University Hospitals of Morecambe Bay
NHS Foundation Trust

Document Type: **Procedure**	**Unique Identifier:** CORP/PROC/004
Document Title: **Management Procedure for the Investigation and Resolution of Complaints**	**Version Number:** 10.1
	Status: Ratified
Scope: Trust Wide	**Classification:** Organisational
Author / Title: Janet Garnett, Patient Relations Manager	**Responsibility:** Patient Relations Department
Replaces: Version 10, Policy for the Management, Investigation and Resolution of Complaints, Corp/Proc/004	**Head of Department:** Mary Aubrey, Director of Governance
Validated By: Mary Aubrey, Director of Governance	**Date:** 12/06/2018
Ratified By: Procedural Documents and Information Leaflet Group	**Date:** 11/07/2018
Review dates may alter if any significant changes are made	**Review Date:** 01/06/2021

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 3	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 1, 2

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Reference Check Completed by: Joanne Phizacklea, 15.6.18

To be completed by Library and Knowledge Services Staff

CONTENTS		
		Page
	BEHAVIOURAL STANDARDS FRAMEWORK	4
	Procedure on a Page	5
1	SUMMARY	6
2	PURPOSE	6
3	SCOPE	6
4	PROCEDURE	6
4.1	Definition	6
4.2	Introduction	7
4.3	Responsible Officers and Duties	7
4.3.1	The Chief Executive	7
4.3.2	The Director of Governance	8
4.3.3	Executive Directors	8
4.3.4	The Trust Executive Lead	8
4.3.5	The Patient Relations Manager	8
4.3.6	Patient Relations	8
4.3.7	Care Group Management Teams	8
4.3.8	Consultants, Matrons, Service Managers and Specialty Leads	9
4.3.9	Every Member of Staff	9
4.4	Support Mechanisms and General Governance	9
4.4.1	Supporting Staff Involved in Complaints	9
4.4.2	Prevention of Discrimination as a Result of Complaints	10
4.4.3	Exclusion Criteria	10
4.4.4	Data Protection	10
4.4.5	Complaints which may lead to Litigation or Criminal Proceedings	11
4.4.6	Complaints where Patient's Death has been referred to the Coroner	11
4.5	Concerns	11
4.5.1	Patient Advice and Liaison Service (PALS)	12
4.5.2	Independent Complaints Advocacy Service	12
4.6	Communication and Publicity	12
4.6.1	Public and Patient Involvement in Resolving Issues and Complaints	12
4.7	Complaints Management Process	13
4.7.1	Who Can Complain	13
4.7.2	Consent	13
4.7.3	Governor / Constituent Complaints	14
4.7.4	Making a Complaint – Time Limits	14
4.7.5	Investigation of a Complaint	15
4.7.5 (i)	Revisits and Meetings	18
4.7.6	Lesson Learned and Action Plan: Complaints as a Source of Improvement	18
4.7.7	Complaints Involving Other Service Providers	19
4.7.8	Regular, Unreasonable and Persistent Complaints or Insistent Complainants	19

BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

Compliments, Comments, Concerns or Complaints – Procedure on a Page

University Hospital of Morecambe Bay NHS Foundation Trust is committed to providing you and your loved ones a respectful and positive experience.

All of us are here to listen and help address any concerns that you may have. Our goal is to ensure you and your family are provided with safe, high quality and compassionate care and service.

We would like to hear from you if you think we have done something well or if you have suggestions on how we could do something differently. Equally we want to know if you are unhappy with the service provided or have a complaint.

Compliments and Comments Feedback

If you would like to tell us about your experience, give thanks or comment, please use the simple feedback online form below. Any compliments and comments received by the Patient Advice and Liaison Service (PALS) will be passed onto the relevant staff members. Alternatively, you might like to publish your feedback or leave a review of our services on the NHS Choices website.

Getting help

Sometimes things don't always go just as you would like them to. You have several options to raise concerns, but first of all we would ask that you speak with the Doctor involved in your care, Ward Manager or Matron in the department. Many problems can be resolved quickly by talking things over. Misunderstandings can easily happen and sometimes just as easily be put right.

If your concern remains unresolved, please contact the Patient Advice and Liaison Service (PALS).

Patient Advice and Liaison Service (PALS)

If you do not want to discuss your concerns with the staff or their manager, or if you have tried this and are still unhappy, ask to speak to the PALS.
Our PALS Officers are here for you – providing confidential advice, information and support for patients, relatives and carers. PALS Officers are available to assist with concerns and liaise with staff on your behalf, ensuring you receive an appropriate response.

The PALS team can:

- **Actively listen and respond** to concerns, suggestions or queries to help make patients' experiences as easy as possible
- **Provide information** on NHS services
- **Offer advice** on the complaints service and provide information on how to seek independent advice if you wish to make a complaint
- **Support** you through an anxious time as a patient, relative, friend or visitor
- **Feedback** your views to the Chief Executive and Trust Board
- **Monitor** any problems arising and identify any gaps in services
- **Help** the organisation learn from patients' experiences and comments.

The PALS Offices are located on each site and are open Monday to Friday, 9am - 5pm (excluding bank holidays).

Sometimes it may not be possible to see to a PALS Officer immediately, so you may prefer to contact them on 01539 795497 (answer machine service is available), or email pals@mbht.nhs.uk

If you decide to make a complaint

You have the right to make a complaint about any aspect of care provided by the Trust.
Many people find it useful to discuss concerns straight away with the ward or department, or with one of our PALS Officers. However, if you do decide to make a complaint, this should normally be no more than twelve months after the event you are complaining about.

Our experience has shown that when someone puts their complaint in writing or via email, it gives them the opportunity to really consider the questions they wish to be addressed, along with their desired outcome, all of which are very helpful in assisting us to resolve complaints. You can contact the Patient Relations department on 01539 716621, or email: CommentsandComplaints@mbht.nhs.uk or you can raise a concern or make a complaint by using the simple online feedback form available on the Trust's website, or you can write to:

Chief Executive
University Hospitals of Morecambe Bay NHS Foundation Trust
Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

The Chief Executive will ask one of our Patient Relations Officers to investigate your concern or complaint. A Patient Relations Officer will contact you to discuss your complaint so please provide a telephone number when submitting a complaint.

Can I get help to make a Complaint? - Independent Advocacy
Advocacy Services offer a free and confidential service that is independent of the NHS and tailored to individual client needs. Their staff can also support you through the NHS complaints process.

For the Cumbria area, please contact:
Best Life Independent Advocacy by People First on 03003 038037 or email admin@peoplefirstcumbria.co.uk.
Further details are available via their website www.peoplefirstcumbria.org.uk

For the North Lancashire area, please contact:-
Advocacy in Lancashire on 033 000 222 00 or email admin@advocacyinlancashire.co.uk

1. SUMMARY

This procedure stipulates the mandatory and local arrangements for the investigation and resolution of complaints within the University Hospital of Morecambe Bay NHS Foundation Trust (UHMBT), also referred to in this document as, 'the Trust'. The purpose of this procedure is to inform our staff and service users of the process for complaints handling within the Trust. Furthermore, we will ensure that all complainants will be able to access the Trust's Complaints Procedure and will be treated sympathetically and with respect throughout the process.

2. PURPOSE

The purpose of this Procedure is to ensure that all staff and service users are able to access the process for complaints handling within the Trust.

Implementation of the procedure will lead to:

- Complaints being investigated in line with the requirements of the statutory regulations
- A patient focussed, consistent approach to investigating complaints
- Providing a detailed written response to complainants as promptly as possible
- Equitable and non-discriminatory treatment for service users who complain
- Identification of necessary service improvements that arise from complaints
- Implementation of necessary service improvements that arise from complaints

3. SCOPE

This procedure applies to all grades of staff, both clinical and non-clinical, throughout the Trust.

4. PROCEDURE

4.1 Definition

For the purposes of this procedure, a complaint is defined as *any expression of dissatisfaction with the services, care or facilities provided by the Trust that requires a response*.

Expressions of dissatisfaction may be made in a variety of ways: verbally, in person or by telephone; in writing, including electronically by email; or online mediums.

This wide definition enables front-line staff to resolve minor comments, concerns and problems immediately and informally at a local level.

The decision as to whether a matter is dealt with informally as a concern or as a formal complaint will depend on whether an immediate response can be given, whether further investigation is required, or at the complainant's wishes.

4.2 Introduction

This document reflects the legal requirement placed upon all NHS organisations, to have written procedures in place which highlight the arrangements for the handling of complaints, in accordance with *The Local Authority Social Services and National Health Service Complaints (England) Regulations* (2009)[1].

Complaints are a means of identifying users' feedback and perspective of the service and care we provide. They can act as an early indicator of problems within a system or care within the patients' pathway, and provide trend analysis of issues where improvements may be necessary.

An important element of effective complaint handling is to detect, analyse and learn from patients' experiences, including adverse events and system failures. By listening to our users and receiving feedback from complaints; this allows the Trust to learn valuable lessons from patient experiences and improve the quality of the services offered.

UHMBT is committed to the early resolution of complaints and believes that all staff have a duty to recognise an expression of dissatisfaction at the earliest stage and to resolve it personally, or if unable to resolve it, personally refer the matter promptly to the appropriate person (more senior manager) or service (e.g. Patient Advice and Liaison Service (PALS)).

UHMBT promotes that all staff should make every effort to resolve complaints as they arise, particularly those involving relatively minor criticisms. Comments, queries, and suggestions are not complaints; they are service user feedback, and staff should endeavour to respond to these promptly and to give appropriate advice and information in order to prevent them escalating and becoming complaints.

4.3 Responsible Officers and Duties

This section outlines the roles and responsibilities of individual post holders and identified members of staff, in relation to the investigation of complaints.

All staff have a responsibility to listen and respond to patient and visitor complaints, ensuring timely and effective resolution where appropriate. Staff are able to log all service user feedback, and complaints, made verbally, and especially where the complainant's wish is for the matter to be escalated through the Trust's Complaints Management process. This is completed electronically via the UHMBT Ulysses Safeguard System. It is the responsibility of the Patient Relations Department to routinely access these records to be entered into the pertinent process, if relevant, i.e. Complaints or PALS.

'*Compliments or Complaints'*, and *Patient Advice and Liaison Service* (PALS), leaflets are readily available and should be visible within wards and departments. This information should be made accessible to patients and visitors especially when informal, or timely resolution is not possible or appropriate. Stocks may be replenished by contacting the Patient Relations Department on internal telephone extension 46621.

4.3.1 The Chief Executive

The Chief Executive has overall accountability for ensuring compliance with the Statutory Regulations, and this procedure, to ensure that appropriate action is taken at the conclusion

of a complaint investigation.

4.3.2 The Director of Governance

The Director of Governance is responsible for signing off all written complaint responses on behalf of the Chief Executive. On occasions, where they are not available to do so, a Deputy will be designated to sign the response on their behalf.

4.3.3 Executive Directors

Executive Directors are responsible for deciding whether or not it is appropriate to inform the police, and at what stage, if it is reported to them that a complaint alleges, or it becomes apparent during the investigation that a criminal offence may have been committed. It would be usual for escalation to arise from the Patient Relations Team to the Patient Relations Manager, who would then directly inform the Director of Governance.

4.3.4 The Trust Executive Lead

The Trust Executive Lead is the Director of Governance for the management of complaints and has responsibility for the co-ordination and oversight of the complaints management process.

4.3.5 The Patient Relations Manager

The Patient Relations Manager is the Trust's Complaints Manager and is responsible for the management of all complaints received by the Trust, in accordance with the Regulations and this policy.

Where it is apparent, either upon receipt of a complaint or during the investigation, that a Serious Incident Requiring Investigation (SIRI) has, or may have, occurred, this will be escalated to the Patient Relations Manager and in turn the relevant Governance Lead who will, if deemed appropriate, commission a Root Cause Analysis (RCA) (see UHMBT's *Policy for the reporting and management of incidents including serious incidents*).

If the Patient Relations Manager becomes aware during any complaint investigation that patients or complainants are being discriminated against, they will take appropriate action to ensure that the discrimination is addressed immediately, and that this is taken up with staff members involved via relevant procedures.

4.3.6 Patient Relations

The Patient Relations Case Officers and Assistants are responsible for initiating and maintaining close liaison with the complainant, any pertinent staff involved in the complaint, and the Governance Leads for advice and support. The Case Officers and Assistants have a responsibility to thoroughly investigate each complaint, ensuring that the response provided by the Trust is applicable to the complainant's initial queries and concerns, as agreed during the initial Case Officer contact.

4.3.7 Care Group Management Teams

The Care Group Management teams are responsible for local resolution through early contact with the complainant, if appropriate, and for co-ordinating any complaint investigations within their Care Group, ensuring that necessary service improvements and lessons learned are identified as a result of a complaint investigation and implemented.

Following complaint investigations, and prior to the Trust's formal response letter being sent, the relevant Care Group Management Teams are responsible for Care Group final approval

of the letter.

Care Group Management teams will receive regular reports from the Patient Relations Department, detailing complaints received during a specific period and incorporating information in relation to the cause of a complaint, location, staff groups involved, and target response date. This will support the Care Group to manage their complaints effectively and will enable the Care Group to target interventions where themes in complaints present themselves.

4.3.8 Consultants, Matrons, Service Managers and Specialty Leads

Consultants, Matrons, Service Managers and Specialty Leads are responsible for investigating those elements of the complaints relating to them and their staff, and for providing the Case Officer with appropriate information, to include, overviews and action plans, within the specified time frame.

4.3.9 Every member of staff

Every member of staff has a responsibility for prompt and effective resolution of concerns and complaints within their area as they arise. All staff have a responsibility to provide any information reasonably requested from them during the investigation of a complaint, and in a timely manner.

All staff must be aware of the Patient Advice & Liaison Service (PALS) and their role in helping to resolve concerns quickly. Contact details are available on the Trust's intranet, internet page, *Patient Advice and Liaison* (*PALS)* leaflet, and in the *Compliments or Complaints* leaflet.

4.4 Support Mechanisms and General Governance

UHMBT aims to provide all complainants with an honest, open response to the concerns which they raise.

It is common practice for complainants to be offered local resolution / conciliation meetings, to discuss their concerns or any unresolved issues as appropriate. Meetings will be recorded, where consent has been received from the complainant, and a CD recording of the meeting will be provided; alternatively a précis of the discussion can be provided to the complainant.

Where a complaint identifies a serious patient safety incident or it is considered by the Patient Relations Manager to highlight serious concerns in relation to the care received, UHMBT "Being Open" policy will be invoked.

4.4.1 Supporting Staff Involved in Complaints

UHMBT recognises that staff whose actions are the subject of a complaint may be upset and distressed and require support during the process. Any support should be arranged by the Senior Manager investigating the complaint within the specialty, and normally comes from line managers or the peer group. However, the services of the Occupational Health Department may be required. Details of the way in which this support is provided are available in UHMBT's *Policy for Supporting Staff Following Traumatic or Stressful Incidents*.

NHS staff may complain about the way they have been dealt with when involved in a

complaint investigation via UHMBT's *Grievance Procedure*.

4.4.2 Prevention of Discrimination as a Result of Complaints

UHMBT expects all staff to treat patients and complainants with respect at all times and will not tolerate discrimination against them as a result of a complaint being made. During any complaint investigation, if it becomes apparent that patients or complainants may be being discriminated against, the Patient Relations Manager will take appropriate action to ensure that the discrimination is addressed, and appropriate action taken in relation to the staff members involved.

All staff should be aware that documentation relating to complaints should not be filed in patients' medical records, as this causes concern that it may give rise to future discrimination. All information relating to complaints is held centrally within the Ulysses Safeguard system. Reports are provided, upon request, for appraisal and revalidation purposes.

4.4.3 Exclusion Criteria

The *Local Authority Social Services and National Health Service Complaints (England) Regulations* (2009)[1] state that certain complaints are not required to be dealt with. These are stipulated under section 8a–h of the regulations and are as follows:

(a) a complaint made by a responsible body ("responsible body" means a local authority, NHS body, primary care provider or independent provider)
(b) a complaint made by an employee of a local authority or NHS body about any matter relating to that employment
(c) a complaint which is made orally and is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made
(d) 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 sub-paragraph (c) above
(e) a complaint, the subject matter of which has previously been investigated under: these [2009] regulations: the [NHS complaints] 2004 regulations; the [NHS complaints] 2006 regulations; or a relevant complaints procedure in relation to a complaint made under such a procedure before 1 April 2009
(f) a complaint, the subject matter of which, is being, or has been, investigated by a local commissioner under the Local Government Action 197(a) or a health service commissioner under the 1993 Act
(g) 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[4] (b)
(h) a complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services etc.) or section 24 (compensation for loss of office etc.) of the Superannuation Act 1972[5] © or to the administration of those schemes.

4.4.4 Data Protection

If a complaint is received, of an alleged breach, or suspected breach, of the Data Protection Act 2018[6], the Patient Relations Manager should inform the Trust's Data Protection Manager.
Complaints are recorded on the Trust's Ulysses Risk Management database and associated documents are scanned and attached to the electronic file.

Copies of files containing the original documentation will be retained for **8** years <u>from the</u>

date of closure. The archive is reviewed annually and files closed more than **8** years previously are destroyed in accordance with the Trust's policy, *Confidentiality*.

Information or correspondence relating to a complaint MUST NOT be kept in the patient's records.

4.4.5 Complaints which may lead to Litigation or Criminal Proceedings

Complainants may pursue a complaint under the Trust's Procedure and make a clinical negligence claim simultaneously; however, when legal action is being pursued at the same time that a complaint relating to the same matter is made, or when an investigation is on-going into a criminal offence, the Trust should consult with its legal advisors and/or the Police, in order to determine whether progressing with the complaint might prejudice subsequent legal, or judicial, action. If this is deemed to be the case, the Trust will notify the complainant, in writing, that further investigation is not possible. This includes Public Liability Claims.

4.4.6 Complaints where a Patient's Death has been Referred to the Coroner

The fact that a death has been referred to the Coroner does not mean that investigations into any complaint about the patient's care should be suspended. The complaint investigation should continue, unless the complainant requests a suspension, regardless of the Coroner's enquiries, but it is advisable to notify the Head of Legal Services, who is the Coroner's point of contact within the Trust, and that they are kept informed of the progress of the complaint investigation.

4.5 Concerns

Minor criticisms can often be addressed immediately. Concerns raised should be listened to sympathetically, and if possible the member of staff to whom these are expressed, or the person in charge should provide an answer or explanation.

The patient, relative, friend or carer should be made aware of the Patient Advice and Liaison Service (PALS). In addition, if staff require support in order to resolve an informal complaint they should contact the Ward or Department Manager, the appropriate Matron, Service Manager, Consultant, or the PALS service.

All staff should be aware of the correct procedure to follow should a patient or relative wish to make a complaint.

Where the matter is resolved, staff should make a record of the concerns, and the outcome, and any action taken should be input at ward or department level onto the UHMBT Safeguard System on the Trust intranet.

A complainant whose concerns cannot be resolved verbally, and/or who wishes to make a formal complaint, should be advised to write to the Chief Executive via the Patient Relations Department. Information is available in the *Compliments or Complaints* leaflet. If a complainant is unable or unwilling to put their concerns in writing, the person to whom the complaint is made should do so on their behalf, and have the document signed by the complainant to confirm the content is correct and sign it themselves. The document should then be forwarded to the Patient Relations Department via internal post or scanned and sent to comments.complaints@mbht.nhs.uk or commentsandcomplaints@mbht.nhs.uk

If concerns are raised out of hours and the staff are unable to resolve them, or the matter is considered serious, then the *Patient Relations Out of Hours Service Standard Operating Procedure* must be complied with.

4.5.1 Patient Advice and Liaison Service (PALS) (See Appendix 2)

The Patient Advice and Liaison Service (PALS) will provide to patients, relatives, carers and friends:

- Help to resolve their concerns quickly, often within 24/48hours.
- Support, should they require help navigating NHS services
- Support with information requests
- Signposting to external services, such as those provided by voluntary, charitable or private sector.

All wards and departments should have PALS leaflets and contact details available. The service details are available on the Trust website here: https://www.uhmb.nhs.uk/patients-and-visitors/compliments-concerns-complaints/ and intranet here: http://uhmb/cd/Governance/Pages/PatientExperience.aspx .

4.5.2 Independent Complaints Advocacy Services

Should a patient or service user wish to seek independent advice when making a complaint, there are a number of independent bodies who can be contacted to provide support and advocacy services to patients going through the NHS complaints process.

They can be contacted on:

Lancashire residents:	Advocacy in Lancashire	0330 002 22 00
Cumbria residents:	People First	0300 303 80 37

4.6 Communication and Publicity

Compliments or Complaints leaflets and *PALS* leaflets must be available in all wards and departments in the Trust. Ward and Department Managers are responsible for maintaining stocks at all times and replacements can be obtained from PALS officers or the Patient Relations Department on internal extension number 46621.

Information relating to UHMBT's Complaints Procedure is available on the Trust's public website, which can be found at https://www.uhmb.nhs.uk/patients-and-visitors/compliments-concerns-complaints/ Accompanying posters are also on display in public areas. Staff can access the procedure via the Trust's intranet.

4.6.1 Public and Patient Involvement in Resolving Issues and Complaints

Public and Patient involvement in resolving issues and complaints is a fundamental factor in assisting the Trust to learn and develop. Public and Patient involvement is a means of utilising service users' feedback, and perspective of the service and care we provide. It can highlight early indicators of problems within a system, or care within the patients' pathway and allow early resolution to issues arising.

UHMBT actively involve the public and patients in the daily running of the Trust, alongside a more corporate overview. We do this by engaging the public and patients in a variety of

forums and mediums.

4.7 Complaints Management Process (Appendix 1 Flowchart)

4.7.1 Who can complain

- A patient
- Any person who is affected by or likely to be affected by, the action, omission or decision of the Trust

A complaint may be made by a person acting on behalf of another person mentioned above, in any case where that person:

- Has died
- Is a minor (a child under the age of 16 years)
- Is unable, by reason of physical or mental incapacity to make the complaint themselves, or has authorised the representative to act on his/her behalf.

4.7.2 Consent

UHMBT endeavours to protect patient information and applies strict criteria regarding who may receive clinical information related to patients.

It is preferable that the complaint is made by the person affected; however, if this is not possible, a complaint can also be made by someone who has been asked by the patient to act on their behalf. When a representative is complaining on behalf of a patient, care must be taken to ensure that the patient is aware of the complaint, has asked the representative to act on their behalf, and has provided written or verbal consent to the Patient Relations Case Officer for details of their case to be divulged, including medical records, to the third party. If consent is not included with the complaint, a consent form will be sent to the patient for completion. This will not delay the investigation, but must be returned before the final complaint response can be shared. If consent is given in verbal form, via a face to face meeting or by telephone, the Case Officer must record this within the Contacts section of the case on Safeguard, as a précis of the conversation. The 35 working day target response will not begin until consent has been given.

If consent is not received within one month of the request, the Case Officer will consider withdrawing the complaint and will write to the complainant to confirm their decision.

The complaint is investigated without delay, based on the information provided by the complainant, even if there is a lack of consent, or delayed consent. This is to avoid any shortfalls in practice, and harm to patients being missed, and so that any actions and learning from the complaint is addressed. The findings of the investigation will not be released to a third party until consent has been received. This process allows Care Group to still be made aware of any concerns that may need remedial action as a result of an investigation.

With regard to complaints made on behalf of a deceased person, or patients who lack capacity, *The Local Authority, Social Services and National Health Services complaints (England) regulations (2009)*[1] allows for these complaints to be made by a person acting on their behalf. In this situation, the representative must be a relative, or other person, who, in the opinion of the Trust, has or had, sufficient interest in the patient's welfare, and is a

suitable person to act as representative.

If the Trust is of the opinion that:
i) a representative does not, or did not, have sufficient interest in the patient's welfare; or
ii) is unsuitable to act as a representative; or
iii) the patient stated they did not wish this, or any person, to be a representative

The Case Officer must notify that person in writing, stating the reasons for the decision.

When responding to the complaint, the Trust will access the patient's records and only the clinical information that is necessary, proportionate and in the best interest of the patient will be provided to the complainant in the Trust's response. Any additional clinical records required by the complainant must be requested independently under the *Access to Health Records Act* (AHRA) 1990[7].

In the case of a minor (a person under the age of full legal responsibility), the representative must be a parent, guardian or other adult with parental responsibility. Minors who are, in the opinion of the Trust, deemed to be '*Fraser competent' may make a complaint, i.e. where a child (16 years or younger) has an understanding of the process and is able to consent to his or her own medical treatment, without the need for parental permission or knowledge (*The standard based on a decision of the House of Lords: *see Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984]*)[8].

4.7.3 Governor / Constituent Complaints

A complaint or concern, can be raised via a Foundation Trust Governor on a person's behalf. Information and consent forms support this process and further information can be obtained by contacting your local Foundation Trust Governor, or alternatively the Foundation Trust Membership office on telephone number 01229 404473.

Where MPs write on behalf of their constituents, consent is presumed as being given by the constituent approaching the MP. Where third parties are involved, for example, a constituent writes to their MP about their relative (wife, husband, son, daughter etc.) the MP should provide consent from the patient. Where consent is not provided, a limited response may be sent direct to the constituent and the MP or the MP will receive a letter confirming the response has been sent to the constituent.

4.7.4 Making a complaint - time limits

A complaint must be made within:

- twelve months after the date on which the matter which is the subject of the complaint occurred; or
- twelve months after the date on which the matter which is the subject of the complaint came to the notice of the complainant

Where a complaint is made after the expiry of the time limits mentioned above, the Patient Relations Manager will ask the Director of Governance to review the complaint, who will decide if the complainant had good reasons for not making the complaint within the time period, and if it is still possible to investigate the matter effectively and fairly. If it is decided to investigate the complaint, the Trust should endeavour to provide as much information as

possible, but will make the limit of any investigation clear to the complainant.

Where it is decided not to investigate a complaint which is received outside the time limits, the CEO, or nominated deputy, must write to the complainant, informing them that their concerns cannot be dealt with under the Complaints Procedure.

4.7.5 Investigation of a Complaint

In all cases, the Ulysses Safeguard System should be updated in real time with every action taken throughout the life of a complaint.

On receipt into the Patient Relations Department, all complaints and concerns are acknowledged by letter, or e-mail, within three working days of receipt by the Patient Relations Manager. If the complaint or concern is received by post, it is stamped with the date and name of department in which it was received.

All complaints and concerns received in to the Patient Relations Department are assessed and graded (triaged) according to severity and likelihood of recurrence and deemed either a formal complaint or a PALS case. Should a complaint score as moderate or above for severity using the Assessment and Risk Rating tool, then the Case Officer must check whether an incident form has been submitted and inform the Care Group Governance Lead if this is not the case.

If the complaint is regarding a Workforce matter, this is to be sent to the Workforce Department asking them to action as appropriate. A letter will then be sent to the complainant informing them that the Workforce Department will be dealing with the issue, providing them with the correct contact details.

Formal complaints are dealt with by Case Officers and are allocated to the Case Officer aligned to the Care Group involved, or in the case of cross-Care Group complaints, to the Case Officer of the Care Group on which the majority of the complaint is focused.

All complaints are registered onto the Ulysses Safeguard System which automatically generates a case number; the complaint and acknowledgement are then scanned and attached to the case. A case file and complaint summary is subsequently created to include the original complaint and the acknowledgement.

On receipt of the complaint, the Case Officer contacts the complainant by telephone, or letter, within five working days of receipt of the complaint. In the absence of the allocated Case Officer (annual leave etc.), either another Case Officer will make contact, or an acknowledgement letter will be sent, explaining the Case Officer's absence and that they will contact them on their return, giving them the option to contact Patient Relations if they are not happy with the timeframe proposed.

The Case Officer identifies with the complainant the issues to be addressed (if telephone contact is viable). During the initial contact, the Case Officer confirms the complaints process, agrees a timescale, taking into account the complexity of the complaint, (which will be completed within 6 months as per the 2009 Complaint Regulations), and agrees in what format the complainant would like to receive their response letter.

If a third party is the source of the complaint, consent must be obtained, in writing or

verbally, and a record of the consent recorded on the case, as outlined in section 4.7.2 of this procedure.
If the complaint involves external services or organisations, the Case Officer requests authorisation from the complainant, prior to forwarding the complaint to those services and organisations, in order for them to investigate the concerns.

Following initial contact, the Case Officer outlines the complaint in a formal acknowledgement letter, providing details of the complaint process, contact details and information regarding advocacy services. If initial telephone contact is not viable, the formal acknowledgement letter outlining the complaint from the initial details provided by the complainant, serves to be the initial contact.

The Case Officer contacts the appropriate Care Group staff members, and senior staff, to initiate the investigation into the complaint. This will ideally be within three working days from contact with the complainant.

Where a formal complaint has risen from a PALS case, the Case Officer should still contact appropriate Care Group staff members, and senior staff to initiate the investigation into the issues raised within the complaint. If there is no additional relevant information, this must be documented on the complaint case.

The Case Officer, or Assistant, arranges for the medical records to be forwarded to the senior staff being asked to provide information, as appropriate.

On receipt of a complaint, the senior Care Group staff asked to provide comments should identify members of their staff from whom they will require information and/or whom they will need to interview and make prompt arrangements for this work to be undertaken.

The Case Officer identifies the 10 day working target, within which the initial investigation should be completed and responses sent to the Case Officer. The relevant Care Group staff are made fully aware of this target date. In exceptional circumstances, an extension to this target may be agreed.

Should the information not be received within 10 working days, the Case Assistant will send a reminder to the Care Group staff members. A further reminder will be sent at 15 working days, if the information is still outstanding.

Should the information not be received within 15 working days, then a member of the Patient Relations Department will telephone the member of staff asking for the information by return.

Should the information requested still not be received after the telephone call, the Case Assistant notifies the Patient Relations Manager who escalates to the Director of Governance on the 16th day, who, in turn, escalates the request for information to the relevant Care Group Senior Manager.

Once the Care Group responses are received, the Case Officer reviews the information to ensure it addresses, in sufficient detail, all the issues raised within the complaint. Care Group staff should inform Case Officers of any shortfalls which have occurred, or any necessary remedial action which has been, or which is intended to take place.

A drafts response incorporating the information provided is prepared, which is reviewed for quality assurance (QA) by the Patient Relations Manager or nominated deputy in their absence.

Following internal QA, the response letter will be sent to all the staff members involved in the case to approve or amend. On receipt of the returned response from the staff involved, any relevant amendments will be made before re-sending the response letter for final approval to the Care Group Assistant Chief Nurse or Care Group Management Team. If the response letter is significantly amended or re-drafted, the response letter must be sent back to all parties for approval.

Final QA is actioned by Patient Relations Manager, or nominated deputy in their absence, prior to the finalised version being provided to the Chief Executive's Office (CEO) or nominated deputy for signature.

Should there be an unavoidable delay at any stage of the complaint process, the Case Officer must be informed promptly, so that, if necessary, an extension of the response time can be arranged with the complainant.

As per the Trust's set timescale, the formal CEO response letter must be signed by the CEO, or nominated deputy, within 35 working days from receipt of the complaint, unless another timescale has been agreed with the complainant i.e. when the complaint is complex.

The response should address all issues raised by the complainant, be written in terms that can easily be understood by the recipient and people with a non-clinical background and include any information regarding lessons learned, i.e. any action taken, planned or recommended (see 4.7.7).

The letter should also explain what the complainant should do if they have further questions or are dissatisfied with the response. Details of the Parliamentary and Health Service Ombudsman (PHSO) should also be included in the response letter.

Following provision of the Trust's response to the complainant, the complaint case is closed on the Ulysses Safeguard System.

On closure of a complaint file, a whole case information review takes place by the Case Officer, including the risk rating and, if necessary, the initial risk rating is amended following this. Where appropriate, it is ensured that staff mentioned in the complaint have been added to the case on Ulysses Safeguard. A record is made as to whether or not the complaint has been upheld (partially or totally), on the Ulysses Safeguard system.

An anonymous Complaints Handling Questionnaire is sent to the complainant the month following the closure of the complaint.

All investigations will be carried out in line with the deadlines specified in this procedure, unless the content of a complaint relates to a Serious Incident Requiring Investigation, that has not previously been reported. In this instance, the investigation will be undertaken in line with the deadlines set out in the Trust's *Policy for the Reporting and Management of Incidents including Serious Incidents*. In this instance, it remains the responsibility of the Patient Relations Team to maintain contact with the complainant. Exceptions of this kind will

be monitored by the Patient Relations Manager.

4.7.5 (i) Revisits *(See Appendix 4 for the process flowchart)* **and Meetings**
If a complainant contacts the Patient Relations Department requesting further action to a closed case, this is called a Revisit case. The Case Officer, reviews the case to identify what actions need to be taken.

Possibilities for further action include: the opportunity to meet with appropriate senior staff; reinvestigation of outstanding concerns; or review by the Trust's clinical staff not involved in the patient's care.

For Revisit cases, Case Officers must aim to respond ideally within 25 working days, if the original questions have not been answered satisfactorily, and within 35 working days if new questions have arisen as a result of the initial response. Where these timescales are not possible, an update contact letter should be provided to the complainant updating them as to the progress of the investigation.

When a meeting is to take place between the complainant and Trust staff, finalised arrangements for the meeting must be communicated to the complainant, ideally within 25 working days of agreement to arrange the meeting, and the meeting itself should ideally take place within two months of the agreement to arrange the meeting.

If a meeting takes place, with the consent of all parties involved, it will be digitally recorded. If consent is not given, summary notes will be taken. The Case Officer drafts a meeting outcome letter, summarising the discussions, and any actions to be taken, and once approved by the staff who attended the meeting, the letter is sent to the complainant from the CEO Office or nominated Deputy, together with any CD recording.

The administrative closure of a revisit complaint is completed as in section 4.7.5Investigation of Complaints.

4.7.6 Lesson Learned and Action Plan: Complaints as a Source of Improvement.
The Lessons Learned/Recommendations sections on the Ulysses Safeguard System must be completed for every case as of January 2018. As well as this, a final response copy and compiled Lessons Learned document will be shared with all staff involved in the complaint, in order that they are aware of each other's Lessons Learned information.

This is facilitated by all relevant staff involved in a complaint investigation being asked to complete and return a Lessons Learned and Action Plan pro-forma (Appendix 7), and the Lessons Learned (Appendix 5) and Action Plan (Appendix 6) processes being completed.

Lessons Learned will be reported in the quarterly complaints report and reported monthly to Care Group through the automated safeguard system for inclusion in Care Group governance reporting arrangements. (Appendix 8)

Lessons Learned may be shared to relevant external bodies, if appropriate.

All Action Plan information will be provided to the Care Group Governance Lead on a monthly basis, and monthly to the Care Group Management Teams to support the implementation of actions. Monitoring of actions relating to service improvements will be

undertaken monthly at the Care Group Governance Committees and quarterly at the Quality Committee.
Some complaints identify actions required to resolve the individual issue, but it is also important to monitor complaints received for trends developing, which need to be taken up with Care Group Governance Teams or via the Learning to Improve Group and/or the Quality Committee.

4.7.7 Complaints involving Other Service Providers

When a complaint also involves other Service Providers, the Patient Relations Team must contact the complainant, ideally by telephone, to establish whether the complainant is happy for their complaint to be copied to the relevant Service Provider. Once the complainant confirms that they are happy for this to occur, the Case Officer should share the complaint with the other providers involved, ideally within three working days. A discussion should take place with them to establish which organisation will take the lead in co-ordinating the complaint response; this will generally be the provider on whom most of the complaint is focused. The lead provider will co-ordinate the handling of the complaint, ensure the complainant is kept informed of the progress of the investigation, and will ensure a comprehensive response is sent.

Any complaint that is not substantively a UHMBT one, but is one that we consider would be in the patient's best interest to lead on, will be passed to the Patient Relations Manager for review, before any investigation commences.

When it is decided that UHMBT is to take the lead in a multiple agency complaint, the Patient Relations Team will write to the complainant, to advise that this Trust is taking the lead and will be obtaining and including comments from other service providers. The draft response must be shared with the other Service Providers involved, and their agreement obtained, before the response is signed by the CEO Office, or nominated Deputy.

If a complainant does not wish for their complaint to be shared with the other providers involved, the Patient Relations Team will write to the complainant advising them of the issues which UHMBT can investigate, and give details of how to contact other providers involved directly should the complainant wish to do so.

4.7.8 Regular, Unreasonable and Persistent Complaints or Insistent Complainants

In a small number of cases, complainants may become unreasonably persistent, despite reasonable attempts having being made to resolve their concerns. This can lead to a disproportionate amount of time and resources being spent on them, and may also cause unacceptable strain to the staff dealing with them. See Appendix 9 regarding the identification of such complainants and advice regarding dealing with them.
Should a complainant be insistent that they have personal contact (via telephone or a meeting) with the Chief Executive, or an Executive Director, the process for this must be adhered to. (See Appendix 10)

4.8 The Parliamentary and Health Service Ombudsman (PHSO)

If a complainant remains dissatisfied after a complaint has been investigated, and all reasonable attempts by the Trust for resolution has taken place, they have the right to ask the PHSO to investigate their case. The Trust has a dedicated PHSO Liaison Officer.

4.9 Analysis and Reporting of Complaints

The Patient Relations Department will provide regular reports to:

- Care Group Governance Leads (Monthly)
- Care Group Management Teams (Monthly)
- Lessons Learned reports to Care Group (Monthly)
- Quality Committee (Quarterly)
- Trust Board (Annually)

An annual report will be produced on adherence to the Complaint Management process, which will be provided to Quality Committee and the Trust Board Directors. Additional reports will be provided to Commissioners in accordance with agreed quality monitoring arrangements.

Patient Relations will inform Legal Services of any complaints where it is believed a clinical negligence claim may ensue (see section 4.4.5).

4.10 Complaint Training

Complaint training is delivered in line with the Trust's Training Needs Analysis (TNA).

The Patient Relations team works with individual Care Group, by providing tailored workshops, to ensure appropriate training provision is provided to support staff involved in complaints handling.

A Patient Relations e-Learning package is readily accessible on the Training Management System (TMS) for all staff to complete. This training includes the *Six Steps in Handling Complaints* in order to resolve at a local level, and how to log complaints on the Ulysses Safeguard System.

Regular Patient Relation Workshops are provided on the three main sites to allow all staff members to attend; these Workshops include a full overview of the department and the complaints process. The Patient Relations Workshops are advertised in the Trust's communication newsletter, *The Weekly News*.

Induction of new staff includes basic information on complaints handling as a part of their Corporate Induction on day one of service.

4.11 Whistleblowing

Any staff that observe colleagues, or suspect colleagues of, behaving inappropriately towards a patient should raise their concerns with their line manager at the earliest opportunity. If, however, there is a reason why they feel unable to do so, they should refer to the Trust's *Policy for Whistleblowing*, available on the Trust's intranet, for guidance.

4.12 External Reviews of a Care or Service

Should a complaint highlight an area of concern regarding a service or an area of care, the Trust may commission an external investigation/review. The process initiating an external

investigation/review is documented in the Trust's *Management of External Agency Visits, Inspections and Accreditations*.

4.13 Process for Recalling the Patient

Where it is identified that a patient should be recalled following investigation of a complaint, the responsible clinician has the responsibility for co-ordinating the recall process. The full process for recalling a patient is documented in the Trust's *Policy for the Reporting and Management of Incidents including Serious Incidents*.

4.14 Dissemination and Implementation

4.14.1 Dissemination
The procedure will be distributed and communicated as outlined in the distribution plan. A copy of the procedure will be available to all staff on the intranet via the appropriate document management system.

4.14.2 Implementation
It is expected that any procedure will be fully operational by the training and implementation dates identified.

4.15 Document Control

4.15.1 Library of Procedural Documents
All current approved documents are kept on the Procedural Documents Library which is available through the Trust intranet.

4.15.2 Archiving
An electronic archive of strategies, policies, protocols, SOPs and guidelines is maintained by the Procedural Documents Team.

4.15.3 Process for retrieving archived documents
Requests for access to archived documents should be made to the Policy Coordinator.

4.16 Monitoring Compliance

Adherence to this procedure will be reported at the Quality Committee (QC) meeting.
The quarterly Quality Committee report will include:

- the total number of complaints received
- details of complaints by Care Group
- details of complaints by category
- details of complaints by speciality
- details of any action to improve the service
- percentage of Care Group responses within 15 working days
- percentage of responses within 35 working days/agreed timescale

In addition to a range of indicators and compliance for PALS.

The annual report will include:

- the number of complaints received
- analysis by Care Group
- any significant trends arising
- actions taken to improve services
- number of complaints referred to the PHSO
- adherence to the process milestones identified in this policy
- an evaluation of the effectiveness of the current process
- activity data for the previous and current year

4.17 Standards/ KPIs

The standards that will be audited as part of the monitoring of compliance with this procedure include:

- Compliance with acknowledging complaints within 3 working days
- Compliance with the 15 working day investigation target within Care Group
- Compliance with agreed 35 working day response target
- Customer satisfaction measure of complaints process
- Number of complaints referred to the Ombudsman
- Action taken on identified lessons learned
- Number of revisited complaints

Monitoring arrangements are indicated in the table below.

4.18 Monitoring of the procedure:

Requirement	Method	Frequency	Lead	Monitoring Group	Action Plan Lead	Committee/ group overseeing Action Plan
% compliance with Agreed response date	Safeguard report	Monthly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)
2.3 b & 2.3dCustomer satisfaction Measure of complaints process	Questionnaire	2x yearly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)
Number of complaints Referred to ombudsman	National PHSO report	Annual	Patient Relations Manager	Quality Committee (QC)	Patient Relations Manager	Quality Committee (QC)
2e % of complaint response templates received where “lessons learned / action taken” has been completed	Audit of investigation templates	Monthly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)
% compliance with 3 day acknowledgement requirement	Safeguard report	Monthly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)
% compliance with 15 day target for Care Group	Safeguard report	Monthly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems	Quality Committee (QC)

investigation stage					Administrator	
% compliance with 35 day target for resolution	Safeguard report	Monthly	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)
Number of revisited complaints as a proportion of total received	Safeguard report	Annual	Patient Relations Manager	Quality Committee (QC)	Patient Relations Systems Administrator	Quality Committee (QC)

5 ATTACHMENTS	
Number	**Title**
1	Complaints Process Flowchart
2	Patient Advice & Liaison Service (PALS) Process Flowchart
3	Assessment and Risk Rating
4	Complaints Cases Re-Visit Process Flowchart
5	Lessons Learnt Process Flowchart
6	Action Plan Process Flowchart
7	Lessons Learnt / Action Plan Pro Forma
8	Sending Signed Response and Lessons Learned to Staff
9	Advice on Handling Unreasonable, Regular or Persistent Complainants
10	Insistent Complainants Process Flowchart
11	Equality and Diversity Impact Assessment Tool

6 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Proc/022	Reporting and management of incidents including serious incidents http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx
Corp/Pol/023	Being open UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-023.docx
HR2	Policy for supporting staff following traumatic or stressful Incidents http://uhmb/cs/tpdl/Documents/HR2.pdf
PtRel/SOP/001	Patient relations out of hours service UHMB http://uhmb/cs/tpdl/Documents/PTREL-SOP-001.docx
Corp/Pol/112	Whistleblowing policy UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-112.docx
Corp/Proc/030	Management external agency visits, inspection and accreditations http://uhmb/cs/tpdl/Documents/CORP-PROC-030.docx
Corp/Pol/123	Grievance procedure UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-123.docx
Corp/Strat/001	Risk Management Strategy http://uhmb/cs/tpdl/Documents/CORP-STRAT-001.docx

7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	NHS (2009) The Local Authority, Social Services and National Health Services complaints (England) regulations 2009 (309). Available at: http://www.legislation.gov.uk/uksi/2009/309/contents/made (accessed 15.6.18)
2	Parliamentary and Health Service Ombudsman (PHSO) (2009), Principles of good complaints handling. Available at: https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling (accessed 15.6.18)
3	Great Britain (2000) Freedom of Information Act 2000 (c. 36) Available at: http://www.legislation.gov.uk/ukpga/2000/36/contents (accessed 15.6.18)
4	Great Britain (1972) Superannuation Act 1972 Available at: http://www.legislation.gov.uk/ukpga/1972/11/contents (accessed 15.6.18)
5	Great Britain (2018) Data Protection Act 2018 Available at: https://www.legislation.gov.uk/ukpga/2018/12/contents (accessed 5.9.18)
6	Great Britain (1990) Access to Health Records Act 1990. Available at: http://www.legislation.gov.uk/ukpga/1990/23 (accessed 15.6.18)
7	Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security [1984]. Available at http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm (accessed 15.6.18)
Bibliography	
	Medical Protection Society (2014) Consent - Children and young people. Available at: http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-eng-consent-children-and-young-people (accessed 15.6.18)

8 DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
PALS	Patient Advice and Liaison Service
ICAS	Independent Complaints Advocacy Service
UHMBT	The University Hospitals of Morecambe Bay NHS Foundation Trust
KPI	Key Performance Indicator
PHSO	Parliamentary & Health Service Ombudsman

9 CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
Mary Aubrey	Director of Governance	
Janet Garnett	Patient Relations Manager	
Kay Gilbey	PHSO Lead	
Sally Totton	PFSO	
Stephen Greaves	Case Officer	
Rachael Parkinson	Case Officer	

10 DISTRIBUTION PLAN	
Dissemination lead:	Patient Relations Manager
Previous document already being used?	Yes
If yes, in what format and where?	Version 9.5, Policy for the Management, Investigation and Resolution of Complaints on SharePoint Document Library
Proposed action to retrieve out-of-date copies of the document:	Version 9.5 of the above policy will be archived from SharePoint Document Library when this procedure is ratified and uploaded.
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11 TRAINING Is training required to be given due to the introduction of this procedural document? No		
Action by	**Action required**	**Implementation Date**

12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
5.2	01.11.13			
6.1	25.06.14	2 Throughout document 11 – 7.6 16 – 13 & 14	Contents page amended. Title of Customer Care Department changed to Patient Relations Department throughout the document. Minor amendments to section 7.6 Investigation of a complaint. Additional sections added – Re. External Investigations and Patient Recalled.	
6.2	11.08.14	11 14 All	Narrative around where complaints should be sent updated to Patient Relations Department. Error “appendix 5” changed to “appendix 4”. Document title changed.	
6.3	16.09.14	All	Document transferred to new template	
6.4		All	Amendments throughout	07.07.18
7	07.07.15	4.7.6 4.7.6(i)	Sections updated and expanded to outline the full	01.06.2015

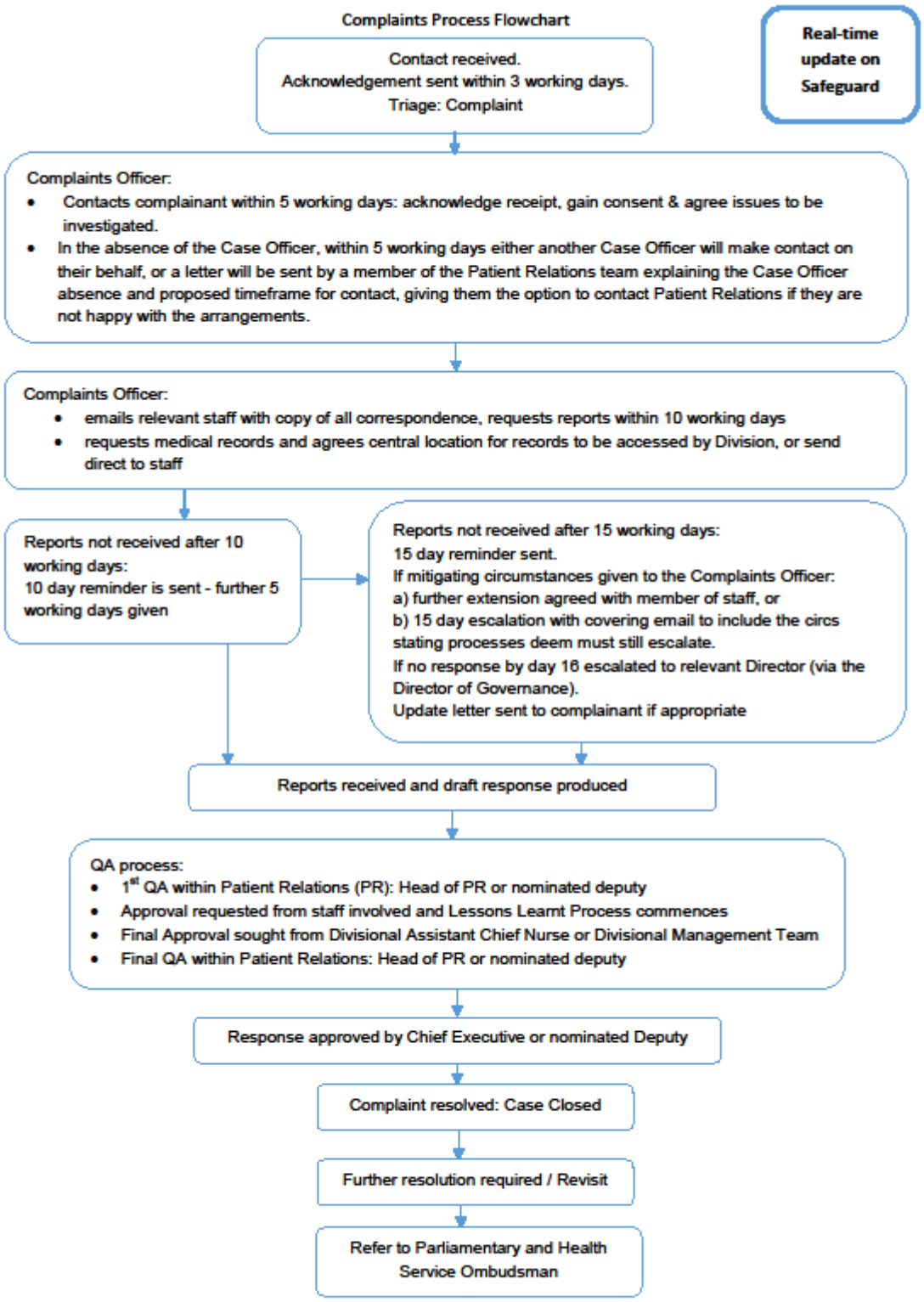
12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
		4.7.7 Appendix 6	procedure following the creation of audit documentation.	
9.1	03.05.16	All 4.7.4 4.7.6 4.7.7 Appendix 6	Complaint Officer/Assistant changed to Case Officer/Assistant Narrative changed for clarity of complaint time limits Narrative changed for clarity of when to seek incident input evidence and process following Lessons Learned process amended to clarify that the Head of Patient Relations reminds staff information overdue Amended to reflect above re Lessons Learned.	01.11.2018
9.2	09/11/2016	Page 4	Procedure on a page added	01/11/2018
9.3	09/11/2016	4.7.6 4.7.7 Appendix 10	Sections updated to include requesting information from all staff and sending re-drafted responses back to all staff for approval Included information as to the process when sending a complaint to the Workforce Department to deal with. Section updated to include new process of sending final response and Lessons Learned information to all staff involved in the complaint Inserted new Appendix 10 which refers to section 4.7.7	01/11/2018
9.3	01/12/2016	Appendix 4	New PALS Process Flowchart inserted at Appendix 4. Subsequent appendices have changed numbers.	

12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
9.4	25/01/2017	4.7.8	"other Trusts or GPs" replaced with "Other Service Providers"	
9.5	November 2017	4	Added Trust Behavioural Standards Framework	
		5	PALS Office opening times amended to 9am – 5pm Amended People First Advocacy telephone number and web details	
10	April 2018	Throughout document	Consistent wording of UHMBT Comments and Complaints leaflets – amended as new leaflet is called "Compliments or Complaints" Any reference to Head of Patient Relations changed to Patient Relations Manager Any reference made to Divisions changed to Care Groups Appendices re-ordered	01/06/2021
	April 2018	6 – 1. Summary	Removed "appropriate" from last sentence	
	April 2018	6 – Section 4.1	Remove reference to "fax"	
	April 2018	7 – Section 4.2	Remove section about Patient Association Good Practice Standards	
	April 2018	8 – Section 4.3.5	2nd paragraph, 2nd line Delete "is" and replace with "will be"	
	April 2018	12 – Section 4.5.1	Links to web pages updated	
	April 2018	12 – Section 4.5.2	Update N Compass details to Advocacy in Lancashire with relevant telephone number	
	April 2018	12 – Section 4.6	Links to web page updated	

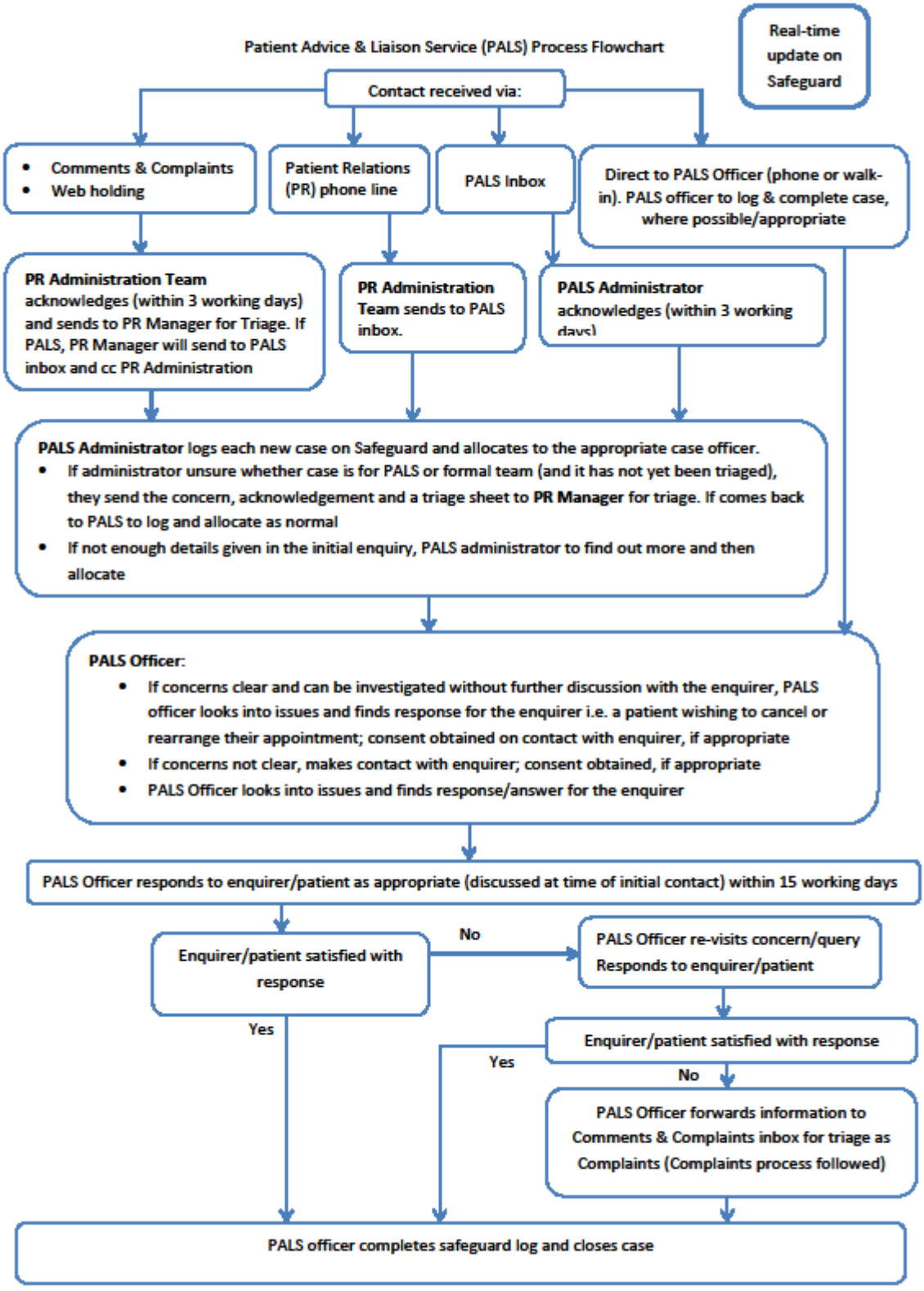
12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
	April 2018	13 – Section 4.6.1	List of organisations removed	
	April 2018	13 – Section 4.7.2 2nd paragraph	Rewording of 2nd sentence	
	April 2018	14 – Section 4.7.2	Additional paragraph (3rd) added clarifying consent	
	April 2018	15 – Section 4.7.3	Process updated for Governor / Constituent Complaints	
	April 2018	15 – Section 4.7.4	Time Limits – updated to reflect NHS 2009 Complaints Policy	
	April 2018	15 – Section 4.7.5	Section deleted as covered in other section	
	April 2018	16 – Section 4.7.6	Additional paragraph clarifying what happens when Case Officer is absent	
	April 2018	16 – Section 4.7.6	Clarification included on timescales for complex complaints	
	April 2018	17 – Section 4.7.6	Updated process when 15 working day target is not met	
	April 2018	19 – Section 4.7.6(i) 4th paragraph	Last sentence amended to read "… any meeting may be provided …."	
	April 2018	20 – Section 4.7.7	Action Plan added to Lesson Learned. Updated process when Lessons Learned is not received	
	April 2018	20 – Section 4.7.8	Remove reference to "faxed"	
	April 2018	21 – Section 4.7.8	New paragraph added to clarify position regarding investigating complaints not substantively UHMBT ones	
	April 2018	21 – Section 4.8	PHSO process updated	
	April 2018	22 – Section 4.9	Updated circulation of Annual Report	
	April 2018	27 – Section 9	Update list of staff consulted	
	April 2018	29 – Section 10	Reference Heritage changed to SharePoint Document Library	

12 AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
	April 2018	30 – Section 11	No training now required	
	April 2018	34 – Appendix 1	Removed from document and subsequent Appendices renumbered	
	April 2018	Appendices – Flowcharts	All updated to reflect processes	
10.1	05/09/2018	Section 4.4.4 Section 7	Reference to Data Protection Act updated	01/06/2021

Appendix 1: Complaints Process Flowchart



Appendix 2: Patient Advice & Liaison Service (PALS) Process Flowchart



Appendix 3: Assessment and Risk Rating

Assessment and Risk Rating

Initial Complaint Assessment

This process will ensure that any subsequent handling and any associated investigation are proportionate to the severity of the complaint and the related risks.

Figure 1 Initial Assessment

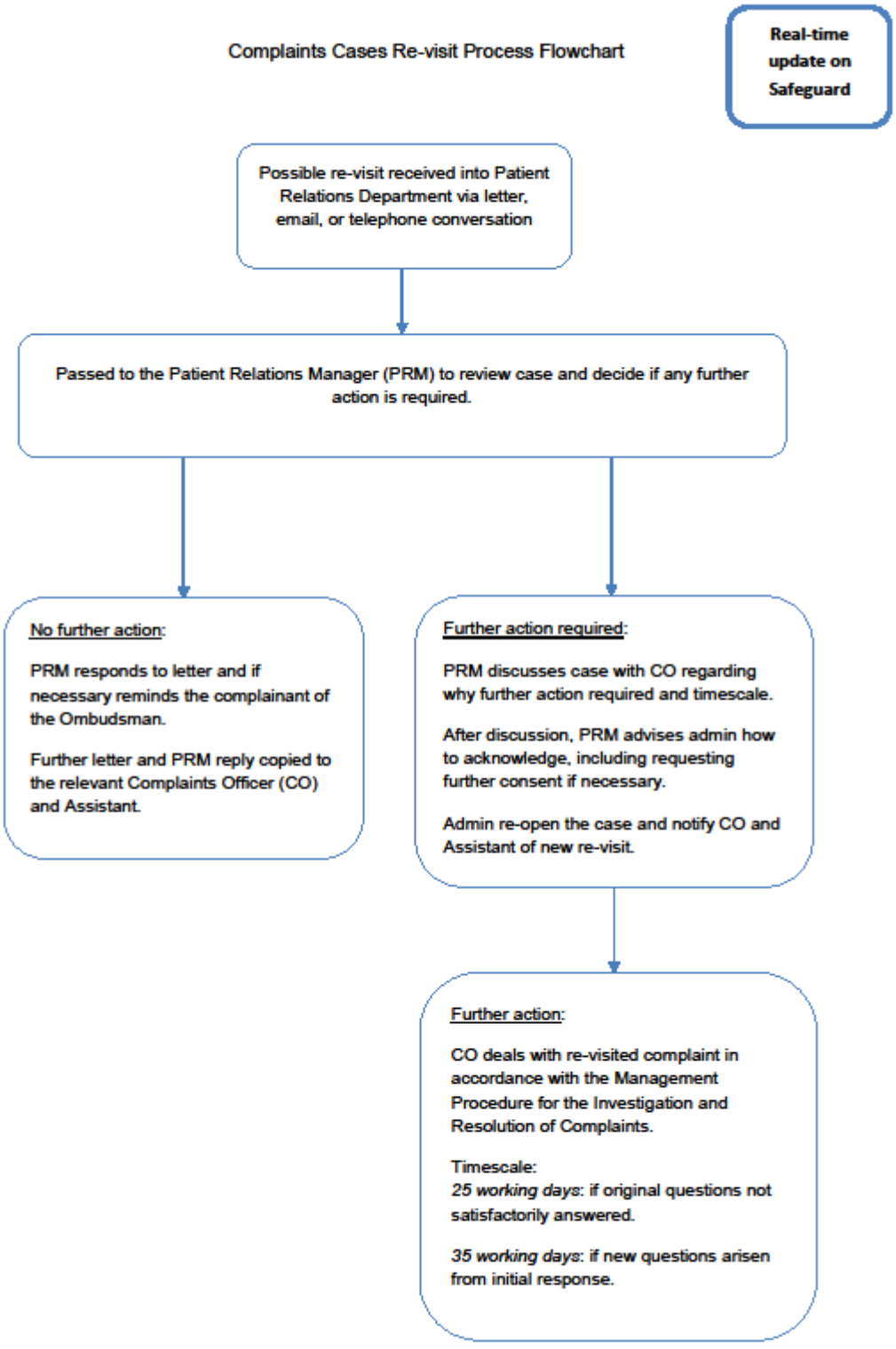
Initial assessment of complaint	Type of complaint	Level of investigation and response period
Low level - formal complaint	Simple, non-complex complaints Cancelled outpatient appointment/admission Waiting time	Low level of investigation required. Response may be provided verbally or in writing by the Patient Relations Team/PALS/Matron/Departmental Head, with the complainant's agreement. Response period – within 35 working days from receipt of complaint by Patient Relations team, or within timescale agreed with the complainant.
Medium level – formal complaint	Several issues relating to clinical care	More detailed investigation involving clinical matters. Response signed by Chief Executive Response period – within 35 working days from receipt of complaint by Patient Relations team or within timescale agreed with the complainant.
High level – formal complaint	Complex complaint involving several Care Group or more than one organisation. Issues may have been investigated as a serious untoward incident or may have the potential for a legal action.	Investigation by clinicians with option to obtain advice from Associate Medical Director/Lead Clinician. Response signed by Chief Executive Response period negotiated with complainant

Risk Rating of Complaints

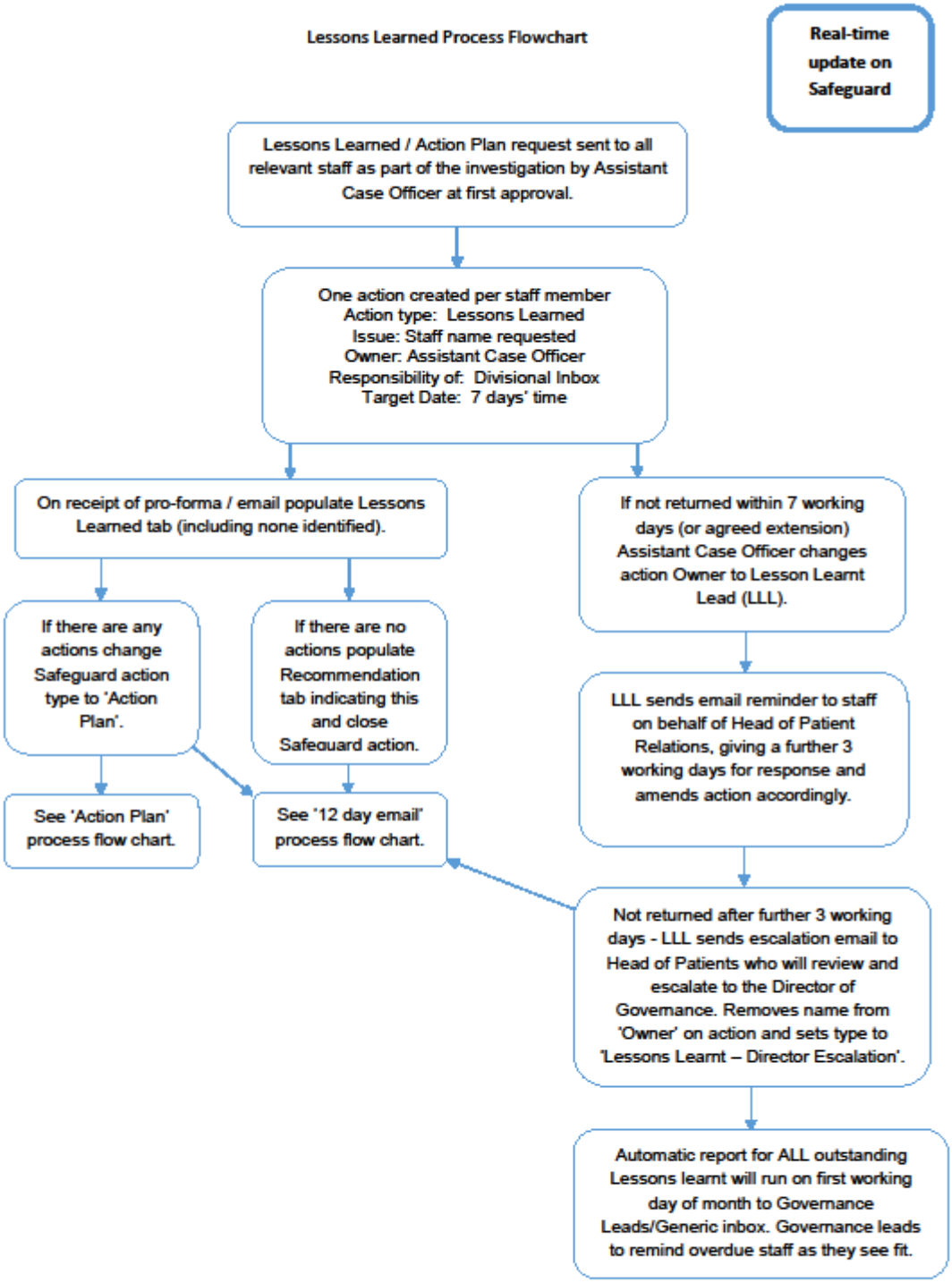
This involves an estimate of the likelihood of the risk associated with the complaint occurring and the impact or severity if it does.

An assessment of the risks attached to a particular complaint or concern will be undertaken using the Trust's Risk Matrix by mapping the likelihood of occurrence against the severity/impact to determine the risk grading/score. The Risk Matrix is contained within the Trust Risk Management Strategy. This can be used as the basis of identifying acceptable and unacceptable risk, in line with 'Listening, Acting, Improving', the guidance supporting the 2009 Regulations and NPSA advice.

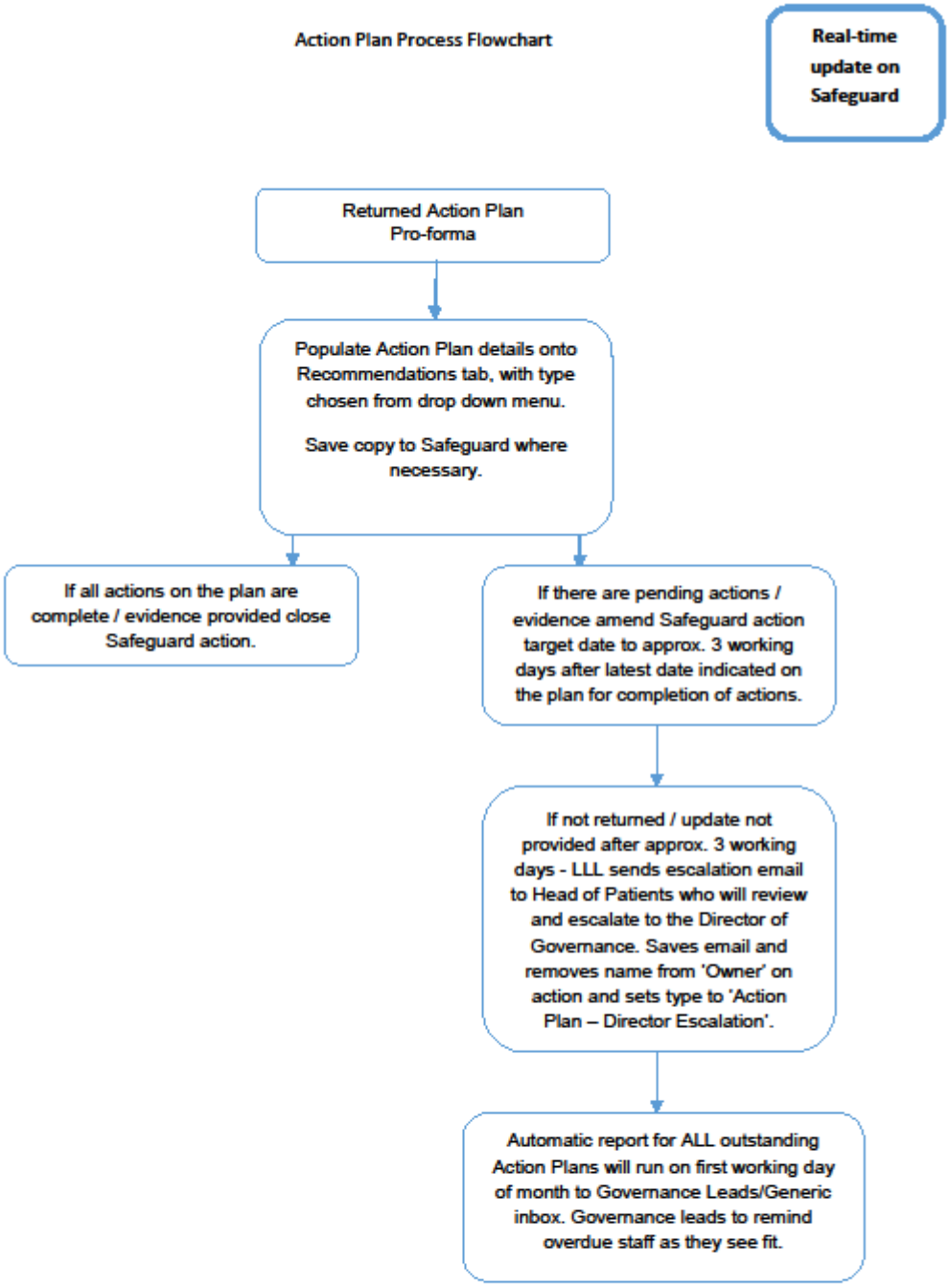
Appendix 4: Complaints Cases Re-Visit Process Flowchart



Appendix 5: Lessons Learned Process Flowchart



Appendix 6: Action Plan Process Flowchart



Appendix 7: Lessons Learnt / Action Plan Pro Forma

University Hospitals of Morecambe Bay NHS Foundation Trust

Lessons Learnt / Action Plan Pro-Forma

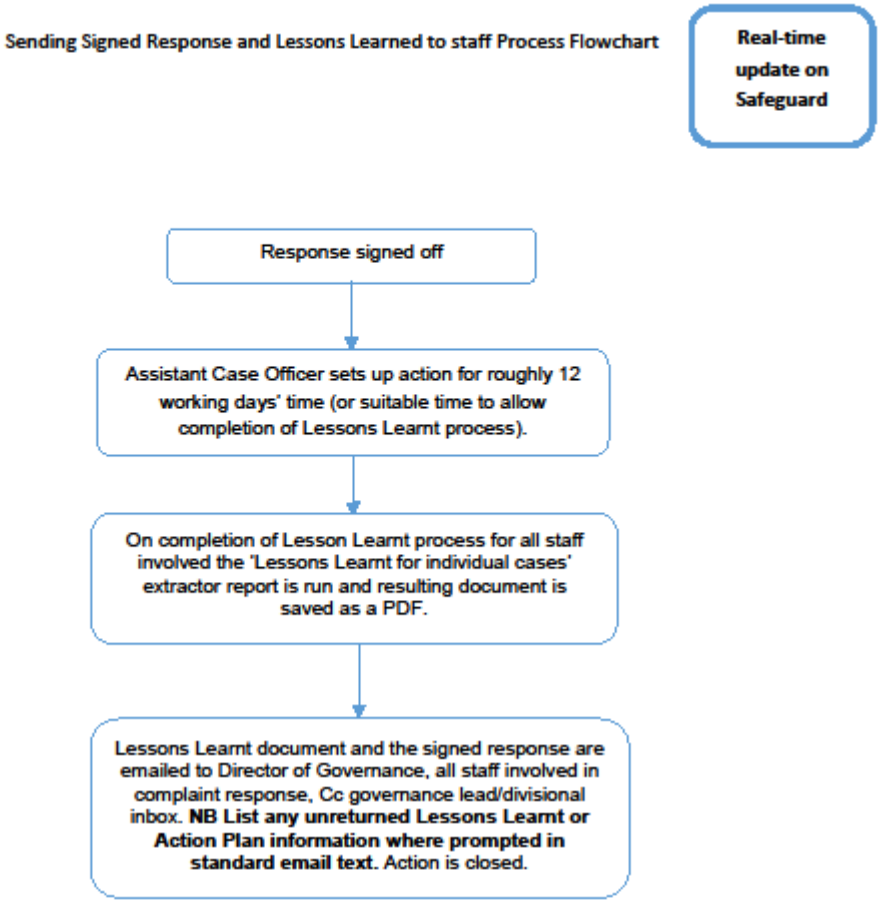
Complaint Reference:		**Staff Name:**	
Date			

Key Lessons/Issues	Action Required/ Recommendation	Action Date	Evidence	Completion Date	Future Action Plans
	(e.g. to be shared at team meeting)	(e.g. date of team meeting)	(e.g. Minutes from meeting. To be sent at a later date if action will be completed future)	(e.g. date minutes completed and shared with Patient Relations)	(e.g. any further action stemming from discussion)

If there were no Lessons Learnt or Action Plans please indicate here	
If there are no Actions to implement please indicate here	

Thank you for completing this Pro-Forma, please return it to the Patient Relations Department, WGH.

Appendix 8: Sending Signed Response and Lessons Learned to Staff



Appendix 9: Advice on Handling Unreasonable, Regular or Persistent Complainants

1. Purpose of Document

Complaints about Trust services are processed in accordance with NHS complaints procedures. During this process Trust staff inevitably have contact with a small number of complainants who absorb a disproportionate amount of NHS resources in dealing with their complaints. The aim of this document is to identify situations where the complaint might be considered to be vexatious or persistent and to suggest ways of responding to these situations.

It is emphasised that this procedure should only be used as a last resort, and after all reasonable measures have been taken to try to resolve complaints following the NHS complaints procedures, for example through local resolution, conciliation, or involvement of an Independent Complaints Advocacy Service (ICAS), as appropriate.

Judgement and discretion must be used in applying the criteria to identify potential vexatious, unreasonable, or persistent complaints, and in deciding action to be taken in specific cases. The procedure should only be invoked in exceptional circumstances, and implemented following careful consideration by the Patient Relations Manager in conjunction with the Legal Team, the Director of Governance, and with the authorisation of the Chief Executive of the Trust, or in their absence, a nominated Executive Director.

2. Definition Of A Vexatious, Unreasonable Or Persistent Complaint

Complainants (and/or anyone acting on their behalf), may be deemed to be unreasonable or persistent where previous or current contact with them shows that they meet one or more of the following criteria – Where complainants: -

a) Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted, e.g. where investigation has been denied as 'out of time' or where a request for Independent Review has been turned down.

b) Continually change the substance of a complaint; continually raise new issues; seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints).

c) Are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, medical case notes or computer records, nursing records; where they deny receipt of an adequate response in spite of correspondence specifically answering their questions; where they do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

d) Do not clearly identify the precise issues to be investigated, despite reasonable efforts of Trust staff to help specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

e) Focus on a relatively insignificant matter to an extent that is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a 'relatively insignificant' matter can be subjective and careful judgement must be used in applying this criteria).

f) Have threatened or used actual physical violence towards staff, or their families or associates, at any time – this will in itself cause personal contact with the complainant, and/or their representatives, to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented and reported to the Health and

Safety Department.

g) Have harassed, or been personally abusive or verbally aggressive, on more than one occasion, towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress, and should make reasonable allowances for this. They should document all incidents of harassment and report them to the Health and Safety Department).

h) Have in the course of addressing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, e mail or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section, using judgement based on the specific circumstances of each individual case).

i) Are known to have recorded meetings or face-to-face/telephone conversations without the prior knowledge and consent of other parties involved.

j) Display unreasonable demands or patient/complainant expectations, and fail to accept that these may be unreasonable, e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice.

3. Options For Dealing With Unreasonable Or Persistent Complaints

Where complaints have been identified as unreasonable, or persistent in accordance with the above criteria, the Chief Executive (or nominated Executive Director in their absence), will determine what action to take. The Chief Executive (or nominated Executive Director) will implement such action, and will notify complainants, in writing, of the reasons why their complaint has been classified as vexatious or persistent, and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. practitioners, advocacy services, or Member of Parliament. A record must be kept for further reference of the reasons why a complainant has been classified as vexatious or persistent.

The Chief Executive (or nominated Executive Director), may decide to deal with complaints in one or more of the following ways: -

a) Try to resolve matters, before invoking this procedure, by drawing up a signed 'agreement' with the complainant (and if appropriate involving the relevant manager in a two-way agreement), which sets out a code of behaviour for the parties involved, if the Trust is to continue processing the complaint. If these terms are contravened, consideration can then be given to implementing other action as indicated in this section.

b) Once it is clear that a complainant meets any one of the above criteria, it may be appropriate to inform them in writing that their behaviour contravenes Trust approved policy, explaining why, copying this procedure to them, and advising them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest the complainant seeks advice in processing their complaint, e.g. through the relevant Advocacy Service.

c) Decline contact with the complainant either in person, by telephone, fax, e mail, letter or any combination of these, provided that one form of contact is maintained, or alternatively, to restrict contact to liaison through a third party. (If staff withdraw from a telephone conversation with a complainant it is advised that they first inform the caller that they intend to do so, before curtailing the conversation).

d) Notify the complainant in writing, that the Chief Executive has responded fully to the points raised, and has tried to resolve the complaint, but that there is nothing more to add and

continuing contact on the matter will serve no useful purpose. The complainant should also be notified that the correspondence is at an end, and that further letters received will be acknowledged but not answered.

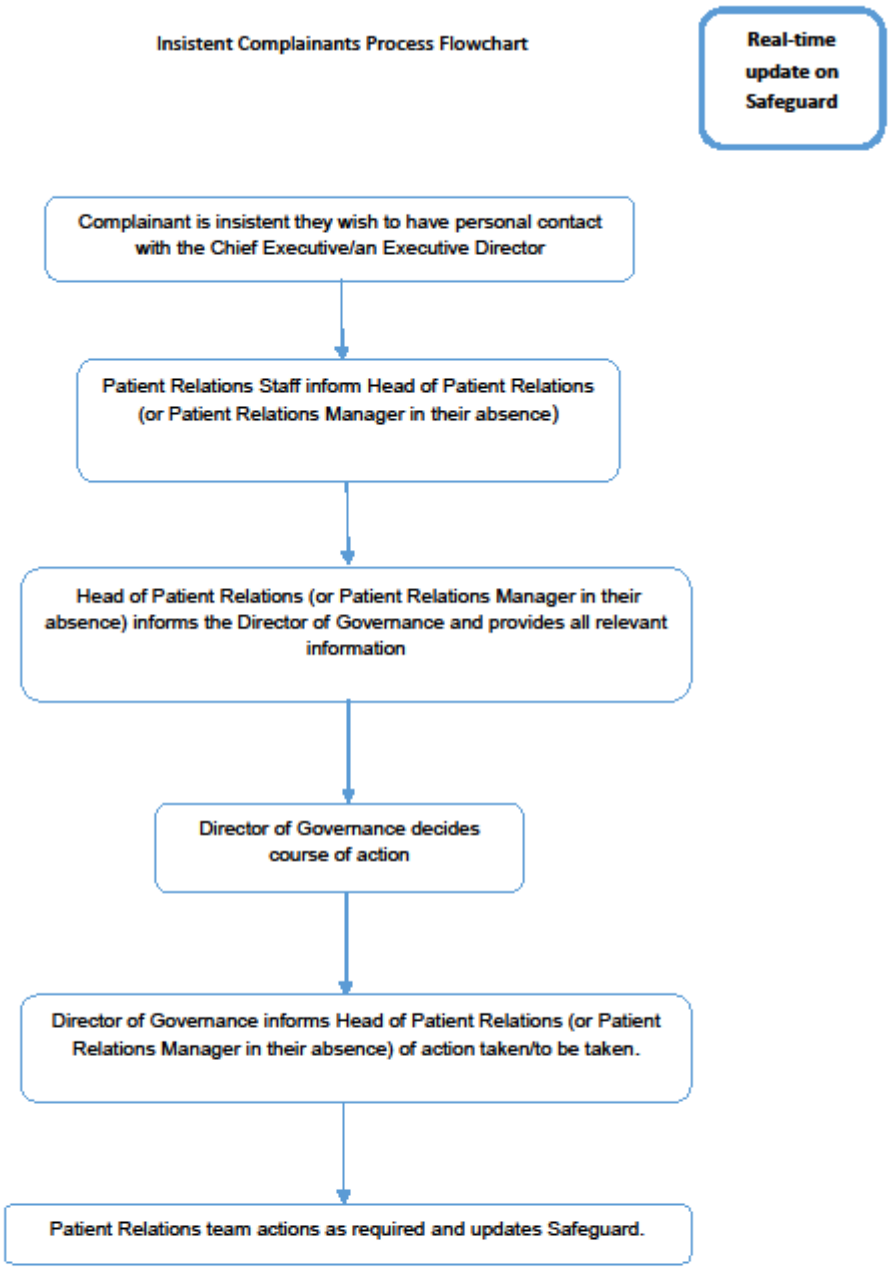
e) Inform the complainant that in extreme circumstances, the Trust reserves the right to notify the Trust's solicitors of unreasonable or vexatious complaints.

f) Temporarily suspend all contact with the complainant or suspend investigation of a complaint, whilst seeking legal advice or guidance from NHS England, NHS Executive, or other relevant agencies.

4. Withdrawing 'Unreasonable Or Persistent' Status

Once a complainant has been designated, as 'unreasonable or persistent', there needs to be a mechanism for withdrawing this status at a later date, if, for example, the complainant subsequently demonstrates a more reasonable approach, or if they submit a further complaint for which normal complaints procedures would appear appropriate. Staff should previously have used discretion in recommending 'vexatious or persistent' status at the outset, and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Chief Executive (or nominated Executive Director). Subject to their approval, normal contact with the complainant and application of NHS complaints procedures will then be resumed.

Appendix 10: Insistent Complainants Process Flowchart



Appendix 11: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Patient Relations Department			
Lead Assessor	Janet Garnett			
What is being assessed?	Management Procedure for the Investigation and Resolution of Complaints			
Date of assessment	April 2018			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?		
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Neutral	
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Neutral	
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.