



Complaints, Compliments, Concerns and Comments Policy

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<p>Effective Date: 14 August 2018</p>	<p>Review Date: 13 August 2021</p>
<p>Approval at: Policy Management Sub-Committee</p>	<p>Date Approved: 14 August 2018</p>

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
29.03.12	4.0	20.12.12	Chief Nurse	Logo and wording updated for new organisation	
25.11.12	4.1		Executive Director of Nursing	Updated in line with NHSLA requirements	
6.12.12	4.2		Executive Director of Nursing	Agreed at Quality & Patient Safety Committee with amendments	
14.12.12	4.2		Executive Director of Nursing	Agreed and Policy Management Group	
17.12.12	5.0	17.12.15	Executive Director of Nursing		Approved at Executive Board
30.11.15	5.1		Executive Director of Nursing	Policy reviewed and updated in line with new Organisational Process and best practice documents.	
30.11.15	5.2		Executive Director of Nursing	As above	Out for consultation with key stakeholders
28.04.16	5.3		Executive Director of Nursing	As above	Sent to Trust Executive Committee, Draft Policy Site, sent to Matrons and Head of Nursing and Quality via Directorate Nursing Team (DNT)
07.06.16	5.3		Executive Director of Nursing	As above	Sent to Healthwatch IOW and SeAp – Independent Complaints Advocacy for review.
12.07.16	6.	12.07.16	Executive Director of Nursing	Approved	Approved subject to minor amendments
24.01.18	6.1	24.01.18	Director of Quality Governance	Policy review in line with new organisational changes	
May 2018	6.2		Director of Quality Governance	Reviewed by External Consultant. Minor amendments made	
June 2018	6.3		Director of Quality Governance	Approved	Patient Experience Sub-Committee
August 2018	7	14.8.18	Director of Quality Governance	Approved	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

- 1.1 This policy has been formulated to ensure staff investigate and respond to complaints in a timely manner and to a high quality standard. The Complaint handling must comply with the requirements contained within The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The Trust will also follow guidance issued by the Care Quality Commission, NHS Resolution and National Patient Safety Agency and act in accordance with the NHS Constitution (27 July 2015); and comply with the Principles of Good Complaint Handling as defined by the Parliamentary and Health Service Ombudsman (PHSO), and in 'My Expectation for Raising Concerns and Complaints' (November 2014).
- 1.2 The Trust recognises the complaints and compliments policy as being a valuable tool for improving the quality of health services it provides. High Quality Care for All (2008) recognised that patient experience can only be improved by analysing and understanding patient satisfaction with their experiences. In the wider context of Patient and Public Engagement (PPE), complaints and compliments capture both positive and negative feedback on the services the Trust already provides and may identify areas for future service development

2 Introduction

- 2.1 The Trust is committed to providing the public with what it needs, not only in respect of excellent clinical care and safe and efficient treatment, but also in passing on their thanks, providing them with information, answering their questions and concerns, or resolving their complaints, in an open, efficient and timely way to ensure that they receive an appropriate response to whatever their specific needs are. It will provide a focal point for provision of accurate, effective and sensitive information, supporting all patients, their representatives or anyone who may be affected by the actions of the Trust or needs information from it.
- 2.2 All feedback from patients and relatives / carers, including concerns and complaints, provides essential information about the Trust services. This valuable feedback enables us to identify areas which are working well, and those areas which require change or an improvement.
- 2.3 In line with the NHS Complaints regulations (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) all health organisations must have a procedure in place for the management of complaints and concerns.

- 2.4 All formal complaints received by the Trust will be properly investigated in accordance with the regulations, and in line with the Parliamentary and Health Service Ombudsman (PHSO) good complaint handling principles. The Trust aims to resolve all complaints locally, wherever possible. In particular, the Trust will ensure that the way it manages all issues will also:
- Enhance the reputation of the Trust;
 - Avoid protracted correspondence;
 - Use complaints as a means of improving services;
 - Be fair to staff and contracted staff;
 - Maintain proper accountability for the actions of the Trust and its staff;
 - Guarantee that all contacts and complaints will be dealt with fairly and impartially and therefore will not be treated differently as a result of making a complaint /concern.

General Principles:

- 2.5 All staff are committed to listening to the patient voice by responding to complaints, compliments, concerns and comments during the course of their work.
- 2.6 Patients, families and the public can feedback to all staff members, including nursing and medical staff, ward and service managers, or via the Patient Advice and Liaison Service (PALS) and the Patient Experience Team.
- 2.7 The Isle of Wight NHS Trust welcomes all feedback verbally, face to face, via the telephone, letters, emails or other social online media

3 Definitions

- 3.1 A Complaint: is defined as an expression of dissatisfaction, (written or verbal) about a service provided, or which is not provided, which requires a response. Examples include: complaints about the quality of service provided, the following of standard procedures and good practice, poor communication and the attitude or behaviour of a member of staff.
- 3.2 A Complainant: is the person making the complaint, whether on behalf of themselves or another.
- 3.3 A Concern: An expression of dissatisfaction (written or verbal) about a service provided, or which is not provided, which requires a response, but is resolved to the complainant's satisfaction within three working days.
- 3.4 Recordable compliment: Expressions of appreciation by letter, card, gift or donation. Letters of appreciation / compliments as well as acknowledgement letters should be reported to the Divisions 'Good News Co-ordinators' who then reports them to the Patient Experience Team on a monthly basis via the patient experience management system (Datix). Verbal compliments are not recorded in the overall statistics, although these compliments should be reported locally

and the service or member of staff recognised as a result. With regards to gifts the Trusts Standards of Business Conduct Policy should be followed.

- 3.5 Comments or Questions: Anyone is free to communicate with the Trust and provide it with their views and comments about the service it provides. They may also ask a question of the Trust or seek advice. This may be a patient, those affected by the actions of the Trust, member of public, GP or MP, or any other person.

4 Scope

- 4.1 This policy applies to all staff employed by the Isle of Wight NHS Trust, including sub-contractors, locum/agency staff and volunteers, and will act as a guide to the NHS Complaints procedure, and includes the collating and recording of compliments and concerns received by the Trust.

5 Purpose

- 5.1 The purpose of this policy is to provide a framework for listening, responding and learning from all patient feedback including complaints.
- 5.2 The aim of this policy is to ensure that we comply with the Parliamentary and Health Service Ombudsman (PHSO) principles of good complaint handling including:
- Ensuring that the complaints procedure is **accessible** and **well publicised**;
 - Complaints will be responded to in a **rapid** and **sensitive** manner;
 - Complaint responses that are **open** and **transparent**;
 - A complaints procedure that is **supportive** of those who may find it difficult to complain;
 - Seeking **continuous improvement** from feedback;
 - Ensuring patients and carers are able to complain without fear of being discriminated against.

6 Roles and Responsibilities

- 6.1 The **Trust Board** is responsible for reviewing learning from complaints and ensuring that this is heard at every level of the Trust.
- 6.2 The **Chief Executive** (CEO) is the responsible person for complaints, and oversees and signs all final response letters in reply to all formal complaints received by the Trust; or nominates a deputy in their absence.
- 6.3 The **Director of Quality Governance** is the Executive Lead for ensuring that there is an effective complaints handling framework and policy in place; and will ensure policy development and review takes place at least every three years, or sooner in line with local and national guidance.

6.4 The **Complaints Manager** for the Isle of Wight NHS Trust is the Head of Patient Experience and Quality who is responsible for

- Monitoring the implementation of the Complaints, Compliments, Concerns & Comments Policy;
- Day to day operational management of the Patient Experience and PALS Team and associated procedures;
- Providing reports to Trust committees and external stakeholders;
- Providing statistical returns;
- Ensuring the implementation of national policies guidance and requirements in relation to complaints and that robust systems are in place for the management of compliments, concerns and complaints;
- Ensuring mediation and or conciliation is available to complainants and practitioners, if required;
- Providing information to and ensuring any recommendations made by the Parliamentary and Health Service Ombudsman (PHSO) are implemented;
- Ensuring all complaints are logged on the patient experience management system;
- Updating this policy in line with national guidance and policies.

6.5 The **Patient Experience Officer** (s) is responsible for

- Supporting the Head of Patient Experience and Quality by managing all aspects of administration of the complaints process and report writing;
- Acting as a single point of access to complainants;
- Triaging complaints to identify potential risks early; linking with other Trust procedures such as Safeguarding Vulnerable Adults or Children or Serious Incidents requiring investigation;
- Working closely with the Divisional Quality Managers to ensure effective complaint handling;
- Ensuring data is collected in relation to complaints and concerns and for entry of this on the Trust's patient experience management system.

6.6 **Senior Patient Experience Officers (SPEOs)** are responsible for:

- Providing a proactive approach to capture feedback from patients.
- Supporting patients, relatives and carers in problem resolution, at the earliest possible stage to prevent the escalation to a formal complaint (managed within 3 working days).
- Ensuring that the designated Senior Manager is informed of a complaint / concern so that it can be appropriately actioned.
- Meeting with patients, carers and relatives to advise on problem resolution, including action planning to support resolution.
- Signposting and advising patients, relatives and carers appropriately when issues raised do not relate to the Isle of Wight NHS Trust.
- Ensuring data is collected in relation to complaints and concerns and for entry of this on the Trust's patient experience management system.

6.7 **Divisional and Corporate Services** are responsible for ensuring that when complaints are received they are logged with the complaint team; disseminated

to appropriate management teams to be thoroughly investigated, and responded to by letter. The letter must be compiled to appropriately cover all issues in a chronological order. The **designated senior manager / Quality Manager** is responsible for letting the Patient Experience Team know if the response will be outside the agreed timescale, the reasons for delay and the expected date of completion.

6.8 The **Head of Nursing and Quality** is responsible for:

- Ensuring services are organised and delivered by learning and improving from incidents and complaints;
- Ensuring systems and processes are in place to monitor and assure the quality of care and patient experience within the services of the Business Unit;
- Monitoring complaints and SI's ensuring that learning from these events is undertaken and shared appropriately to improve the Division's overall approach to risk management.

6.9 The **Quality Managers** are responsible for:

- Managing the Division's compliments, concerns and complaints, and providing reports accordingly;
- Ensuring that Complaints and Concerns are managed within required timeframes and lessons learnt are shared across the Division;
- Providing oversight to the Head of Nursing and Quality of the compliments, concerns and complaints process within the directorate, ensuring timely and appropriate responses. Ensure lessons learnt are shared widely and where necessary action plans are put in place across the Division to improve performance;
- Supporting the investigation of complaints, and provide reports as necessary;
- Liaising with patients when they have compliments, concerns or complaints about services. If necessary they may be required to act as an advocate in the resolution of complaints;
- Ensuring all information relating to the complaints handling is captured on the patient experience management system.

6.10 The **Lead Investigator** is responsible for coordinating, obtaining and collating comments from appropriate staff and drafting the response in accordance with a strict timeline.

- **Lead investigators** for complaints will be appointed by the Divisional Head Of Nursing and Quality/ Quality Manager. This does not apply to corporate, facilities or financial complaints, when the relevant department manager will allocate a lead investigator.
- It is the responsibility of the nominated **Lead Investigator** to liaise with, and obtain relevant information from, other departments.
- The **Lead Investigator** must ensure that any response referring to matters of medical care or clinical judgement is agreed by the consultant or

clinician concerned before it is sent to the Patient Experience Team for review.

- A proactive approach to resolving the complaint is encouraged and should be taken wherever possible. This may involve inviting the complainant in for a meeting with those involved in their care or the use of external conciliation services if appropriate before a final response is given. **Lead Investigators** wishing to adopt this approach should discuss this with the Patient Experience Team.
- Where a meeting takes place it is the responsibility of the **Lead Investigator** to ensure an appropriate note/recording of the meeting is taken with the complainant's consent.

6.11 **All Trust Staff** have a role to play in complaint handling and supporting local resolution by ensuring that:

- As far as possible, their attitude, approach or behaviour do not give service users cause for complaint;
- Action is taken to respond to complaints / concerns in first instance, requesting advice and support from their line manager as needed;
- Informing their line manager of any complaints they receive;
- They deal with any issues courteously and efficiently;
- They keep good quality records;
- They refer on to an appropriate senior manager if the limits of their authority or experience are exceeded;
- They cooperate fully with the investigation of each complaint, ensuring that any staff for which they have responsibility respond to investigations in a timely and appropriate manner in line with the complaints procedure.

6.12 **Patient Advice and Liaison Service (PALS):**

The Trusts **PALS** service provides a single point of access for all patients, carers and their families.

6.12.1 **PALS** provide help to patients by:

- Providing information and signposting;
- Assisting patients in accessing services and answering queries;
- Receiving feedback about services;
- Helping with concerns, and providing advice on the formal complaints process.

6.12.2 **PALS** provide a service to the Trust by:

- Actively seeking views from the public to ensure effective services
- Identifying trends to senior managers
- Providing on the spot help for staff to negotiate solutions to problems
- Supporting services to involve the patients / relatives in relevant service changes/improvements

- Supporting staff at all levels of the Trust to encourage a responsive culture through positive support, training and awareness sessions and sharing good practice.

6.12.3 The **PALS** service can be accessed by telephone, email, face to face and written correspondence.

6.12.4 All enquiries will be logged on the patient experience management system in order to build up a picture of trends in enquiries.

6.12.5 The **PALS** office is based in the main hospital reception area and is open 09:00 to 4.30 Monday to Friday.

7 Policy detail/Course of Action

This section sets out the processes to be followed to ensure compliance with the NHS complaints procedure and best practice as recommended by the Parliamentary and Health Service Ombudsman (PHSO)

7.1 Being Open and Duty of Candour

Being open and duty of candour involves:

- acknowledging, apologising in writing 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 a recurrence of the incident; and
- 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.

7.1.1 Openness and communicating effectively with patients, their families and carers is a vital part of the process of dealing with patient safety incidents in healthcare. Research has shown that patients are more likely to forgive medical errors when they are discussed in a timely and thoughtful manner and that being open can decrease the trauma felt by patients following a patient safety incident.

7.1.2 As well as being open when managing complaints, Duty of Candour must be considered and applied in accordance with Regulation 20. The Trusts Being Open and Duty of Candour Policy should be referred to during the investigation and management of complaints.

7.2 Matters excluded from this Policy

In accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 the Trust is not required to deal with the following complaints:

- A complaint by a responsible body;
- A complaint by an employee of a local authority or NHS body about any matter relating to that employment;
- An oral complaint resolved not later than the next working day on which it was made;
- A complaint the subject matter of which is the same as that of a complaint that has previously been made and resolved in accordance with the above bullet point;
- A complaint the subject matter of which has previously been investigated under the regulations;
- A complaint the subject matter of which is being or has been investigated by:
 - A local Commissioner under the Local Government Act 1974 or
 - A Health Service Commissioner Under the 1993 Act;
- a complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000(b); and
- A complaint which relates to any scheme established under section 10 (superannuation of person engaged in health services etc.) or section 24 (compensation for loss of office, etc.) of the Superannuation Act 1972, or to the administration of those schemes.

7.3 Who can raise a concern / complaint?

7.3.1 Anyone who receives or has received services from the Trust

7.3.2 A person who is affected or likely to be affected by an omission or decision of the Trust.

7.3.3 A third party e.g. MP, family member, friend, carer, independent advocate such as the Independent Complaints Advocacy Service or legal representative if they can show relevant consent / authority.

7.3.4 All concerns will be investigated, but in order to release the full findings to the complainant in cases where a patient is unable to raise concerns due to capacity or death suitable evidence must be presented to show that the representative has authority to act in this capacity and is acting in the best interests of the complainant (for example by holding an Enduring Power of Attorney or proof of executor of the will).

7.3.5 Detained patients should be made aware of their entitlement, at any stage, to contact the Care Quality Commission (CQC) with complaints, and helped to do so if necessary.

7.3.6 In instances when a complaint and claim are brought at the same time, the complaints process will still apply unless contrary to the advice of the Trust's legal advisors.

7.4 Who cannot complain via the NHS Complaints Process?

7.4.1 Staff of the Trust and other providers or commissioners can only use the NHS complaints procedure if their complaint relates to their own health care or that of a friend or relative. In both situations they are acting as the patient or member of public and not a member of staff.

7.4.2 Staff grievances cannot be dealt with through the complaints process. The Trust has local procedures in place for handling staff concerns, including the established grievance and raising concerns (whistleblowing) process. Staff should refer to their line manager or HR department for further guidance

7.5 How to raise a concern / complaint

7.5.1 By telephone or in person in which case a written record must be made setting out the issues requiring investigation and signed by the complainant.

7.5.2 In writing to the Ward Manager / Head of Department, Chief Executive, Patient Experience Team or Patient Advice and Liaison Service, this can be via post, email, or using the complaint form on the Trust's website.

7.6 Time Limits

7.6.1 Complaints should be made within one year of the incident, or within one year of the complainant realising there is something to complain about. This timescale is in place due to the difficulties in obtaining accurate information about a patient's care after such a period of time.

7.6.2 Discretion can be applied to extend this time limit where it would be unreasonable in the circumstances for the complaint to have been made earlier and where it is possible to still investigate the facts of the case. Staff should use their discretion flexibly and sensitively.

8 Compliments

8.1 Compliments are as important to the Trust as complaints and should be seen as a means of learning how things have gone well. Information on compliments should be reported to the Board and also cascaded to the staff.

8.2 Compliments are collated by the Good News Co-ordinator for each Division on a monthly basis and numbers sent to the Patient Experience Team for reporting via the Trust's monthly Quality Report.

- 8.3 All staff / teams must share the numbers of significant thanks they have received (cards & letters) with their Good News Co-ordinator on a monthly basis to be recorded centrally on the patient experience management system.

9 Procedure for Handling Concerns

- 9.1 A concern is an expression of dissatisfaction that should be resolved quickly and efficiently to the satisfaction of the complainant, no later than 3 working days after which it was raised.
- 9.2 All patients and their families must be encouraged and supported to raise concerns at an early stage, in order to resolve any worries or problems with care and to improve services.
- 9.3 Concerns may be raised verbally or in writing. Patients should be encouraged where possible to raise concerns directly with the staff members involved in their care. Alternatively, concerns can be shared with the service / ward manager, or via the PALS service.
- 9.4 Early resolution should always include initial attempts at resolution within the relevant department, only escalating to the Patient Experience Team if unsuccessful or if specifically requested by the complainant. Consideration should always be given to the seriousness of the issues resolved at a local level and whether further actions should be taken.
- 9.5 The method of resolution must be decided in discussion with the complainant and should be proportionate to the complexity of the issues raised.
- 9.6 PALS staff will try to resolve any concerns patients, carers or relatives may have about the care provided or the services they receive as soon as possible. PALS staff will, at their request, attend meetings to discuss concerns/issues as appropriate. In this role PALS staff will be present to assist and provide support to the patient, carer or relative. They will liaise with Trust staff and other providers to obtain relevant information about any aspect of care; this may include signposting to external organisations.
- 9.7 Concerns raised through the PALS team will be dealt with quickly by the Senior Patient Experience Officers (SPEOs), through early resolution or escalation to, and action by, relevant staff. If the issue is passed to the appropriate manager, the responsibility for managing this in 3 working days will also pass to that manager. Where the matter cannot be resolved within 3 working days, consideration should be made to manage this under the NHS complaints procedure following discussion and negotiation with the complainant. Action taken will be recorded on the patient experience management system for inclusion in quarterly reports. PALS staff will ensure feedback is obtained within 5 working days confirming resolution or escalation of the matter.

- 9.8 In some instances where the complainant has agreed that the issue will take longer to resolve, e.g. the complainant or relevant staff member is on holiday, a longer timescale can be negotiated in which to respond, but this must be fully documented and the agreed timescales adhered to.
- 9.9 PALS staff will escalate any failure to respond to their request within 3 work days / agreed timeframe to the relevant Head of Nursing and Quality and Head of Patient Experience & Quality.
- 9.10 Where a concern raised involves another NHS or Local Authority organisation, PALS staff will ensure input is received from the other organisation to resolve the issue. Consideration must be given to patient confidentiality and consent before contacting another organisation and consent sought where appropriate. Where the concern is to be handled by another organisation, PALS staff will request follow up to ensure the matter is resolved.
- 9.11 The individual raising the concern will be kept informed of all progress made and should be fully involved in the process. If the enquirer is not satisfied with the outcome it should be escalated to the Patient Experience Team.

10 Procedure for Handling Complaints

- 10.1 See Appendix A for the Trust's complaints handling procedure.
- 10.2 Where a complaint relates to a serious incident or safeguarding investigation the response time may be extended pending completion of the internal investigation.

Withdrawal of a complaint

- 10.3 If a complainant withdraws a complaint at any stage in the procedure, the complained against should be informed immediately, in writing and the complainant should also be sent a letter by the Chief Executive confirming that the decision of the complainant has been noted by the Trust. Any identified issues must be followed up within the service area and any learning cascaded to staff.

Complaints involving other organisations

- 10.4 The Trust has a duty to co-operate with other organisations (e.g. health and social care) to ensure full co-ordination of the handling of and response to a complaint.
- 10.5 Consent must be obtained from the complainant to liaise directly with the other organisation. If a joint response is necessary, discussion will take place with the organisation to establish who will take the lead.

- 10.6 Complainants will be informed of which aspects of the concerns raised are not within the Trust's jurisdiction. Where a complaint involves more than one NHS or non-NHS body, for example Portsmouth Hospitals NHS Trust, the Trust will forward the complaint to other agencies concerned with the complainant's permission. Agencies will work together to determine how best to respond.

Performance Targets for resolution of complaints

Timescales:

Resolution of written complaints - written complaints must be forwarded to the Patient Experience Team **immediately**.

- 10.7 The Patient Experience Team will acknowledge receipt of the complaint within three working days agreeing the way to proceed – this will include an offer of a meeting.
- 10.8 The Patient Experience Team will provide the complainant with a copy of the Trust's leaflet 'How to raise a complaint about the Isle of Wight NHS Trust', and include information about the Parliamentary Health Service Ombudsman (PHSO) and the Independent Complaints Advocacy Service (seAp).
- 10.9 The Patient Experience Team will circulate the complaint to the relevant Division via the relevant division complaints mailbox for investigation – thorough investigation and timely resolution is essential.
- 10.10 A Lead Investigator will be appointed who will ensure timely investigation by relevant person and preparation of a draft response to be provided to the Patient Experience Team within agreed timescales. In exceptional cases where this may not be possible – the Lead investigator and / or Divisional Quality Manager will inform the Patient Experience Team immediately.
- 10.11 The Patient Experience Team will ensure that the complainant is updated regarding the delay in the investigation, and agree a new response date.
- 10.12 The Lead Investigator will return the draft response, completed complaint investigation and action plan to the Divisional Quality Manager.
- 10.13 The Divisional Head of Nursing and Quality will quality assure and check that the complaint process has been followed prior to circulating for agreement.
- 10.14 The Divisional Quality Manager will provide the complaint response and completed action plan to the Patient Experience Team for preparation for signing by the Chief Executive.
- 10.15 It is Trust policy that the final response is sent to the complainant within 30 working days of receipt of the complaint however, in exceptional circumstances this can be extended by the Patient Experience Team with the

agreement of the complainant. The period of extension will be discussed with the Lead Investigator to ensure it is realistic.

Some complaints may be investigated by the Serious Incident route, and this decision will be taken by an Executive Director as part of the SI process. Where this is the case, a decision at the first SI strategy meeting must be made on what elements of the complaint will be investigated by the SI process, and what will be responded to via the Trust's complaint process. A member of the Patient Experience Team should be involved in this meeting. The complaint response must not be delayed awaiting the outcome of the SI investigation.

Resolution by Meeting:

10.16 For those complainants requiring a meeting in the first instance rather than a written response, a suitable date will be negotiated by the Divisional Quality Managers with the complainant and relevant staff members.

10.17 The Lead Investigator will be advised of the timescale for completion of investigation to fit in with the date of the meeting.

The following applies to all complaint resolution meetings:

- A recording of the meeting will be taken (with the complainants consent) and provided together with a written summary of the action taken.
- The Patient Experience Team does not undertake written transcripts of minutes of the meeting; if written minutes are required, the care group/division will be responsible for providing this support.
- Any notes / recording taken of the meeting, action plan and outcomes and follow up letter must be provided to the Patient Experience Team within 7 working days of the meeting.
- A final response and any relevant documents should be provided to the complainant within the agreed 30 working days of initial receipt of the complaint, or within 10 working days of meeting as agreed with complainant.

Unresolved complaints

10.18 Where the complainant is dissatisfied with the Trust's response and further explanation is required this should be given if possible; a complainant meeting may be appropriate if this has not previously been explored. If it is not possible to assist further, the complainant can seek review by the Parliamentary and Health Services Ombudsman.

10.19 The complainant has one year from the end of local resolution to do this. The Ombudsman will independently review the complaint and decide what action should be taken.

- 10.20 If the Ombudsman decides to investigate the complaint independently, the Trust will provide every assistance to the Ombudsman, and in particular will ensure that all requested information is provided within stated deadlines and that all the principles of redress are considered.
- 10.21 This is the last stage of the complaints process and the Ombudsman's decision is final. There is no appeal against a decision made by the Ombudsman

11 Confidentiality and Consent

- 11.1 It is not necessary to obtain a patient's express consent to use his/her personal information to investigate a complaint, the exception being when contacting another organisation for comment; in such circumstances written consent should be requested and received.
- 11.2 If the complainant is not the patient and the complaint relates to treatment received by the patient, consent will be required. If the patient lacks capacity to consent to the complaint the complaint should be brought where possible by the patient's personal representative in law, such as lasting power of attorney for welfare or court appointed deputy. Alternatively, the Head of Patient Experience and Quality supported by Information Governance will confirm whether or not a person is a suitable representative or nominate an appropriate person. In any event the complaint will be investigated through the complaints process in the best interests of the patient.
- 11.3 Where a complaint is made on behalf of a patient who has not provided consent, care must be taken not to disclose personal health or patient-identifiable information.
- 11.4 Proof of identity as Executor will be required if the complaint is made on behalf of a deceased patient in accordance with the Trust's Access to Health Records policy.
- 11.5 Only those investigating the issues should access a patient's personal information.
- 11.6 A member of staff requested to provide a statement should be given access to the relevant information, if necessary, to aid investigation.
- 11.7 A complaint should only be made known to those directly involved in responding to or investigating the issues raised i.e. on a "need to know" basis.
- 11.8 Complaint records must be kept separate from health records and must not be placed on any electronic record; or in any paper record unless the information is strictly relevant to the patient's healthcare. This includes when a

member of staff from the Patient Experience Team has visited the patient in relation to raising a complaint or concern.

11.9. All staff must comply with the requirements of the Data Protection Act 2018.

12 Providing a statement

12.1 Please refer to the statement and interview templates and guidance (Appendices B and C).

12.2 Statements provided for investigation of a complaint can be disclosed to the complainant or their representative under the Data Protection Act 2018.

12.3 If staff have any difficulty preparing a statement they should contact their line manager or the Patient Experience Team for assistance.

12.4 It is the responsibility of the Lead Investigator in conjunction with the staff member's line manager to ensure staff have access to a computer or administrative support in order to type the statement

Providing a written response

12.5 The Lead Investigator will ensure the written response is in an appropriate format for the complainant, covers all points raised by the complainant, as far as possible, and identifies where, if any, changes to practice have been made as a result of the complaint. If there is a reason why a specific issue cannot be addressed this should be clearly included.

12.6 Consideration must be given to complainants who require the response in an alternative format. The Trust will tailor a response to the initial complaint and if the Patient Experience Team are aware the complainant has a sensory impairment or learning disability the letter should be prepared in an appropriate format and a meeting offered to ensure understanding.

12.7 The draft response must be factually correct and should:

- Include an apology as appropriate;
- Address each of the points raised with a full explanation or give the reason(s) why it is not possible to comment on a specific matter;
- Give specific details about the investigation, i.e. who was interviewed, what was discovered, etc.
- Give details of action taken as a result of the complaint and what lessons have been learned;
- Clearly state whether the complaint is upheld/partly upheld or not upheld;
- Provide the name and telephone number of the appropriate senior manager for further queries/questions;
- Include details of further action the complainant can take.

A template response is available on the Trusts intranet site but must be personalised on an individual basis.

- 12.8 The draft response should be sent via e-mail to the Patient Experience Team or uploaded to the record on the patient experience management system for approval and amendment. All statements and documentation obtained during the investigation including meeting notes; must be uploaded to the record on the system.
- 12.9 Where clarification is required from the Patient Experience Team or Divisional Quality Manager, the Lead Investigator should respond promptly to avoid delay in the response being sent to the complainant.
- 12.10 The response will then be reviewed, approved and signed by the Chief Executive or nominated deputy.
- 12.11 Where it is apparent from the response that it raises a risk of litigation, the Director of Nursing Midwifery, Allied Health Professional's, Medical Director and Clinical Director should be alerted and referral made to the NHS resolution for consideration before the response is sent to the complainant.
- 12.12 An e-mail response should only be provided at the complainant's request with the Patient Experience Team having informed the complainant that such communication may not be secure at the point of acknowledgement.

13 The provision of redress and ex-gratia payments

- 13.1 Remedying injustice or hardship is a key feature of the Ombudsman's Principles for Remedy suggesting that where there has been maladministration or poor service, the public body restores the complainant to the position they would have been in had the maladministration or poor service not occurred.
- 13.2 Financial redress will not be appropriate in every case but the Trust will consider proportionate remedies for those complainants who have incurred additional expenses as a result of poor service or maladministration.
- 13.3 This does not include a request for compensation involving allegations of clinical negligence or personal injury where a claim is indicated. Should a request for compensation be requested as part of the complaint, the complainant will be provided with information on making a clinical negligence claim and the Trust's Clinical Risk and Claims Manager advised.

14 Monitoring Performance Management and data collection

- 14.1 The Trust will maintain a record of:
 - Each complaint, concern, compliment or comment received;
 - The subject matter and outcome of each concern/complaint;

- Whether the Trust regards the complaint as having been well-founded;
 - Lessons learned and follow up actions taken.
- 14.2 Each complainant, where appropriate, will be invited to complete a quality survey at the time of receipt of the Trust's final response letter. The survey will cover aspects of complaint management and quality of investigation and response. The results will be reported to the Patient Experience Sub-Committee on a quarterly basis.
- 14.3 The Patient Experience Sub-Committee will be responsible for monitoring the effectiveness of the policy. In particular, they will monitor arrangements for local complaints handling against national guidance as specified by the Department of Health including:
- Consideration of trends in complaints and appropriate risk management actions;
 - Identification of significant risks for inclusion on the Trust's Risk Register;
 - Consideration of any lessons which can be learned from complaints, particularly for service improvement;
 - Consideration of the findings of the complainant survey which will be reported annually;
 - Measure timescales for response and quality of investigations and response letters.
- 14.4 The Patient Experience Team will provide a report to be included in the Trust's annual quality account; as well as producing an annual complaints report.
- 14.5 The Trust ensures that it provides information to the Health and Social Care Information Centre via completion of the central return KO41(A) which is reported quarterly.
- 14.6 Equality and Diversity data will be collected where possible by PALS and complaints staff as required by the Department of Health. The Lead Investigator will provide such information to the Patient Experience Team, if known, about staff members involved.
- 14.7 The following reports on complaint, concerns and compliments are provided:
- Weekly flash reports to Director of Quality Governance, Director of Nursing Midwifery, AHPs and Head of Nursing and Quality;
 - Monthly reports including numbers of complaints and concerns received, trends and themes and compliment data as part of the Quality Report;
 - Quarterly reports to the Patient Experience Sub-Committee on compliance with response times, complaints trend analysis including focus on specific themes;

- An Annual Complaints report will be presented to the Patient Experience Sub-Committee;
- A patient story which could be from a complaint presented to the Patient Experience Sub-Committee by the Divisional Head of Quality bi-monthly;
- A quarterly review of ten complaints files to ensure compliance with the Policy will be undertaken, including assurance of lessons learnt and presented to Patient Experience Sub-Committee as part of quarterly reports;
- Weekly meetings will take place between the Divisional Quality Managers and Patient Experience Team.

15 Complaints Investigation and Risk Management

- 15.1 The procedures for managing complaints, incidents and claims for negligence are dealt with under separate policies. However, if during the course of investigating an incident, a complaint is received, the Serious Incident procedure should take precedence in terms of investigation. If the investigation of a complaint reveals the need to take action under the Serious Incident procedure, the Lead Investigator should inform the Director of Nursing, Midwifery, AHPs and Out of Hospital Services or Medical Director and again the incident procedure should take preference in terms of investigation. In these circumstances the complainant should be informed of the investigation, kept updated on progress and informed of the outcome.
- 15.2 It may not always be clear whether a complainant is intending to make a claim. It may be that an open approach will satisfy the complainant. A hostile or defensive reaction is more likely to encourage the complainant to seek remedy through the courts.
- 15.3 Complaints correspondence and accident/adverse incident reporting information will **not** be regarded by the courts as privileged (although there continues to be some uncertainty about the legality of a claim of privilege in respect of documents created in the course of an internal Trust investigation into an adverse outcome). This means that all correspondence and papers generated in the course of a complaint investigation, including staff statements etc. may have to be disclosed if a claim for negligence is subsequently brought.
- 15.4 In line with the Data Protection Act 2018, complaints documentation is classified as personal data. Patients are able to request copies of complaints files in the same way as they do for their health records.
- 15.5 If the investigation of a complaint reveals a possibility that there may have been negligence the Clinical Risk and Claims Manager will be informed. The existence of negligence does not prevent a full explanation being given and if appropriate, an apology. An apology is not an admission of liability.
- 15.6 **Risk rating** - assessing the seriousness of a complaint will determine the correct level of investigation required. All complaints will be given an individual

initial risk rating by the Patient Experience Team at first contact. The Lead Investigator will be responsible for the final risk rating score depending on the outcome of the investigation (see Appendix B).

- 15.7 In liaison with the Divisional Quality Manager the owner of actions will be responsible for ensuring that any identified actions arising from a complaint are implemented.

16 File Storage and archiving

- 16.1 The PALS and Patient Experience Teams aim for a paperless working environment relying on patient experience management system to record information.
- 16.2 Existing paper files will be added to the system on the closure of each complaint; and files destroyed in line with Trust policy.
- 16.3 The patient experience management system will hold a comprehensive record of the investigation including all internal correspondence such as e-mails and file notes which should be timed and dated where possible.
- 16.4 In accordance with the NHS Complaints Procedure copies of concern/complaint correspondence must not be kept in the patient's medical records, unless the information is strictly relevant to their health and if found by any member of staff, must be sent to Head of Patient Experience and Quality or Patient Experience Team.

Learning from Complaints

- 16.5 The Trust considers concerns/complaints as a positive mechanism for feedback about its services. Complaints management contributes to what the Department of Health identifies as the 4 'Cs' (Complaints, Compliments, Concerns and Comments) which:
- Tell you what's working;
 - Help you identify potential service problems;
 - Highlight opportunities for improvement;
 - Provide the information you need to review services and procedures effectively.
- 16.6 The Head of Nursing and Quality will ensure complaints are discussed at quarterly divisional meetings to identify service improvements where possible.
- 16.7 The Head of Patient Experience and Quality or a representative will attend Divisional or corporate meetings on a quarterly basis to discuss complaints received and ensure that identified learning outcomes are discussed openly and actioned within the required timeframe.

- 16.8 A quarterly report will be circulated throughout the Trust which will include the details of complaints closed that quarter with details of any action taken as a result of the complaint. Anonymised closed complaint summaries are also published on the Trust's website.
- 16.9 The Patient Experience Team will take the opportunity to attend departmental meetings where possible to share learning on complaints by reference to past complaints.
- 16.10 Patient confidentiality must be maintained but also, where possible, that of staff involved.

17 Publicity

The Trust ensures that the right to raise a concern/complaint, advice about relevant procedure and the help available from staff and other sources, is well publicised to all patients, other users of its services and to Trust staff.

18 Complaints and Disciplinary Procedures

- 18.1 In accordance with Section 4 of "Guidance on Implementation of the NHS Complaints Procedure" the Complaints Procedure is separate from any investigation under the Disciplinary Procedure, referral to one of the professional regulatory bodies, an independent inquiry into a serious incident, under Section 84 of the National Health Service Act 1977 or an investigation of a criminal offence.
- 18.2 The purpose of the complaints procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants and to learn any lessons for improvements in service delivery. If, however, a complaint identifies information about a serious matter relating to a staff member, which indicates a need for disciplinary action, this will be managed under the Trust's Disciplinary Policy.

19 Complainants with Communication Difficulties

- 19.1 The Trust is committed to making reasonable adjustments as required by the Equality Act 2010. The Trust will ensure that its Complaints, Concerns and Compliments Policy is accessible to complainants and provided in other languages, Braille and large print if required. An easy read version of the complaints leaflet is available.

20 Out of Hours Contact Arrangements

- 20.1 The Patient Experience Team is generally available between 8.30 and 4.30 pm, Monday to Friday. Service users may also visit the PALS office located St Mary's Hospital between 8.30 and 4.30pm Monday to Friday. Issues raised outside these hours should be directed to the appropriate Ward/Departmental Manager, or to the Duty Clinical Site Practitioner.

- 20.2 Any immediate clinical need **must** be passed to the appropriate clinician.
- 20.3 If the concerns do not require immediate action, as much detail as possible, including the person's contact details, should be obtained and forwarded to the Complaints or PALS Team by the next working day. The complainant should be informed of the action taken and given the direct telephone number for the Complaints or PALS Team.

21 Consultation

This document has been shared with relevant staff involved in complaints handling, being updated in line with the review of the Trusts Complaint Handling Process.

The Patient Experience Sub-Committee have endorsed this policy at their meeting on 13 June 2018, the Sub-Committee includes representatives from all Divisions, Healthwatch and Patients Council representation.

The Policy was circulated for Trust consultation via the Trusts intranet to all staff.

22 Training

This Complaints, Compliments, Concerns and Comments Policy does not have a mandatory training requirement but the following non-mandatory training is available.

- 22.1 The Patient Experience Team will provide training for Lead Investigators on the relevant policies and how to investigate and draft responses including using examples from past complaints.
- 22.2 The Patient Experience Team will provide training Trust-wide to all staff; including familiarisation with the use of the Patient Experience Management System (Datix) and relevant policies and procedures in relation to complaint handling.
- 22.3 Staff who has responsibility for investigating a complaint or chairing meetings with complainants should receive training as part of their local induction organised by their line manager.
- 22.4 Training in informal/local resolution is also provided on an ad hoc basis to Wards and Departments, and at staff induction.
- 22.6 The Patient Safety Team provide training in Root Cause Analysis and investigation procedures which should be used to investigate complex complaints.
- 22.7 The Patient Experience Team are responsible for providing training in the concerns and complaints procedure to all relevant staff to ensure that staff is fully aware of their responsibilities when dealing with issues of concern raised by complainants.

Attendance is monitored as part of the general training recording within the Education, Training and Development Department.

23 Monitoring Compliance and Effectiveness

As well as the ongoing monitoring of complaints management, via the normal reporting mechanisms listed at section 14, an annual audit will be undertaken to ensure that the following areas are monitored:

- Duties of all staff
- How the organisation listens and responds to concerns from patients, their relatives and carers
- How joint concerns are handled between organisations
- How the organisation makes sure that patients, their relatives and carers are not treated differently as a result of raising a concern or complaint.

This policy is reviewed and updated every 3 years by the Head of Patient Experience and Quality or more frequently where necessary in the light of any new guidance received.

24 Links to other Organisational Documents

- Being Open & Duty of Candour Policy
- Safeguarding Adults – Multiagency Policy
- Capability Policy
- Disciplinary and Dismissal Policy
- Grievance Policy
- Raising Concerns (Whistleblowing) Policy
- Confidentiality – Code of Practice
- Incident Reporting and Management Policy
- Records Management
- Counter Fraud and Corruption Policy
- Standards of Business Conduct Policy, including registering interests, gifts, hospitality in compliance with the Bribery Act 2010

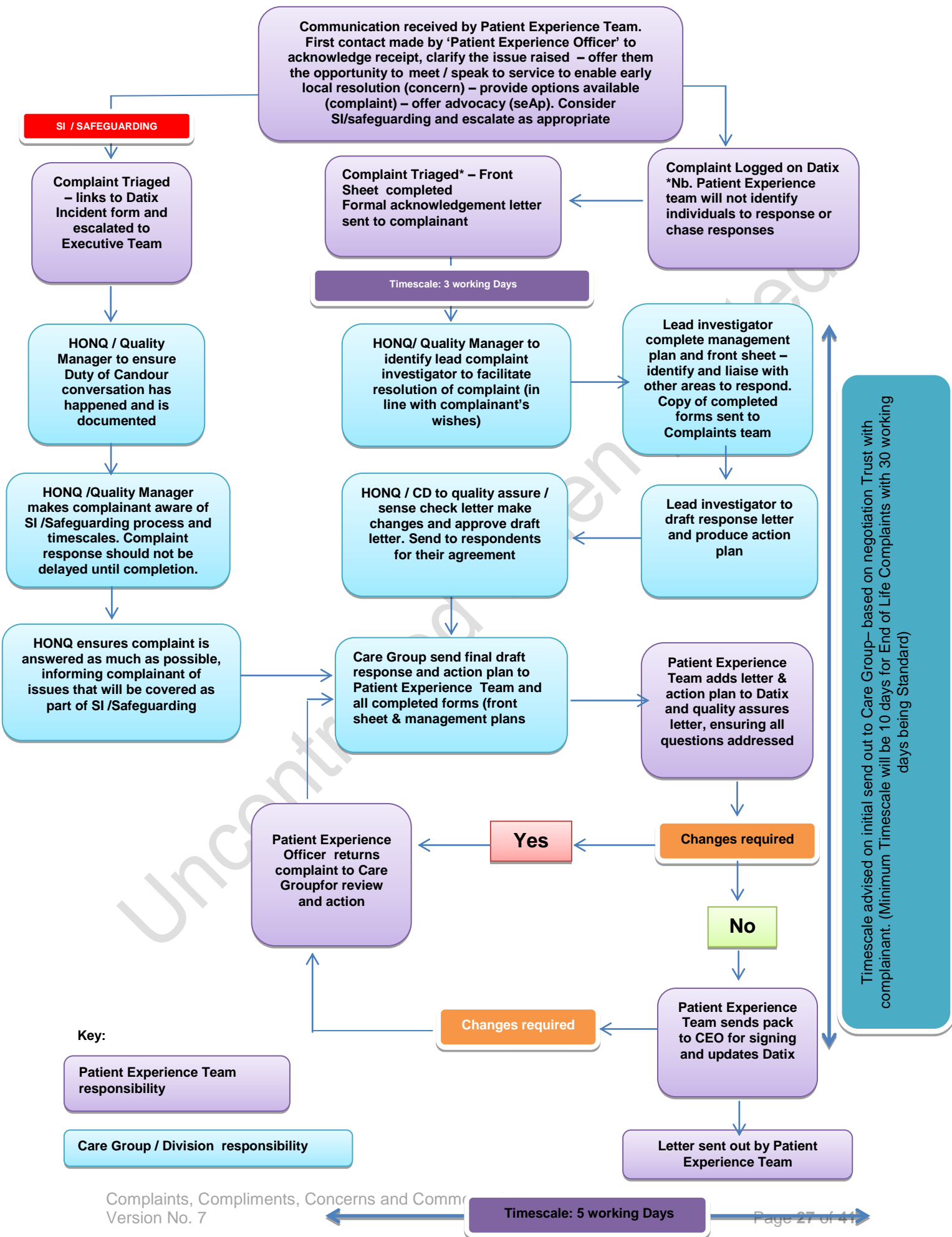
25 References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 – Statutory Instruments No. 309.
- Care Quality Commission - Regulation 20: Duty of Candour March 2015
- The NHS Constitution for England – 27 July 2015
- Parliamentary Health Service Ombudsman - My expectations for raising concerns and complaints November 2014.
- National Patient Safety Agency – Being Open

- Listening, Responding, Improving – A guide to better customer care – Department of Health 2009
- Independent Complaints Advocacy Services (ICAS)
- Data Protection Act 2018

26 Appendices

Appendix A	Trusts complaints / Concerns Management
Appendix B	Complaint Risk Assessment Tool
Appendix C	Interview/Statement Record Sheet
Appendix D	Support for staff writing a statement
Appendix E	Statement template
Appendix F	Financial & Resourcing Impact Assessment on Policy Implementation
Appendix G	Equality Impact Assessment Screening Tool



COMPLAINT ASSESSMENT TOOL

- The complaint is assessed in terms of the impact on the people involved and the adverse consequence that might arise for the organisation. The effect on the organisation and effects for the individual may be very different, especially in circumstances of poor health, communication difficulties or recent bereaved.
- The seriousness/consequence score (Table 1) and likelihood score (Table 2) are based on the highest descriptor applicable.
- The scores are plotted (Table 3) and the colour band will determine: a) any immediate action required; b) the appropriate level of investigation; c) level of organisation involvement/awareness (Table 4).

Table 1: Seriousness/Consequence Score

	Consequence score (severity levels) and descriptors				
Impact on patient /family	1.Minimal	2.Low	3.Moderate	4.Serious	5.Severe/catastrophic
Quality & Patient Experience Emotional, psychological or physical health. Includes misinformation & miscommunication.	Unsatisfactory service usually related to a single resolvable issue or issues not directly related to care. E.g. transport, single call bell, worries, fears.	Unsatisfactory service causing immediate minor impact/problem. Usually easily resolvable. May be repeated or multiple issues.	Care, service, quality, standards or experience below reasonable expectations in several (or repeated single) ways. Impact does not cause lasting problems.	Care, service, quality, standards or experience falls below expected standards. Failure to meet care needs/standards. Significant immediate impact on patient/ family and/or longer term effects.	Care, service, quality, standards or experience falls significantly below expected standards. Totally unacceptable quality/gross failure to meet care needs /standards. Includes serious harm, death, and neglect.
Quality & Patient Safety. Extent of injury, physical health or loss of function. Increase Length of stay/ increase level of care.	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention E.g. Cut, strain, bruise. Increase Length of Stay (LoS) by 1-3 days	Moderate injury requiring intervention. E.g. fracture. Increased LoS by 4-15 days	Major injury leading to serious or long-term incapacity/ disability Increase in LoS by >15 days.	High Harm Serious Adverse Events including: Death Permanent/multiple injury Irreversible health effects Or impact on large number of patients
Human resources, staffing, competence, development. Leadership, attitude & professionalism	Staffing level temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality. Poor attitude of staff.	Late delivery of care /service due to lack of staff or staff competence. Significant poor attitude or professional behavior.	Uncertain delivery of care/service due to lack of staff or staff competence. Lack of professionalism & leadership	Non-delivery of service due to lack of staff or competence. Professional misconduct

Statutory duty, inspections, audit	No or minimal impact or breach of guidance/ statutory duty. Medical records missing.	Breach of statutory legislation Potential breach of confidentiality	Single breach of confidentiality. Single failure to meet waiting time, targets & non-compliance with single standards	Serious breach of confidentiality. Multiple failures to meet waiting time, targets & non-compliance with core standards	Multiple breaches in statutory duty/breach in confidentiality. Includes prosecution, fraud & Zero performance rating.
Adverse publicity/ reputation	Rumours/ Potential for public concern	Local media coverage/ public expectation not being met. MP involved in complaint.	Local media coverage/long-term reduction in public confidence. SoS involved.in complaint	National media coverage with <3 days service well below reasonable public expectation	National media coverage >3 days. Total loss of public confidence
Finance including claims	General lost property. Local remedy <£50.00	Property of higher personal/monetary value. . Local remedy <£100.00	Slight potential for litigation. Remedy < £1,000	Possibility of litigation. Trust level Remedy decision >£1,000	Probability of litigation high
Service/business interruption Environmental impact	Loss/interruption of >1 hour No environmental impact.	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence score – EXAMPLE				
Impact on patient /family	1. Minimal	2. Low	3. Moderate	4. Serious	5. Severe/ Catastrophic
<i>E.g. cancelled clinic</i>	<i>Single cancellation</i>	<i>2-3 cancellations. Leading to upset /inconvenience</i>	<i>Cancellation leading to anger, frustration. Potential impact on clinical symptoms & care pathway</i>	<i>Cancellation leading to significant increase in symptoms/ delay in treatment with longer term implications.</i>	<i>Delay in treatment with irreversible damage/death.</i>

Table 2: Likelihood Score

Descriptor	• Rare	• Unlikely	• Possible	• Likely	• Almost certain
Frequency How often might it/does it happen	Will probably never happen or recur	Not expected to happen/recur but possibly may do.	Might happen or recur occasionally	Will probably recur but not a persisting issue. Includes issues similar in circumstances to previous complaints.	Will undoubtedly happen/recur, possibly frequently

Table 3: Complaint matrix score

Likelihood	Consequence				
	• Minimal	• Low	• Moderate	• Serious	5 .Severe/ Catastrophic
Rare 1	1	2	3	4	5
Unlikely 2	2	4	6	8	10
Possible 3	3	6	9	12	15
Likely 4	4	8	12	16	20
Certain 5	5	10	15	20	25

Table 4: Complaint assessment grade & investigation framework

Grade	Management of complaint	Typical response timeframe	Complaint Lead*	Level of escalation*
Minimum	Generally resolved at local level. Obtain facts. Provide information/explanation. Requires minimal level of fact finding prior to prompt remedy or resolution.	20 working days	Clinical Business Unit	Clinical Business Unit
Minor	May be resolved at local level. Full detailed analysis of complaint. Collate requested statements. Examine, contrast & collate information available. Consider whether additional investigative processes required; consider proportionality. Conclusions & recommendations made for approval by Complaint Lead.	30 working days	Clinical Business Unit	Clinical Business Unit are Group
Moderate	Full detailed analysis of complaint. Collate requested statements. Consider health record chronology, policy/ best practice review, staff interviews, advice from Trust specialist, departmental visit. Examine, contrast & collate information available. Judgement made regarding outstanding/more in-depth investigative processes required. Consider proportionality. Conclusions & recommendations made.	45 working days	Clinical Business Unit	Specialty/ relevant Trust Specialist/ Corporate if themes repeated.
Major	Requires scoping meeting with HONQ/CD within 48 hours to plan any immediate actions, consider any adjunct processes & involvement required. Agree Complaint Lead (Clinical Business Unit, cross-specialty, corporate, external). Agree investigation plan & timeframe. In-depth analysis of complaint. Collate requested statements. Consider health record chronology, legislation/policy/ best practice review, codes of conduct, staff interviews, advice from Trust or external specialist, departmental visit, benchmarking. Examine, contrast & collate information available. Judgement made regarding outstanding/more in-depth investigative processes required.	60 working days	Clinical Business Unit/ relevant Trust Specialist.	Corporate

	Consider whether more information is required from complainant. Conclusions & recommendations.			
Severe	Requires SIRI scoping meeting within 48 hours to plan any immediate actions, consider any adjunct processes & involvement required. Agree Complaint Lead (Clinical Business Unit, cross-specialty, corporate, external). Agree investigation plan, timeframe & complainant communication lead. Investigation as above	4- 6 months	Clinical Business Unit	Corporate/ External

*Depending on primary focus of complaint

Interview / Statement Record Sheet

Taken by (<i>full name & designation</i>):	Interview with (<i>include full name and designation</i>):
Contact number:	Contact number:
Date of Interview taken/ statement written:	

Record of interview / statement

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Support to staff writing a Statement

Statements must be presented in the format set out at Appendix E

- 1 Staff who are required to give a statement or be interviewed following a complaint should be supported throughout the investigation by their line manager with advice and guidance provided by the Divisional Quality Manager/Patient Experience Team.
- 2 Formal and informal debriefing should be offered to all those involved in the complaint throughout any investigation by their line manager
- 3 Information should be given on the support services available,
- 4 A statement is a written or spoken declaration, especially of a formal kind; a written or spoken report of events, a description. When investigating a complaint it is essential that as much factual information as possible is obtained in order to respond to the complainant and any member of staff named in a complaint may be asked to give an account of their involvement.
- 5 Giving a statement provides an individual with the opportunity to offer an explanation, to give their view of events and should be given as soon as possible after the event. If a written statement is requested it should be legible or preferably typed, and each paragraph should deal with each individual issue raised.
- 6 When writing a statement you should include:
 - **Personal Information:**
 - Your full name, professional qualifications, grade;
 - Your current post;
 - The post held at the time of the incident.
 - **Content:**
 - Answer the points raised in chronological order
 - Keep to the facts
 - Make clear what part is from memory, what part from notes, what part from your standard practice
 - Refer to any policies/procedures/guidelines in use
 - Do not be rude, hostile or defensive – remember complainants can ask to see your statement
 - Write/type clearly and do not use jargon
 - **Concluding Paragraph:**

Your statement should conclude with the following phrase:

‘The contents of this statement are true to the best of my knowledge.’

- Ensure that you sign and date it and retain a copy for your own information.
 - Giving a statement will provide the Trust with an overview of events; the Trust will base the final response on all information received. When writing a statement it is important to remember that although the majority of statements will go no further, it can be copied to the complainant or used as evidence in defending a legal claim.
- 7 Staff requiring additional information should contact their line manager, Patient Experience Team or their professional organisation.

Further guidance on writing a statement can be found on the intranet here:
<http://intranet.iow.nhs.uk/Clinical-Risk>

Statement Template

This statement (consisting of *(insert number of pages)* each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it, anything which I know to be false, or do not believe to be true.

1. This is the statement of (insert full name).
2. I am a(insert job title/Grade) at the Isle of Wight NHS Trust
3. I have had(insert number of years) years' experience as a(insert job title/Grade). My qualifications are(please insert relevant qualifications).
4. I make this statement for the Coroner touching the death of (insert name of deceased) who was born on (insert date of birth) and who died on (insert date of death). **OR**
I make this statement as part of an incident investigation/SIRI investigation/complaint/clinical negligence claim regarding (insert name of patient with some other relevant identification e.g. date of birth, date of death if applicable). ***(Please delete as appropriate)***
5. This statement is based on my own recollections/medical records etc. (insert the data source(s)).
6. On (insert date) at(insert time using 24 hour clock) I was on duty when(describe event in past tense). In chronological order set out what happened when you were involved with the case, starting from your first contact with the patient (or knowledge of

the patient) or the start of the event or incident, and finishing with your last involvement or relevant facts you learnt afterward. Keep your narrative short but accurate.

7. On(insert date) at(insert time)
.....(describe next chronological event in past tense).
8. On(insert date) at(insert time)
.....(describe next chronological event in past tense).
9. Continue in this manner, covering each fact relevant to each event leading up to the incident, to the incident itself and to each relevant event following the incident

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	Complaints, Compliments, Concerns and Comments Policy
-----------------------	--

Totals	WTE	Recurring £	Non-Recurring £
Manpower Costs	0	0	0
Training Staff	0	0	0
Equipment & Provision of resources	0	0	0

Summary of Impact: The impact of full implementation of this policy will be an improved process for managing and responding to complaints. Providing positive experience for complainants and relatives, improved quality governance and positive impact on the CQC reviews.

Risk Management Issues:

Benefits / Savings to the organisation: Benefit in the improved experience of users of our services; improved complaint responses, less complaints referred to Parliamentary and Health Service Ombudsman (PHSO) and lower costs associated to the upheld complaints by Parliamentary and Health Service Ombudsman (PHSO). Improved processes leading to better outcomes of CQC inspection reviews.

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	WTE	Recurring £	Non-Recurring £
Operational running costs	0		

Totals:	0		

Staff Training Impact	Recurring £	Non-Recurring £
Totals:	0	

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed		
Building alterations (extensions/new)		
IT Hardware / software / licences		
Medical equipment		
Stationery / publicity		
Travel costs		
Utilities e.g. telephones		
Process change		
Rolling replacement of equipment		
Equipment maintenance		
Marketing – booklets/posters/handouts, etc.		
Totals:	0	

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Complaints, compliments, concerns and comments document.
Purpose of document	To ensure complaints are handled in line with NHS regulations; providing a positive experience for users of our services.
Target Audience	All Trust staff and users of Trust services.
Person or Committee undertaken the Equality Impact Assessment	Vanessa Flower, reviewed by Patient Experience Sub-Committee

1. To be completed and attached to all procedural/policy documents created within individual services.
2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below? **All complainants will be treated in the same way, and no group will be disadvantaged by the implementation of this policy. Complaints will be handled in line with NHS Complaints Regulations 2009.**

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men			
	Women			
Race	Asian or Asian British People			
	Black or Black British People			
	Chinese people			
	People of Mixed Race			
	White people (including Irish people)			

	People with Physical Disabilities, Learning Disabilities or Mental Health Issues			
Sexual Orientation	Transgender			
	Lesbian, Gay men and bisexual			
Age	Children			
	Older People (60+)			
	Younger People (17 to 25 yrs.)			
Faith Group				
Pregnancy & Maternity				
Equal Opportunities and/or improved relations				

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	NO
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or

improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	Vanessa Flower
Date Initial Screening completed	17 June 2018

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