# COMPLAINTS POLICY

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Leeds Teaching Hospitals NHS Trust Complaints Policy.</th>
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<tbody>
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<tr>
<td>Lead Board Director:</td>
<td>Suzanne Hinchcliffe, Chief Nurse, CBE.</td>
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<tr>
<td>Policy Lead (and author if different):</td>
<td>Clare Linley Deputy, Chief Nurse.</td>
</tr>
<tr>
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<td>Patient Experience Sub Committee.</td>
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| Keywords | Complaints, Concerns, PALS, Learning, Clinical Governance, Patient Experience, Staff Behaviours. |
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Staff Summary

Where any person experiencing the services we provide expresses dissatisfaction; an apology must be given and action must be taken to resolve the issues as soon as possible. The action taken should be discussed with the person raising the concern and any resolution should be to their satisfaction.

The spirit of the complaints policy is that all staff are empowered to resolve minor comments, grumbles and problems immediately.

A key objective of the organisation is the willingness to listen, to change, improve and evolve in response to complaints. The lessons learned and trends identified through complaints play a key role in improving the quality of care received by patients and are a priority for the Trust. This policy sets out the Trust's processes for handling, responding to and learning from complaints, both formal and informal. This policy is to support all Trust staff to guide them in what to do if a patient, relative or carer raises any concern or complaint with them.

The effects of harming a patient can be widespread. Patient safety incidents can have devastating emotional and physical consequences for patients, their families and carers, and can be distressing for the professionals involved. Being open about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the aftereffects. Openness and honesty can also help to prevent such events becoming formal complaints and litigation claims.

It is important to offer the complainant an early face to face opportunity to discuss their dissatisfaction, discuss how their complaint will be investigated and what outcome they would like to receive. Direct, personal contact must be made with all complainants as soon as possible after a written complaint is received.

The language of complaint responses must demonstrate compassion and empathy. The key purpose of a complaint response is to acknowledge and apologise for the issues raised and describe the changes made in response to the complaint.

In addition, where staff become aware that services have not met the high standards expected by the Trust; staff must acknowledge this with the patient, apologise and take action to resolve the issues to the satisfaction of the person raising the concern. This provides a better outcome for the person raising the concern and also prevents them from having the inconvenience and sometimes additional worry of entering into a formal complaints process.

Patients and service users are encouraged to express complaints, concerns and views both positive and negative about the treatment and services they receive, in the knowledge that:

- they will be taken seriously
• they will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond
• appropriate action will be taken
• lessons will be learnt and disseminated to staff accordingly
• there will be no adverse effects on their future care or that of their families

The Trust recognises that patients and their relatives have a right to raise concerns about the services they receive. It is expected that staff will not treat patients or their relatives unfairly as a result of any complaint or concern raised by them. Any complaints of unfair treatment as a result of having made a complaint will be investigated and appropriate action will be taken as necessary. Discrimination against people who make complaints or raise concerns is unacceptable and will not be tolerated.

All complaints from children will be handled in accordance with the ‘Common Principles for a Child Friendly Complaints Process’ published by the Childrens Commissioner for England (appendix H)

Leeds Teaching Hospitals is a co-signatory to ‘Speak Out Safely’ a national campaign by the Royal College of Nursing. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity. If staff have concerns about professional and or clinical practice of any of their colleagues, they should in the first instance raise this with the relevant line manager, with a view to escalating this internally to a member of the Clinical Service Unit or Clinical Support Unit (CSU) Management Team. Staff also have access to the Trust’s Whistle-blowing Policy, which refers to such issues as potential unlawful conduct, financial malpractice or fraud, dangers to the public or the environment including health and safety of patients.

The Trust’s general rules for handling formal complaints and concerns (PALS) are set out at appendix A of this Policy.

The process for handling formal complaints is described in detail in the flow charts at appendix C (Complaints involving patient services in a single CSU) and appendix D (Complaints involving services in more than one CSU).

The process for handling informal complaints is described in detail at appendix G of this policy.

This policy is closely aligned with the Investigation of Incidents, Complaints and Claims Policy (‘Investigations’ Policy)

Further information is available on the Patient Experience Complaints Intranet page http://lthweb/sites/complaints or by contacting the Patient Experience Team on (0113 2066018).

1 PURPOSE

A key objective of the organisation is the willingness to change, improve and evolve in response to complaints. The lessons learned and trends identified through complaints play a key role in improving the quality of care received by patients and is a priority for the Trust. This policy sets out the Trust’s processes for handling, responding to and learning from complaints, both formal and informal. This policy is relevant to all Trust
staff who must know what to do if a patient, relative or carer raises any concern or complaint with them.

People accessing our services are encouraged to express complaints, concerns and views both positive and negative about their experience, in the knowledge that:

- They will be taken seriously.
- They will receive a speedy and effective response by a member of staff appropriately qualified and trained to respond.
- Appropriate action will be taken.
- Lessons will be learnt and disseminated to staff accordingly.
- There will be no adverse effects on their care or that of their families.

The aim of this policy is to provide all those involved in the complaints process with a clear understanding of the Trust’s expectations and requirements. The policy is based on legislation, best practice and guidance from national bodies.

Failure to follow this policy could result in the instigation of disciplinary procedures.

2 BACKGROUND AND CONTEXT

Under the NHS Complaint Regulations 2009, the issues raised and the way in which the complainant would like them to be handled must be paramount, the approach chosen must be reasonable and proportionate in relation to the issues raised and the circumstances of the complainant.

The Parliamentary and Health Service Ombudsman’s Principles of Good Complaint Handling will be used by the Trust as the standard to be observed in the handling of all complaints; they are summarised as follows;

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

National Patient Safety Agency, National Reporting and Learning Service issued guidance in 2009 on communicating patient safety incidents with patients, their families and carers. These principles will also be used by the Trust in the handling of all complaints. Being open about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients and professionals to cope better with the aftereffects. Openness and honesty can also help to prevent such events becoming formal complaints and litigation claims. Being open involves:

- Acknowledging, apologising and explaining when things go wrong.
- Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- Providing support for those involved to cope with the physical and psychological consequences of what happened.
It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

Guidance following the final report by Right Honourable Ann Clwyd MP and Professor Tricia Hart “A Review of the NHS Hospitals Complaints System - Putting Patients Back in the Picture” published on 31st October 2013 has also been considered in the refresh of this policy.

3 DEFINITIONS

A complaint can be defined as: “any expression of dissatisfaction that requires response or action”.

Use of the word “complaint” should not automatically mean that someone expressing dissatisfaction enters the formal complaints process. It may be more appropriate for concerns to be dealt with and resolved in a more immediate and timely manner. As long as this is done with the agreement of the person raising the complaint then this approach is appropriate and preferable.

Dissatisfaction may be expressed orally or in writing (letter, email, text and form or web submission). A complaint may also be raised via external agencies for example Members of Parliament and the NHS Choices website.

CSU is used within this policy to refer to all operational management units in the Trust including Clinical Service Units and Clinical Support Units, The Women’s and Children’s Hospital and The Cancer Centre.

4 POLICY EFFECT

4.1 Handling of Complaints

The Trust’s general rules for handling complaints are set out at appendix A of this Policy. They provide further information on issues such as consent, confidentiality, and handling complaints of a criminal nature.

Direct, personal contact must be made with all complainants as soon as possible after a written complaint is received. A face to face meeting must be offered and the opportunity must be provided to allow the complainant to explain their dissatisfaction, discuss how their complaint will be investigated and what outcome they would like to receive.

Where staff become aware that services have not met the high standards expected by the Trust; staff must acknowledge this with the patient, apologise and take action to resolve the issues to the satisfaction of the person raising the concern. This provides a better outcome for the person raising the concern and also prevents them from having the inconvenience and sometimes additional worry of entering into a formal complaints process.

The Trust is committed to resolving all formal complaints in less than 40 working days. The key timeline for handling formal complaints is described in detail in appendix B of this policy. The language of complaint responses must demonstrate compassion and empathy. The key purpose of a complaint response is to acknowledge and apologise for the issues raised and describe the changes made in response to the complaint.
The process for handling formal complaints is set out in detail in the flow charts at appendices C, D and of this policy.

Appendix F details the process for handling informal complaints.

4.2 Process for Risk Assessing and Investigating Complaints

All complaints must be risk scored upon receipt using the Trust’s risk matrix. A full explanation of this scoring system and the associated investigation process may be found on the Trust intranet pages http://lthweb/sites/risk-management/incident-reporting/investigation/what-to-investigate.

The CSU will review the Risk Score, adjusting if necessary and ensure the correct score is logged on DATIX. All red risk complaints are reviewed at the weekly quality meeting chaired by the Chief Nurse or the Chief Medical Officer.

The CSU will commission a level 2 investigation for all red risk complaints and a level 1 investigation for all amber risk complaints.

- Level 1: a local, basic investigation for incidents scoring 8-15 (amber risk) conducted by the area concerned, concentrating on the learning outcomes.
- Level 2: an intermediate investigation for those incidents with a risk score of 16-25 (red risk) which may require a lead investigator from another area, and that considers the issues in greater depth and produces a more detailed report (a template and further guidance for a Level 2 Complaints investigation may be found on the Trust intranet http://lthweb/sites/complaints).
- Level 3 (SUI): a comprehensive investigation, commissioned by the Chief Medical Officer and Chief Nurse, with specific terms of reference and carried out by a trained SUI Lead Investigator, which considers relevant literature, Trust Policy, and a breadth of evidence to produce an in-depth report and action plan.

Completed investigation reports must be signed off by the Clinical Director for the CSU and inserted into DATIX.

4.3 Quality Meeting

The weekly quality meeting will be led by the Chief Nurse or Chief Medical Officer. The group will review all potentially serious complaints (red risk). The membership of the group consists of the Chief Nurse, Chief Medical, Director of Quality, Medical Director (Governance and Safety), Medical Director (Operations), Deputy Chief Nurse, Head of Nursing for Professional Practice, Standards and Safety and Head of Patient Experience. This enables all potentially serious complaints to be reviewed together to ensure that these are connected and managed through the correct process.

The Quality meeting may commission an independent investigator for individual complaints. This may be external to the CSU in which the complaint originates or external to the organisation.

The Quality meeting may commission a peer review of individual complaints or a number of complaints as a means of ensuring the quality of investigations and responses.

4.4 Process for Learning from Complaints
Learning arising from and good practice identified in complaints investigations and responses will be shared across the organisation.

CSUs are responsible for ensuring that any actions identified as a result of the investigation of complaints are carried out. CSUs must maintain a log of completed and outstanding actions and monitor their progress through their Clinical Governance Forums. CSUs must review the trends arising from their complaints quarterly to ensure all relevant improvements are identified and acted upon. CSUs must identify and share any learning arising from complaints which may benefit other services across the organisation.

4.5 Ensuring that everyone is treated equitably when making a complaint
The process for making a complaint will be made as easy as possible. The Patient Experience Team is the co-ordinating body who have responsibility for promoting and raising awareness of complaints processes both internally and externally using a variety of media.

Discrimination against people who make complaints or raise concerns is unacceptable and will not be tolerated. Copies of documentation relating to formal complaints must not be kept in a patient's medical records. Any referral letters should not include reference to the fact that a complaint has been made. At all times, a patient who is the subject of a complaint will continue to have their health needs addressed and will be treated with dignity and respect. Assurance will be given within patient literature and in all complaint acknowledgement information that people will not be treated differently because they have made a formal complaint.

Any complaints of unfair treatment as a result of having made a complaint will be investigated and appropriate action taken.

The Patient Experience Team has responsibility for linking with outside voluntary, advocacy and community groups in respect of any aspect of the Trust’s complaints process. The Patient Experience Team will support complainants for whom English is not their first language using translators. The Patient Experience Team will ensure that learning and good practice arising from inter-agency complaint handling processes are shared with partner agencies and recorded as part of our Care Quality Commission Standard evidence.

4.6 Management and Storage of Complaint Files
A complaint file has the same status as any other created by a healthcare organisation and is thus a confidential record. The Trust will, therefore, at all times provide facilities for the storage of complaints files which enable complaints files to:

- Be easily located by appropriately authorised individuals.
- Be retained safely, without danger of damage or corruption and in a complete state.
- Be easily retrieved and understood, in the event of further enquiry.
- Contain relevant items such as statements or investigation notes, or to clearly identify where such materials are located.
- Be kept for 10 years from the date upon which the complaint was completed (25 years in relation to a child).
- Complaints about Reproductive Medicine service will be stored in a locked cabinet in a locked office.
• Be disposed of confidentially when they have expired.

The Trust will ensure that its management and storage of complaints files is consistent with current Department of Health guidance and any other guidance which may apply.

5 ROLES AND RESPONSIBILITIES

5.1 The Chief Executive is responsible for
• Compliance with the complaints and concerns process and the NHS Complaints Regulations (2009).
• Signing all complaint responses.

5.2 The Trust Board will:
• Approve the Leeds Teaching Hospitals NHS Trust Complaints Policy.
• Regularly receive assurance from the Quality Committee (via the Patient Experience Sub-Committee) that the Complaints policy and process is working effectively.
• Regularly receive updates on serious complaints.
• Be assured that learning from complaints occurs, is shared across all parts of the organisation and results in improvements to services.
• Ensure all complaint responses are reviewed and receive executive sign off.

5.3 The Chief Nurse is responsible for
• Overseeing the implementation of the Complaints Policy and process through responsibility for the Patient Experience Team.
• Ensuring the Trust is compliant with the national complaints regulations and that learning from complaints is embedded in the organisation.
• Regularly reporting to the Trust Board in relation to complaints activity and providing assurance of lessons learned.

5.4 The Head of Patient Experience is responsible for
• Ensuring that the Trust is aware of and complies with its statutory duties in relation to complaints.
• Providing regular reports for the Trust Governance and Quality Committee and Trust Board with regard to complaints.
• Ensuring mechanisms are in place for the collection, collation and presentation of assurance evidence.
• Ensuring feedback from commissioners is sought and acted upon.
• Ensuring appropriate internal governance and assurance arrangements exist for complaints.

5.5 The Chief Operating Officer is responsible for
• Monitoring CSU complaints performance within the performance review structures.
• Ensuring each CSU has a complaints lead.
• Ensuring learning from complaints is embedded within clinical governance monitoring structures.
• Ensuring mechanisms are in place in each CSU for the collection, collation and presentation of assurance evidence in relation to learning and service improvement arising from complaints.
5.6 **Corporate Complaints Quality Assurers are responsible for**

- Ensuring an apology is offered in all responses.
- Ensuring the language used in all complaint responses;
  - demonstrate compassion.
  - demonstrate empathy.
  - are not unnecessarily technically complex or detailed.
  - are factually accurate.
  - are written in plain English.
  - do not undermine the validity of the complainant's concerns.
  - are not confrontational.
  - describe how the complaint was investigated.
  - describe the action taken to prevent a recurrence of the issues raised.
  - clearly illustrate the learning that has taken place and how this has been shared.
  - describe the changes that have been made in response to the complaint.
- Ensuring all complaint responses follow the Trust complaints template and are accompanied by the complaints checklist. These may be found at [http://lthweb/sites/complaints](http://lthweb/sites/complaints).
- Ensuring an appropriate investigation has been completed in line with the complaint risk score.
- Ensuring all complaint responses are accompanied by an action plan which details actions taken and actions planned in response to the complaint, includes timescales and, responsible persons for completion. A Complaints Action Plan template can be found at [http://lthweb/sites/complaints](http://lthweb/sites/complaints).
- Any responses which do not meet the required standard will be returned to the CSU complaint lead and the author for revision.
- Feedback will be provided to support the author to improve future complaints responses.

5.7 **Clinical Directors are responsible for**

- Embedding robust systems and processes within the CSU to ensure;
  - personal contact is made with every complainant.
  - all complainants are offered a face to face meeting with the CSU.
  - an appropriate investigator is allocated to every complaint.
  - complaints are fully investigated in accordance with the Trust’s Complaints Policy and the ‘Investigations Policy’.
  - Heads of Nursing, Matrons and Lead Clinicians are notified of all medical/nursing complaints.
  - staff are supported through any complaints investigations.
  - staff are aware of how their behaviour influences patient experience.
  - staff have appropriate skills in the prevention and handling of complaints.
  - deadlines and agreed timescales for responding to complaints are met.
  - staff feel able to raise any concerns they may have on behalf of a patient with reference to the Trust’s Whistleblowing Policy.
  - sign off all Level 1 or Level 2 investigations for medium or high risk complaints.
- Providing evidence in respect of improvements made as a result of complaints in their CSU.
- Ensuring an action plan is produced which details actions taken and actions planned in response to the complaint. This plan must include timescales.
and responsible persons for completion. A Complaints Action Plan template can be found at [http://lthweb/sites/complaints](http://lthweb/sites/complaints)

- Ensuring complaints are included within the terms of reference of Clinical Governance meetings to monitor the completion of investigations, the implementation of actions and the dissemination of learning to prevent similar occurrences.
- Implementation of learning arising from complaints within other CSUs.

5.8 **Heads of Nursing/Service are responsible for:**

- The coordination of complaints investigations within their CSUs.
- Investigating complaints which arise elsewhere in the Trust and are identified by the Weekly Quality Meeting as requiring an independent investigator and allocation of these investigations to staff with appropriate skills.
- Investigating formal complaints within their CSU and allocation of investigations to staff with appropriate skills.
- Handling informal complaints ensuring that these are addressed quickly, to the satisfaction of the enquirer.
- Escalating to the Patient Experience Team, where informal complaints are not resolved locally within 48 hours of being raised.
- Ensuring that informal complaints received within their local area are input to the PALS module on DATIX to ensure that learning occurs.
- Operationally ensuring that the process for formal and informal complaint handling is functioning within the CSU and that information on all complaints is readily available within all clinical areas.
- Monitoring of complaints action plans to ensure agreed deadlines and improvements are achieved.
- Auditing of completed complaints action plans to ensure they have been fully implemented.
- Ensure mechanisms are in place to feedback on learning from complaints to all staff at specialty and team meetings.
- The collection, collation and presentation of assurance evidence in relation to learning and service improvement arising from complaints.

5.9 **Business Managers/Matrons/Ward/Department Leaders are responsible for:**

- Ensuring current, up to date versions of literature informing the public of the Trust complaints process is visible and available in all public areas.
- The investigation of complaints or sections of complaints relating to operational functions within their own areas, other areas with their CSU and other parts of the organisation.
- Handling informal complaints ensuring that these are addressed quickly and to the satisfaction of the enquirer.
- Ensuring all patients are aware of how to raise a complaint.
- Ensuring complaints are resolved at source at time of being raised.
- Actively seek to provide a high standard of care in order to prevent reasons for complaints

5.10 **Consultants are responsible for:**

- Assisting in the investigation of complaints relating to their clinical care and are involved in forming the response where necessary.
• Undertaking any further action agreed with their lead Clinician in response to a complaint investigation and reporting to the lead Clinician on the implementation of actions.
• Utilising lessons learned from complaints for teaching purposes and shared learning.

5.11 The Patient Experience Team under the leadership of the Complaints Manager is responsible for:
• Ensuring all complainants have easy access and are supported when using to the Trust’s complaints systems.
• Ensuring everyone making a formal complaint is advised of advocacy agencies in their locality.
• Ensuring complainants for whom English is not their first language have access to interpreters where required.
• Operational management of the Trust process for handling and resolving complaints in an effective and timely way.
• Accurate recording of complaints and concerns on DATIX.
• Accurate recording of complaints investigation and action plans on DATIX.
• Ensuring systems are in place to enable complaints monitoring to comply with equality legislation and the Trust’s Equality and Diversity Policy.
• Ensuring that the process of handling complaints is accessible in meeting the diverse needs of the people who may wish to make a complaint.
• Ensuring publicity materials on how to access the PALS (Patient Advice and Liaison Service) and how to make a complaint are available and up-to-date.
• Ensuring that requests for information from the Ombudsman are met within deadlines and that information from the Ombudsman’s office is shared with Trust staff as and when appropriate.
• Providing CSUs with the tools required to carry out their roles within the Complaints policy in conjunction with Risk Management, e.g. Investigations training.
• Producing complaints performance reports for circulation both internally and externally, where required;
  - reports will highlight trends, themes and areas for service improvement.
  - provide quantitative and qualitative information that identify lessons learned and actions taken.
• Working with outside voluntary, advocacy and community groups in order to publicise and seek feedback on the Trust’s complaints process.
• Liaising with the Trust’s Safeguarding Vulnerable Adults and Children teams, and referring complaints to the Safeguarding team as appropriate.
• Obtaining information of complainant satisfaction of the complaints handling process and relaying the outcome to CSUs.
• Working with internal and external stakeholders to review and improve the complaints handling process.

5.12 The Risk Management Team are responsible for:
• Supporting and advising CSUs and the Patient Experience Team in the handling of individual complaints especially those which refer to litigation, compensation or redress.
• Providing independent reviews of complaint investigations or responses upon request.
• Acting as a source of support for staff affected by a complaint.
• Attending Being Open meetings in relation to complaints as and when required.
• Advising on the management of vexatious/persistent complainants.
• Advising on the management of complainants who act out of line with zero tolerance policy.

5.13 **All Trust Staff are responsible for:**
All staff have a responsibility to behave in a way that contributes to a positive patient experience and does not give rise to dissatisfaction.

Where staff become aware that services have not met the high standards expected by the Trust; staff must acknowledge this with the patient, apologise and take action to resolve the issues to the satisfaction of the person raising the concern.

Where complaints do arise; staff have a responsibility to resolve the issues with the emphasis on ‘on the spot’ resolution.

6 **EQUALITY ANALYSIS**

This Policy for Complaints and Concerns in the Leeds Teaching Hospitals NHS Trust has been assessed for its impact upon equality. The equality impact assessment document for this policy can be seen in Annex 1. The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff, reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.
7 CONSULTATION AND REVIEW PROCESS

This Policy has Trust wide implications, with staff, patients, carers, relatives and visitors all as major stakeholders, but also other health and social care organisations. Staff are bound by the policy and required to implement it. Directors and senior managers in operational and corporate functions have specific interest in its detail. Patients, carers, relatives and visitors to the Trust require knowledge of and easy access to this Policy in order to know their rights if they wish to make a complaint or raise a concern about any aspect of Trust services.

This policy has been shared in draft form with a number of key health and social organisations and voluntary and user groups. This includes Leeds Independent Health Complaints Advocacy (Advonet) and North Yorkshire NHS Complaints Advocacy Service (Cloverleaf Advocacy).

8 STANDARDS/KEY PERFORMANCE INDICATORS

The following key performance indicators will be monitored and reviewed.

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<tr>
<th>KPI</th>
<th>Key Performance Indicators</th>
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<tbody>
<tr>
<td>1</td>
<td>numbers of complaints acknowledged within 3 working days</td>
</tr>
<tr>
<td>2</td>
<td>numbers of complaints responded to within agreed timeframe (40 days for Single sector LTHT complaints)</td>
</tr>
<tr>
<td>3</td>
<td>numbers of complaints risk scored</td>
</tr>
<tr>
<td>4</td>
<td>numbers of re-opened complaints</td>
</tr>
<tr>
<td>5</td>
<td>numbers of complainants satisfied with complaints handling (including not being treated differently as a result as a result of raising a concern / complaint)</td>
</tr>
<tr>
<td>6</td>
<td>improvements made as a result of learning from complaints and concerns are evidenced within Clinical Governance Action Logs (&amp; minutes)</td>
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<tr>
<td>7</td>
<td>annual equality profile of all complainants</td>
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## MONITORING COMPLIANCE AND EFFECTIVENESS

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<th>Policy element to be monitored</th>
<th>Process for monitoring</th>
<th>Responsible individual for monitoring</th>
<th>Frequency of monitoring</th>
<th>Responsible individual for development of action plan</th>
<th>Responsible group for review of assurance &amp; monitoring of action plan</th>
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<tr>
<td>Process for listening and responding to concerns/complaints of patients, their relatives and carers</td>
<td>Quarterly report presenting a minimum data set as identified in the Learning from Experience Policy.</td>
<td>Complaints Manager</td>
<td>Quarterly Report</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee and Risk Management Group</td>
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<td></td>
<td>Review at CSU Clinical Governance Forums</td>
<td>Clinical Directors</td>
<td>Quarterly Reports</td>
<td>Clinical Directors</td>
<td>CSU Clinical Governance Forums (For local actions)</td>
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<tr>
<td>Democrats</td>
<td>Audit of complaints &amp; concerns process (audit 1 as detailed below)</td>
<td>Complaints Manager</td>
<td>4 audits per year on rolling programme</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
<tr>
<td>Democrats</td>
<td>Annual report covering above</td>
<td>Complaints Manager</td>
<td>Annual Report</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
<tr>
<td>Duties</td>
<td>Audit of complaints &amp; concerns process (audit 1 as detailed below)</td>
<td>Complaints Manager</td>
<td>Annual</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
<tr>
<td>Policy element to be monitored</td>
<td>Process for monitoring</td>
<td>Responsible individual for monitoring</td>
<td>Frequency of monitoring</td>
<td>Responsible individual for development of action plan</td>
<td>Responsible group for review of assurance &amp; monitoring of action plan</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------</td>
<td>--------------------------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Process for the handling of joint complaints between organisations</td>
<td>Audit of Complaints process (audit 1)</td>
<td>Complaints Manager</td>
<td>Annual</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
<tr>
<td>Process for ensuring that patients, their relatives and carers are not treated differently as a result as a result of raising a concern / complaint</td>
<td>Audit of complaints &amp; concerns process (audit 2)</td>
<td>Complaints Manager</td>
<td>Complaints - On-going with bi -annual reporting, Concerns - Annual audit, Bi-annual reporting</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
<tr>
<td>Process by which the organisation aims to improve as a result of concerns/complaints being raised</td>
<td>Audit of complaints &amp; concerns process (audit 3)</td>
<td>Complaints Manager</td>
<td>Annual</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub-Committee</td>
</tr>
</tbody>
</table>
Compliance with the processes outlined in the policy document will be monitored by:

- annual assurance report to the Quality Committee
- quarterly monitoring report to Patient Experience Sub Committee and Risk Management Group. The data set to be reported is identified in the Learning from Experience Policy.
- 3 audits being undertaken on a rolling programme by the Patient Experience Team involving relevant colleagues as appropriate:

<table>
<thead>
<tr>
<th>No</th>
<th>Audit</th>
<th>Lead</th>
<th>Method</th>
<th>Reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Audit of Complaints &amp; Concerns Process (Complaints handling)</td>
<td>Head of Patient Experience</td>
<td>Rolling programme of 4 audits - one audit per quarter</td>
<td>Patient Experience Sub Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints Manager</td>
<td>testing of a 5% sample of complaints received within a selected quarter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>testing of a 5% sample of all PALS received within a selected quarter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>testing of a 5% sample of all mixed sector complaints received within a selected quarter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>testing of a 10% sample of re-opened complaints received within a selected quarter</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Audit of Complaints &amp; Concerns Process (Complainant satisfaction)</td>
<td>Head of Patient Experience</td>
<td>On-going programme with bi-annual reporting:</td>
<td>Patient Experience Sub Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints Manager</td>
<td>100% of complainants will receive a satisfaction survey following their complaint response</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5% sample of all enquiries raising a PALS query within a selected quarter will receive a satisfaction survey</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Audit of Complaints &amp; Concerns Process (Learning)</td>
<td>Chief Operating Officer</td>
<td>Annual audit involving:</td>
<td>Patient Experience Sub Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deputy Chief Nurse Operations</td>
<td>testing of a 10% sample of complaints received within a selected quarter with a review of the respective clinical governance action logs, minutes or via resultant action plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Directors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The resulting audit findings will be reviewed and incorporated into a report and action plan. The Patient Experience Sub Committee will be responsible for reviewing assurance and monitoring of the action plan.
10. REFERENCES/ASSOCIATED DOCUMENTATION

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. February 2013. Robert Francis QC.
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. July 2013. Professor Sir Bruce Keogh KBE.

Appendix A

THE LEEDS TEACHING HOSPITALS NHS TRUST
Guidance for handling formal complaints

Complaints Policy - Final - Approved November 2013
INTRODUCTION

1.1 This document is an appendix to the Leeds Teaching Hospitals NHS Trust's Complaints Policy.

GUIDANCE

2.1 Local Resolution within the Trust - As far as possible, complaints will be concluded to the complainant’s satisfaction as part of local resolution, so that complainants don’t find it necessary to pursue their complaint to the Parliamentary and Health Service Ombudsman. All complaints will be welcomed positively by Trust staff, as valued feedback and a way of improving services.

2.2 Involvement of Complainant - The complainant will be provided with information to help them understand all possible options for pursuing their complaint. The complainant will be involved in decisions about how their complaint is handled and considered, including the need to obtain agreement from the complainant in respect of the timeframe of the investigation. If agreement cannot be negotiated, the reasons for this will be recorded.

2.3 Independent Advocacy - It is important that those wishing to complain are made aware of the Local Authority Commissioned Advocacy Services or other specialist advocacy agencies (such as mental health, learning disability, elderly or disadvantaged groups). Detail of such agencies is available on the Trust’s complaints leaflet and can be obtained from the Patient Experience Team. Information is also available on the complaints webpage of the Trust’s website. All publicity material will include this information.

2.4 Multi agency and mixed sector complaints - In cases where a complaint is received which also involves services provided by another organisation, agency or provider, the Patient Experience Team will seek consent to forward any correspondence / information received to the other relevant organisation(s).

The Patient Experience Team will liaise with all involved organisations to agree a lead organisation, agree who will answer which parts of the complaint and agree who will be the central contact point for the complainant.

Every effort should be made to resolve the complaint in a cooperative manner, with a coordinated response sent to the complainant unless specifically requested otherwise. Time limits for responding to multi-agency complaints will be agreed on an individual, case-by-case basis with the complainant and other organisations involved.

2.5 Compensation or Financial Recompense/Redress

If the complainant requests compensation or financial recompense at any stage during the handling of the complaint, Risk Management must be informed immediately and advice sought. The draft response must be reviewed by the Trust Risk Manager.

Following an investigation, where it has been determined compensation is warranted; the complaint file will be referred to Risk Management for consideration. Every effort will be made to reach an early decision so that this can be included in the response letter to the complainant.

2.6 Who can complain about the way they have been treated - Anyone can make a complaint that is affected by, or likely to be affected by, the action, omission or decision of the Trust. A complaint can also be made by a person acting on the patient's behalf (see...
2.10 below).

2.7 Complaint issues for consideration and for exclusion - A complaint may be about any matter reasonably connected with the exercise of the Trust’s functions. Each complaint will be taken on its own merit and responded to appropriately. If an issue is to be excluded, the Complaints Manager will be notified of the reasons why and an audit trail kept by the individual dealing with the issue. There are specific matters that fall outside the complaints processes that may require resolution by other means. Excluded from the complaints process are matters which:

- are purely requests for information
- are about patients not associated with the complainant and from whom there has been no signed consent received
- are of a criminal nature (see 2.8 below)
- arise out of the Trust’s alleged failure to comply with a data subject request under the Data Protection Act 1998
- arise from a request for information under the Freedom of Information Act 2000
- relate solely to the functions of another body
- are issues that have already been investigated as a legal matter are staff contract of employment issues
- are about the Trust taking, or proposing to take disciplinary action
- are being, or have been investigated by the Parliamentary and Health Ombudsman or its successor previously
- are about private medical treatment provided in an NHS setting. However, if the patient is using the Trust’s staff or facilities, they can use the complaints procedure to investigate such specific issues
- are staff queries or concerns either internally or from another organisation, about service issues that are not about a specific patient

2.8 Complaints of a Criminal Nature - The complaints procedure is not geared to investigate matters of a serious criminal nature e.g. accusations of sexual or physical abuse. In such circumstances the Patient Experience Team will immediately highlight the matter with the Deputy Chief Nurse to determine the correct course of action, which may involve direct referral to the Police or appropriate other authority.

2.9 Safeguarding - If there are concerns about safety of children and or adults at any stage in the process, these will be acted upon immediately in accordance with policies already in place in respect of LTHT Safeguarding Children and Adults.

2.10 Consent if the complainant is not the patient - In many circumstances it will be an ‘interested other person’ such as relative, friend, advocate who complains on behalf of a person who is or has been a patient. If this is the case, it is essential that permission is obtained from the patient for the ‘interested other person’ to act on their behalf. If the person lacks capacity and is unable to sign, decisions for consent will be determined by the Patient Experience Team. They will seek advice from the Trust Risk Manager or the Safeguarding Team if necessary, based on the individual circumstances and in accordance with the Mental Capacity Act. The Patient Experience Team will be responsible for obtaining written consent. MPs may complain on behalf of their constituent without written consent, where the patient has directly contacted the MP. If a third party has approached the MP then written consent is required from the patient.
It is very important to obtain the patient’s or their representative’s consent before sharing confidential information with another body or organisation. Consent should be obtained in writing wherever possible. If this is not possible, verbal consent should be logged by the person receiving it. If anyone is in any doubt about whether or not information should be released, they should consult their line manager or alternatively the Patient Experience Team for advice.

2.11 Patient Confidentiality - The requirement to maintain confidentiality is absolute during all aspects of the complaints process in accordance with Caldicott principles. Investigation of a complaint does not remove the need to respect a patient’s confidentiality. No member of staff should divulge information about the identity or medical condition of any patient to anyone who does not have a clear entitlement and need to receive it. This also applies if the complaint involves more than one organisation, i.e. another Trust or the Local Authority.

2.12 If the patient has died - If a patient has died, or is otherwise unable to act for themselves, the complaint can be accepted from a close relative, friend, organisation or individual suitable to represent the patient. Where the case notes or Patient Administration System has a next of kin detailed consent should be obtained from the person named. It is always important in these circumstances to respect the patient’s confidentiality and any known wishes expressed by the patient, that information should not be disclosed to anyone else. If such wishes are known they should be reported to the relevant line manager who will take responsibility for decisions on such matters.

2.13 Coroner’s Cases - The fact that a death has been referred to the Coroner’s Office does not mean that all investigations into a complaint need to be suspended. In such circumstances, the Patient Experience Team will request permission from the Coroner’s Office to proceed to investigate.

2.14 If the patient is a child - In the case of a child, the representative must be a parent, guardian or other adult 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 that organisation. Consent will be sought from patients aged 16 or over. All complaints from children will be handled in accordance with the ‘8 Common Principles for a Child Friendly Complaints Process’ by the Children’s Commissioner for England.

The Leeds Children’s Hospital will lead on the monitoring of the Trust Complaints Policy in relation to its effect on children who access Trust services. This will be achieved through the Children’s Hospital governance structures and will follow the common principles described by the Children’s Commissioner for England. The Patient Experience Team will work with the Children’s Hospital to ensure LTHT Complaints process continues to adhere to these principles and meets the needs of children using LTHT services.

2.15 Time Limit for Initiating Complaints - Advice and or information given to patients about the complaints procedure will encourage them to raise any complaint as soon as possible. Although the time limit for making a complaint is identified as 12 months of such an event as referenced in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. It is important that members of the public feel able to raise issues of concern and that every opportunity is taken to respond where it is still possible to investigate the facts of the case. Reasons for any decision will be documented in DATIX. In some cases addressing the complaint informally (where notes are available) is appropriate.
2.16 **Conciliation, Mediation and Independent Medical Opinion** - In some situations and in agreement with all parties, it may be appropriate to make arrangements for conciliation or mediation for the purpose of resolving the complaint at local resolution stage. Confidentiality must be strictly observed during the conciliation process. Consequently, conciliators should never be required to report to any NHS body, detail of the cases in which they are involved. It may be helpful, depending on the circumstances, to involve an independent clinical adviser. This may be a Leeds Teaching Hospitals Trust Consultant who is independent of the clinical team providing the care complained about. In some instances where this is not possible, consideration will be given to obtaining independent external consultant opinion.

2.17 **Complaints from Members of Staff** - Members of staff who are patients are entitled to use the NHS complaints procedure in the same way as other patients. Leeds Teaching Hospitals is a co-signatory to ‘Speak Out Safely’ a national campaign by the Royal Collage of Nursing. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

If a member of staff wishes to raise a complaint on behalf of a patient, this must be done with the patient's permission.

If staff have concerns about professional and or clinical practice of any of their colleagues, they should in the first instance raise this with the relevant line manager, with a view to escalating this internally to a member of the CSU Management Team.

Staff also are supported by the Trust’s Whistle Blowing Policy which may be found at [http://lthweb/policies/policy.php?id=148](http://lthweb/policies/policy.php?id=148). This policy refers to such issues as potential unlawful conduct, financial malpractice or fraud, dangers to the public or the environment including health and safety of patients. It also describes the protection available to staff who raise concerns and how support can be accessed.

2.18 **Freedom of Information and Data Protection Issues** - Any matters that may be highlighted within a complaint that refer to either a Freedom of Information request, or a Data Protection issue, will be immediately referred to the Information Governance Team.

2.19 **Access to Health Records** - There will be occasions when a complainant asks for access to the patient’s health records. Access to Health Records is subject to a separate procedure in accordance with the Health Records Act 1990. In such circumstances, the Trust’s Access to Health Records Department will be notified by Patient Experience Team and the complainant advised of the procedure to follow.

2.20 **Possible Legal Action** - In the likelihood of legal action, or if a complaint reveals a *prima facie* case of negligence, the Patient Experience Team and or CSU staff will immediately inform and seek advice from the Trust’s Risk Management Team. It will not be inferred that the complainant has decided to take formal legal action, even if their initial communication is via a solicitor’s letter and this will not delay a full explanation of events and, if appropriate, an apology. In such circumstances the complaint investigation will continue in the normal way unless a member of the Patient Experience Team or Risk Management Staff advises differently.

2.21 **Possible Disciplinary Proceedings** - Staff involved with a complaint investigation should be informed of support services that are available to them. This complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters and the purpose is not to apportion blame amongst staff. Consideration as to whether or not
disciplinary action is warranted is a separate matter for management and is subject to a separate process of investigation. However, information gathered during the complaints procedure may be made available for a disciplinary investigation. Should disciplinary action be taken, as part of the separate process of investigation, the outcome cannot be shared with the complainant in accordance with the Human Rights Act.

2.22 **Staff Complaints and Concerns Training** - In order to make the Complaints process more effective and to enable staff to understand the process to follow, regular training for Trust staff will be available.

All Trust staff will receive awareness training to support them to resolve patient and public complaints at the point at which they are raised.

Further in depth training on complaints handling will be provided for groups of staff. This training will be focused on the areas in which these staff groups work.

Specific training will be provided for all trust Staff who are responsible for investigating and responding to formal complaints.

In addition ‘Customer Service’ training will be provided to all Trust staff. This training will focus on delivering an excellent patient and public experience and actions to address the causes of dissatisfaction.

Ad hoc targeted training sessions will be provided where appropriate. The Patient Experience Team will run the training courses and details will be made available on the complaints web page of the Trust’s website.

2.23 **Handling Unreasonable complainants** - There are occasions when the person making a complaint can become aggressive or unreasonable. This causes undue stress for staff and resulting in a disproportionate use of resources. When appropriate, such complainants should be managed in line with either the Zero Tolerance Policy or Vexatious or Persistent Complaints Guidance. In dealing with such situations the Complaints Manager will ensure the complaints policy and process has been correctly implemented and that no material element of a complaint has been overlooked or inadequately addressed. It will be taken into consideration that any complaint being made by an unreasonable complainant may have aspects, which contain genuine substance.

At all times, if the complainant is a patient, their health care needs will continue to be addressed. Any complainants who are patients will not be discriminated against in any way.

It is important, however, to identify the stage at which a complainant has become unreasonable and for action to be taken accordingly. A separate procedural document “Procedure for Handling Vexatious or Persistent Complaints” is available from the Patient Experience Team and on the complaints web page of the Trust’s Intranet site.
<table>
<thead>
<tr>
<th>Compliance deadline</th>
<th>Process</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 0-3</td>
<td>Complaint received</td>
<td>Oral complaint that has not been resolved informally If oral complaint then make record of complaint on the DATIX system Acknowledge complaint in writing. Obtain consent where required. The letter will include: details of advocacy agencies, process of handling complaint, target response date (multi), PET contact details, also reiterate offer of meeting. PET will grade all complaints, assess the complexity and question whether it is also a safeguarding case, to ensure that the complaint is appropriately managed. Serious complaints will be escalated to the Quality Meeting. CSU notified of complaint once consent obtained. Email to the relevant Clinical Director, copy to Site Leads advising of complaint. Complaint file is raised and sent to Clinical Director. DATIX updated.</td>
<td>PET</td>
</tr>
<tr>
<td></td>
<td>Written complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electronic (complaints inbox) complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 3-28</td>
<td>Negotiate</td>
<td>Clinical director assigns complaint to the relevant CSU lead who will appoint an investigator. Direct contact with the complainant (Single by CSU, agreeing target date and Multi by PET) at this stage to negotiate issues/timescale for response is encouraged by the Ombudsman and should be considered for all complaints. Where the issues are unclear or it is very obvious that the 25 day default target cannot be met then the lead should automatically contact the complainant. All contact must be documented and PET advised.</td>
<td>CSU/PET</td>
</tr>
<tr>
<td></td>
<td>Investigate</td>
<td>Investigator is responsible for managing the investigation of the complaint issues, collating statements, completing investigation report, together with an action plan for any remedial action arising from the investigation.</td>
<td>CSU</td>
</tr>
<tr>
<td></td>
<td>Draft</td>
<td>Single - CSU draft complete response to complainant Multi - CSU draft section of response to complainant and send to PET who collate complete response.</td>
<td>CSU/PET</td>
</tr>
<tr>
<td>Day 28 - 35</td>
<td>Quality Assurance</td>
<td>CSU - (Single) and PET - (multi) send response to Corporate QA link who will review the reply to ensure that: - all issues are answered and the tone and style are empathetic - it is clinically accurate - explanation of how the complaint was investigated - lessons learned and what has been done to prevent occurrences - Apology is given - the complaints checklist and action plan/s is completed - investigation is completed and L2 report received for serious complaints QA link forward approved response to PET</td>
<td>CSU/PET</td>
</tr>
<tr>
<td></td>
<td>Sign Off and Reply</td>
<td>Sign off by Chief Executive. Response sent to complainant.</td>
<td>PET</td>
</tr>
</tbody>
</table>
Appendix C
Leeds Teaching Hospitals NHS Trust
Process for Complaint Handling (Single)

Complaint received by Patient Experience Team (PET) and logged into DATIX
Consent requested (if required) and received
Risk graded (Red/Amber/Green) \(^1\)
DATIX entry
All serious complaints will be brought to attention of CSU prior to consent being received.

Complaint forwarded to CSUs involved \(^2\)
(Head of Nursing & General Manager & Clinical Director)

CSU identify lead investigator who contacts complainant by telephone to agree concerns to be investigated, to offer a meeting and to agree date by which response will be posted

CSU returns completed Complaint resolution Plan (CRP) which includes agreed target date

CSU investigate complaint in line with Investigations Policy.
Red=L2, Amber=L1
(completed investigation report and action plan added to DATIX record by CSU)

CSU draft response \(^3\) to complainant in line with complaints checklist and forward with complaint letter, investigation, and action plan and complaints checklist to QA link.

QA link approves full response and forwards to PET or requests amendments and returns to CSU complaints lead and author.

PET arrange review by Executive Officers and sign off by Chief Executive

\(^1\) Red complaints reviewed by Quality Meeting
\(^2\) Sent to Deputy Medical Director if involving medical staff
\(^3\) Ensure watermark stating “Draft”
Appendix D
Process for Complaint Handling (Multi)
Complaint received by Patient Experience Team (PET) and logged into DATIX

1. Red complaints reviewed by Quality Meeting
2. Sent to Medical Director if involving medical staff. Deputy Chief Nurse receives all complaints
3. Ensure watermark stating "Draft"
Consent requested (if required) and received
Risk graded (Red/Amer/Green) ¹
DATIX entry
All serious complaints will be brought to attention of CSU prior to consent being received.

Complaint forwarded to CSUs involved ²
(Head of Nursing & General Manager & Clinical Director & QA link)

CSU identify lead investigator

Lead CSU ring complainant, explain handling process, ascertain if complainant would like to meet and agree date by which response will be posted.

CSU investigate complaint in line with Investigations Policy. Red=L2, Amber=L1 (completed investigation report and action plan added to DATIX record by CSU)

CSU draft response ³ to complainant in line with complaints checklist and forward with complaint letter, investigation, and action plan and complaints checklist to QA link.

QA link approves draft sections and forwards to PET copying in CSU lead. If not approved QA link informs CSU of required amendments

PET draft complaint response ³, collate checklist, review and forward to lead CSU QA link and to each CSU involved

Lead QA link approves full response and forwards to PET. If not approved QA link informs PET of requested amendments

PET arrange review by Executive Officers and sign off by Chief Executive

CRP = Complaint Resolution Plan

¹ Red complaints reviewed by Quality Meeting
² Sent to Medical Director if involving medical staff. Deputy Chief Nurse receives all complaints
³ Ensure watermark stating "Draft"
Appendix E
Process for Quality Assuring and Sign Off
Complaint Responses

PET (multi) or CSU (single) forward draft complaint response\(^1\), copy of complaint letter, completed complaints investigation, action plan and checklist to the appropriate QA link (including all details of any other intended recipients)

Corporate link quality assures complaint response

Approved

Corporate link forwards to named PCPI lead in Patient Experience to arrange sign off (copy in CSU lead)

PCPI Officer removes water mark, electronically forwards approved complaint response, (with corresponding complaint letter and complaints checklist) to PA for Chief Nurse and Chief Medical Officer.

PA allocates to Chief Medical Officer/Chief Nurse. Chief Medical Officer/Chief Nurse reviews the response and forwards to Chief Executive for signature. PA returns signed letter to PCPI Officer. PCPI Officer posts letter to all recipients

PET inserts signed copy into DATIX and closes file

Not approved

Corporate link request revisions via CSU (single) or PET (multi)

PET (multi) or CSU (single) make required revisions
Appendix F

Flowchart for Handling Informal Complaints (Outside of PALS Team)

Step 1:
- Dealt with on the spot by staff member. Immediate apology or explanation or suggestion of change/action to be taken
- If not satisfied opportunity offered to discuss with line manager

On the spot

By Staff Member involved in incident

Step 2: If Enquirer is satisfied
- Complete the Contact sheet - WNN332
- Pass the completed form to Line Manager
- Line Manager will ensure form is logged in to DATIX PALS module (locally or by forwarding to Patient Experience team.)

Within 3-5 working days of concern being raised

Step 3: If Enquirer is not satisfied
- Staff member to seek immediate help from someone, usually line manager.
- Staff Member to return to Enquirer to offer a solution or provide assurance that matter being dealt with and named person will contact them. Agree time period.
- Documentation to be completed as in Step 2 above.
- The line manager may obtain assistance from senior colleagues or the Patient Experience Team.
- Once resolved the Contact sheet WNN332 completed and passed to line manager.
- If not resolved, Enquirer to be given the option of going through the formal complaints route and given tel. no. /e-mail address and leaflet or summary of issue sent by CSU to PET.
Appendix G

Flow Chart for Handling Informal Complaints (PALS Team)

Step 1: Contact with Patient Experience
- PALS Staff will take the details (via email, phone or letter) and agree a course of action, resolving at time of call if possible.
- People voicing dissatisfaction should not feel obliged to follow this process first in order to make a formal complaint. If a person wishes to make a formal complaint from the outset; PALS staff will support them to do so.
- If this is not possible. PALS staff will pass the call to someone who is able to resolve the problem on the spot or, email an appropriate person and ask them to make contact with the Enquirer.

Step 2: If Enquirer is satisfied
- Record the incident and outcome on the PALS section of DATIX.
- Where the matter has been referred to be dealt with elsewhere in the Trust, it will be the line manager’s responsibility to ensure actions are taken and details forwarded to the PALS team for central recording.

Step 3: If Enquirer is not satisfied
- Advice and contact information for pursuing a formal complaint is given and advice on advocacy agencies if required
Appendix H

The Leeds Children’s Hospital will lead on the monitoring of the Trust Complaints Policy in relation to its effect on children who access Trust services. This will be achieved through the Children’s Hospital governance structures and will follow the Common Principles for a Child Friendly Complaints Process described by the Children’s Commissioner for England. These principles have been developed based on the views, experiences and voices of children and young people, as well as discussions with professionals who have a responsibility for complaints.

1. All organisations working with children and young people should value and respect them, and develop positive and trusting relationships.
2. All complaints from children and young people should be seen as positive, valuable service user feedback and considered from a safeguarding perspective.
3. Children and young people should be involved in the development and implementation of the complaints process they may wish to use.
4. All children and young people should have access to information about complaints processes. This should be provided in a variety of formats, including online, and should be age appropriate and take account of any additional needs that a young person may have.
5. All children and young people should be able to make complaints in a variety of ways.
6. Written responses to complaints should be timely and where possible discussed with the young person. The young person should always be given an opportunity to provide feedback.
7. Staff should be well trained and have access to training in listening to, and dealing with, complaints from children and young people.
8. Children who need support to make a complaint should have access to an independent advocate.

The Patient Experience Team will work with the Children’s Hospital to ensure LTHT Complaints process continues to adhere to these principles and meets the needs of children using LTHT services.