**LEEDS TEACHING HOSPITALS NHS TRUST**

**COMPLAINTS POLICY**

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Complaints Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>Version 4.0</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Executive Team Meeting</td>
</tr>
<tr>
<td>Date of approval:</td>
<td>26 March 2018</td>
</tr>
<tr>
<td>Policy supersedes:</td>
<td>Complaints Policy version 3.0</td>
</tr>
<tr>
<td></td>
<td>March 2016</td>
</tr>
<tr>
<td>Lead Board Director:</td>
<td>Professor Suzanne Hinchliffe CBE,</td>
</tr>
<tr>
<td></td>
<td>Chief Nurse and Deputy Chief</td>
</tr>
<tr>
<td></td>
<td>Executive</td>
</tr>
<tr>
<td>Policy Lead (and author if different):</td>
<td>Craig Brigg, Director of Quality.</td>
</tr>
<tr>
<td></td>
<td>Authors:</td>
</tr>
<tr>
<td></td>
<td>Dawn Preston, Complaints Manager.</td>
</tr>
<tr>
<td></td>
<td>Tracy Cryer, Lead Nurse, Patient</td>
</tr>
<tr>
<td></td>
<td>Experience</td>
</tr>
<tr>
<td>Name of responsible committee/group:</td>
<td>Patient Experience Sub Group.</td>
</tr>
<tr>
<td>Date issued:</td>
<td>March 2018</td>
</tr>
<tr>
<td>Review date:</td>
<td>28 February 2021</td>
</tr>
<tr>
<td>Target audience:</td>
<td>All staff in permanent, temporary or</td>
</tr>
<tr>
<td></td>
<td>voluntary roles acting for or on behalf of the Leeds Teaching Hospitals NHS Trust.</td>
</tr>
<tr>
<td>Keywords</td>
<td>Complaints, Concerns, PALS, Learning,</td>
</tr>
<tr>
<td></td>
<td>Clinical Governance, Patient</td>
</tr>
<tr>
<td></td>
<td>Experience, Staff Behaviours.</td>
</tr>
</tbody>
</table>

Complaints Policy, Version 4.0 - Approved 26 March 2018
## Contents

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Summary</td>
<td>3</td>
</tr>
<tr>
<td>1 Purpose</td>
<td>5</td>
</tr>
<tr>
<td>2 Background/Context</td>
<td>5</td>
</tr>
<tr>
<td>3 Definitions</td>
<td>6</td>
</tr>
<tr>
<td>4 Policy Effect: Processes under the Policy</td>
<td>6</td>
</tr>
<tr>
<td>5 Roles and Responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>6 Equality Analysis</td>
<td>14</td>
</tr>
<tr>
<td>7 Consultation and Review Process</td>
<td>14</td>
</tr>
<tr>
<td>8 Standards/Key Performance Indicators</td>
<td>15</td>
</tr>
<tr>
<td>9 Process for Monitoring Compliance and Effectiveness</td>
<td>16</td>
</tr>
<tr>
<td>10 References</td>
<td>20</td>
</tr>
<tr>
<td>Appendix A Guidance for Handling Formal Complaints</td>
<td>21</td>
</tr>
<tr>
<td>Appendix B Formal Complaint Procedure - Key Timescales</td>
<td>27</td>
</tr>
<tr>
<td>Appendix C Flow Chart/Process for Complaint Handling</td>
<td>28</td>
</tr>
<tr>
<td>Appendix D Flow Chart/Process for Quality Assuring and Sign Off Complaints Responses</td>
<td>29</td>
</tr>
<tr>
<td>Appendix E Flow Chart for Handling Informal Complaints (outside of PALS team)</td>
<td>30</td>
</tr>
<tr>
<td>Appendix F Flow Chart for Handling Informal Complaints (PALS)</td>
<td>31</td>
</tr>
<tr>
<td>Appendix G Common Principles for a Child Friendly Complaints Process</td>
<td>32</td>
</tr>
<tr>
<td>Appendix H Action</td>
<td>33</td>
</tr>
<tr>
<td>Appendix I Audio Recording Guidance</td>
<td>34</td>
</tr>
<tr>
<td>Appendix J Minimum DATIXweb contents of completed Complaints File</td>
<td>43</td>
</tr>
<tr>
<td>Annex 1 Equality Analysis Screening</td>
<td></td>
</tr>
<tr>
<td>Annex 2 Plans for Dissemination and Implementation of Policy</td>
<td></td>
</tr>
<tr>
<td>Annex 3 Checklist for Review and Approval of Policy</td>
<td></td>
</tr>
<tr>
<td>Annex 4 Version Control</td>
<td></td>
</tr>
</tbody>
</table>
**Staff and Public 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 as far as possible.

The spirit of the Complaints Policy is that all staff are empowered to resolve minor comments, concerns, 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 that are received by either the Complaints team or the Patient Advice and Liaison Service (PALS). This policy is to support all Trust staff to guide them in what to do if a patient, relative or carer raises a 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 after effects. Openness and honesty can also help to prevent such events becoming formal complaints and litigation claims.

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

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 Freedom To Speak Up 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 appendices C and D of this policy. The process for handling informal complaints is described in detail at appendices E and F of this policy.

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

This policy is closely aligned with the Investigation of Incidents & Complaints: Investigations Procedure. Further information is available on the Patient Experience Complaints Intranet page 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 that are received by either the Complaints team or the Patient, Advice and Liaison Service (PALS). 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.

The 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 after effects. 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.

The Complaints Policy ensures the Trust meets current national guidance in respect of complaints handling, including the recommendations made in the PHSO report “My Expectations” November 2014.

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 either by local resolution or through the PALS service. As long as this is in agreement with the person raising the complaint, then this approach is appropriate and preferable.

Dissatisfaction may be expressed orally or in writing (complaint form, letter, email, text or web submission).

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 Institute of Oncology.

4 POLICY EFFECT

4.1 Handling of Complaints and Concerns

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 complaint is received. An opportunity will 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. An opportunity to meet with key, senior staff members will be considered for all those raising concerns.

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 it is not
possible to resolve concerns locally, patients should be directed to the Patient Advice and Liaison Service (PALS) in the first instance; unless it is clear patients are unwilling to pursue this route. Generally, 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 PALS concerns within 2 working days and formal complaints within 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 to 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 E of this policy. Appendices E and F detail the process for handling informal complaints.

### 4.2 Process for Risk Assessing and Investigating Complaints

All complaints and concerns 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 Risk Management intranet pages. Any complaint or concern that carries a safeguarding concern will be shared with the LTH Safeguarding Team and handled in line with LTH Safeguarding processes.

All red risk complaints are reviewed at the weekly quality meeting chaired by the Chief Nurse or the Chief Medical Officer.

In line with the Investigations procedure the CSU will commission a level 2 investigation for all red risk complaints. All amber complaints require a level 1 investigation and green risk complaints require a complaint response only.

- **Level 1**: a local, basic investigation for incidents scoring 8-14 (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 15-25 (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 Complaints intranet page).

Completed investigation reports must be signed off by the Clinical Director for the CSU and will be retained in 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 Officer, Director of Quality, Medical Director (Operations), Associate Medical Director (Risk), Associate Medical Director (Corporate Governance), Deputy Chief Nurse and Nurse Director (Operations), Nurse Director (Corporate Services) and Head of Nursing for Professional Practice, Standards
and Safety. 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. For example, if there are related incidents they may commission a Level 3 investigation; Serious Incident (SI): a comprehensive investigation commissioned by the Chief Medical Officer and Chief Nurse, with specific terms of reference and carried out by a trained SI Lead Investigator, which considers relevant literature, Trust Policy and a breadth of evidence to produce an in-depth report and action plan.

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. In addition, they may request that an assurance visit is undertaken to ward/area named in the complaint; co-ordinated by the Head of Nursing for Professional Practice, Standards and Safety.

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. The sharing of learning will be delivered via the Lessons Learned Group (Lessons Learned bulletins).

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. Each CSU will complete an action plan for every complaint (stating no actions if none were taken). The action plan must be sent to the Patient Experience Team with the complaint response. This will be retained in DATIX, ensuring that a summary of actions taken is available.

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 (whether in paper or electronic format); this includes the original letter of complaint, statements from staff, investigation notes and the drafted/final response. 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 expressed dissatisfaction with care received. 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 Policy. They 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 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 made (for complaints about a child, kept for 10 years or until child is 21, whichever is the longest).
- Be stored in a locked office, when they are hard copy complaint files.
- Be disposed of confidentially when they have expired.

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

4.7 Complaints Resolution Meetings
Where a complainant wishes for their concerns to be addressed via a complaints resolution meeting; all parties involved will be offered the choice of a written response (to include summary, non-verbatim meeting notes and cover letter from the Chief Executive) or an audio recording of the meeting with a cover letter from the Chief Executive.

The process for undertaking audio recordings can be found at appendix I.

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 Management Group (via the Patient Experience Sub Group) that the Complaints policy and process is working effectively.
- Regularly receive updates on serious complaints.
- Be assured that learning from complaints 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 Quality Management Group and Trust Board about 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 Deputy Chief Executive is responsible for:**
- Monitoring CSU complaints performance within the performance review structures.

5.6 **Corporate Complaints Quality Assurers are responsible for:**
- Ensuring an apology is offered in all responses.
- Ensuring 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 can be found on the Complaints Intranet page.

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:**
- Ensuring each CSU has a complaints lead
- 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.
  - an appropriate investigation has been completed in line with the complaint risk score.
  - Heads of Nursing, Matrons and Lead Clinicians are notified of all medical/nursing complaints.
  - staff are supported through any complaints investigations and signposted to support where needed.
  - 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 Freedom To Speak Up Policy.
- Providing evidence in respect of improvements made as a result of complaints in their CSU.
- Signing off all Level 1 or Level 2 investigations for medium or high risk complaints.
- 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 (Appendix H) can be found on the Complaints Intranet page.
- 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 co-ordination 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.

Ensuring that frequently occurring themes raised as informal complaints in local areas e.g by “Message to Matron” are reviewed within the CSU to ensure that appropriate action is taken and 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.

Reviewing draft complaint responses to check they are ready for sign off before they are submitted to the designated CSU QA link.

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

- Actively seeking to provide a high standard of care in order to prevent reasons for complaints.
- Ensuring all patients are aware of how to raise a complaint and how to access support.
- Ensuring current, up to date versions of literature informing the public of the Trust complaints process is visible and available in all public areas.
- Ensuring staff are empowered to resolve concerns and grumbles at source, at time of being raised.
- 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.

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 Complaints Team under the leadership of the Complaints Manager and the PALS Team, under the leadership of the PALS Manager are responsible for:

- Ensuring all complainants have easy access and are supported to make a complaint.
- Ensuring everyone making a formal complaint is advised of local advocacy agencies.
- Ensuring complainants are contacted within Trust targets of three working days.
- Making initial contact and maintaining contact with complainants.
- 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.
- Co-operating with external agencies to provide a single unified response for mixed sector complaints
- Accurate recording of complaints and concerns on DATIX.
- Accurate recording of complaints investigation and action plans on DATIX.
- Ensuring complaint files are always up to date.
- 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 other departments where appropriate.
- Producing complaints and PALS 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.
  - Fortnightly report to monitor timeliness of individual complaint responses
- 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.
- Working with internal and external stakeholders to review and improve the complaints handling process. Providing training and support to CSUs
through regular masterclasses, provision of useful materials and bespoke support where this is required.

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 the Conflict Resolution 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 cause concern. 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 act 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. All staff should know and be able to explain how patients/carers can raise a concern, what support is available and signpost to access this process, if they are unable to resolve issues of concern themselves.

6 EQUALITY ANALYSIS
This Complaints Policy 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 with a number of key health and social organisations and voluntary and user groups. This includes Leeds Independent Health Complaints Advocacy (Advonet) and the LTHT Patient Reference Group. This policy has also been shared with senior operational staff at the Trust, the Trust Equality and Diversity team and a number of patient representatives.
8  STANDARDS/KEY PERFORMANCE INDICATORS

The following key performance indicators will be monitored and reviewed.

<table>
<thead>
<tr>
<th>KPI</th>
<th>Key Performance Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percentage of complaints acknowledged within three working days.</td>
</tr>
<tr>
<td>2</td>
<td>Percentage of PALS responded to within two working days.</td>
</tr>
<tr>
<td>3</td>
<td>Percentage of complaints responded to within agreed timeframe (target 40 working days).</td>
</tr>
<tr>
<td>4</td>
<td>Numbers of complaints risk scored.</td>
</tr>
<tr>
<td>5</td>
<td>Numbers of re-opened complaints.</td>
</tr>
<tr>
<td>6</td>
<td>Number of complaints received compared against activity.</td>
</tr>
<tr>
<td>7</td>
<td>Numbers of complainants satisfied with complaints handling (including not being treated differently as a result of raising a concern / complaint).</td>
</tr>
<tr>
<td>8</td>
<td>Improvements made as a result of learning from complaints and concerns are evidenced within Clinical Governance Action Logs (&amp; minutes).</td>
</tr>
<tr>
<td>9</td>
<td>Annual equality profile of all complainants and patients the care related to.</td>
</tr>
<tr>
<td>10</td>
<td>Percentage of PALS uploaded in DATIX with actions taken and learning within target of 40 days.</td>
</tr>
<tr>
<td>11</td>
<td>Percentage of PALS reopened by CSU.</td>
</tr>
</tbody>
</table>
9. **MONITORING COMPLIANCE AND EFFECTIVENESS**

<table>
<thead>
<tr>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Process for listening and responding to concerns/complaints of patients, their relatives and carers</td>
<td>Trust Board Complaints Report</td>
<td>PALS and Complaints Manager</td>
<td>Twice yearly (an annual and a half year update)</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub Group</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td></td>
<td>Audit of the management, processing and investigation of formal complaint and PALS processes (audit 1 as detailed below)</td>
<td>PALS and Complaints Manager</td>
<td>Yearly</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub Group</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 Group</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; PALS process (audit 2)</td>
<td>PALS and Complaints Manager</td>
<td>Yearly</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub Group</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; PALS process (audit 3)</td>
<td>PALS and Complaints Manager</td>
<td>Annual</td>
<td>Head of Patient Experience</td>
<td>Patient Experience Sub Group</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>Compliance with national standards associated with complaints management</td>
<td>Submission of the Hospital and Community Health Services Written Complaints Return known as ‘KO41’ data.</td>
<td>Complaints Manager Health &amp; Social Care Information Centre (HSCIC)</td>
<td>Quarterly</td>
<td>Quarterly</td>
<td>Head of Patient Experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Head of Patient Experience Health &amp; Social Care Information Centre (HSCIC)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Audit</td>
<td>Lead</td>
<td>Method</td>
<td>Reported to</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 1  | Audit of Complaints & Concerns Process (Complaints handling)          | Head of Patient Experience                     | • testing of a 5% sample of complaints received within a selected quarter  
    |                                                                       | PALS and Complaints Manager                    | • testing of 25 - 30 PALS records within a selected quarter  
    |                                                                       |                                                | • testing of a 5% sample of all mixed sector complaints received within a selected quarter | Patient Experience Sub Group                     |
| 2  | Audit of Complaints & Concerns Process (Complainant satisfaction)     | Head of Patient Experience                     | On-going programme with annual reporting:  
    |                                                                       | PALS and Complaints Manager                    | • 100% of complainants will have the opportunity to receive a satisfaction survey following their complaint response  
    |                                                                       |                                                | • 100% sample of all enquiries raising a PALS query within a selected quarter will have the opportunity to receive a satisfaction survey | Patient Experience Sub Group                     |
| 3  | Audit of Complaints & Concerns Process (Learning)                     | Chief Operating Officer                        | Annual audit involving:  
    |                                                                       | Deputy Chief Nurse Operations                  | • testing of a 5% sample of complaints received within a selected quarter with a review of the respective clinical governance action logs, minutes or via resultant action plans | Patient Experience Sub Group                     |
|    |                                                                       | Clinical Directors                             |                                                |                                                |

The resulting audit findings will be reviewed and incorporated into a report and action plan. The Patient Experience Sub Group 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.
- Leeds Teaching Hospital NHS Trust Investigation of Incidents and Complaints Procedure - current version
- 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.
- “My Expectations” - PHSO November 2014
- “ A review into the quality of NHS complaint investigations” PHSO 2015
Appendix A

THE LEEDS TEACHING HOSPITALS NHS TRUST
Guidance for handling formal and informal complaints

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

2. 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. The Patient Experience Team will support the complainant throughout the life of their complaint.

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 Intranet Page of the Trust’s website. All publicity material will include advocacy 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/PALS, 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 or are staff contract or 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 or 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 or for younger patients, decisions to allow self-consent will be based on Gillick/Fraser competencies. 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. Child friendly publicity material will be available across the Trust to encourage children to contact the PALS service to raise concerns.

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 from the event occurring or 12 months from realising that there is something to complain about. 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. The Regulations state that complaints outside this limit can still be investigated if there is a reason why the complaint wasn’t made earlier and where it is still possible to investigate we will endeavour to do so, although this may in some cases be by addressing the complaint informally (where notes are available). Reasons for any decision will be documented in DATIX.

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 Safety’ 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 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 are supported by the Trust’s Freedom to Speak Up Policy. 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 formal complaints and PALS 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 available for 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 distress for staff and results in a disproportionate use of resources. When appropriate, such complainants should be managed in line with either the Conflict Resolution or Vexatious/Persistent Complainants guidance. In dealing with such situations the PALS or 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. Advice for specific cases is available from the Complaints, PALs or Risk Management Teams.
## Appendix B

### Formal Complaints Procedure - Key timescales

<table>
<thead>
<tr>
<th>Compliance deadline</th>
<th>Process</th>
<th>Action</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day 0-3</strong></td>
<td>Complaint received</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oral complaint that has not been resolved informally</td>
<td>If oral complaint then make record of complaint on the DATIX system. PET to phone complainant where possible to: acknowledge complaint, obtain consent where required, offer support and offer a meeting. All complainants will receive an acknowledgement letter which will include: details of advocacy agencies, process of handling complaint, target response date, PET contact details, also reiterate offer of meeting.</td>
<td>PET</td>
</tr>
<tr>
<td></td>
<td>Written complaint</td>
<td>PET will risk score all complaints, assess the complexity, consider if safeguarding concern 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></td>
</tr>
<tr>
<td></td>
<td>Electronic (complaints inbox) complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Day 3-28</strong></td>
<td>Negotiate</td>
<td>Clinical director assigns complaint to the relevant CSU lead who will appoint an investigator. Direct contact with the complainant 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 40 day default target cannot be met then the lead should automatically contact the complainant. All contact must be documented and PET advised. Meeting date arranged if requested by complainant.</td>
<td>CSU/PET</td>
</tr>
<tr>
<td><strong>Day 28 - 35</strong></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>CSU - 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></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 - 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 and multi CSU)

Complaint received by Patient Experience Team (PET) and logged into DATIX
Consent requested (if required)
Risk graded, consideration to safeguarding
Complaint Handler contacts to explain process and offer a meeting.

Complaint pack (detailing contact preference, concerns to be addressed and whether meeting needs to be arranged) forwarded to CSUs

CSU identify lead investigator who will arrange meeting (if required)
CSU investigate

CSU draft response to complainant in line with complaints checklist and forward the draft complaint response and complaint letter/complaint pack to QA.

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

For Multi Complaints Only
PET draft response and forward to lead CSU QA who approves full response and forwards to PET. If not approved QA informs PET of requested amendments

PET arranges review by Executive Officers and sign off by Chief Executive or nominated deputy.

PET = Patient Experience Team
CSU = Clinical Service Unit
Appendix D
Process for Quality Assuring and Sign Off
Complaint Responses

PET forward draft response and copy of complaint letter/complaint pack, to the appropriate QA link after it has been reviewed by Head of Nursing

Corporate link quality assures complaint response

Approved

Corporate link forwards to Complaint Handler in PET to arrange sign off (copy in CSU lead)

Not approved

Corporate link request revisions via CSU

PET make required revisions

Complaint Handler proof reads and passes approved complaint response, with corresponding complaint letter to PA for Chief Nurse and Chief Medical Officer.

PA actions Executive Team review, approval and signature. PA returns signed letter to PET who send letter to all recipients

PET inserts signed copy into DATIX and closes file
Appendix E
Flowchart for Handling Informal Complaints (Outside of PALS Team)

Step 1:
- Dealt with at source by staff member. Immediate apology or explanation or suggestion of change/action to be taken
- Consideration given to whether a safeguarding concern and a referral completed if required.

Step 2: If Enquirer is satisfied
- Ensure any actions taken or learning is shared within CSU where appropriate

Step 3: If enquirer is not satisfied
- If not satisfied opportunity offered to discuss with line manager, using the “Message to Matron” and “Speak to Sister” initiatives.
- 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.
- The line manager may obtain assistance from senior colleagues or the PET
- If not resolved, enquirer given tel. no. /e-mail address and concerns leaflet.
- If the enquirer is clear they wish to make a formal complaint at that time, the CSU must contact the PET with a summary of the issues to instigate the process on the enquirer’s behalf.
Appendix F

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 not possible to immediately resolve, PALS staff will pass the call to someone who is able to resolve on the spot or, email an appropriate person and ask them to make contact with the enquirer.
- Record details within DATIX and Risk score
- Consideration given to whether a safeguarding concern and a referral completed if required

**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 G

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.
Appendix H

Complaints Action Plan

| Ref:   |   |   |   |   |
| CSU:   |   |   |   |   |
| Speciality: |   |   |   |   |
| Investigator: |   |   |   |   |

If staff have been supported through this investigation please insert the job title of the person who provided this:

**Please ensure any supporting evidence of action taken is forwarded to your Complaints Handler e.g. policy changes/procedural changes**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Action Taken</th>
<th>Date Due</th>
<th>Date Done</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

Recording of Local Resolution Meetings

Information Pack for CSUs
Recording of Local Resolution Meetings - Process to follow

- Discuss with the complainant and Trust staff to obtain confirmation that they are happy for the meeting to be recorded. The Complaints Team will provide support for staff new to the process of recorded meetings.

- Agree the meeting date and time and contact your Complaints Handler to book out the recording equipment.

- Prior to the complaint meeting, liaise with your Complaints Handler to collect the equipment and to ensure you are familiar with how to use it.

- At the meeting, please complete the template letter and ensure any actions, lessons learnt or improvements are agreed and documented. These should be confirmed at the end of the meeting and included in the recording.

- After the meeting, please return the recording equipment and completed guidance template letter (hand written will suffice) to your Complaints Handler who will download the recording, save it to a CD and finalise the template letter. This will be sent for Executive review and sign off in the usual way.

- Please note that recording equipment is available on a “first come, first served” basis. Sufficient time should be allowed to ensure any previous recordings are downloaded and deleted from the recorder and the equipment is fully charged.

Frequently Asked Questions

Q. What if a staff member is not happy to be recorded?
A. The CSU will be given the opportunity to check with staff that they are happy to be recorded prior to recording being offered to the complainant. If a staff member does not want to be recorded, the CSU should instead organise a note taker who will take the minutes.

Q. What if a complainant or their advocate does not want to be recorded?
A. This should be identified by the Complaint Handler and fed back to the CSU. In such cases, the CSU will organise a note taker to take the minutes of the meeting.
Q. What do I do if my meeting is not at St James’s?
A. Speak to your Complaint Handler. We will be able to collect and deliver the recording equipment to other sites however this needs to be planned in advance.

Q. How do I book the equipment?
A. Please refer to the “Process for booking a meeting” document, or contact your Complaint Handler.

Q. How do I use the equipment?
A. Refer to the instructions provided with the equipment. If you are concerned, please allow sufficient time when collecting the equipment so that a member of the Complaints team can talk you through it and demonstrate the equipment.

Q. How do I charge the equipment?
A. The Complaints Team will ensure that the equipment is fully charged. The battery lifetime is up to 23 hours recording time.

Q. Is there anything I need to say for the benefit of the recording?
A. Please refer to the “Checklist for the Chair” document included with the equipment and instructions.

Q. How do I save the recording?
A. The recording will save automatically onto the device at the meeting. You must then return it to Patient Experience who will save it and transfer it onto CD. An additional copy will be retained with the hard copy complaint file.

Q. How do I get a copy of the recording?
A. The Complaints team will save all recordings in a secure Drive on the Trust Computer System.

Q. Do I still need to write a letter/meeting notes?
A. Whilst you do not need to send a verbatim set of meeting notes, we do require you to write a cover letter which summarises who investigated the concerns, how these were considered, lists all actions taken (with target dates) as agreed at the meeting. A summary of the concerns raised and whether or not we identified any failings is required to assist the complainant if they are considering approaching the Ombudsman. Ask your Complaint Handler for a cover letter guidance template.
Q. How does the recording get to the complainant?

A. The Complaints Team will download the recording onto a CD which will be sent out by special delivery to the complainant. A covering letter produced by the CSU and signed off by the Executive Team will go with the CD.
The complainant requests a meeting during initial conversation with Complaint Handler (CH)

CH informs CSU

CSU seeks consent from staff to be recorded at the meeting.

Staff do not consent

CSU liaises with CH to identify mutual availability of CSU and recording equipment

No dates available

Dates are available

CH or CSU contacts complainant to offer meeting dates and identify how to document the meeting

Meeting agreed. CSU collects equipment from PET on the day of the meeting

Wants to be recorded

PET burn CD and CSU provide cover letter. Complaint Closed.

Return equipment to PET

Complainant does not want to be recorded

Staff Consent

No dates available

CSU should arrange meeting and use note taker in usual way

Wants to be recorded
Checklist for the Chair

During the meeting there are a few things the Chair needs to stay aware of:

1. Ensure the complainant signs the disclaimer form (provided with equipment).

2. At the start of the recording, introduce the meeting and state the patient's name, reference number of the complaint (e.g. D15/9999), the date, location and time.

3. Ask everybody to individually state their name and that they are happy to be recorded.

4. Be aware of people talking over each other as this may make the recording difficult to listen to.

5. Capture any actions to include in the response letter

6. If the recording needs to be paused for any reason, please state this clearly so it can be heard on the recording. When the recording is resumed, please state this also.

7. At the end of the meeting, state that the meeting is closed and the time.
Consent to Record Complaint Meeting

I confirm that I am happy to be recorded during the meeting to discuss my complaint and I understand that the audio recording of the meeting is intended for private use only and must not be reproduced in any way or publically shared without the consent of all parties present.

<table>
<thead>
<tr>
<th>Our Ref</th>
<th>Print name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Signature</td>
</tr>
</tbody>
</table>
Dear

Thank you for your method of complaint which was received on date. I was sorry to learn of your concerns regarding xxxxx. Your concerns were investigated by staff name, title and as a part of their investigation they considered the following: e.g. medical records, incident reports, staff accounts, CCTV, etc

I understand you attended a meeting on date of meeting to discuss your concerns relating to the care that name of patient received at Leeds Teaching Hospitals. The meeting was also attended by names of attendees. The following concerns were discussed: describe, list or use table

I hope the team were able to address all of your concerns and answer your questions. I understand that during the meeting no/the following areas of care were found to be below the level we aspire to deliver List.

The actions detailed below were agreed:

- List agreed actions and include timescale/target date

As agreed, I enclose a copy of the notes/recording that were/was taken to record the concerns you raised and the discussions that took place.

I would like to thank you for bringing your concerns to our attention. We welcome complaints as a genuine means of helping us to improve the way we care for patients and deliver our service.

On behalf of the management team for CSU(s), I apologise for the experience that name of patient had using our service and I hope that any future experiences of our services are more positive and in line with your expectations. I hope that this response has fully addressed the concerns that you have raised, however, if this is not the case please contact the Patient Experience Team (Complaints) and ask us to look at your complaint again.

Yours sincerely

Julian Hartley

CHIEF EXECUTIVE

Enc: Notes from meeting/Recording of meeting held on date of meeting

Action plan (if one)
If you feel that there is nothing further the Trust can do to resolve your complaint you do have the right to ask the Parliamentary and Health Service Ombudsman to review the way in which the complaint has been handled. The Ombudsman can be contacted by:

- visiting [www.ombudsman.org.uk](http://www.ombudsman.org.uk)
- calling the complaints helpline on 0345 015 4033 (Mon to Fri 8:30 to 17:30)
- emailing [phso.enquiries@ombudsman.org.uk](mailto:phso.enquiries@ombudsman.org.uk)
- faxing 0300 061 4000, or
- writing to The Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London, SW1P 4QP
Appendix J

Minimum DATIXweb contents of completed Complaints File

- Complaint, including photographs if sent
- Initial review sheet
- Acknowledgement letter
- Signed Form of Authority
- Complaint Pack
- Letter to Coroner and response if applicable
- Email to CSU(s) forwarding complaint
- Email(s) to outside organisation(s) forwarding complaint
- Holding letters
- Chaser emails
- Email queries to/from CSU(s)
- Emails if CSUs added or removed
- Correspondence/emails to/from complainant
- QA approved response or paragraphs
- Response sent for Executive Review/signature
- Rejected response and signing slip
- Scanned copy of signed final response
- Meeting notes or copy of recording
- Thank you letters
- Investigation evidence - scope of investigation, summary and outcome, statements, L2 completed investigation, copy of policies/NICE guidance referred to (including confirmation of staff support)
- Action plans (including confirmation of staff support)
- NB - As above for reopened complaints