DOCUMENT CONTROL PAGE	
Title	**Title: Complaints, Concerns and Compliments Policy** Version: Version 6 – January 2016 Reference Number:
Supersedes	**Supersedes**: Version 5.1 Interim Complaints Policy
Minor Amendment	**Date: January 2016** **Notified To**: Quality Committee **Date: 20th January 2016** **Summary of amendments**: See Summary of Amendments – Page 2
Author	**Originated / Modified By:** Debra Armstrong, Sue Ward, Stephen Hodges & Angie Nisbet **Designation:** Deputy Director of Nursing (Quality), Director of Nursing, Head of Patient Services, Interim Head of Patient Services
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Summary of Amendments

Major updates		
Section No.	**Section Name**	**Amendments made**
3	Definition and Glossary of Terms	Section added
5	Scope of the Complaints Policy	Section added
6	Principles of Handling Comments, Concerns and Complaints	Section added
8	Supporting Staff and Complainants	Section expanded to include complainants
9	Complaints process	Risk assessment of complaints added and minor updates made
11	Unreasonable and persistent complaints	Section added
13	Process for Handling Compliments	Section added
14	Monitoring of Compliance and KPIs	Sections amalgamated
15	Further reading	References updated to reflect current national policy and added as footnotes within the policy. Further reading updated.
old S9	Consultation, Approval and Ratification Process	Section removed
old S10	Dissemination and Implementation	Section removed
Minor updates		
1	Introduction	Minor updates to introduction and vision
2	Purpose	Minor updates
4	Associated documents	Minor updates and placed at an earlier point in the policy
7	Roles and Responsibilities	Updated to reflect new staff structures and to clarify roles

1. Introduction

1.1 Central Manchester University Hospitals NHS Foundation Trust (referred to as CMFT or the Trust) welcomes feedback from patients and the public about the services we provide.

1.2 The Trust is committed to delivering the very best high quality healthcare services and is proud to serve patients and service users from widely diverse communities covering local, regional, national and international locations. The Trust's vision is to be recognised internationally as leading healthcare; excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for our diverse population.

1.3 To deliver this vision we are committed to providing a working environment which takes full advantage of a culturally and professionally diverse workforce that provides world class services. The Trust's Values (pride, respect, compassion, empathy, consideration and dignity) are set out in our Behavioural Framework which demonstrates the behaviours that are expected of staff across the organisation.

1.4 It is recognised that at times things can go wrong. When complaints are raised the Trust has a responsibility to acknowledge the concern or complaint, put things right as quickly as possible, learn lessons and prevent a recurrence by identifying and implementing service improvements. In most circumstances the quickest, most effective way of resolving a concern is to deal with the issues when they arise or as soon as possible after this (early local resolution). Usually this is best undertaken as close to the point of care or service delivery as possible and whereever we can resolve complaints quickly and informally we will do so.

1.5 The Trust will take all complaints seriously and make sure they are properly investigated and responded to in an unbiased, non-judgmental, appropriate and timely way. Complaints will be dealt with fairly for both the complainant and those complained about.

1.6 This policy sets out the Trusts's approach to dealing with complaints about its services that is flexible and responsive to individual's needs. It provides a framework for handling, responding to and learning from complaints as a vehicle to improve services in line with the Trust's Vision to be a leader in the delivery of excellent patient care.

1.7 The policy complies with the legal requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Act[1] in accordance with

[1] The Local Authority Social Services & NHS Complaints (England) Regulations (Amended) 2009; Department of Health, April 2009. http://www.legislation.gov.uk/uksi/2009/309/contents/made

the NHS Constitution[2] and the Duty of Candour (2014). It also aligns to the recommendations of the Francis Report (2013)[3] and Clywd Hart Review (2013)[4] and the policy reflects the Parliamentary and ealth Service Ombudsman's Principles of Good Complaints Handling (2009), namely:

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

1.8 In addition, the policy also takes account of the principals of ***'My Expectations for Raising Concerns and Complaints'*** (2014)[5], published jointly by the Local Government Ombudsman, Healthwatch and the Parliamentary and Health Service Ombudsman. Specifically the Trust is committed to making improvments at all stages of the complaint journey in line with the user-led vision for complaints.

2. Purpose

2.1. The purpose of this policy is to provide staff with support and assistance in dealing with complaints, concerns and compliments. The document provides a framework for CMFT to meet the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

2.2 Implementation of the policy will ensure that:

- Patients and their representatives have easy access to the best and earliest resolution of their concerns and complaints.
- People who complain are listened to and treated with courtesy and empathy and are not disadvantaged as a result of making a complaint.
- Complaints are investigated promptly, thoroughly, honestly and openly.
- Complainants are kept informed of the progress and outcome of the investigation in a timely manner.
- Staff involved in complaints are given support.

[2] NHS Constitution; Department of Health, March 2013. https://www.gov.uk/government/publications/the-nhs-constitution-for-england

[3] Francis Inquiry into Mid Staffordshire Hospital Recommendations http://francisresponse.dh.gov.uk/

[4] A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture. Final report Right Honorable Ann Clwyd MP and Professor Tricia Hart https://www.gov.uk/.../file/255615/NHS_complaints_accessible.pdf

[5] My expectations for raising concerns and complaints. http://www.ombudsman.org.uk/__data/assets/pdf_file/0007/28816/Vision_report.pdf

- Actions to rectify the cause of the complaint are identified, implemented and evaluated.
- Learning from complaints informs service development and improvement and the personal and professional development of staff.
- The Trust complies with national guidance and regulations for complaints Management.
- Complaints handling complies with confidentiality and data protection policies and is in line with the Trust's Being Open Policy.

2.3 All complainants must be treated with respect and receive a thorough investigation of their complaint and a written response. A patient's care must not be detrimentally affected because they have made a complaint. The policy emphasises the importance of early resolution of concerns and complaints and sets out the performance standards; the individual roles and responsibilities of staff involved; the reporting and assurance processes in place to ensure compliance with national regulations and the means by which learning from complaints will be achieved.

2.4 The purpose of the Complaints Policy and procedure is not to apportion blame amongst staff, but to investigate complaints aiming to provide both a satisfactory outcome for the complainant, to learn any lessons and make improvements. If however, a complaint identifies information which indicates a need for disciplinary action this will be managed separately under the Trust's Disciplinary Policy and Procedures.

3 Definition of Terms and Glossary

- A **complaint** is an expression of dissatisfaction that requires a formal response. It is usually a problem which has not yet been resolved, or which concerns past treatment. It can be made face-to-face, over the telephone (verbal complaints), by letter or e-mail (written complaints).
- A **concern** is a problem, which can be dealt with more quickly and informally. This is usually by the end of the next working day.
- A **compliment** is positive feedback which is provided in writing (often in the form of a thank-you card), regarding the experience of a service(s) received by patients, their relatives and carers.
- **Local Resolution** is the investigation and resolution of complaints under the first stage of the NHS Complaints Procedure. It includes everything we do locally, before a complaint is considered by an Ombudsman.
- A **complainant** is a person who raises a complaint.

- A **Serious Incident** (SI) is an event in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to develop a comprehensive response. Serious incidents can extend beyond incidents, which affect patients directly and include incidents, which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare.
- The **Ombudsman** refers to the Parliamentary and Health Service Ombudsman (PHSO) who are the final stage of the NHS Complaints Procedure. If the Trust cannot resolve a complaint, the complainant has the option to approach the Ombudsman and request a review. The Ombudsman will assess if the Trust has acted fairly in the complaint investigation and if the response has adequately addressed the complaint.
- Local **advocacy** services are available to act on a patient's behalf throughout the complaint process including dealing with the Ombudsman.
- The **Local Authority Social Services and National Health Service Complaints (England) Regulations 2009** is the legislation which provides the framework for managing complaints in the NHS.
- **Safeguard** is the Trust's Governance System, which is used for the recording and reporting of incidents, complaints, PALS, claims and organisational risks.

4 Associated Documents

- Supporting Staff and Providing Feedback following an adverse incident, claim or complaint.
- Being Open and Duty of Candour Policy.
- On Call Managers Handbook.
- Incident Reporting and Investigation Policy.
- Risk Management Strategy.
- Trust Behavioural Framework.

5. Scope of the Complaints Policy

5.1 The policy deals with the handling of compliments, concerns or complaints regarding Trust services, buildings or the environment. The policy incorporates the work of the Patient Advice and Liaison Service (PALS) in assisting patients, service users and staff to highlight compliments, resolve concerns or to offer access to the complaints process if needed.

5.2 Who can make a complaint?

5.2.1 A concern or complaint may be raised under this policy and procedure by:

- Anyone who is receiving, or has received NHS treatment or services, which are provided or commissioned by CMFT.
- A relative or friend on behalf of the patient, if they have been given permission
- Anyone who is affected by or likely to be affected by the action, omission or decision of CMFT.

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

- **is a child (under 18 years);** if the child or young person is considered to have the understanding to make a complaint themselves they must be supported to do so. If a representative complains on behalf of a child they must be a parent, guardian or other adult person who has responsibility for care of the child.

  Where the child is in the care of a Local Authority or a voluntary organisation, the representative must be a person authorised by the Local Authority or the voluntary organisation, and in the opinion of a relevant senior manager, is making the complaint in the best interests of the child. If you're the parent of a child under 18, you can make a complaint on their behalf, but only if the NHS thinks the child can't make the complaint themselves.

- **has died;** In the case of a patient or person affected who has died, the representative must be a relative or other person, who had sufficient interest in their welfare, and is a suitable person to act as a representative.

- **has physical or mental incapacity;** In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act (2005)[6], to make the complaint themselves, the representative must be a relative or other person, who has sufficient interest in their welfare and is a suitable person to act as a representative, has given consent to a third party acting on their behalf.

- In the case of a third party pursuing a complaint on behalf of the 'affected' person the Trust will request the following information:

[6] Cabinet Office. (2005) Mental Capacity Act 2005. London. HMSO

- Name and address of the person making the complaint;
- Name and either date of birth or address of the affected person; and
- Contact details of the affected person so that we can contact them for confirmation that they consent to the third party acting on their behalf. This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the affected person
- Has delegated authority to do so, for example in the form of Power of Attorney.

- Is an MP acting on behalf of and by instruction from a constituent.

5.2.3 Carers Rights: Carers can make a complaint on behalf of the person they care for; where the person is a child, has asked the carer to act on their behalf, or is not capable of making the complaint themselves. The organisation has the discretion to decide whether the carer is suitable to act as a representative in the individual's best interests.

5.2.4 If a senior manager is of the opinion that a representative does or did not have sufficient interest in the person's welfare, is not acting in their best interests or is unsuitable to act as a representative, they must consult the PALS and Complaints Department for advice and notify that person in writing stating the reasons.

5.2.5 If a complaint or concern is an allegation or suspicion of abuse, for example sexual abuse, physical neglect or abuse, or financial abuse, it should immediately be investigated in line with appropriate Trust Safeguarding or Serious Incident policies and procedures.

5.2.6 In a situation where a person discloses physical or sexual abuse, or criminal or financial misconduct, it must be reported using appropriate policies and procedures even if the person does not want to make a complaint.

5.2.7 In cases involving vulnerable adults or children, including threat of self harm and/or harm to others, all staff should implement effective safeguarding policies and practice, referring to the appropriate safeguarding board.

5.3 Complaints outside the scope of the policy

5.3.1 Complaints made in the following context are outside the scope of this policy:

- Complaints that have previously been investigated and closed under the

complaints regulations and have been reviewed by the Parliamentary Health Service Ombudsman (PHSO).

- Complaints from professionals about other professionals.
- Staff complaints about employment issues.
- Complaints about privately funded care.
- Complaints which are the subject of an on-going police investigation or legal action where a complaints investigation could compromise the investigation.
- Complaints that allege a failure to comply with a request for information under the Freedom of information Act (2000)[7] or failure to comply with a data subject request under the Data Protection Act (1998)[8]. These complaints will be managed by the Trust Information Governance team.
- Allegations of a criminal nature such as fraud. Allegations of fraud of financial misconduct should be referred to the Local Counter Fraud Specialist on 0161 206 1911. Details should **NOT** be taken by the PALS and Complaints Department.

5.3.2 Complaints of a Criminal Nature

The complaints procedure is not designed to investigate matters of a serious criminal nature e.g. accusations of sexual or physical abuse. In such circumstances the Deputy Director of Nursing (Quality) will immediately highlight the matter with the Divisional Director and Director of Nursing who will discuss with the Chief Nurse/Medical Director to determine the correct course of action, which may involve direct referral to the Police and/or appropriate other Authority.

5.3.3 Staff complaints – Speak Out Safely

5.3.2.1 CMFT is committed to a culture of safety and learning in which everyone feels able, empowered and safe to raise a concern and for these conversations to take place as part of everyday practice, without fear of blame or reprisal. The Trust has a zero tolerance approach to bullying.

5.3.2.2 Everyone working in a healthcare environment has a duty and responsibility to speak up about their concerns. This will enable the Trust to continually improve the services provided to the general public.

5.3.2.3 Staff who have concerns about the way another staff member has treated patients must alert their line manager immediately. Support will be given to any staff

[7] Cabinet Office. (2000) Freedom of Information Act 2000. London. HMSO

[8] Cabinet Office. (1998) Data Protection Act 1998. London. HMSO

member seeking to protect the interests of patients. Staff should write a statement detailing their concerns to their immediate manager or another senior manager at their earliest opportunity. Managers must review these complaints and appoint an officer to investigate them.

5.4 Timescales for Making a Complaint

5.4.1 A complaint must be made not later than 12 months after:

5.4.2 The date on which the matter which is the subject of the complaint occurred; or
If later, the date on which the matter which is the subject of the complaint came to the notice of the complainant.

5.4.3 Where a complaint is made after the expiry of the period mentioned the complaint may be investigated having regard to all the circumstances the complainant had good reason for not making the complaint within that period; and notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

5.4.4 The discretion to vary the time limit should be used flexibly and with sensitivity. An example of where discretion might be applied would be where the complainant has suffered such distress or trauma that he/she could not make the complaint at an earlier stage. Variation to the time limit must be discussed with the Head of Patient Services.

6. Principles of Handling Comments, Concerns and Complaints

6.1 The Trust is responsible for ensuring that complaints are considered in accordance with the law and this policy. This Policy is underpinned by the following principles.

6.2 The Statutory Duty of Candour,[9] which came into force in November 2014. This Involves giving patients accurate, truthful and timely information when mistakes are made or treatment does not go to plan. Saying sorry when things go wrong is vital for the patient,families and carers who should receive a meaningful apology; one that is a sincere expression of sorrow or regret for the harm that has occurred. This policy therefore must be applied in association with the Trust's Being Open and Duty of Candour Policy.

6.3 The Parliamentary and Health Service Ombudsman (PHSO) 2009 guidance details the 'Principles of Good Administration'[10], Principles of Good Complaints Handling and

[9] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

[10] Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy; PHSO, February 2009.

Principles for Remedy.' These principles outline the approach to be taken by public bodies when delivering good administration and customer service, and how to respond when things go wrong. They underpin the Ombudsman's assessment of performance, their vision of good complaint handling and their approach to put things right.

6.3.1 The following six themes within each of the principle documents are:

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

6.3.2 These documents also identify some specific rights for patients. These include:

- To have their complaint acknowledged and properly investigated.
- To discuss how the complaint will be handled and when they can expect a reply.
- To be kept informed of the progress and promptly told the outcome.
- To have access to further redress through the PHSO, the Information Commissioners Office or legal channels including Judicial Review.

6.4 The PHSO also issued 'My Expectations for Raising Concerns and Complaints' in 2015, which articulates a user-led vision for raising complaints and concerns based around a series of 'I' statements across the life cycle of a complaint. For example, when someone is considering making a complaint they should be able to say 'I felt confident to speak up' and they would know they had a right to complain, they would know how to complain, they could receive support to complain and their future care would be unaffected. A summary of the 'I' statements is set out below.

Stage of Complaint	**I Statement**
Considering a complaint	I feel confident to speak up
Making a complaint	I felt that making my complaint was simple
Staying informed	I felt listened to and understood
Receiving outcomes	I felt my complaint made a difference
Reflecting on the experience	I would feel confident making a complaint in the future

http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples

6.5 The 'Good Practice Standards for NHS Complaints Handling' was published by the Patients Association in September 2013. The standards can be summarised as:

- Openness and transparency, including well-publicised and accessible information that is understood by all parties to the complaint.
- A consistent approach, centred on evidence based and complainant led investigations and responses.
- A logical and rational approach.
- Provide opportunities to give feedback on the complaints service.
- Offer support and guidance throughout the complaint process.
- Provide a level of detail, which is proportionate to the complaint.
- Identify the cause of the complaint and take action to prevent recurrence.
- Using lessons learned to make changes and improvements.
- Ensure that on-going care is not affected by having complained.

6.6 The Trust's complaints system must enable patients and the public to readily make their own views known, without fear of discrimination and forms part of an integrated process for reporting and handling of concerns/ complaints that ensures that lessons learned are widely disseminated.

6.7 The Trust will promote equality of access to making a complaint and will ensure that people from minority and disadvantaged communities are given full and equal access to the Complaints and Concerns process. We acknowledge that it may be difficult for some people to express their concerns and the Trust will encourage and support people to voice their opinions where appropriate. The PALS service will be an important point of contact, or referral, to facilitate this.

6.8 The handling of complaints must operate to the principles of the Mental Capacity Act (2005), Care Act (2014) and the Data Protection Act (1998). Confidential patient information must never be disclosed to a third party unless the patient has given their consent to do so. The Trust will assume a person has capacity to make their own decisions, and support them to do so. If we assess that a person cannot give consent to investigate a complaint themselves we will seek evidence that the person complaining on the patient's behalf has the authority to pursue the complaint.

7 Roles and Responsibilities

7.1 Board of Directors and other committees

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

the arrangements made under this policy and that action is taken in the light of the outcome of any investigation.

7.1.2 The Quality & Performance Scrutiny Committee is responsible for monitoring and reviewing the risk, control and governance processes, which have been established in the organisation to manage complaints. This will support the Board of Directors to be fully assured that the most efficient, effective and economic risk, control and governance processes are in place, and that the associated assurance processes are appropriate.

7.1.3 The Trust Risk Management Committee (TRMC) ensures that risks of all types at an operational level are identified, monitored and controlled to an acceptable level.

7.1.4 The Chief Nurse and Medical Director have delegated authority and responsibility for effective and efficient complaints management ensuring the Trust is compliant with national standards.

7.2 **Chief Executive**

7.2.1 The Chief Executive is the designated Responsible Officer under Regulation 4 (1) (a) of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, and is ultimately accountable for the quality of care within the Trust. The Chief Executive is responsible for ensuring the implementation of this policy, maintaining an overview of complaints and in particular ensuring that action is taken if necessary in response to complaints investigation outcomes.

7.3 **Chief Nurse and Medical Director**

7.3.1 The Chief Nurse and Medical Director have delegated authority and responsibility for effective and efficient complaints' management ensuring the Trust is compliant with national standards.

7.3.2 The Medical Director will ensure that clinical advice is provided to the Trust's Head of Patient Services and individual clinicians when necessary. However, there may be occasions where it is more appropriate to seek advice from another expert clinician, either within or externally to the Trust.

7.3.3 The Chief Nurse will ensure that appropriate action is taken to implement service improvements where appropriate as a result of complaints.

7.4 **Directors of Nursing, Deputy Director of Nursing (Quality) and Head of Patient Services**

7.4.1 The Directors of Nursing are accountable to the Chief Nurse for the structures and processes in place for ensuring compliance with complaints management standards.

7.4.2 The Directors of Nursing will :

a. Ensure a culture of openess across the Trust that instills confidence in patients, their family and carers to raise concerns. This is supported by a complaints management process that is simple,coordinated, keeps people informed on progress and demonstrates learning and service improvements are made as a result.
b. Ensure appropriate review of all formal responses to complainants relating to adults and children, prior to the Chief Executive's approval and signature and review all incidents involving adults classed as high risk (refer to Quality Assurance Process).
c. In accordance with the 'Extension Protocol' and upon request of a Divisional Director, consider extensions to complaints responses in exceptional circumstances (refer to Extension Procedure).

7.4.3 The Deputy Director of Nursing (Quality) supported by the Head of Patient Services will :

a. Be responsible for the implementation, updating and maintenance of a Trust complaints management process that encorages people to raise their concerns, is simple to navigate, keeps people informed on progress and assures lessons are learned, shared and services are improvemenst are made.
b. Ensure all complaints are managed in accordance within national regulations and guidelines.
c. Ensure systems are in place to support complaints management and learning from complaints.
d. Work closely with the Directors of Nursing to provide clear management and leadership of complaints.
e. Ensure Parliamentary and Health Service Ombudsman reviews/reports are disseminated and that action plans are agreed with the Divisions.
f. Ensure relevant papers are prepared for the Board of Directors.

7.5 **Customer Relations Manager**

7.5.1 The Customer Relations Manager is readily accessible to both the public and members of staff, particularly to patients and their visitors. The Customer Relations Manager will be responsible for the provision of the PALS, which has a duty to provide

advice and assistance to the complainant and to facilitate local resolution through effective contact with key people across organisational boundaries (inclusive of health, social care and education).

The Customer Relations Manager will also be responsible for:

a. Ensuring the Trust operates within the requirements of the NHS Complaints Regulations 2009.
b. Interpretation of the NHS Complaints Procedure and developing policies and guidance to support implementation.
c. Leading the PALS, creating a culture that encorages complaints and supports patients, their family and carers throughout the complaint process.
d. Monitoring and reporting on the Trust's performance.
e. Ensuring the Trust complaints' process is adhered to.
f. Provision of training for Trust staff on handling complaints.
g. Notifying the Head of Patient Services of any changes to investigation timescales that will affect responses being provided within the timescale agreed with the complainant.
h. Maintaining a comprehensive complaints database (Safeguard).
i. Monitoring the development / provision of appropriate action plans relevant to issues requiring improvement.
j. Ensuring that all complaints are registered and dealt with openly,accurately and in a timely manner.
k. Reporting to appropriate Trust wide groups and Divisions, key trends and themes and areas of developing concerns (hotspots).

7.6 Complaints Case Managers – Patient Advice and Liaison Service

7.6.1 The PALS Case Managers will (on behalf of the Chief Executive) provide confidential assistance to service users in resolving problems and concerns. They will liaise with and advise staff, managers and where appropriate other relevant organisations to negotiate full and timely resolutions. For complaints, the Complaints Case Managers will adhere to the Trust's Complaints Process.

In addition the Case Managers will:

a. Advise and support teams at all levels within the organisation to resolve issues of concern and complaints as they arise within their services, with a view to ensuring immediate solutions or speedy resolution of concerns.
b. Co-ordinate investigations and support the administrative processes where appropriate.

c. Attend Divisional and Directorate meetings to review the progress of on-going complaint investigations, to discuss key trends and hotspots emerging from concerns/complaints' data and to ensure action planning and evidence of lessons learned.
d. Ensure the views of patients, their carers and others when expressing concern or complaint, are taken into account in designing, planning, delivering and improving healthcare services.
e. Provide training to staff (including Induction Training) on the rights of patients, relatives and carers to make complaints and how to deal with complaints.
f. Chair Local Resolution Meetings between complainants and Trust staff when required.

7.7 Divisional Directors,Clinical Heads of Divisions, Directorate Managers, Heads of Nursing & Midwifery, Lead Nurses and Matrons

7.7.1 **Divisional Directors** will ensure timely investigation and response to all complaints regarding their services, achieving complaint performance targets, implementing action plans arising from complaints, ensuring complaints are managed and actions completed in accordance with this policy, ensuring learning is identified and shared and that identified training is in place for staff.

7.7.2 Where a complaint involves more than one division, the Divisional Director of the Lead Division will ensure that a single, co-ordinated response is provided within the agreed timeframe. Divisional Directors for contributing divisions will ensure that contributions are submitted in a timely manner.

7.7.3 Divisional Directors,Clinical Heads of Divisions,Directorate Managers,Heads of Nursing & Midwifery, Lead Nurses and Matrons will encourage patients, their families and carers to raise concerns, and ensure complaints that arise within their services are managed appropriately and promptly. They have a key role in enabling a culture where patients and their family/carers feel confident to raise concerns. If these concerns cannot be resolved informally then patients their family/carers should be signposted to the Patient Advice and Liaison Service for formal investigation.

7.7.4 They will:

a. Seek to ensure expressions of concern and complaint are encouraged and handled competently at a local level and assist in improving the quality of care to our patients.
b. Ensure complainants feel listened to and understood; supported and confirdent that their ongoing care will not be compromised from raising a concern.
c. Enable a timely local resolution of complainant concerns through the right investigating team being assigned and partnership working between this team, the

Case Coordinator and the Case Manager.

d. Ensure a full investigation of complaints under the guidance of the Trust's complaints process.
e. Work with Case Manager and Case Coordinator to keep complainants fully updated on the progress of their case.
f. Ensure regular feedback on the progress of the complaint to the members of staff involved.
g. Ensure action plans are produced and monitored to completion and these are uploaded and kept up to date on the Safeguard system.
h. Ensure an action plan or complaint outcome form is submitted for consideration with the reply to the complainant.
i. Ensure key learning points are shared through the appropriate Trust Governance frameworks.
j. Ensure that individual complaints, trend analysis and case reviews inform changes in practice, service developments and risk assessments.
k. Ensure service improvement strategies are developed, implemented and monitored.
l. Provide advice and support to Divisional Complaints Co-ordinators as necessary, for example when there are delays in responses to complaints, or when a second medical or professional opinion is required.
m. Ensure the provision of information to the PHSO, and when necessary, the completion of recommendations.

7.8 Divisional Complaints Co-ordinators

7.8.1 Divisional Complaints Co-ordinators are responsible for:

a. Co-ordinating a thorough investigation with the Lead Investigator or staff member.
b. Where required assist in the collation and drafting of the final response letters within the agreed time period.
c. Co-ordinating and if required, attending meetings with complainants.
d. Liaising closely with the Complaints Case Manager paying particular attention to the Safeguard complaints management system and ensuring all divisional information is included on the system and is accurate.
e. Escalate to the Divisional Director any delays within the complaint response process.

7.9 Lead Investigator

7.9.1 The Lead Investigator is responsible for carrying out the investigation into a

complaint by:

a. Identifying and discussing the complaint with the appropriate staff.
b. Obtaining statements from staff.
c. Reviewing any other documentation relevant to the complaint i.e. incident reports, clinical records etc.
d. Forwarding a written response to the Divisional Complaints Co-ordinator within the time limit specified in the Safeguard system, ensuring that all the issues raised have been addressed and an appropriate action plan is developed.
e. Ensuring that any actions identified as a result of the complaint are taken.
f. Provide support for members of staff, particularly junior staff, who have been involved in a complaint, and help them to reflect on the issues raised and learn lessons to improve future clinical practice and communications with patients, their family and carers.
g. Liaise with the Complaints Department at the earliest opportunity for a re-negotiation of the response period, if it becomes apparent more time is required to complete the investigation.

7.10 Director of Clinical Governance

7.10.1 The Director of Clinical Governance should identify and be informed of any significant issues or risks that are identified through a complaint (s) being raised. This role ensures that complaints management is integrated with other components of clinical effectiveness.

7.10.2 The Director of Clinical Governance and the DeputyDirector of Nursing (Quality) will liaise to ensure that complaints and high level investigations are co-ordinated and a single response is provided to the complainant.

7.11 Divisional Clinical Effectiveness Leads

7.11.1 Divisional Clinical Effectiveness Leads will ensure trend data is considered at Divisional, Directorate and group level to ensure all learning is identified and practice improvements are implemented.

7.12 Risk Management Department

7.12.1 The Risk Management Department will support staff following an adverse incident, and provide advice on statement writing if required. The team will support an integrated governance approach to learning lessons which takes account of learning from complaints and support the use of Safeguard/Ulysses

as an integrated governance tool.

7.13 Associate Director of Strategic Communications

7.13.1 The Communications Manager will manage approaches from the media and will be the contact point for the Trust. She/he will liaise closely with the Head of Patient Servies and Deputy Director of Nursing (Quality) in all matters where a comcern or a fomal complaint has the potentail for a media enquiry and will manage any external press communication.

7.14 All Trust staff

7.14.1 All Trust staff have a responsibility to respond to any concern or complaint raised to them by patients or visitors, with an emphasis on early resolution. All staff have a responsibility to deal with a concern or complaint in an open, constructive, non-judgmental and compassionate manner. Where possible the staff member will resolve the concern immediately or as soon as possible, or refer to a more senior staff member on duty at the time.

7.14.2 All staff have responsibility to direct patients and carers to appropriate information regarding how to give feedback and how to raise concerns or complaints.

7.14.3 When requested to do so, all staff will provide statements and information in a timely manner to contribute to complaint investigations and responses.

7.14 External Agencies

In some instances, it may be necessary to seek external assistance with the management of an investigation or for supporting complainants. For some complaints, it may be necessary to get independent expert advice on a case, the Police may be involved if a criminal act is suspected or a Clinical Commissioning Group/Commissioning Support Unit or Social Services if the incident crosses boundaries of care.

Other agencies to consider may include:

a. Independent Complaints Advocacy (ICA)*.
b. Parliamentary and Health Service Ombudsman (PHSO)**.
c. Citizens Advice Bureau (CAB).
d. Health and Safety Executive (HSE).

e. NHS Litigation Authority (NHSLA).
f. Local Clinical Commissioning Groups (CCGs) / Commissioning Support Units (SCUs).
g. Manchester City Council / Trafford Metropolitan Borough or other local Government Organisation.
h. Ambulance Trusts.
i. Independent Carers Associations.
j. Her Majesty's Coroner.
k. National Bereavement Trust.
l. Equality and Human Rights Commission.
m. Independent Mental Capacity Advocate (IMCA).
n. Other independent advocacy, mediation or conciliation services.

ICA* provided by the Carers Federation will focus on helping individuals wishing To pursue formal complaints relating to NHS services. It will aim to ensure that complainants have access to the support they require to articulate their concerns and will guide them through the complaints' system.

** The Trust is obligated to refer the complainant to the Parliamentary and Health Service Ombudsman if we cannot satisfactorily resolve the complaint at the local (Trust) level.

7.15 Complaints involving Coroner's Cases

The reporting of a death to the Coroner's Office does not mean that all investigations into a complaint need to be suspended. It is important to initiate proper investigations regardless of Coroner's inquests and, where necessary, to extend these investigations if the Coroner so requests.

A copy of the file must be passed to the Legal Services Office if the complaint becomes a legal issue. The Coroner also has his own separate Complaints procedures.

If a Coroner's Inquest is opened during the complaints process, the Legal Services Department will ascertain if a complaint is being pursued by inputting the Coroner's case into the Safeguard system which will highlight that a complaint is pending. The Legal Services Department will then contact the Complaints Department to obtain a copy of the documents and will obtain regular updates in respect of the complaint in order to update the Inquest file and the Coroner.

7.16 Possible Claims for Negligence (sent to Legal services to review)

The Legal Services Department will be informed if correspondence or other communication is received under the NHS Complaints Procedure where the complainant indicates an intention to take legal action or requests compensation in respect of a complaint. They will also be informed by the relevant Divisional Director or his/her delegate if an incident is likely to generate substantial compensation, is publicly or media sensitive, if the complaint involves a fatal accident; including an unexplained death, involves the misdiagnosis of a life threatening illness or involves potential professional misconduct.

A complaint can run concurrently with the complainant's pursuit of a legal claim. If a complaint reveals a prima facie case of negligence, or there is indication that there is a likelihood of legal action being taken, the Legal Services Office must be informed by the responding Division. If the complainant's initial communication is via a solicitor's letter it should not necessarily be inferred that the complainant has decided to take formal legal action.

It may be that an open and sympathetic response giving an appropriate explanation and apology plus assurances that any failure in service will be rectified for the future, will satisfy the complainant.

8. Supporting Staff and Complainants during the Complaints Process

8.1 The Trust recognises that there are occasions when staff are under some considerable stress when an incident, complaint or inquest is being investigated or has occurred against the treatment, services or management, which has been provided in good faith. The Trust has ensured that full support and advice will be provided by the relevant departments, Risk Management and Complaints and Legal Services departments.

8.2 Staff who have had complaints made about them my require support during and /or after the investigation. They may seek support in-house from their Manager, Professional Lead, Directorate Manager or Divisional Director or Staff Support Services. Professional bodies and staff side unions also have support systems. Line Managers have an obligation to actively ensure that adequate support mechanisms are available to their staff in such situations, which may include pro-active referral to Staff Support. Some staff from a particular equality group (protected characteristic) may feel targeted. It is important that staff in these circumstances are given the appropriate support which, can be made available through their line manager, staff side representative or Human Resources team.

8.3 Staff will be asked to comment and make statements in relation to the complaint that

has been made and their comments will then be incorporated into the Trust's response to the complainant.

8.4 The Trust is committed to ensuring that patients whose first language is not English are able to communicate appropriately with healthcare staff and receive the information they need. Patients and staff should be advised that it is not acceptable to use children to interpret for family members who do not speak English. It is best practice to identify the need for interpreting services as early as possible. Should this be required, contact the Trust Interpretation and Translation Service on telephone (0161 27) 66202 or by email to: interpreter.bookings@cmft.nhs.uk. Online interpreter bookings can be made via the Interpretation and Translation Appointments Management System at: itams.xcmmc.nhs.uk

8.5 Other groups of patients may require special support including but not exclesively those with visual or hearing impairments or a learning disability. The Trust will ensure that accessible information or appropriate support is made available, on request or proactively following assessment of communication needs, for people who have a disability.

8.6 The Trust recognises that making a complaint can be a worrying experience for many complainants, who sometime fear it may have a detrimental effect on the care they or their loved one may receive. Any such concerns expressed by the complainant to the PALS Department are reported to the Complaints Manager and escalated immediately to the Head of Patient Services, Deputy Director of Nursing (Quality) and appropriate Divisional Director to investigate.

9. Complaints Process (Local Resoultion)

9.1 Each part of the complaint process and the associated actions are detailed in the table provided as Appendix 1 of this policy.

9.2 All Trust staff will welcome the complainant's concerns or complaint positively. Prompt action by staff can prevent escalation to a complaint and it is important that staff recognise such a situation. It is appropriate to say sorry; this is not an admission of liability; however, where there is doubt the issue should be discussed initially with the appropriate line manager or the PALS and Complaints Department.

9.3 Receiving and Registering Complaints

9.3.1 All written complaints must be date stamped on receipt within the PALS/ Complaints Department, recorded and registered into the Safeguard database, and passed via a 'Safeguard Notification' to the appropriate Divisional Complaints Co-ordinator. All relevant and appropriate staff will receive a notification via Safeguard to alert them that a complaint has been received and that they should commence an investigation. Junior staff will be notified of a complaint relating to them by the complaints investigator of their line manager.

9.3.2 Complaints cases will be updated and monitored using Safeguard and all Divisional Complaints Coordinators will use this system to access details of their respective divisional cases. All action relating to the complaint will be recorded on Safeguard.

9.3.3 The PALS and Complaints Department must acknowledge the complaint within 3 working days following receipt and provide an Equality Monitoring Form to the complainant. This acknowledgement process will include a telephone call (where possible) to the complainant summarising the proposed actions and a letter confirming acknowledgment of the complaint. If a phone call is not possible, this acknowledgement will be made in writing.

9.3.4 The following points will be discussed and agreed with the complainant:

a. The manner in which the complaint is to be handled.
b. The time period within which the investigation of the complaint is likely to be completed. This will be within 25 working days usually, unless there are good reasons for extending this period.
c. The option of a Local Resolution Meeting (LRM) (See 8.11 below and Local Resolution Meetings Standard Operational Procedure).

9.3.5 If the complaint is received over the telephone the complainant will normally be asked to sign and return a copy of the complaint summary, which will have been completed by the PALS Case Manager. Usually written complaints are directed to the Chief Executive from where they are passed to the PALS and Complaints Department; however a complaint is received, the date of receipt must be recorded.

9.3.6 In the event where the complainant is not the patient; signed or verbal consent from the patient must be obtained, wherever possible, or that of their appropriate representative, such as a parent or 'next of kin', before the investigation can begin and information shared with the complainant.

9.3.7 Complaints received without consent can be investigated at the discretion of the Deputy Director of Nursing (Quality) if the nature of the alleged concerns indicates possible patient safety issues. However, the findings of the investigation cannot be shared with the complainant until consent has been received.

9.3.8 Complaints made by Members of Parliament (MPs) on behalf of a constituent do not require consent. However, consent is required when the MP is acting on behalf of a third party; for example when a relative makes a complaint on behalf the patient regarding their care.

9.4 Risk Assessing the Complaint

9.4.1 Upon registration onto the Safeguard system, formal complaints will be assessed by a PALS Acknowledgement Officer or Case Manager and given a risk rating. By correctly assessing the seriousness of a complaint about a service, the right course of action can be taken. The Safeguard system will calculate the level of risk taking into account the seriousness of the complaint and the likelihood of recurrence. The risk assessment of a complaint will be undertaken again when investigation reports are received and clinical review has been undertaken.

9.4.2 The following personnel must be alerted immediately of all 'Red' graded complaints:

a. Chief Nurse
b. Chief Operating Officer
c. Medical Director
d. Divisional Director for the Division concerned
e. Head of Patient Safety and Risk Management
f. Deputy Director of Nursing (Quality)
g. Directors of Nursing
h. Head of Patient Services
i. Customer Relations Manager
j. Legal Services Manager

9.4.3 Risk assessment has three steps and must be undertaken using the grading tools provided in Appendix 2 of this policy.
Step 1: Measuring the severity of consequences (Appendix 2: Table 1)
Step 2: Measuring the likelihood of the consequence (Appendix 2: Table 2)
Step 3: Measuring the severity and the likelihood (Appendix 2: Table3)

9.5 Out of Hours Complaints

9.5.1 If a staff member is unable to resolve the concern, they must offer the Trust leaflet *"Your Experience Matters"* highlighting the telephone number to ring and the address to write to. The member of staff may also give the complainant the choice of being contacted the following working day by the PALS and Complaints Department, for which a contact number should be obtained.

9.5.2 Should the complainant request to talk to 'someone in charge' then the issue must be escalated to the most senior staff on duty to try and resolve the issue immediately, or in cases where it is felt necessary, the Duty Manager or Senior Nurse Bleep Holder should be contacted. This must be done via the usual on call procedure.

9.5.3 The Duty Manager or Senior Nurse Bleep Holder must make notes of complainant's concerns, attempt to address any immediate issues and, if the complainant remains dissatisfied, repeat the offer to the complainant(s) to contact PALS on their behalf or invite them to make their complaint during the next working day. If the matter remains unresolved the Duty Manager should document their actions and forward details to PALS the next working day.

9.6 Investigating Complaints

9.6.1 Complaints will be thoroughly investigated by an appropriately skilled Lead Investigator in a manner appropriate to resolving the issues speedily and efficiently and within the agreed timeframe.

9.6.2 Divisional Directors will ensure that appropriately skilled Leads are identified within the lead division to undertake the investigation and that contributions to investigations led by other divisions are submitted in a prompt manner.

9.6.3 If it is necessary, an independent opinion on clinical comments will be sought. The investigating team will ensure that all of the points raised by the complainant are covered in the investigation report. Where a complaint primarily relates to one service, but involves issues relating to others, the team must discuss the complaint with the relevant professionals and include all relevant information in a single coordinated response, overseen by the lead Divisional Director.

9.6.4 PALS Case Managers will work with the Divisions to ensure deadlines are adhered to and any concerns about overdue investigations and action plans are highlighted to the appropriate senior manager. A completed Action Plan Pro-

forma will be requested for any case in which further action/s are required, along with statements from staff and any other papers relevant to the investigation (e.g.Incident reports).

9.6.5 If the Divisional deadline is exceeded and responses have not been received, an email (or Safeguard action) will be sent via Safeguard to remind the person concerned, Lead Investigator and Complaints Co-ordinator. If this does not result in receipt of the necessary information the matter will be escalated to the Head of Patient Services, Divisional Manager and Divisional Director. All emails and conversations must be recorded on the Safeguard database and staff are reminded that such records are open to scrutiny. Once investigation replies are received with an action plan (if required), the investigation entry must be updated by the Divisional Complaints Co-ordinator to ensure Directorate and Divisional performance can be monitored, reviewed and actions taken as appropriate.

9.7 Safeguarding Children and Adults

In the event of concerns expressed in a complaint or during its investigation issues regarding the safety of children and/or adults will be acted upon immediately in accordance with Trust policies already in place in respect of Safeguarding Children and Adults.

9.8 Duty to co-operate

9.8.1 Where a complaint involves a second provider such as, another healthcare organisation or Local Authority, the PALS Case Manager will inform the second provider. The relevant managers will determine if the complaint will be handled jointly, and a decision will be reached as to which provider will be responsible for leading the investigation, communicating with the complainant and sending the response. The PALS Case Manager will advise the complainant accordingly and inform other contacts as necessary. The PALS Case Manager will supply to the other provider information relevant to the consideration of the complaint, which is reasonably requested by the other body. The Trust will ensure it is represented at, any meeting reasonably required in connection with the consideration of the complaint. Respective issues will be handled separately, however, where possible a combined response should be sent.

9.8.2 In the event that a concern can only be resolved by contacting another organisation, permission must first be sought from the complainant.

9.9 Local Resolution Meetings

9.9.1 It may be appropriate to meet with the complainant(s). This will be discussed on an individual basis between the PALS Case Manager, complainant and responding Division(s). The Trust will audio record all Local Resolution Meetings, a copy of which will be provided to the complainant, with a copy retained electronically by the Trust in the complaint file.

9.9.2 The PALS Case Manager will be responsible for preparing a briefing note prior to the meeting and a summary letter of the discussion and outcome for staff to proof read prior to sending a copy, along with the recording of the meeting, to the complainant(s),which they may amend. The Standard Operational Procedure for Local Resolution Meetings is provided via the link below.
Local Resolution Meetings Standard Operational Procedure

9.10 Preparing a Response

9.10.1 The responsible Division will arrange for the final response, together with a scan of the original complaint letter, to be sent to the Director of Nursing by email within 20 working days from the date that the complaint was received by the Trust. This period can vary dependent on the overall response period agreed with the complainant. If an unavoidable delay is anticipated the Case Manager must be informed of the cause of the delay and the expected date of completion, in order that the complainant may be informed as soon as possible and a new response date negotiated, if required.

9.10.2 The decision to vary the deadline for the completion of a complaint response must be agreed early in the complaint handling process with the complainant and via Safeguard with the appropriate Divisional Director and Director of Nursing. The Request for Extension Standard Operational Procedure can be accessed via the following link: Request for Extension Standard Operational Procedure

9.10.3 The response must be written in understandable language and clinical/technical terms must be explained. The author and responsible Divisional Director must ensure that the response is coordinated, answers all aspects of the complainant's concerns, offers an appropriate apology and advises the complainant of action that has or will be taken to prevent a recurrence of the issue.

9.10.4 All formal complaint responses will undergo a rigorous quality assurance process that will include review for completeness and grammatical correctness then sign off by the respective Divisional Director; followed by sign off by the Chief Nurse or a Director of Nursing and finally by the Trust Chief Executive. This process will be audited through a

quality assurance sign off sheet, signed and dated at each stage of the process.

9.10.4 A copy of the signed final response will be forwarded to the Divisional Complaints Co-ordinator who **MUST** ensure that all appropriate staff involved have access to a copy.

9.11 Re-opening Complaints

9.11.1 In cases where the complainant is not satisfied with the Trust's response, the complaint should be re-opened. This may be because the complaintant considers the investigation to be inadequate, incomplete or unsatisfactory; and/or the complainant believes that part of the complaint has not been answered to their satisfaction by the investigation.

9.11.2 The issues that remain unresolved will be clarified with the complainant by the PALS Case Manager and a further investigation initiated with the timescale of 25 working days to provide a response. If the complainant contacts the Trust with new issues not raised in the original complaint, this may be considered as a new complaint. The PALS Case Manager will provide advice on the appropriate course of action in this instance.

9.12 Communication with Complainants

9.12.1 Ensuring the complainant is kept fully informed of progress is vital in good complaints handling and should be provided in a way that is suitable for the complainant. For example, for a person who does not speak English or has a visual impairment, a face to face meeting or a telephone call maybe more appropriate then a letter. Answers to complaints must be full, frank, open and honest and all points addressed. The PALS Case Manager will contact the Complainant 10 working days after complaint acknowledgement to provide a progress update. This regular update will be maintained at time periods agreed with the complainant.

9.12.2 Following the complaint response, satisfaction questionnaires will be sent to obtain feedback on the handling of the complaint by the PALS and Complaints Department.

10. Independent Review - The Parliamentary and Health Service Ombudsman (PHSO)

10.1 The Parliamentary Health Service Ombudsman (PHSO) was set up by Parliament and is independent of the NHS. The PHSO is not part of government, the NHS in England, or a regulator. They are neither a consumer champion nor arbitrator. The Ombudsman is the final stage for complaints about the NHS in England and its role is to investigate complaints where individuals have been treated unfairly or have received poor service

from the NHS or NHS funded services. The Ombudsman's service is free to use and open to everyone.

10.2 The Ombudsman investigates complaints about 'maladministration' and 'service failure'. If there has been a failing, the Ombudsman will consider whether it has caused injustice or hardship (Health Service Commissioners Act 1993, section 3(1)).

10.3 If the Ombudsman finds that there has been injustice or hardship, they may suggest a remedy. Recommendations might include asking the organisation to apologise, and, in some cases to pay a financial remedy, for example, for inconvenience or worry caused. The Ombudsman may also recommend the organisation takes action to stop the same mistakes happening again.

10.4 The Ombudsman will ask for evidence of actions taken to be shared with the complainant and in some cases with Monitor and the Care Quality Commission (CQC).

11. Unreasonable and Persistent Complainants

11.1 This term broadly applies to complainants who have demonstrated abusive behaviour as well as those who make unreasonable demands or become unreasonably persistent. Trust staff are committed to dealing with all patients and their representatives fairly and impartially, and to providing a high quality complaints service. However, the Trust recognises that a small number of people utilise a disproportionate amount of time (and resources) in pursuing enquiries and complaints. In such circumstances the Trust should consider applying its 'serial and unreasonable complainants' procedure' to apply restrictions. The Serial and Unreasonable Complainants Procedure cn be accessed via the link below.

Serial and Unreasonable Complainants Procedure

12. Learning from Complaints

12.1 The Trust aims to maintain its organisational memory to minimise repetition of similar complaints, and to build upon it through organisational learning. Complaints provide a crucial source of feedback on the services provided. As a consequence of some complaints, actions are identified by the Trust to prevent similar occurrences. The respective divisions must initiate an action plan, or incorporate the action into an existing work stream. Trust wide learning and or action plans are raised at the Trust's Patient Safety Forum to ensure the learning is disseminated throughout the organisation.

12.2 On a monthly basis the Divisional Clinical Effectiveness Committees will be provided with reports by the PALS Team on the concerns and complaints

received within their area, to allow trends to be identified and considered as appropriate.

12.3 Complaints handling is reviewed two monthly by the Trust's Complaints Review Scrutiny Group (CRSG), which is chaired by a Non Executive Director, and has an Associate Medical Director included in the core group. The CRSG provides scrutiny of the Trust's complaint handling, examining the communication with the complainant, the internal communication and investigation, including the quality of the final response.

12.4 The Trust's Operational Management Group receives regular reports from the Director of Nursing (at least quarterly) on the management of complaints, highlighting trends and any concerns. From this report, a quarterly report is produced by the Deputy Director of Nursing (Quality) and is presented by the Chief Nurse to the Board of Directors to ensure awareness of issues and enable appropriate action.

13. Process for Handling Compliments

13.1 For the purpose of this policy a compliment is defined as positive feedback which is provided in writing (often in the form of a thank-you card), regarding the experience of a service (s) received by patients, their relatives and carers.

13.2 Patients, relatives and carers may have valuable feedback relating to an observation they made and are willing to share with the Trust as a comment. Compliments provide an opportunity to learn from positive experiences and to let our staff know that their care and professionalism have been noticed.

13.3 All written compliments received by PALS are registered on Safeguard by the PALS Department.

13.4 All compliments received by Divisions, if identifiable by name and with a postal address, should be registered on Safeguard by the Divisional Complaints Coordinator.

13.5 All Divisional Complaints Coordinators are notified via the Safeguard system and are able to access details of their respective divisional cases.

13.6 A response acknowledging receipt of the compliment is prepared by the Divisional Complaints Coordinator and signed off by the Divisional Director. This will be within **10 working days** usually, unless there are good reasons for extending this period.

13.7 Themes from compliments should be monitored and analysed within divisions and best practice shared with staff with a view to replicating positive patient experience.

14. Equality Impact Assessment

14.1 The Trust is committed to promoting Equality, Diversity and Human Rights in all areas of its activities. The Trust undertakes Equality Impact Assessments to

ensure that its activities do not discriminate on the grounds of:

Religion or belief	Age
Disability	Race or ethnicity
Sex or gender	Sexual orientation
Human Rights	Socio economic

The Service Equality Team (SET) on Ext 65651 (or 0161 276 5651) is able to support staff to complete an initial assessment. Upon completion of the assessment, SET will assign a unique EqIA Registration Number.

14.2 It is also important to address, through consultation, the diverse needs of our communities, patients, their carers and our staff. This will be achieved by working to the values and principles set out in the Trust's Equality, Diversity and Human Rights Strategic Framework. Additionally, on acknowledgement of a complaint, an Equality & Diversity Form is sent to the complainant to contribute to the Trust's monitoring, analysis and review of practice involving certain Equality & Diversity protected characteristics. In this way, the Trust is able to work towards meeting the diverse needs of the wide variety of communities we serve and learn from their different experiences. A further Equality & Diversity form is also sent after a complaint has been handled. The resultant analysis of this information will be shared with the appropriate forums throughout the Trust to ensure learning is applied.

15. Monitoring Compliance and Effectiveness of the Complaints Policy

15.1 The Quality Committee in conjunction with the Directors of Nursing and Divisional Governance leads are responsible for monitoring compliance with the Complaints Policy.

15.2 This will be completed on an ongoing basis and reported to the Quality and Performance Scrutiny Committee. Significant risks will be reported to the Trust Risk Management Committee.

15.3 The following will be monitored for compliance:

- Complaints acknowledgement within statutory timescales
- Complaint final response within agreed timescales
- Development and implementation of improvement action plans where indicated
- Completed implementation of action plans within agreed timescales
- Audit of Divisional complaint management
- Audit of patient experience of the complaints process

15.4 Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.

15.5 Progress with live improvement action plans will be reviewed at every Divisional

Clinical Governance Board.

15.6 Weekly Key Performance Indicators (KPI) reviews will be conducted by the Head of Patient Services of PALS operational arrangements and progress of Divisions.

15.7 Complaints performance will be included in the monthly Board Assurance Report to the Board of Directors along with an annual report on complaints and informal concerns.

16. Further Reading

Listening, Responding, Improving – A Guide to Better Customer Care; Department of Health, February 2009.

Results of the Peer Review Panels; Patients Association & Mid Staffordshire NHS Foundation Trust, Various http://patients-association.com/

NHS England 6Cs of Nursing. www.england.nhs.uk/tag/6cs

Cabinet Office. (2006) Equality Act 2006. London. HMSO

Cabinet Office. (1998) Access to Health Records Act. London. HMSO

Appendix 1: Summary of Complaints Process (Local Resolution)

Complaint Phase	Responsible for Actions	Action
Encourage Patients, their family and carers to raise concerns to enable early informal resolution	All Divisional front line staff	• Ensure *Patient Experience Matters* posters and leaflets are readily available and visible in all clinical areas
Receipt and Assessment	Complaint Acknowledgement Officers	• Complaint is assessed as being within the scope of Trust services and acknowledged within 3 working days of receipt • Complaint is Risk Assessed • Complaint is registered on Safeguard • Advocacy services offered • Consider early and informal resolution
Summary of complaint	Complaint Acknowledgement Officers	• Make personal contact with the complainant to agree a summary of the complaint and desired outcomes • Explanation of process and agree timescales • Consent sought if required
Investigation	Led by Divisional Directors Supported by Complaint Case Managers; Complaint Case Coordinators	• Complaint sent to Divisional Complaints Co-ordinator for investigation stating agreed timescale and desired outcome • Investigating officer may contact the complainant to make introduction and clarify concerns for investigation • Offer a local resolution meeting within the timeframe agreed with the complainant for resolution • Complaint Case Manager to keep complainant informed of progress • Investigation response received and accepted
Divisional Preparation of Complaint Response	Lead Divisional Director	• Co-ordinated response to complaint drafted, finalised and

		quality assured
Quality Assurance of Complaint Response	Chief Nurse; Directors of Nursing; Deputy Director of Nursing (Quality)	• Response agreed and quality assured for sign off by the Chief Executive
Complaint Response sign off	Chief Executive	• Signed by Chief Executive and sent out to complainant
Lessons Learned	Divisional Directors	• Patient, their family/ carers are informed of the lessons learned and service improvements made/to be made. • Further actions identified to resolve the individual complaint • Wider service improvements identified and implemented
	Deputy Director of Nursing (Quality); Head of Patient Services; Head of Quality Improvement;	• Collation and Trust-wide communication of themes from lessons learned
	Divisional Clinical Effectiveness Leads	• Monitoring implementation of practice changes in response to lessons learned

Appendix 2: Complaint Risk Assessment and Grading Tools

Table 1 Measure of Severity of Consequence (C)

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality of the Patient Experience/Outcome	Unsatisfactory patient experience which is able to be resolved locally Non-complex	Unsatisfactory patient experience – minimal risk to patient safety in the short term Potential complaint / Local resolution Low complexity	Mismanagement of patient care - possible short term effects. impacting on a small number of patients but could significantly impact on patient safety if unresolved Medium complexity	Significant mismanagement of patient care - possible long term effects, unsatisfactory patient outcome or experience Highly complex Possible HLI	Totally unacceptable level or quality of treatment/service Extremely complex Possible HLI Inquest/ombudsman inquiry
Adverse publicity/ reputation	Rumours Low potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met Potential for public concern	Local media coverage – long-term reduction in public confidence Topical issues of public interest	National media coverage with service well below reasonable public expectation Highly topical issues of public interest	National media coverage with service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Table 2 Likelihood score (L)

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

The final step in quantification is to combine the measures of severity and likelihood in a Risk Matrix, refer to Table 3.

Table 3 Risk Matrix

Severity	**Likelihood**				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2: Slight	2 Very Low	4 Very Low	6 Low	8 Low	10 Low
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5: Catastrophic	5 Very Low	10 Low	15 High	20 High	25 High

Risk scoring = consequence x likelihood (C x L)

1 - 5	Low risk (Green)
6 - 8	Moderate risk (Yellow)
9 - 12	High risk (Orange)
15 - 25	Extreme risk (Red)