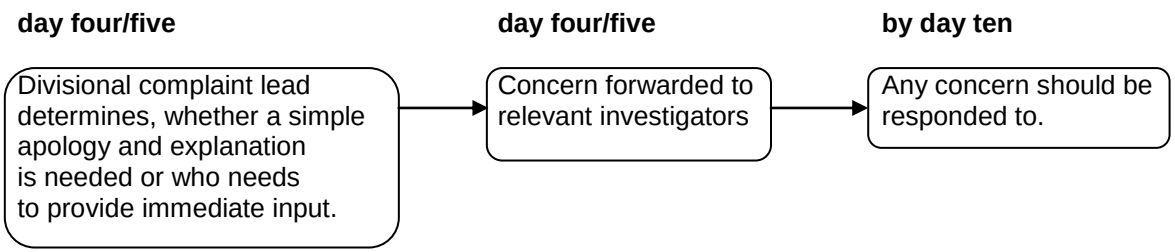
9.11 The actions of an angry, demanding or persistent client may result in unreasonable demands or unacceptable behaviour towards staff. Staff are not expected to tolerate abusive or threatening behaviour, but all complaints must be given equal consideration and be investigated.

10 The progression of a complaint

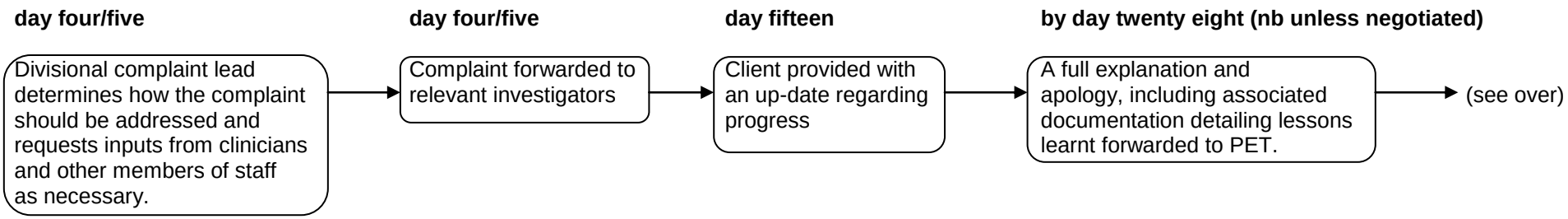
Initial Stage



Investigation Stage - Concerns



Investigation Stage – Complaints



by day twenty eight

PET checks the response against the complaint correspondence, ensuring all aspects covered, readily understandable and empathetic

by day twenty nine

CE (or deputy) reviews correspondence and if satisfactory, signs it off.

by day thirty

PET logs the signed response, sends it and any enclosures, ensures copies are forwarded, records the outcomes, checks RAG rating, closes

Learning from Complaints

Heads of Division/clinical governance lead identify lessons learnt.

Lessons learnt discussed at relevant team meetings.

Action plans put in place to embed learning.

Appointed team member to forward lessons learnt and actions taken to PET.

PET to include selected cases in 'Lessons Learnt' newsletter, in training, on the website and also 'Patient Story' for the Board.

The Parliamentary and Health Service Ombudsman (PHSO).

Clients have a right to approach the PHSO if they are unhappy with the way that EKHUFT has handled their complaint. NB PHSO will only consider complaints that have exhausted the Trust's complaints procedure and does not investigate all complaints forwarded to the Ombudsman.

First Stage

PHSO contacts EKHUFT, outlines what the client is unhappy with, asks for copies of the complaint and medical file. Provides a deadline.

By day three

Quality Assurance Manager (QAM) reviews deadline and negotiates with PHSO officer if necessary.

Day four

QAM provides items requested by PHSO by email or hardcopy as appropriate.

Second Stage

PHSO informs EKHUFT of its findings and requirements QAM forwards to Division For comments by a stated deadline.

Third Stage

PHSO issues report. Where recommendations made, Division should comply with these by stated deadline

Fourth Stage

QAM monitors compliance of Recommendations, reviews draft responses and action plans. by the stated deadline

Fifth Stage

CE (or deputy) review correspondence and If satisfactory, signs it off. QAM despatches, logs, records outcomes, closes.

Fifth Stage

A redacted version of the complaint and the actions taken by EKHUFT in light of the PHSO recommendations is posted on the website and EKHUFT ensures that all learning is embedded (subject to consent)

11 Staff Responsibilities

11.1 All staff will:

- Be made aware of this Complaints Policy at induction.
- Take into account and act on the 'We Care' commitments, values and behaviours.
- When dealing with a complaint face to face ensure that they take time to listen and ensure they full understand the concerns. This may mean asking for clarification where elements are unclear.
- Respond to the issues raised or refer the client to someone who can assist the client further.
- Contact their line manager if any issue is serious or cannot be readily resolved.
- Note that only those investigating the issues should access a patient's personal information.
- A member of staff requested to provide a statement should be given access to the relevant information if necessary to aid investigation.
- A complaint should only be made known to those directly involved in responding to or investigating the issues raised i.e. on a "need to know" basis.
- Complaints records **must** be kept separate from health records and should **not** be placed on the Electronic Patient Record (EPR).
- All staff must comply with the requirements of the Data Protection Act 1998.

11.2 PALS staff will:

- Endeavour to answer all telephone calls 'live' between 8.30am and 5.00pm each working day.
- Ensure that the answerphone message is clear and in line with the 'We Care' values and behaviours.
- Ensure that email messages to the PALS generic email account are responded to as soon as possible but certainly by 5.00pm the following working day.
- Ensure that all messages are responded to as promptly as possible and certainly by 5.00pm the following working day.
- Escalate appropriately when a PALS issue becomes a concern or a complaint.

11.3 PET staff will:

- Ensure that email messages to the PET generic email account are responded to as soon as possible but within three working days, noting that the 'out of office' message acknowledges receipt of the client's email.
- Ensure that all post is scanned and sent to the PET generic email account.
- Add all new concerns, comments and complaints to the daily workload database which is then allocated to the relevant PET officers who liaise with the Divisions.
- The PET relevant officer will then create a Datix record, ensuring all the fields are correctly populated.
- Then ensure that a contact is made with the client, preferably by telephone, to acknowledge receipt of the concern, comment or complaint and to discuss with the client the preferred avenue to follow.
- Then contact the Division link to advise about the receipt of the complaint and to provide the documentation.
- Will advise when the response is due in PET.

- Be responsible for keeping a dialogue with the client, particularly if an extension to the allocated time is required.
- See if there is anything practical to assist the client, for instance, with obtaining a new appointment.
- Maintain a dialogue with the Division to ensure a prompt response to the complaint.

11.4 The Quality Assurance Manager will:

- Ensure that the Division's draft letter for the Chief Executive complies with the style guide.
- Ensure that the letter answers all the points raised in the letter of complaint.
- Ensure that the 'We Care' values and behaviours, including the language and tone of voice used in the letter, are complied with.
- Ensure that all typographic and spelling errors are corrected.
- Ensure that the Chief Executive's office receives the letter in a timely fashion complying with the response time.
- Ensure all 'cc'd' recipients receive a copy of the letter.
- Ensure that all enclosures are made.
- Ensure that the Division is alerted that the letter has gone and the file is closed.
- Provide reports to the Board, Committees, Divisions and others as routinely required or on an ad hoc basis.
- Be the Trust's point of contact for the PHSO.

11.5 The Head of PET and the Deputy Head of PET will:

- Ensure a seamless continuity of the department.
- Provide expert advice as required.
- Ensure escalation if a response is not forthcoming in a timely fashion.
- Be a point for others to escalate to.
- Draft letters where responses can be made relatively easily.
- Provide Customer Care and Complaints Handling training to Trust staff.
- Attend complaints meetings as required.
- Ensure best practice is always maintained and improved.
- Ensure seamless liaison between the Divisions, PET and the clients.
- Be the Customer Service liaison point for other organisations within and outside the health economy.
- Identify if the investigation of a complaint identifies the potential need to take action under the serious untoward incident procedure, when the lead investigator should inform the Chief Nurse or Medical Director. Advice should always be taken if there is any uncertainty. The incident procedure should take preference in terms of investigation. In these circumstances the complainant should be informed of the investigation, kept updated on progress and informed of the outcome.

11.6 The Head of PET is responsible under section 4(1)b of the legislation for managing the procedures for handling and considering complaints in accordance with the arrangements made under these Regulations

11.6 The Divisional complaints liaison officer will:

- Provide a liaison point with PET
- Ensure that the complaint is reviewed and the points of complaint identified.
- Forward the complaint to the appropriate staff members, both clinical and non-clinical for investigation and response.
- Will liaise with PET if a meeting is to be held with the client, providing a meeting cover letter and the meeting recording after the meeting.
- Collate the responses and draft a response, usually for the signature of the Chief Executive, following the Trust's style guide.
- Ensure that the Division's lead for complaints has approved the response.
- Ensure that the draft response is sent to PET in a timely fashion.
- Provide the Division's lead for complaints with regular reports concerning progress of open complaints.

11.7 The Divisional complaints lead will:

- Liaise on a regular basis with the Deputy Head Nurse and Deputy Director of Quality to provide assurance that the Division is handling complaints in an appropriate and timely fashion.
- Oversee the management of complaints within the Division
- Take necessary action should escalation be required at a high level.
- Check the response letters to ensure that they have been written with the ideals 'We Care' at the heart of them and that they comply with the Trust's style guide. Moreover, that they properly answer the aspects of the complaint.
- Ensure that an action plan for points of learning has been created.
- Provide evidence that the action plan has been implemented.

11.8 The Divisional Directors will ensure that robust internal systems are in place to meet the Divisional responsibilities within this policy.

11.9 The Chief Executive;

- Is the Responsible Person under section 4.(1)a of the legislation to ensure compliance with arrangements made under the Regulations and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint.
- The Chief Executive should take personal responsibility for the complaints procedure, including signing off letters responding to complaints.

11.10 The Chief Nurse and Director of Quality and Operations, Clinical Quality and Patient Safety is the Designated Responsible Person under section 4.(2) of the legislation.

11.12 The Trust Board is required:

- To receive assurance that robust systems are in place to enable feedback to be heard, actioned and lessons learned in order to provide the best possible care leading to an improved patient experience or service.
- To receive monthly reports on complaints and the action taken, including an evaluation of the effectiveness of the action. These reports should be available to the Chief Inspector of Hospitals.
- To provide Board level scrutiny of complaints, which should regularly involve lay representatives.

- To publicise an annual complaints report, in plain English, which should state what complaints have been made and what changes have been put in place. The emphasis should be on commentary rather than data.

11.13 The Quality Assurance Board receives a quarterly assurance report about complaints, concerns, comments and compliments.

12 Joint Working Protocol

The Trust is part of the Kent and Medway Joint working group and adheres to the process of joint working that has been agreed within the group. Where complaints are raised that will require cross agency involvement to respond to the client's concerns the joint working protocol for the Kent and Medway joint complaints group (Appendix F) must be followed.

13 The Parliamentary and Health Service Ombudsman (PHSO)

13.1 If local resolution is not successful, and the client has been advised that no further resolution can be provided by Trust, then the client has the opportunity to contact the PHSO direct and ask for a review of their case.

13.2 The PHSO review will seek to demonstrate that the Trust has acted appropriately when assessing the complaint and will identify if there is evidence of maladministration or service failure. The PHSO will ask the Trust to provide a copy of the complaint file and health care records.

13.3 After undertaking the review the PHSO will inform the Trust whether the review has upheld the complaint and the corrective action that the Trust must implement.

13.4 Complaints referred to the PHSO will be monitored by the Quality Assurance Manager and reported to the Quality Assurance Board and the Trust Board of Directors.

13.5 In line with the Francis report, the Trust will publish PHSO findings on the Trust's website.

14 The provision of redress and ex-gratia payments

14.1 Remedying injustice or hardship is a key feature of the Ombudsman's Principles for Remedy suggesting that where there has been maladministration or poor service the public body restores the complainant to the position they would have been in had the maladministration or poor service not occurred.

14.2 Financial redress will not be appropriate in every case but the Trust will consider proportionate remedies for those complainants who have incurred additional expenses as a result of poor service or maladministration. This does not include a request for compensation involving allegations of clinical negligence or personal injury where a claim is indicated.

14.3 The Trust's procedure for dealing with claims for financial redress is available separately.

15 Equality Impact Assessment

This policy ensures that we listen and learn from our patients' experiences. It is designed to be accessible and suited to all. All patients, employees and members of the public should be treated fairly and with respect, regardless of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social and employment status, HIV status, or gender re-assignment at an early stage, whether The policy also recognises the rights of staff within the process.

16 Consultation, Approval and Ratification Process

16.1 The process for consultation, approval and ratification of this policy is as follows:

- The first draft of the paper was shared with the Patient Experience Board Members, Divisions and PETs for consultation and comment in 2009.
- The draft policy was made available for comment on the Trust's website in 2009.
- The second draft of the paper was presented at a meeting of the Chief Executive's Group (CEG) for consultation and comment in 2009.
- The revised version of this draft was shared with the Divisions, and PET in December 2011.
- The revised draft was shared with the Patient and Staff Experience Governance Group In February 2012.
- The revised draft of this paper was presented to the Risk Management Governance Group in February 2012.
- A revised draft of this paper was reviewed and agreed by the Chair of Risk Management and Governance Group in October 2012
- A revised draft of this paper was reviewed at the Risk Management and Governance Group in July 2013.
- A further revised draft of this paper was reviewed at the Risk Management and Governance Group, and shared for comments with SEAP's independent complaints advocacy service in November 2013.
- The paper was approved at the Risk Management and Governance Group in March 2014.
- This draft was written in November 2014 for approval by the Quality Assurance Board in January 2015.

17 Review and Revision Arrangements including Version Control

17.1 The policy will be reviewed bi-annually, or at any stage when changes are made to the processing of the complaints, concerns, comments or compliments or to the governing legislation and/or national guidance. The outcome of these reviews will be noted in the version control sheet at the front of the document and version numbers amended accordingly.

17.2 Major changes to the policy will be ratified by the Quality Assurance Board.

18 Dissemination and Implementation

18.1 The Trust will ensure that the right to raise a comment or concern, advice about relevant procedure and the help available from staff and other sources, is well publicised to all patients, other users of its services and to Trust staff.

18.2 **Dissemination to the public:** Information about making complaints, raising concerns or providing comments or compliments will be available across the Trust by way of leaflets and posters in all public areas and on the Trust's website. PET Offices will be signposted on the three main sites.

18.3 The Trust will ensure both its Policy for Management of Complaints, Concerns, Comments and Compliments and the Concerns and Complaints Procedure are accessible to complainants, including via the Trust's website. Copies of the Concerns and Complaints Procedure can be provided in other languages and formats, including Braille, easy read, large print and audio if required.

18.4 The Trust will publish lessons learnt from complaints on the Trust's website.

18.5 The policy and guidance will be available for review by Trust staff on the Trust intranet site. Training sessions will be provided for Divisional staff with key roles in the process. Dissemination will take place via Clinical Governance meetings and Patient Experience Training will be provided to all staff regarding how to deal with complaints and concerns pro-actively as part of the "Improving the Patient Experience." Programme. The policy will be highlighted within the Trust's induction programme.

18.6 PET's competency and skills will be assessed within the formal Performance Review process. Training will be provided to meet identified gaps. The Head of PET will ensure that the teams keep abreast of national changes and developments and that suitable expertise is available to ensure that PET's services are accessible to, and meets the needs of everyone (including hard-to-reach groups).

19 Out of hours contact arrangements

19.1 PET is generally available between 8.30am and 5.00pm, Monday to Friday. Issues raised outside these hours should be directed to the appropriate Ward or Divisional Manager.

19.2 Any immediate clinical need **must** be passed to the appropriate clinician.

19.3 If the concerns do not require immediate action, as much detail as possible, including the client's contact details, should be obtained and forwarded to the complaints department by the next working day. The client should be informed of the action taken and given the direct telephone number for the complaints department.

20 Document Control including Archiving Arrangements

20.1 The Head of PET is responsible for maintaining the archive copies of the policy on behalf of the Chief Nurse and Director of Quality and Operations and for ensuring copies are provided to the Trust Secretary.

20.2 An electronic archive relating to individual cases is to be retained for a minimum of 10 years after closure of the case.

21 Monitoring Compliance With and the Effectiveness of Procedural Documents

21.1 The Trust considers concerns/complaints as a positive mechanism for feedback about its services. Complaints management contributes the Department of Health's identification of the 4 'Cs' (Complaints, Compliments, Concerns and Comments) which:

- Highlight what is working well
- Help identify potential service problems
- Help identify risks and prevent them from getting worse
- Highlight opportunities for improvement
- Provide the information needed to review services and procedures effectively.

21.2 The Divisional Leads will ensure complaints are discussed at quarterly divisional meetings to identify service improvements where possible.

21.3 The Quality Assurance Board is responsible for monitoring the effectiveness of the policy to ensure the standards of the NHS Litigation Authority are met in complaints handling. In particular, they monitor arrangements for local complaints handling against national guidance as specified by the Department of Health including:

- trends in complaints and appropriate risk management actions
- identification of significant risks for inclusion on the Trust's Risk Register
- any lessons which can be learned from complaints, particularly for service improvement
- the findings of the complainant survey, which will be reported annually.

21.4 The Trust provides a report to be included in the Trust's annual Quality Account to be sent to:

- Monitor, the independent regulator for foundation trusts
- Local Clinical Commissioning Groups
- The Quality Care Commission
- Local Healthwatch
- SEAP

21.5 The Trust ensures that it provides information to NHS England and the Health and Social Care Information Centre (HSCIC) via completion of the central return KO41(A) which is required annually.

21.6 Equality and Diversity data are collected where possible by PET staff as required by the Department of Health. The lead investigator will provide such information to the complaints department about staff members involved. The Equality Steering Group receives an annual report on those complaints relating to equality and diversity issues.

21.7 The Quality Assurance Board considers how information from data collected in respect of complaints is disseminated within the Trust.

21.8 The Quality Assurance Board considers how to collect data deriving from patients' comments and suggestions and surveys of patient satisfaction with the way in which complaints are handled. In addition, use will be made of the data received via the HSCIC's published Friends and Family Test statistics, comments posted on the Patient Opinion and NHS Choices websites and the iPad based Real-Time Monitoring Questionnaire completed by inpatients.

21.9 In addition, the following reports are provided:

- Monthly reports to the Board of Directors on compliance with response times, complaints trend analysis including focus on specific themes, and actions taken
- 'Patient Stories' included as an agenda item for monthly Board of Directors meetings
- Biannual reports to the Standards Monitoring Group on compliance with NHSLA standards and actions taken to support the PET Improvement Plan
- A quarterly review of ten complaints files to ensure complaints documents have not been placed in the medical records or on EPR
- Follow up actions will be monitored to ensure actions completed
- The Trust will provide the Independent Regulator (Monitor) with an annual report on all concerns/complaints received Monthly meetings of the Complaints Steering Group will take place, comprising the Divisional Complaints Leads, Deputy Chief Nurse and Deputy Director of Quality, and the Head of PET

22 References

- The Local Authority Social Services and National Health Service Complaints (England) regulations 2009, archived at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/MakingExperiencesCount/index.htm
- Principles of Good Complaint Handling (2009) and other publications from the Office of the Parliamentary and Health Service Ombudsman are available at http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full
- Principles of Good Administration (PHSO March 2007)
- Principles for Remedy (February 2009)
- Trust Information Governance Policy (v2 November 2013)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC (February 2013)
- A Review of the NHS Hospitals Complaints System: Putting Patient back in the Picture (October 2013)
- Department of Health: Listening, Improving, Responding 2009
- NHS Constitution (March 2013)
- Making Experiences Count – A New Approach to Responding to Complaints (June 2007)
- NHSLA Risk Management Standards Regulations 2013/14 Criterion 2.3
- http://www.ombudsman.org.uk/reports-and-consultations/reports/health/the-nhs-hospital-complaints-system.-a-case-for-urgent-treatment

23 Associated Documentation

- Major Incident Plan 2015: East Kent Hospitals University NHS Foundation Trust. Available for staff on SharePoint.
- Policy for the Development and Management of Organisation Wide Policies and other Procedural Documents 2014: East Kent Hospitals University NHS Foundation Trust. Available for staff on SharePoint
- Policy on Violence and Aggression (2014): East Kent Hospitals University NHS Foundation Trust. Available for staff on SharePoint
- Information for staff regarding ‘duty of candour: http://www.ekhuft.nhs.uk/staff/clinical/duty-of-candour/

Appendix A

Guidelines for the management of complaints

1 Summary

This document provides guidelines for responding to Complaints raised by users of, and visitors to, the Trust. It should be read in conjunction with the Policy for Management of Complaints, Concerns, Comments and Compliments

2 Introduction

2.1 A complaint is an expression of dissatisfaction about the services provided by the Trust which requires a formal response.

2.2 The overall aim of complaints management is to provide a timely and comprehensive response to complaints with compassion and understanding with a view to improving the client's experience and rebuilding confidence in any future care. The response should ensure that apologies are offered when errors are identified, clients are advised of any actions that will take place as a result of the concerns that they have raised, that the organisation learns from mistakes, and redress is considered where the organisation feels this appropriate.

2.3 The Chief Executive has delegated the management of complaints, concerns, comments and compliments to the Patient Experience Team (PET). Any complaint, concern or comment which requires investigation and input should always be logged with PET. PET staff are specialists in complaints handling and can provide assistance and advice, particularly where the client may be angry and distressed.

2.4 While clients may be recommended to put their complaint in writing to the Chief Executive, they should not be advised to telephone the Chief Executive with a complaint. The complainant will not be put through to the Chief Executive and it is not within the remit of the Chief Executive's office to deal with complaints. Any complaint, comment or concern made to the Chief Executive is relayed immediately to the Patient Experience Team. This also ensures that all issues are dealt with in an even-handed manner. Clients may be advised that the Chief Executive will review the complaint and the response before its despatch.

3 The National Complaints System is a two stage process:

3.1 Stage 1: Structured, Division-directed response known as Local Resolution

Local Resolution involves working with the client to understand and resolve their concerns in a timely and proportionate manner. This process offers flexibility and choice in line with the needs and wishes of the service users and the severity of each particular problem. Issues raised will be managed to ensure that a timely and proportionate response is provided to the client according to the nature of the concern and will always be in accordance with the client's wishes.

3.2 Stage 2: The Parliamentary Health Service Ombudsman (PHSO)

If local resolution is not successful, and the client has been advised that no further resolution can be provided then the client can contact the PHSO and ask for a review of their case.

4 Concerns and comments

4.1 The Trust seeks to empower all front line staff to handle concerns and comments on-the-spot, in line with the 'We Care' behaviours. If an immediate front line response is the most appropriate way to respond to the issue(s) raised, or where the client can be provided with a response within ten working days, a discussion should take place with the client with regard to how their issues might be best addressed and responded to. It may be necessary to obtain patient consent, if the client is not the patient. There is a consent form available for printing on Sharepoint. The client should be advised that all complaints, concerns and comments are recorded and reported to the Divisional leads and statistically to the Board on a monthly basis. See the guidance document, 'How to deal with Concerns and comments' for more details.

5 Making a Complaint

5.1 If the issues being raised by the client are more complex and require a period of time before they can be responded to, the complaint needs to be addressed in line with the Department of Health's Guidelines. These advise that while there is no set time limit, the time taken to provide the client with a thorough explanation of events, apologies and actions plans, where appropriate, must be negotiated with the client. The Trust now only permits 'extensions' to complaint response times in extreme circumstances.

5.2 When a patient, a family member or their carer (the client) alerts a member of staff that they wish to make a complaint and the member of staff becomes aware that the matter cannot be readily resolved, then the client should be provided with a copy of the leaflet, Talk to Us'. Just providing the leaflet is not enough; the client should be guided through how to make the complaint and the stages it will go through, as shown in the leaflet.

5.3 The client can also be provided with a copy of the complaints form, which can be downloaded from Sharepoint, or directed to the Trust's website, where more information and links to the complaints form can be found.

6 The Role of the Patient Experience Team and its liaison with the Divisions

The response to a complaint generally lies with the Division about which the complaint is being made (or Divisions or outside organisations, if the complaint is more complex). The Patient Experience Team manages the complaints process, but the timeliness and content of the response lies with the Division concerned.

6.1 On receipt of a complaint, whether in person, by telephone, email, letter, fax or any other means, PET will always endeavour to contact the client by telephone to acknowledge. If telephone contact is impossible, then email or post will be used. In any case, acknowledgement within three working days is a statutory requirement.

6.2 **Triage the complaint**
The Deputy Head of Patient Experience or the Head of Patient Experience triages all complaints to identify:

- Which Division(s) the complaint is about.
- Whether the issues can be resolved in part, or completely, quickly and easily. There may be aspects, such as the request for a sooner appointment, that can be resolved straight away, while the rest of the complaint is resolved later.
- The reason many people make a complaint is that they want an apology for what happened. If an apology can be provided, then this is the priority.
- Which member of the PET team will lead on the complaint.
- Whether patient permission, or deceased permission is required.

6.3 **Logging onto Datix**
The complaint will then be logged onto Datix. All complaints, concerns, comments and compliments are recorded in this manner. From this system all the reports to the Board and various management committees are compiled. KO41 reports for the Department of Health are also produced from Datix. Divisions may collate their own working spreadsheets, but they are obliged to note that the Datix record is the base standard and they should ensure that their records reconcile with the Datix record.

6.4 **Listen and understand – acknowledging the complaint**
PET will contact the client, preferably by telephone within three working days. This reassures the client that a member of staff is dealing with their complaint and provides them with a named contact. PET will let the client explain what the problem is, to understand all aspects of the complaint, while not making any assumptions. The aim is to understand the client's situation and do not immediately react to concerns that staff identify as a priority, which may not be the client's priority.

PET will also ensure that the client knows about the complaints advocacy service SEAP and that if the client is dissatisfied with the way the complaint has been handled, their next step is to go to the Parliamentary and Health Service Ombudsman.

6.5 **Reassuring the client**

Many people are worried that by raising a concern they, or their relative, will be penalised. It is essential that the clients are reassured that they or the patient concerned are not treated any differently as a result of the concerns being raised. Raising concerns should be seen as a positive opportunity to improve services.

6.6 **Agree a plan**

PET will explain to the client what can be done to address the problem and discuss with them what will happen, explaining the processes and agree with them the likely timescales involved in the process at this point. As a rule of thumb, the Trust aims to provide a response to a complaint within 30 working days. PET will discuss how the client wishes the response to be made, which could be by telephone, email, a letter, or a meeting. All these details will be logged onto Datix.

6.7 **Liaising with the Division**

Without delay PET will contact the relevant complaint colleague in the Division, providing them with all the details of the complaint, the timescales agreed with the client and in what format the client requires the response.

At this initial stage, if the Division advises that the timescale agreed with the client is not possible, for instance, if a staff member integral to the response is on leave, the Division must immediately inform PET, who can advise the client.

6.8 **Missed targets**

The process of 'Extensions' to complaint targets has been disbanded. If a complaint is to miss the target agreed with the client, then it is the Division's responsibility to contact the client to explain why this is the case. It is an expectation that this will be a senior person, for instance the Head of Nursing for the Division. PET must be informed so that the matter can be properly logged on Datix.

6.9 **Progress Reports to the Divisions**

As a <u>minimum</u> PET will provide:

- A weekly report to each division highlighting those complaints where the draft letter is due the following week.
- A monthly report of all formal complaints and also concerns. This will be produced the third week (or before) of the month after a complaint was received. It also enables Divisions to add 'actions' to their change registers.

6.10 **Keeping the client informed**

If a client hears nothing from anyone for weeks, they will be a dissatisfied customer and the complaint will only become compounded. There may be good reasons for the delay in a response and the client must be informed about this. The Divisions and PET will liaise concerning each complaint and PET will ensure that communication to the client is timely and informative.

6.11 **Client meeting**

Despite the fact that meetings are often difficult to arrange because it is difficult to get all the clinicians together at a mutually agreeable time with the client, this is often a very effective method of resolving a complaint and may prevent a complaint from returning.

All returning complainants must be offered a meeting.

The Division should propose suitable times and a location and PET will liaise with the client to make the arrangements, but PET will only rarely attend and are not in a position to provide 'minutes'. All meetings should be audio recorded wherever possible and a CD of the recording provided to the client. When sending the copy of the recording, it should be accompanied by a letter which provides an outline of what was discussed, apologies where necessary and an action plan.

6.12 **Complex cases involving other organisations**

PET is responsible for liaising with other organisations in cases where the concerns cross organisational boundaries; in keeping with the principles agreed by the Kent and Medway Partnership and also the Department of Health's Guidelines.

6.13 **The Response**

It is important to be open and honest when responding to a client. The investigation to be undertaken has to ascertain what actually happened. The staff involved must be given the opportunity to explain what happened from their point of view, and statements should always be taken from relevant staff members. Staff should also be provided with any additional support required and where appropriate, a Post Incident Report Checklist should be completed.

Very often the concern will have been raised due to a misunderstanding, poor attitude or poor communication. Explaining what has happened in terms which the client can understand will usually resolve the issue. If a mistake has been made, acknowledge this and offer a truly sincere apology.

If the error has resulted in injustice or hardship and the client has requested help due to this, then this needs to be put right if possible, and other forms of remedy should also be considered in accordance with the Parliamentary Health Service Ombudsman's "Principles for Remedy" (February 2009). Redress should also be considered. As part of the response the client should be advised of any actions that will take place regarding redress including consideration at the redress panel within the Trust.

The response should be written using the template for the Chief Executive's letter of response, a copy of which is on Sharepoint, and following the style guide, also available on Sharepoint.

It should again be noted, that most complaints require an apology. It is unacceptable for a clinician to refuse to provide an apology if the complaint requires it. The clinical procedures may well have been exemplary, but the client for whatever reason was dissatisfied. The apology is needed for the dissatisfaction.

6.14 **Quality Control**

The response letter is then be forwarded to the Quality Assurance Manager in PET, who will examine it to ensure that:

- The response has been written in the tone of voice which reflects the Trust's 'We Care' values.
- All points in the complaint have been responded to.
- All actions to be taken are clearly outlined.
- That appropriate apologies have been given.
- All technical and clinical terms have been properly explained.
- All abbreviations have been shown initially in full.
- There are no typographical or grammatical errors.
- Any interested parties (e.g. MP) are copied into the response.
- Any enclosures mentioned in the letter have been supplied.

The Quality Assurance Manager will then forward the response letter, accompanied by the complaint correspondence and any related information, to the Chief Executive, or the Deputy if absent, for review and signature.

The Quality Assurance Manager is responsible for the despatch of the response to the client. Once the response has been sent, the Datix log will be updated and completed and the file closed. The Division will be alerted to the despatch of the response.

7 Learning from complaints

The role of the Division with regard to learning from complaints is paramount and to ensure robust learning and evidence the Divisions will:

- Ensure that all complaints and concerns are recorded onto their change registers and reported monthly at Divisional Clinical Governance meetings.
- Carry out any actions as advised in the response to the client and evidence that this action has been taken, including evidence of learning.
- Work with the PET as part of the 10% audit of cases carried out to evidence these actions and learning as part of the complaints management process.
- Performance target and improve measures where necessary

8 Reaching a conclusion

8.1 There are three possible outcomes to the investigation:

- The client and Trust agree that local resolution has come to an end, all issues have been resolved, ideally to the satisfaction of the client although there may be agreement to disagree.
- The client, but not the Trust, decides that local resolution has come to an end; there is nothing further to be done but the matter remains unresolved.
- The Trust, but not the client, decides that local resolution has come to an end: there is nothing further to be done but the matter remains unresolved

8.2 **If the client remains unhappy**

If the client contacts the PET to advise that they are unhappy with their response the PET will:

- Clarify with the client exactly with what they are unhappy and what resolution they seek.

- Advise the client if any further resolution can be provided, dependent on the response and the further questions that the client has raised.
- If the client has raised additional questions in direct response to the information that has been provided in the complaint letter and regarding the same episode of care then they can be considered.
- If the client has raised concerns that do not link directly with the original complaint and are not as a result of the response, but new questions, then these should be opened as a new complaint. This will be dependent on the discussion with the client or the clarity provided in any written correspondence.
- If the client has raised new concerns regarding a different episode of care then they cannot be considered and would need to be raised as a new complaint.
- Advise the client how their additional concerns will be taken forward; that the Trust will aim to offer a meeting.
- Advise and liaise with the Division regarding the client's additional concerns, and requests regarding further response.
- Advise the client if no further resolution can be provided under Stage 1 of Local Resolution and the reasons why and provide further advice concerning approaching the Parliamentary and Health Service Ombudsman.

9 Learning from Complaints

- Where it has been identified that an error occurred and action is required to improve the service this will be entered into the Division's change register.
- It is the responsibility of the Division to keep a record of all actions agreed with the client and to monitor performance to ensure actions are completed.
- Where a client has requested feedback regarding actions taken due to the concern that has been raised this will be supplied to the client, with copy to PET
- The Division is required to provide evidence of compliance to the PET on a monthly basis.
- PET will produce a quarterly 'Lessons Learnt' newsletter and will ensure that learning is disseminated through a number of channels, for instance the Trust's website and the Intranet.
- PET will also liaise with Healthwatch, SEAP and CCGs to provide anonymised complaint information

10 Stage Two of the complaints process; The Parliamentary and Health Service Ombudsman (PHSO)

If a client remains dissatisfied after local resolution they can ask the Parliamentary Health Service Ombudsman (PHSO) to undertake a review of their case. The client is advised of the contact details and the process either verbally or in writing at both the beginning and the end of local resolution. The Ombudsman will only consider the client's complaint when local resolution has been exhausted and will not consider the client's concerns if the complaint is still under local resolution or if there are outstanding concerns which have not been addressed.

10.1 **On receipt of correspondence from the PHSO, the Quality Assurance Manager will:**

- Log the correspondence.
- Determine the requirements of the PHSO.
- Inform the Division.
- Gather the requested information for the PHSO and send it, preferably by email and email attachments, complying with the PHSO's timescales.
- Obtain the Division's statement.
- If a letter is required from the Chief Executive, ensure that it is drafted in a timely fashion.
- If the PHSO makes a specific request of the Trust, for instance, a further apology letter to the client, or redress payments, to ensure that these are provided within the timescales of the PHSO.
- Report all contacts with the PHSO to the Board and the Quality Assurance Board.

Please note, no communication or documentation regarding comments or concerns should be kept on the patient's clinical notes; it should all be held separately and can be destroyed once PET have confirmed that they have received and logged it.

Appendix B

Guidelines for Management and recording of Concerns and Comments

Introduction

These guidelines provide information for responding to concerns raised by clients and visitors to the Trust, which would not be taken forward as part of the formal complaints route, and the recording of comments. It should be read in conjunction with the Policy for Managing Complaints, Concerns, Comments and Compliments.

A concern can be any query raised by a patient or client that requires prompt and immediate action and does not require a formal investigation. A comment is normally feedback provided by users of the service regarding the service that has been received or providing suggestions regarding improvements or changes that they feel would improve the service. The system is required to be flexible depending on the issues raised and the overall aim is to provide a speedy response to provide help and resolution and reassurance to the client as necessary.

Clients may need feedback to either their issue of concern or their comment.

1. Concerns

Each concern should be considered individually. Many issues which fall into this category can be dealt with by the member of staff who is liaising with the patient, or the patient's family (the client) and if not, then by their manager. It is important to handle concerns on the spot and quickly to avoid them escalating. The issues raised by the client should be logged onto a Feedback form, preferably by the client rather than a member of staff, so that the client's own words are recorded.

However, it should be noted that the feedback forms should be forwarded to PET for logging onto the Datix system by the Patient Experience Team (PET). Wherever possible this should be done electronically by scanning the feedback form and attaching it to an email to PET. The email should describe the action which was taken to resolve (or try to) the concern. This is paramount to ensure that themes and trends can be identified and acted upon where necessary by using client feedback as a tool for managing concerns to prevent escalation and also to ensure that members of staff are supported regarding the actions that they have taken when necessary.

If it is more appropriate for the client to be referred to the Patient Advice and Liaison Service, the client should be given the 'Talk to Us' leaflet and advice as to how contact can be made.

Some examples of cases that should be taken forward on the spot are:

- Concerns about current treatment where action can be taken quickly to resolve the problem and to return the client to the correct care pathway. It would be expected that these issues are dealt with by a manager (e.g. a ward manager)
- Simple problems for which an explanation is easily found and given, for example concerns about car parking and the fee to pay.
- An occasion where the client wishes to bring the matter to the attention of the Trust but does not want to make a formal complaint.

A report will be provided to the Divisions on a monthly basis providing information regarding all concerns that have been raised including a description of the concern, and the area where the treatment or incident occurred, to ensure that actions can be evidenced, including actions taken and lessons learnt as appropriate.

2. Comments

When a comment is received it is normally generic feedback provided by users of the service regarding general services. Some examples or comment are:

- The amount and type of car parking spaces available on each site.
- The lighting available in the car parks at night.
- Accessibility for clients to various services.
- Suggestion for improvement.

The Feedback form should be used wherever possible and scanned and emailed to PET, with a description of any actions taken. All comments received in writing should be forwarded to PET and will be acknowledged. The client will be thanked and advised of the action that has been taken.

Please note, no communication or documentation regarding comments or concerns should be kept on the patient's clinical notes; it should all be held separately and can be destroyed once PET have confirmed receipt.

Appendix C

How to deal with queries from patients, their families and their carers.

Guidance for staff at all levels

1. Summary

These guidelines provide information about the way in which the Trust expects individual members of staff to respond to concerns raised by the public. They should be read in conjunction with the Trust Policy for Management of Complaints, Comments, and Compliments.

2. Introduction

Every member of staff is responsible for responding politely and appropriately when approached by a user of the service, or visitor to the Trust, who is expressing a concern or asking for help. Taking a few minutes to respond helpfully gives the user of the service a positive experience and can often avoid a formal complaint being made. All users of our service have a right to have their views heard and acted upon. It is the absolute expectation of the Trust that communication standards will reflect the 'We Care' behaviours.

3. Individual Responsibilities

Always introduce yourself; give your full name and your job title. Where possible, always respond immediately to concerns or questions raised by users of the service. However, first consider whether you are able to reply, and whether it is appropriate for you to do so. If the matter is such that you do not have the experience or knowledge to respond, or the issue is of a serious nature and needs escalating, immediately refer the person to a colleague who will able to assist.

If you are able to answer but have another immediate priority, offer to return later to provide the answer and make good on the offer as promised.

Remember to take into account that the hospital environment is unfamiliar to the majority of users. As staff we are accustomed to this world and understand how it works; patients and visitors are not and need help to find their way. If you can help a patient to understand the process that involves them and what they can expect to happen to them, they are far more likely to be satisfied with the service they receive, feel reassured, their confidence restored and receive an improved patient experience as a whole.

Being pro-active in communicating with patients is essential. If you are in a position to do so keep patients informed about events which are affecting them, such as delays in outpatient clinics, so that they can understand what is happening without having to ask. Most people understand about delays, for example, as long as they know what is going on. Be factual and avoid passing comment about a member of staff, the service or Trust, or providing your personal opinion.

In line with the 'We Care' values it is important to treat all clients who have raised concerns as individuals, understanding that are likely to be afraid, stressed or uncertain of what is happening and that most times people are seeking reassurance. Being pro-active provides this reassurance. Here are some examples:

"I'm sorry but the doctor has been held up on his ward rounds and clinic is running about 30 minutes late".

Rather than:

"Doctor is late again, I'm sorry this is always happening; I'm sure he will be here soon".

Try to be positive and diffuse the situation. For example, it is better to respond to complaints about car parking by saying something like:

"I am sorry you've been affected. We are trying to make some changes but in the meantime we do make allowances for people who are late arriving".

Rather than:

"I know, it's awful; we keep complaining about it, but they never do anything about it".

When you have dealt personally with a concern raised by a user of the service, consider whether you need to let your manager know about it. Trends and themes can only be identified, and problems rectified, if information is shared. It is good practice to inform the Patient Experience Team (PET), especially in situations where you feel the client may still be unhappy, so that the Team can be pro-active if and when contact has been made.

Please note that The Patient Advice and Liaison Service (PALS) is the 'front facing' part of the Patient Experience Team. There is at least one PALS officer in each of the three main hospitals. While their chief point of contact is by telephone, they can meet clients face to face. PALS staff are very good at being able to assist patients with their immediate needs and concerns. If an issue later becomes a concern or a complaint, the Patient Experience Team (PET) will assist

Do not send any person(s) to the Patient Experience Team suggesting, '*You need to make a complaint'*. This is not helpful to the patient and does not solve the problem. The first thing the team will need to do is come back to your area to find out the answer. The Team is there to support staff if the front line response has failed and the situation has become more difficult, and to provide advice and training for staff.

Please note: Staff are not expected to tolerate rude or violent behaviour from patients or visitors and guidance in this respect is provided in the Trust's Policy on Managing Violence and Aggression.

4. Managers' Responsibilities

All Managers should ensure that staff have a clear understanding of how to respond and have the responsibility to respond positively and helpfully to expressions of concern from users. At staff appraisal this can be provided through discussion of the communication section of the Knowledge Skills Framework (KSF) to ensure that all team members develop strong and effective communication skills.

Staff members are required attend training sessions provided by the Patient Experience Team as part of the Patient Experience initiative. They should also be made aware that they can job shadow the Senior Patient Experience Officers.

A set of core standards should be agreed with the team regarding customer service and improving the patient experience. This will provide them with the confidence, skills and understanding to enable them to deal with concerns by being pro-active and not reactive.

Managers need to be certain that staff are aware that they can should expect to be treated with respect and courtesy by patients and visitors but that they are the professional in the situation and that each individual may have particular worries or fears that they are handling at that time. Most people who attend hospital feel fear in some way and compassion and understanding is essential to ensure that we deal with all clients concerns actively and pro-actively.

- Where necessary, make sure that systems exist to keep users informed about what is happening.
- In patient areas make sure that the environment allows for privacy and dignity to be preserved. If confidential details need to be discussed, try to make sure the discussion cannot be overheard.
- Managers need to ensure that staff are aware of the types of issues raised by users that are expect them to be escalated to them. This guidance must specifically deal with concerns raised in writing to named members of staff.

In situations where it is felt that the client may make further contact or that the actions taken should be recorded please email the details to the PET at:
ekh-tr.patientexperienceteam@nhs.net
to ensure that the concern is logged onto Datix.

5. Summary

All staff should take personal ownership when approached by the public raising questions or concerns. The problem should be resolved quickly, if possible, or escalated to another colleague who can assist.

Staff should be polite, positive and open in responses. Sorting out a problem at the start, when it is small and manageable, saves everyone time and trouble in the long run.

Appendix D

Guidelines for responding to and recording compliments

1. Summary

These guidelines provide information about the way in which the Trust records and learns from compliments provided by users of our service. It should be read in conjunction with the Trust Policy for Management of Complaints, Comments, Concerns and Compliments.

2. Introduction

The Trust recognises the immense power of positive feedback provided to the organisation. Compliments help to reinforce that we are actually doing a good job and can often make a considerable contribution to job satisfaction. When we learn about compliments we can often learn about and reinforce excellent working practices. If we discover that a particular unit is getting lots of compliments we want to find out what they are doing so well, so that we can cascade the magic.

All staff members are asked to ensure that all compliments, verbal or in writing are recorded since the number of compliments is reported monthly to the Board and other committees. In the normal day staff receive many grateful comments but can be difficult to establish what should be recorded as a compliment. This document advises staff when and how to record the relevant information.

3. Individual Responsibilities

- All staff should be aware of the recording mechanism for compliments within their working area, but we recommend that the attached proforma is used.
- There is a Feedback form which can be supplied for patients and their families for use, should they wish, for written compliments, comments and concerns.
- Clients can also be reminded that they can provide feedback through the website.
- All managers are responsible for ensuring that their staff are aware of how the compliments for their area are recorded, and of the importance of the complimentary feedback.
- Managers must forward the compliments for the month electronically or in paper form at the end of each month to the Patient Experience Team (PET). The cards and notes are not necessary so long as they are properly noted on the form or scanned and sent.
- The Chief Executive is frequently sent letters and emails which are complimentary about our services; these are also forwarded to PET for recording.

4. What's a Compliment?

A verbal compliment is not a simple thank you but should be considered where a patient, family member, carer or friend have taken additional time or made additional effort to say thank you. Some examples are:

Patient: "Thank you for washing me" - this would not be considered a compliment. Alternatively, Patient: "Thank you for washing me. You have made me feel so much better and I am much more comfortable. **You are always so helpful**" - this is a compliment.

Family member: "Thank you for all your help" - would not be considered a compliment but where a family member takes time to come to the nurses' station, or find an individual to thank them personally for all that has been done, this would be considered a compliment.

If a member of staff is unsure they can always consult the PET who can offer advice.

- Any client who has complimented the service either verbally or in writing should have their thanks acknowledged. This can be verbally or in writing.
- PET will record the figures onto a database and this information will be provided to Trust Board in the monthly and quarterly board report, and the Quality Assurance Board on a quarterly basis.
- A compliment will be published in Trust News on a weekly basis as a ‘magical moment’.

Date	Hospital	Locality (e.g. ward)	Patient name and/ or PAS number	Staff being complimented	The compliment

Please ensure this information is sent to the Patient Experience Team promptly at the beginning of each month for the previous month's compliments

Appendix E

Guidelines for managing habitually demanding or vexatious complainants

1. Introduction

1.1 Handling habitually demanding or vexatious complainants can place a strain on time and resources and cause unacceptable stress for members of staff, who may need support in difficult situations.

1.2 While the vast majority of people who do come into contact with staff do not display vexatious behaviour, the procedures outlined in this policy are designed to help staff deal with the small minority who do make unacceptable demands on staff time. The procedures in this policy should only be followed in exceptional circumstances, after all reasonable measures have been taken to try to resolve issues locally or through the NHS complaints procedure.

1.3 Judgment and discretion must be used in applying the criteria to identify such behaviour and in deciding on the action to be taken in each case. The procedure will only be implemented following careful consideration by, and with the authorisation of, the Chief Executive of the Trust and any relevant Director (or their deputy).

2. Purpose

2.1 The procedures described in this section of the Policy are designed to identify situations where a person might be considered to fall into the habitually demanding or vexatious categories and establish methods whereby they can be treated equitably and fairly. It is also intended to protect staff from the nuisance, abuse and threatened or actual harm, which may be caused by such behaviour.

3. Definition

3.1 Complainants or others coming into contact with the Trust may act out of character. They may show signs of vexatious behaviour for a number of reasons and may be unaware that their attitude or behaviour is causing unnecessary distress to others. Unacceptable behaviour that continues through several contacts, however, should be considered against this procedure.

3.2 One definition of vexatious behaviour is to harass, distress, annoy, tease, cause trouble, agitate, disturb or pursue issues excessively. For the purposes of this policy behaviour exhibited by a person may be deemed to be habitually demanding or vexatious where previous or current contact with them shows that they meet any of the following criteria:

- **Persisting in pursuing a complaint** where the NHS complaints procedure has been fully and properly implemented and exhausted, even when an appeal has been made to the Parliamentary Health Service Ombudsman.

- **Seeking to prolong contact** by continually raising further concerns or questions upon receipt of a response. Care must be taken not to discard new issues, which are significantly different from the original issue. These will need to be addressed as separate issues.

- **Unwilling to accept documented evidence** as being factual or denying receipt of an adequate response in spite of correspondence specifically answering their questions, or does not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- **Does not clearly identify the precise problem,** despite reasonable efforts of Trust staff and, where appropriate, the independent complaints advocacy service provided by SEAP (Support, Empower, Advocate, Promote) to help them specify their concerns, and/or where the concerns are not within the remit of the Trust to investigate.

- **Focuses on a matter to an extent, which is out of proportion to its significance** and continues to focus on this point. It is recognised that determining what is justified can be subjective and careful judgement must be used in applying this criterion.

- **Has threatened or used actual physical violence towards staff or their families or associates.** This will, of itself, cause personal contact with the person and/or their representatives to be discontinued and the issue will, thereafter, only be pursued through written communication. This must be reported to the Police and must also be reported as a serious incident in Datix.

- **Has harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their issue** or their families or associates. However, staff must recognise that people may sometimes act out of character at times of stress, anxiety or illness and should make reasonable allowances for this. However, there may be grounds for reporting the incident(s) to be police. Again this must be reported as a serious incident in Datix.

- Has had, in the course of addressing an issue, an **excessive number of contacts with the Trust,** placing unreasonable demands on staff time or resources. A contact may be in person, or by telephone, letter, fax or e-mail. Judgement must be used in determining what is an 'excessive number' of contacts and this will be based on the specific circumstances of each individual case.

- **Has electronically recorded meetings or face to face/telephone conversations** without the prior knowledge or consent of the other parties involved.

- **Displays unreasonable demands or expectations** and fails to accept that these may be unreasonable (e.g. insists on responses to enquiries being provided more urgently than is reasonable or normally recognised practice).

4. Roles and Responsibilities

4.1 Management Responsibilities

- The Head of the PET is responsible for overseeing the management of complaints and complaints received and will liaise closely with the Division concerned if a complainant is deemed vexatious
- Each Division within the Trust has a designated complaints lead to oversee the investigation of each complaint received concerning that Division.
- The Chief Executive's office is not expected to become involved in handling a vexatious complainant, although it is highly likely that the complainant attempts to contact the Chief Executive. The complainant should be firmly advised that the matter has been delegated to the Patient Experience Team.

4.2 Employee Responsibilities

Every member of staff involved with a potentially vexatious complainant needs to be vigilant in fully recording any suggestion of vexatious behaviour. Good documented evidence will be required and the completion of incident forms is mandatory for incidents relating to possible verbal or physical abuse, including telephone conversations.

5. Protocols for dealing with habitually demanding or vexatious complainants and/or habitually demanding or vexatious behaviour

5.1 Once it is clear that an individual meets most of the criteria above, the Head of PET will notify the Chief Executive and the relevant Director (or their deputy) will advise what action should be taken.

5.2 A letter should be sent from the Chief Executive Director stating clearly which elements of their behaviour are causing problems and be accompanied by a copy of this policy.

5.3 The letter should also advise that the complainant can seek advice from SEAP in presenting their complaint if they seem unable to identify the problems.

5.4 The Trust will also consider independent mediation in these circumstances.

5.5 If appropriate, notifications under this policy may be copied for the information of others already involved e.g. Clinical Commissioning Groups, General Practitioners, SEAP, and Member of Parliament.

5.6 An unequivocal record will be kept detailing the reasons why someone has been classified as 'habitual or vexatious'.

5.7 It may be appropriate to try to resolve matters by drawing up a signed agreement with the person, which sets out a code of behaviour for the parties involved, if the Trust is to continue communication or to process a complaint. If these terms are contravened consideration will be given to implementing 5.9 of the procedure.

5.8 A code of behaviour could include the following:

- An agreement relating to appropriate behaviour and conduct. Any such agreement should normally not extend beyond six months.
- Restricting contact to one or two individuals within the Trust.
- Restricting the method of communication to letter sent through the post only; not fax, email or telephone.
- Offering a meeting to attempt to resolve outstanding issues.

5.9 Where the Trust has responded fully to the points raised by the person and has tried to resolve the issues, without success, and continuing contact on the matter would serve no useful purpose, the individual will be notified by the Chief Executive that the contact is at an end and that further contact will be acknowledged, but not answered.

5.10 In extreme cases, or where the safety of staff is at risk, the individual will be informed that the Trust reserves the right to pass information concerning habitually unreasonable or vexatious behaviour to its solicitors and the Police. All contact with the person and investigation of the complaint will be suspended whilst seeking legal advice or relevant professional guidance.

5.11 Any further complaints received from a person who has been designated as habitually demanding or vexatious, under this policy, will be subject to a reasonable investigation as deemed necessary by the Chief Executive in conjunction with advice received from staff dealing with complaints.

5.12 The Chief Executive (or deputy), in conjunction with the Chairman, may, at their discretion, choose to omit one or two of the above stages.

6. Withdrawing Habitual or Vexatious Status

6.1 When individuals have been classified as habitual or vexatious, the status will continue to apply for six months, at the end of which period habitual or vexatious status will automatically be withdrawn.

6.2 In exceptional circumstances, the Trust will consider withdrawing this status earlier if, for example, the person subsequently demonstrates a more reasonable approach.

6.3 The status of 'habitual or vexatious' will only apply to specific issues, not general. If a new issue comes to light, an individual's behaviour may not be deemed habitual or vexatious unless their behaviour demonstrated this relating to the new issue.

6.4 Where it appears to be appropriate to withdraw "habitually demanding or vexatious" behaviour status, the approval of the Chief Executive and relevant Director (or their deputy) will be required. Subject to this approval, normal contact with the person will be resumed.

7. Freedom of Information Act 2000

7.1 Where a Freedom of Information Act request is made by a complainant or person who has been designated as habitually demanding or vexatious, the Trust may take into account the habitually demanding or vexatious complainant's behaviour in assessing whether that individual request is a vexatious request. In doing so, the Trust will also follow Information Commissioner's guidance on vexatious requests.

8. Document Archiving

8.1 Documents will be archived in accordance with the Trust policy.

9. Review

9.1 These guidelines will be reviewed two years from publication, unless circumstances arise requiring an early review or updating of the policy.

Appendix F

Responding to Complaints
Kent and Medway
Joint Working Protocol

Organisations that have signed up to this Protocol are:

- **Kent County Council**
- **Kent Community Health NHS Trust**
- **Kent and Medway NHS and Social Care Partnership Trust**
- **Medway Community Healthcare**
- **Medway NHS Foundation Trust**
- **South East Coat Ambulance Service NHS Foundation Trust**
- **East Kent Hospitals University Foundation Trust**

Document History:
Created: 31.03.2009
1st review: 24.09.2010
2nd review: 2.12.2011 updated 02.10.2012
3rd review: December 2012

RESPONDING TO COMPLAINTS
KENT AND MEDWAYJOINT WORKING PROTOCOL

The overarching principle for this joint working protocol will be that the focus will always be on the client and all work will be undertaken with due regard to the agreement, understanding and acceptance of the client and aim to provide one response wherever possible.

PRINCIPLES

- **Timescales**
  Each organisation will aim to respond within the time frames laid out in their policies. Where there is multi-agency involvement a time scale will be agreed by negotiation between all parties. If issues arise with meeting time frames there may be need to send separate responses to complaints. Complainants need to be in agreement with timeframes.

- **Organisational policies**
  All policies will adhere to the regulations and the three 'Principles of …' documents published by the Parliamentary and Health Service Ombudsman will underpin the policies and procedures of each organisation. These are: Good Administration; For Remedy; and Good Complaint Handling.

  Consideration should be given to other processes/policies taking precedence over complaints process i.e. matters of safeguarding, litigation, disciplinary and communication needs to be escalated to all parties involved.

  The Joint Working Protocol will be attached as an appendix to each organisation's Complaints Policy document and will therefore be ratified within the governance arrangements for that organisation.

- **Outcomes**
  Outcomes will be shared to disseminate good practice where appropriate and with due regard for client confidentiality.

PRINCIPLES IN ACTION

- **Lead Organisation**
  The recipient organisation will take responsibility for establishing a named lead organisation and for issuing an acknowledgement within the regulation timescale and, if applicable, informing the complainant of advocacy services. The recipient organisation will remain as the named lead organisation until there is a formal transfer of responsibility, for which a clear audit trail will be kept.

- **Complaint planning**
  A joint complaint handling plan will be agreed at the earliest opportunity.
  Refer to the Cross Organisation Cases: Practical Response document.

- **Communication**
  All internal and external concerns/enquiries/complaints raised should be processed in accordance to each organisational complaints process via the customer care/complaints department.

  Discussion about cases will be with persons of a sufficiently senior level to ensure they are able to speak for the organisation.

CROSS ORGANISATION CASES

Practical Response

Lead organisation: the main addressee of a 'round robin' letter is deemed to be the lead organisation and responsible for taking the case forward until agreed otherwise.

Step one: The organisation contacts the complainant, acknowledges receipt and obtains verbal consent for the issues to be discussed with all other organisations involved, explaining contact will be made again to discuss the concerns in more detail once we understand what each organisation needs to do. Where there is GP involvement, initial contact will be with the PCT for advice on who to approach. The complainant should be involved in the decision making process for which organisation should take the lead. If it is clear that a different organisation is responsible for all issues within the complaint this should be communicated to the complainant, consent obtained and the documentation passed over.

Step two: The lead organisation shares the details of the case with all other organisations involved in the events and discuss the details and agrees a plan. Paragraphs in all correspondence can be numbered for ease of reference if necessary. Confirmation that verbal consent must be given and this should be followed with a copy of the written consent form as soon as it is received, prior to sending the reply.

All organisations to provide contact details via the Kent and Medway Health and Social Care Complaints Management Network Group for their named individuals who lead complaints and identify their lead responsibility.

Step three: Agree the management plan for the case. Confirm who will be the lead organisation, which issues each organisation will respond to and confirm timeframes.

Ideally an agreement is to be reached with the aim of providing one response covering all issues raised. Consideration must be given at this planning stage as to whether an alternative approach is actually in the best interests of the client. The wishes of the client will be taken into consideration at all times. If it is agreed by all parties that one, joined up response is not the best approach, this should be noted in the record and the reasons for the alternative approach must be clearly documented and communicated to the complainant (review as complaint progresses).

The Lead organisation then takes responsibility for liaising with the client, discussing and agreeing the plan with them. The plan will be shared with the other organisations. Complaint plan to be as precise as possible. If the client becomes unhappy with the plan, it is the lead organisations responsibility to agree the way forward with the complainant and then communicate this to the other organisations.

Step four: Respond to the concerns raised. All organisations then have responsibility for completing their agreed actions within the time frame negotiated. If written information is requested, this should be provided electronically, in a word document wherever possible, to the lead organisation in order that it can be easily transferred into the complaint response letter. This must be shared securely (gcsx/nhs.net) The lead organisation must be notified as soon as it is clear that a time frame cannot be achieved and agreement reached about the best course of action and this must be communicated to the complainant.

It may be necessary during the progress of a complaint to transfer lead agency responsibility to another organisation. This should happen where possible with the consent and agreement of the complainant as well as the other organisation.

Step five: Closing the case. The lead organisation is responsible for ensuring that the final letter sent to the complainant is in a consistent style and appropriate format. The lead organisation is responsible for providing a copy of any correspondence with the complainant to all organisations involved.

Summary of the Process – for the Lead Organisation:

1 Receive complaint
2 Identify other organisations involved
3 Speak to complainant, clarify complaint and get consent
4 Pass complaint to other organisational contacts
5 Complete action plan confirming which organisation provides what
6 Agree timeframe with other organisation leads
7 Communicate with complainant including review if necessary
8 Receive all responses
9 Compile joint response
10 Send response to complainant and copy to other organisations

Each complaints/customer care team is responsible for promoting the joint working protocols within their own organisation. To assist with the operation of the protocols, it is important that organisations route their contacts and enquiries with each other through the complaints/customer care teams and do not contact operational staff directly.

In the exceptional cases where separate response letters will be sent to the complainant, the Lead organisation is responsible for ensuring that the content of separate replies do not result in contradictions or apportionment of blame to another organisation.

Appendix G

Equality Impact Assessment – Management of Complaints, Concerns, Comments and Compliments

Appendix G: Equality Impact Assessment

Name of the policy, strategy or business case:	Policy for Management of Complaints, Concerns, Comments and Compliments

Details of person completing the Analysis	
Name	Liz Coleman
Job Title	Head of Patient Experience
Division/Directorate	Nursing and Quality
Telephone Number	01227 864262

What are the main aims, purpose and outcomes of the policy, strategy or business case?	• To provide all the staff of the East Kent Hospitals University NHS Foundation Trust with a framework for understanding complaints, concerns, comments and compliments (the 4Cs). • To ensure compliance with national regulations and guidance. • To provide the fundamental requirements of good handling of the 4Cs, to deliver arrangements in an easily accessible, equitable, sensitive and open manner. • To demonstrate the elimination of discrimination, harassment and victimisation of both our clients and staff
Does it relate to our role as a service provider and/or an employer?	This policy relates to the Trust's role as a service provider to all people in the wider community. It also relates to how staff are supported an informed during the complaints process.
Information and research: • Outline the information and research that has informed the decision. • Include sources and key findings. • Include information on how the decision will affect people with different protected characteristics.	All NHS Trusts must have a policy of this nature. The documents with which this policy complies are given at sections 22 and 23. Research and use of the previous policy demonstrates that clients expect an accessible and easy-to-use complaints process. They expect that the 4Cs are dealt with in a speedy, equitable, sensitive and open manner. This policy will ensure that members of staff have the correct tools in which to supply good complaints handling. The policy will provide due regard to and foster good relations between person who share a relevant protected characteristic and persons who do not

	share it, by providing a sensitive approach to all people. The policy continues and reinforces the Trust's duty to eliminate discrimination, advance equality of opportunity and foster good relations.
Consultation: • Has there been specific consultation on this decision? • What were the results of the consultation? • Did the consultation analysis reveal any difference in views across the protected characteristics? Can any conclusions be drawn from the analysis on how the decision will affect people with different protected characteristics?	A wide variety of stakeholders within the Trust have been consulted, including staff who manage and respond to complaints, the Deputy Chief Nurse and CAB. People who have made complaints (i.e. clients) have also been consulted and their very useful comments have been included. No one has commented on issues concerning equality.

Is the policy, strategy or business case relevant to the aims of the equality duty?
Guidance on the aims can be found in the EHRC's PSED Technical Guidance.

Aim	Yes/No
1) Eliminate discrimination, harassment and victimisation	Yes
2) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it	Yes
3) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it	Yes

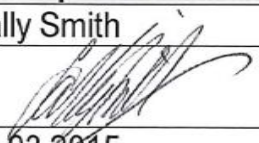
Assess the relevance of the decision to people with different protected characteristics and assess the impact of the decision on people with different protected characteristics.
When assessing relevance and impact, make it clear who the assessment applies to within the protected characteristic category. For example, a decision may have high relevance for young people but low relevance for older people; it may have a positive impact on women but a neutral impact on men.

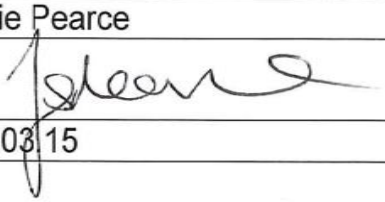
Protected characteristic	**Relevance to decision** High/Medium/Low/None	**Impact of decision** Positive/Neutral/Negative
Age	High	Positive
Disability	High	Positive
Gender reassignment	High	Positive
Marriage and civil partnership	High	Positive
Pregnancy and maternity	High	Positive
Race	High	Positive
Religion or belief	High	Positive

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

Conclusion: • Consider how due regard has been had to the equality duty, from start to finish. • There should be no unlawful discrimination arising from the decision (see PSED Technical Guidance). • Advise on the overall equality implications that should be taken into account in the final decision, considering relevance and impact.	This policy has been written with high regard to the Trust's duty of equality. It demonstrates our commitment to ensure that all clients of the Trust have equal access to the ability to comment on the Trust's services. We have provided a number of ways in which clients can contact us to provide comments, including non-written methods. We will provide interpretation and signing on request. The policy also demonstrates that we will liaise equitably with all members of staff when handling any of the 4C's. It also demonstrates that we will learn from any complaints made and if they were about any issues of inequality, we would ensure that these are rectified

Signature of person completing the Analysis	
Name	Liz Coleman
Signed	
Date	25 February 2015

Approval and sign-off Head of Department/Director	
Name	Sally Smith
Signed	
Date	04.03.2015

Chair of decision making Board/Group/Committee approval and sign-off	
Name	Julie Pearce
Signed	
Date	04.03.15

Appendix H

Plan for Dissemination of Procedural Documents

TIMEFRAME FOR DISSEMINATION	TO WHOM	HOW
Within one month of ratification at the Quality Assurance Board	**All Divisional Leads**	**Electronic format**
Within one month of ratification at Quality Assurance Board	**All Lead Nurses**	**Electronic Format**
Within one month of ratification at Quality Assurance Board	**Public and Staff**	**Available on East Kent Hospitals University NHS Foundation Trust Intranet and web site.**

Appendix I

Certification of Employee Awareness

Document Title	**Management of Complaints, Concerns, Comments and Compliments Policy**
Version Number	**9**
Version Date	**4 March 2015**

I hereby certify that I have:

- Identified (by reference to the document control sheet of the above policy and procedure) the staff groups within my area of responsibility to whom this policy and procedure applies.
- Made arrangements to ensure that such members of staff have the opportunity to be aware of the existence of this document and have the means to access, read and understand it.

Signature	
Print Name	**Elizabeth (Liz) Coleman**
Date	**5 March 2015**
Directorate and Department	**Nursing and Quality, Patient Experience Team**

The manager completing this certification should retain it for audit and other purposes.

Appendix J

Procedure for Managing Claims for Financial Redress

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 (EKHUFT) 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, EKHUFT 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 EKHUFT from independent and third sector providers. In these cases EKHUFT still has an organisational responsibility for the service being provided[1] (see Sections 9 and 10).

1.4 The policy 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 considered

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

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*.* The policy also draws on the principles set out in the Local Government Ombudsman's report *Remedies, Guidance on Good Practice*.

2.2 The NHS Finance Manual[3] 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 EKHUFT, 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 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 EKHUFT 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 EKHUFT 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 EKHUFT'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 EKHUFT's actions or non-actions.

6. General principles of remedy

6.1 The PHSO *Principles for Remedy* 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, EKHUFT must come to its own decision on what is a reasonable, proportionate, remedy. This may include providing a financial 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 EKHUFT 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 EKHUFT'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. EKHUFT 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 EKHUFT'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 EKHUFT's responses, the vulnerability of the individual and whether there has been any element of wilful action of EKHUFT 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 EKHUFT 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 EKHUFT 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 Division or their nominated deputy. There should be a representative from each Division for which there is a request letter to be considered.
c) Head of Patient Experience Team or nominated deputy

It will be quorate when there are at least three members plus a member of PET

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 Patient Experience 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, EKHUFT 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, EKHUFT 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 Divisional 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	

Definitions and Glossary

Patient	The person whose care and treatment is the subject of the complaint, concern or comment, whether alive or sadly deceased.
Client	The person who is raising the complaint, concern or comment. Patient permission is required from the patient in order for the client to be provided with the details of the outcome.
The Regulations	As set out in section 1, Introduction.
An investigation	The process of discovering and evidencing what actually happened in relation to the concerns being raised.
A response	Once the investigation has taken place, a response can be made to the complaint which demonstrates what was discovered as part of the investigation, apologies as required and an explanation regarding the learning made by the Trust, including as appropriate, an action plan.
A complaint/ concern	An expression of dissatisfaction or disquiet with any care or treatment by the Trust which requires an investigation and a response.
The Patient Experience Team (PET)	PET has the responsibility for assisting all clients who wish to provide feedback into the Trust's complaint/concern/comment/compliment service, managing the process to ensure that the issue is properly recorded and reported on, and to ensure a proper and timely response. This is done in liaison with the relevant division(s).
The Patient Advice and Liaison Service (PALS)	PALS offers confidential advice, support and information on health-related matters. They provide a readily accessible (telephone, email or face-to-face) point of contact for patients, their families and their carers. They aim to provide a response to the matter raised within 24 hours.
Division	The part of the Trust which has a responsibility for a particular aspect of care, for instance, Surgical Services.
The Trust	The East Kent Hospitals NHS University Foundation Trust. The three main hospitals within the Trust are the Kent and Canterbury Hospital, the William Harvey Hospital (Ashford) and the Queen Elizabeth the Queen Mother Hospital (Margate).

The PHSO	Clients can go to the Parliamentary and Health Service Ombudsman if they are unhappy with how we have dealt with your complaint, and they also feel that local resolution has been completed. The service is free and the Ombudsman is independent of the NHS or Government. By law, a client should usually approach them within a year of when you first became aware of the problem, but if they have good reasons for the delay, the PHSO may still be able to help. If the Ombudsman decides that we have got things wrong, we will receive advice as to how to put things right.
FOI	Freedom of Information. Some complaints will have an aspect of an FOI request in them which must be separated out and dealt with by the Trust's FOI lead.
Redress	We undertake to supply remedy whereby, if injustice or hardship has been suffered as a result of maladministration or poor service, the person so affected is returned to the position they were in before the maladministration or poor service took place or, if that is not possible, to compensate them appropriately. See the Redress Policy, Appendix J for details.