University Hospitals of Leicester NHS
NHS Trust

POLICY FOR THE MANAGEMENT OF COMPLAINTS

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

June 2015 - Following the publication of the Parliamentary and Health Service Ombudsman's 'My expectations for raising concerns and complaints', this Policy has been again reformatted to incorporate the changes suggested by the revised guidance.

June 2018 – 3-month review date extension agreed by PGC on 15 June 2018.

September 2018 – Complete rewrite of policy

KEY WORDS

Complaints policy, complaints, concerns, PILS, Patient Information Liaison Service, ombudsman, PHSO, verbal, formal

1. INTRODUCTION AND OVERVIEW

1.1 The report into the failings at Mid Staffordshire NHS Foundation Trust was published in February 2013 and placed heavy emphasis on the need, for NHS organisations to recognise the importance of patient complaints. University Hospitals of Leicester NHS Trust is committed to ensuring there are opportunities for everyone who uses our services to raise concerns or make a complaint by providing an effective, timely and open system for dealing with concerns and complaints. Patients or their family and carers need to know how to do this, also feel confident that we will listen to their concerns, they will be taken seriously and any care we provide will not be compromised. The Trust welcomes feedback from patients and this is valued as a source of learning for the Trust.

1.2 The Trust seeks to ensure a satisfactory resolution and increasingly we seek to respond real time to concerns raised to prevent these escalating, ensuring the patient's expectations lie at the heart of complaint handling. As an NHS organisation, the Trust is subject to the NHS Complaints regulations 2009. This policy also reflects the Parliamentary and Health Service Ombudsman 'My expectations for raising concerns and complaints': https://ww.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf

1.3 If we receive a complaint about the services provided by the organisation, we will respond where we can do so. Where the complaint falls outside the scope of this policy, we will assist the complainant to refer the matter to the relevant body, or with agreement we will refer the complaint directly.

1.4 This policy advocates adherence to good complaint handling in line with the universal expectations of good complaints handling have been set out by the Parliamentary Health Service Ombudsman (PHSO), 'Principle of Good Complaint Handling' 2009:

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

1.5 This policy advocates the rights of patients, relatives or carers to feel confident with informing the Trust of their concerns and for them to receive an honest response. The Trust is committed to ensuring they will not be treated differently because they have raised concerns.

The policy aims to encourage and be open to feedback from all service users, investigate concerns fully and respond in a proportionate, appropriate and fair manner.

Complaints, concerns, requests for information and compliments are all managed by the Patient Information Liaison Service (PILS) which is part of the Corporate Patient Safety Team.

1.6 The policy recognises that it is both natural and desirable for UHL to provide an appropriate and meaningful apology, and an explanation of the circumstances relating to any adverse event leading to the complaint or concern raised. This is supported by the Trust Duty of Candour (Being Open) Policy (B42/2010) and the National Health Service Resolution (NHSR) 'Saying Sorry' leaflet, link to leaflet below;

https://resolution.nhs.uk/wp-content/uploads/2017/07/NHS-Resolution-Saying-Sorry-Final.pdf

1.7 The purpose of this policy is to set out what users of Trust services and their family and carers can expect when they raise a concern or make a complaint. The policy is designed to ensure that;

- The patient remains at the centre of the process for dealing with complaints, concerns and comments.
- UHL makes and embeds changes as a result of the lessons learned from any issues raised.

1.8 Exceptions to the NHS Complaints Regulations

Under section 8 a – h of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 the following complaints **ARE NOT** required to be dealt with:-

a. A complaint made by a responsible body.

b. A complaint made by an employee of a local authority or NHS body about any matter relating to that employment.

c. A complaint that 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 (asabove).

e. A complaint, the subject matter of which has previously been investigated under these regulations; the 2004 regulations; the 2006 regulations; or a relevant complaints procedure in relation to a complaint made under such a procedure before 1 April2009.

f. A complaint the subject matter of which is being or has been investigated by the Parliamentary Health Service Ombudsman or Local Government Ombudsman (LGO).

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(b).

h. A complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services etc. of section 24 (compensation for loss of office etc.) of the Superannuation Act 1972 or to the administration of those schemes.

Where the Trust has decided not to investigate a complaint because it falls within one of the categories above, then the Trust will inform the complainant of their decision and give reasons.

If a complaint indicates that there is an obvious need for referral to another process and a decision is made to investigate the issues raised under other procedures, such as serious incidents or safeguarding, the complaints process will stop. However, if there are any other issues in the complaint which are not being investigated under a different process these will continue to be investigated as a complaint. We will agree this with the complainant and if relevant ensure that they are given a new point of contact when the complaint is closed.

2. POLICY SCOPE

2.1 This policy applies to all staff employed by UHL NHS Trust, either directly or indirectly.

2.2 This policy provides staff with clear guidance and expected standards to ensure best practice in investigating and responding to complaints is met and is aligned with the Trusts five key values:

- We focus on what matters most.
- We do what we say we are going to do.
- We are passionate and creative in our work.
- We are one team and we are best when we work together.
- We treat people how we would like to be treated.

The policy also reflects that UHL has a duty to act fairly towards staff involved in any complaint or concerns raised.

3. DEFINITIONS AND ABBREVIATIONS

3.1 Formal Complaint (referred to in this policy ascomplaint)

A complaint is defined as an expression of dissatisfaction about an act, omission or decision by the Trust, either verbal or written and whether justified or not, which requires a formal response within an agreed timeframe.

3.2 Concern

A concern is defined as an expression of dissatisfaction where the individual raising the concern has expressed a wish for their concern not to be subject to a formal investigation these may be responded to informally or formally. Concerns are subject to the same principles as formal complaints.

3.3 Compliments

A compliment is any expression of satisfaction or gratitude for the quality of service provided to patients, relative and/or carers.

3.4 LGO

Local Government Ombudsman

3.5 PHSO

Parliamentary and Health Service Ombudsman

3.6 PILS

Patient Information and Liaison Service

3.7 Re-opened Complaint

A re-opened complaint is a complaint received following closure of a complaint which is about the same issue/s.

3.8 POhWER

POhWER provide NHS complaints advocacy in the East Midlands and are available to assist individuals to raise their concerns with the Trust. PILS can provide you with their leaflet or you can contact them direct at; Telephone 0300 200 0084 (charged at local rate) Website www.pohwer.net

4. ROLES AND RESPONSIBILITIES

4.1 **The Chief Executive** has overall responsibility for the strategic and operational management of the Trust, including ensuring that the complaints policy complies with all legal, statutory and good practice guidance requirements.

4.2 **The Medical Director** has the delegated responsibility for ensuring compliance as stated in point 4.1 above, and for ensuring adequate corporate structures, roles and responsibilities are in place to fulfil said requirements.

4.3 **The Director of Safety and Risk** is responsiblefor:-

- Arbitrating between Clinical Management Groups (CMGs) where there is a dispute in relation to the funding of mediation, conciliation or compensation. (See section15).
- Reviewing those cases where the complaint is felt to meet the criteria for being, unreasonably persistent or unreasonable complainant behaviour making a decision and then writing to the complainant with the Trust's decision. (See section 19).
- Present reports on complaints, data and analysis to the appropriate Trustcommittees.

4.4 **The Trust Board** has a duty to ensure that the requirements of the complaints policyarefulfilled.

4.5 **Executive Quality Board and Quality Outcome Committee** will receive monthly reports on the management of complaints from the Corporate Patient Safety Team and will ensure that relevant comments are communicated to the Trust Board.

4.6 **The Clinical Management Groups** (CMG Clinical Director, Head of Nursing/Midwifery and Head of Operations) are responsible for ensuring effective structures, processes and resources are in place within their areas of responsibility for the management and investigation of complaints, including identifying lessons learnt, actions taken and appropriate sign-off of the final letter/report provided to the Patient Information and Liaison Service within the requirements of the Policy for the Management of Complaints.

They are also responsible for ensuring staff within their areas of responsibility are appropriately trained in order to manage effectively and efficiently complaints, concerns or comments.

They should ensure that all clinical areas have visible Patient Information and Liaison Service (PILS) posters and information leaflets regarding how to make a complaint. These can be ordered via the UHL print rooms.

4.7 **The Senior Patient Safety Manager** (Corporate Patient Safety Team) is responsible for ensuring overall compliance with the policy and its related procedures. This includesensuring:

- The complaints policy and procedures meet legislative requirements.
- Patient Safety Leads are skilled and equipped to provide advice and guidance to the wider organisation on the NHS Complaints Regulations, UHL's Complaints Policy and its associated procedures.
- Patient Safety Co-ordinators are appropriately trained in order to support and advise on investigations, negotiate and otherwise manage individual complaints.
- Adequate processes are in place for organisational learning from complaints.
- Complex and sensitive complaints are identified and personal advice/management provided by the Senior Patient Safety Manager.
- Appropriate and on-going management information regarding complaints is provided to CMGs and corporate committees for information and scrutiny.
- Production of monthly reports for presentation to Executive Quality Board, and other committees as requested.
- Production of UHL's Annual Complaints Report that meets statutory requirements for publication on UHL public website.
- Personal intervention in investigations where appropriate.

4.8 **Patient Safety Leads** (Corporate Patient Safety Team) are responsible for ensuring CMGs investigate appropriately complaints assigned to their CMG. Theywill:-

- Review and agree/challenge, the initial assessment of the complaint and the timescales for investigating and responding to the complainant, and discuss with the Patient Safety Co-ordinator/Patient Safety and Complaints Officer.
- Ensure the appropriate level of investigation has been undertaken, within the agreed timescales, and that the evidence is available to support this.
- Produce a quarterly report identifying numbers, themes and actions following complaints within their CMG.

- Provide advice and support to the Clinical Management Groups (CMGs) and others on all issues relating to complaints.
- Ensure Patient Safety Co-ordinators are skilled and equipped to provide advice and guidance to the wider organisation on the NHS Complaints Regulations, UHL's Complaints Policy and its associated procedures.
- Ensure Patient Safety Co-ordinators are appropriately trained in order to support and advise on investigations, negotiate and otherwise manage individual complaints.
- Chair complaint meetings and advise patients/relatives on the next stage of the process as appropriate.
- Production of monthly reports for presentation to CMG monthly board meetings and other committees as requested.
- To monitor complaint responses to ensure they are fit for purpose, addressing all issues of concern raised and identifies learning and actions for improvement.
- Attend cross-organisational complaint meetings.
- To develop training programmes for the organisation that will provide staff with the techniques, skills and knowledge to competently undertake investigations and identify learning from incidents and complaints.
- Deliver training at all levels across the organisation in relation to complaints.

4.9 **Patient Safety Co-ordinators** (Corporate Patient Safety Team) are responsible for the operational management of the complaints process. In particular:-

- Assessing and triaging the complaint.
- Review Datix reported incidents and Coroners inquest website http://coroners.leicester.gov.uk/coroners-service/current-inquests/ to identify if there are any related incidents, open claims or pending inquests. Inform the Trust Claims and Litigation team if pending inquest or open claim is identified.
- Reviewing and final drafting of the final response, incorporating all information from supplementary specialities and external organisations and forward to the appropriate designated person for review and sign-off.
- Checking the evidence gathered during the course of the investigation.
- As appropriate, leading on multi-organisational complaints.
- Ensuring the CMGs have identified actions that support change andlearning.
- Support the CMGs to complete identified actions to completion.
- Chair complaint meetings and advise patients/relatives on the next stage of theprocess.
- Deliver training at all levels across the organisation in relation to complaints.

4.10 **Patient Safety and Complaints Officer** (Corporate Patient Safety Team) are responsible for the operational delivery of this Policy including:-

- Accurately logging formal and verbal complaints and concerns, requests for information and compliments on the Datix system.
- Acknowledge formal complaints within 3 working days.
- Receiving calls directly from patients, families and carers and facilitating appropriateresolution.

- Ensuring timescales are achieved, and where difficulties are experienced keeping the complainant and Patient Safety Co-ordinator informed.
- Collating the evidence gathered during the course of the investigation.
- Initial drafting of final responses ready for review by Patient Safety Co-ordinator.
- Reviewing responses for accuracy in terms of patient/complainant details/demographics and grammatical accuracy.
- Discussing with the Patient Safety Co-ordinator if they have any concerns about the content of the letter.

4.11 **All Members of Staff,** including temporary, bank and agency staff are required to comply with the requirements of the Policy for the Management of Complaints.

- All staff must send all 'formal written complaints' received, to the Patient Information and Liaison Service on the same day as they are received, via secure e-mail or fax, to facilitate same day receipt.

- All staff are encouraged to deal with any verbal concerns or complaints they receive locally, where practical, and if skilled to do so. Advice/guidance should be sought from the staff member's line manager. Staff side representatives are also available to support members through the complaints process.

- All verbal concerns or complaints should be documented on the verbal concerns form (See appendix A) and sent to the PILS as per above.

- Every member of staff is expected to cooperate fully as required in the reporting, handling and investigation of complaints. This may include attendance at meetings and provision of statements/responses and not delay the completion of the investigation and response.

- PILS contact details can be found in Section 5.6.5.

4.12 **The Independent Complaints Review Panel** is established to provide independent oversight of randomly selected closed complaint files considering their management from beginning to end, including timelines, plain English, communication and complainant satisfaction.

This panel will report to the Director of Safety and Risk, who will provide updates in the Complaints report to the Executive Quality Board and Quality Outcomes Committee. The duties and responsibilities of the group include:

To meet every three months (four times per year). Each meeting the panel review four to five complaint files. Each review considers the following aspects:-

- Triaging.
- Acknowledgement.
- Allocated timescale.
- Consent.
- Staff management of complaint.
- Quality of response.
- What was done well?
- What could have been done better?
- Are there clear actions described?

Provide an anonymous summary report each quarter identifying common themes and trends to the Senior Patient Safety Manager. For Terms of Reference please refer to **Appendix E**.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 MAKING A COMPLAINT

5.1.1 **What is the Patient Information and Liaison Service (PILS)**

The Patient Information and Liaison Service (PILS) is an integral part of the corporate patient safety team. The PILS service acts as a single point of contact for members of the public who wish to raise complaints, concerns, compliments or have a request for information.

The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

5.2 Who can make a complaint?

5.2.1 A complaint may be made by a service user or any person affected by or likely to be affected by the action, omission or decision of the NHS body, independent provider or local authority that is the subject of the complaint.

5.2.2 Someone acting on behalf of another person may make a complaint where that person is unable to make the complaint themselves, or has asked the person to make the complaint on their behalf for example where that person:

- Has died.
- Is a child (an individual who has not attained the age of 18).
- Has physical or mental incapacity (within the meaning of the Mental Capacity Act 2005).
- Has given consent to a third party acting on their behalf which may include advocacy.
- Has delegated authority to act on their behalf, for example in the form of a registered Power of Attorney which must cover health affairs.
- Is an MP, acting on behalf of and by instruction from a constituent.

5.2.3 Where a complaint is made and there is also a Coroner's Inquest, in almost all cases it is appropriate to investigate the concerns within the complaints process and provide a response. However, it is essential that the Trust's Claims and Litigation Team are informed by the Patient Safety Co-ordinator who will ensure appropriate communication is made with the Coroner's office.

5.2.4 A complaint may be raised by a complainant with the direct assistance of an independent legal advisor (solicitor). However, if the Trust is in receipt of formal legal proceedings relating to the issues raised in the complaint, the complaints procedure may have to stop. Advice should be sought from either the Head of Legal Services, or Senior Patient Safety Manager if in any doubt. (Refer to section 16).

5.2.5 Where complaints involve or may need to be referred to bodies, such as the police or other organisations, advice must be sought from the Senior Patient Safety Manager or Director of Safety and Risk.

5.3 Consent if the complainant is not the patient

5.3.1 It is important to establish that the person raising the complaint has the right to do so and that consent, usually in writing, is requested. The complainant should be provided with a full explanation of why consent is being requested.

5.3.2 There is an expectation that when capturing consent for the use and sharing of information, that the patient has made an informed decision and clearly understands the processing and potential sharing of their information. Staff must also understand the expectations of confidentiality that the information is provided under. Sharing of information will be in line with principles of the General Data Protection Regulation (GDPR), which will be incorporated into the process and in line with the Trust Privacy Notice which can be found at; https://www.leicestershospitals.nhs.uk/aboutus/about-this-website/data-protection/

5.3.3 Information will not be disclosed to third parties unless the complainant or appropriate authorised party who has provided the information has given consent to the disclosure of that information. This will subject to confirmation of identity in accordance with GDPRprinciples.

5.3.4 Consent should be pursued. If by the 25th working day consent has not been received the complaint should be closed.

5.3.5 If consent is not provided, the reasons for it not being given, alongside the issues of concern raised will be considered by the Patient Safety Co-ordinator and an assessment made as to whether a response could or should be provided. At all times, information relating to the patient must be protected in line with the requirements of the Data Protection Act and Caldicott principles. However, it may be appropriate to provide a response that deals with issues in 'general terms', without compromising personal detail, and reassures both the complainant and the Trust that appropriate opportunities have been taken to learn lessons and make changes toimprovequality.

5.3.6 In order to investigate a complaint or a concern written consent should be sought in the first instance. Where this is not practical, verbal consent may be taken and this confirmation must be recorded by a member of the PILS team on the electronic complaintrecord.

5.3.7 Where a complaint is received from a Member of Parliament (M.P.) on behalf of their constituent, consent is assumed to be given for the Trust to respond to them without being explicitly sought, where the concerns relate directly to that constituent. If however the issues are in relation to a third party, then consent must be sought from that person, to investigate and respond totheM.P.

5.4 Time limits on making acomplaint

5.4.1 Complaints should be made as soon as possible after the event has occurred. Usually they can only be investigated if they are:

- Made within 12 months of the event or
- Made within 12 months of the complainant realising that they have an issue about which to complain.

5.4.2 If a complaint is made after the 12 months' timescale the issues will be seriously considered as to the feasibility of conducting an investigation and the complainant fully informed asto:-

- The reasons the issues will not be considered within the complaints processor
- If it is to be investigated, any limitations that there may be in relation to the investigation, response and actions.

5.5 How to raise a complaint or concern

5.5.1 Complaints and concerns can be raised with any employee of the Trust or via the Patient Information and Liaison Service This may be done in a variety of waysincluding:-

- Verbally, either face to face or via thetelephone.
- In writing, either in a letter, e-mail or via the UHL NHS Trust website contactforms.

5.5.2 A judgement needs to be made about the issues being raised and the most appropriate management plan will be initiated. The Patient Information and Liaison Service can be contacted to discuss if support or advice is required.

5.6 Support to raise a complaint or concern

5.6.1 Advocacy agencies and other independent groups are available to assist individuals to raise their concerns with the Trust. POhWER provide NHS complaints advocacy in the East Midlands and PILS can provide you with their leaflet or you can contact them direct at; Telephone 0300 200 0084 (charged at local rate) Website www.pohwer.net

5.6.2 The Trust will work and co-operate with all recognised advocates and their agencies.

5.6.3 The Trust PILS Staff will provide advice and support to complainants to achieve resolution to the issues they raise, either as a formal complaint, concern or request for information. This may include accessing services such as translation or signposting to other advocacy or support agencies.

Wherever possible the Trust will try to communicate with complainants in their preferred medium of communication e.g. telephone, face to face, email or letter.

5.6.4 All CMGs must ensure that there are posters and information leaflets visible and available in the wards, clinics and reception desks to assist patients, relatives, carers and visitors in raising concerns.

5.6.5 Information about how to make a complaint or raise a concern is also available on the Trust website, which details the following:-

- Information about PILS.
- An on-line contact form which is secure and goes directly to PILS.
- Free telephone line: 08081 788337.
- Address to write to the Trust.
- E-mail address:pils@uhl-tr.nhs.uk
- Links to other local NHS Services.

6. MULTI-ORGANISATIONAL COMPLAINTS

6.1 Complaints may be received within the Trust that relate to more than one CMG and/or more than one health or social care organisation.

6.2 Multi-CMG complaints will be assessed by the Corporate Patient Safety Team and the CMG where the majority of issues lie will be designated as the lead and therefore responsible for collating and drafting the final written response. The designated person for this CMG will sign off the final response.

6.3 Multi-organisational complaints will be assessed by the Corporate Patient Safety Team and managed in line with the Protocol for the Handling of Local Inter-Organisational Complaints, ensuring that a single response is provided to the complainant. If this is not possible the complainant will be informed and agreement sought to provide individual responses.

7. PRINCIPLES FOR RESPONDING TO COMPLAINTS AND CONCERNS

7.1 The National Complaints Legislation requires that concerns raised are responded to personally and positively, and that lessons are learnt by the organisation/s.

7.2 The national process involves two stages:-

- **Local Resolution** – working with the complainant to understand and resolve their concerns in a timely and proportionate fashion.

- **Referral to the Parliamentary and Health Service Ombudsman (PHSO)** – if local resolution is not successful, the complainant can take their case to the PHSO for review.

7.3 Local Resolution

This involves two stages:-

- Immediate, front-line response. (verbal)
- Formal response

8. PROCESS FOR COMPLAINTS ANDCONCERNS

8.1 The Trust Complaints Management flowchart on the next page defines the complaints management process.

8.2 The full process is defined in section 9.

Trust Complaints Management Process

University Hospitals of Leicester NHS
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Regardless of the point of contact the complaint is reviewed by the Corporate Team, a triage assessment is undertaken and this determines what the response time will be for the complaint based on seriousness, complexity and number of CMG investigation/responses required. The Corporate Team will contact the complainant if this is practicable and required. The Patient Information and Liaison Service are integral to the Corporate Team.	Local resolution
The Corporate Team send a complaint management form to the appropriate service, including the date by which a response must be submitted.	Within 1 working day
The Corporate Team will appoint a case manager (Patient Safety Co-ordinator or Lead) and case handler (Patient Safety and Complaints Officer) for the complaint.	Within 2 working days
The Corporate Team will acknowledge the complaint in writing.	Within 3 working days
Investigation responses will be completed using the Complaints Management form templates. The local investigator can contact the Complaint Team for support / advice during a complaint investigation.	The investigation and response by Team/CMG will be completed within a maximum of 5 working days for 10 day. 10 working days for 25 day and 10 working days for 45 day or a meeting arranged.
If a meeting is requested or agreed, the Corporate Team are responsible for arranging complaint meetings. The case manager will chair the meeting and will ensure that all relevant parties are invited to attend to address the issues raised in the complaint.	
The Corporate Team will review the CMG responses, requesting further information if necessary. The Corporate Team will draft and formulate the final complaint response. This will be forwarded to the respective member of the CMG Senior Management Team for review and sign off at least 3 days prior to deadline (also send a copy of the initial complaint). Once signed off and approved, the final complaint response will be sent to the complainant by the Corporate Team.	At least 2 days working days prior to the deadline

The signed final response letter will be sent to the complainant or meeting held
Within the 10, 25 or 45 working days deadline – unless otherwise agreed
(Following a meeting an audio recording and cover letter will be sent to the complainant within 10 working days)

Any breaches in timescales will be brought to the attention of the appropriate Patient Safety Lead by the case manager.

Extension to Timescales

If the case manager believes that an extension is required, this must be requested as soon as possible.

The agreed extension must be communicated to the complainant by the Corporate Team and documented in the electronic complaints file.

The Corporate Patient Safety Team will be responsible for keeping the complainant informed about how the complaint is being taken forward.

9. VERBAL COMPLAINTS OR CONCERNS

9.1.1 It may be appropriate for the entire process of local resolution to be conducted verbally, without any written communication, leaving the complainant completely satisfied with the outcome. Where an expression of dissatisfaction is resolved to the complaints satisfaction within 2 working days, it does not need to be escalated as a formalcomplaint but is considered to have been dealt with informally.

9.1.2 Front line staff need to be aware of who to call if they are unable, for any reason, to deal personally with a verbal concern within their local area. Each CMG must have clear arrangements for a senior member of staff to be available in the first instance to listen, resolve where possible, or provide advice about the formal complaints process. In addition, the PILS Team can be contacted for advice.

9.1.3 Concerns are most likely to be initiated with front-line staff on the wards, in clinics, at reception desks or with departmental managers. Any member of staff receiving a verbal concern should therefore try to establish the nature of the problem and resolve the matter as quickly as possible by listening carefully and sensitively to concerns, by being helpful and understanding and by taking appropriate action.

9.1.4 If the member of staff is unable to resolve the concerns on the spot or feels unable to give the reassurances that the complainant is looking for, they should refer the matter to their ward sister, matron or designated CMG manager. Staff should record the details on a verbal complaints/concerns form (see **Appendix A**), including whether the concerns have been resolved or if further action is required.

9.1.5 The completed form should be forwarded to the PILS Team who will log the information on to the Datix system and if necessary put in to the formal complaints process.

9.1.6 It is recognised that being subject to a complaint can be difficult and stressful for staff and it is important that line managers take responsibility for ensuring that any staff who are the subject of a complaint arte advised of the content, progress and outcome of the complaint. Staff can also expect to be treated fairly with a focus on learning and seeking improvement rather than individual blame. Staff members can request support from a staff representative or colleague while a complaint is being investigated in line with the Policy for the Support of Staff Involved in Incidents, Inquests, Complaints and Claims (B28/2007).

9.2 Concerns

9.2.1 Concerns may be made verbally or in writing, including via e-mail.

9.2.2 Letters of concern addressed personally to clinicians, other hospital staff, wards or departments should be forwarded immediately to the PILS Team for acknowledgement and investigation.

9.3 Compliments

9.3.1 Compliments should be forwarded to PILS for logging. These will be recorded on the electronic system and sent out to the relevant area/specialty for information.

9.4 Formal Complaints

9.4.1 Formal complaints may be made verbally or in writing, including via e-mail.

9.4.2 Letters of complaint addressed personally to clinicians, other hospital staff, wards or departments should be forwarded immediately to the PILS Team for acknowledgement and investigation.

9.5 Assessment/Triage of a Complaint

9.5.1 All complaints will be assessed/triaged by the Patient Safety Co-ordinators in order to determine the following:-

- Seriousness.
- Complexity.
- CMG, Speciality, external organisation involvement
- Consent issues
- Potential serious incident
- Other interested parties

9.5.2 Following assessment the complaint/concern will be graded for management within one of the following timescales:-

- 2 working days (verbal concern)
- 10 working days
- 25 working days
- 45 working days

9.5.3 Every complaint/concern is allocated a dedicated case handler and case manager. The case handler will be the point of contact for the complainant during the period their complaint/concern is open.

9.5.4 Where possible, and within one working day, personal contact by telephone will be made with the complainant by the Patient Safety Co-ordinator triaging the complaint/concern. This is particularly important if the complaint is complex to;

- Facilitate a conciliatory approach
- Enable the complaint and desired outcomes to be more fully understood
- Identify the key issues which need to be investigated
- Agree how the complainant would like to be kept informed
- If contact cannot be made this will be recorded.

9.6. Acknowledgement of a complaint/concern

9.6.1 A written acknowledgement to the complainant will be made by the Patient Safety and Complaints officer within three working days of receipt of the complaint. Included with the acknowledgement will be information about the complaints process and details of POhWER advocacy Services.

9.6.2 It may also be appropriate on occasions for the Patient Safety Co-ordinator or a Senior Manager from the CMG, to telephone the complainant and offer an immediate apology and explain the complaints process.

9.6.3 If the complaint has been made verbally, this will be logged in the complaints system and closed if locally resolved or progressed into formal complaint if required.

9.6.4 Complaints received directly into the Chief Executive and Chairman's Office will be acknowledged by that office and forwarded onto PILS for initiation of the complaints process.

9.7 Investigation of a Complaint/concern

9.7.1 The Patient Safety Co-ordinator will commence the appropriate level of investigation required according to the assessment grading of the complaint.

9.7.2 Supplementary CMGs in multi-directorate complaints will investigate the issues pertaining to their area and forward the appropriate response and all supporting evidence to the designated lead for collation in their file.

9.7.3 For all 25 and 45 working days complaints statements will be obtained or interviews will be held, documented and signed. Documentation will be held in the complaint files in order that the appropriate designated signatory can confidently assess that an appropriate level of investigation has been undertaken before sign off.

9.7.4 Evidence to support the investigation of complaints will be saved electronically on the Datix system by the Patient Safety and Complaints Officer.

9.7.5 The investigation of a complaint is a fact-finding exercise, which must be conducted in a timely, impartial and sensitive manner.

9.7.6 Statements should be made using the Trust's Statement template (see **Appendix B**) where ever possible, but if not, the guidance within "Stating the Facts" must be followed. (See **Appendix C**)

9.8 Responding to a Complaint/concern

9.8.1 The lead CMG will review all information received from the investigation and collate a response that is open, honest, provides the appropriate apology and describes the actions taken to improve services provided by UHL.

9.8.2 For all complaints, but especially those that are assessed with the 25 or 45 working day timescales, early consideration should be given to offering a face to face meeting, at the earliest opportunity.

9.8.3 How a response is provided is ultimately the choice of the complainant however and therefore, should a meeting be declined a written response must be provided.

9.8.4 If a meeting is agreed the lead CMG will identify possible dates to offer the complainant and a suitable venue.

9.8.5 The Senior Patient Safety Manager, Patient Safety Lead, or Patient Safety Co-ordinator will, if requested, chair a meeting. An audio recording must be taken and forwarded along with a cover letter identifying a summary of the issues discussed and any agreed actions to the complainant within 10 working days.

9.8.6 The final response letter must include information to allow the complainant to either:

a. Request a re-investigation of their concerns (re-open) if they are dissatisfied with our response and/or

b. Approach the Parliamentary Health Service Ombudsman (PHSO) for their consideration of the complaint.

9.8.7 Once the response has been sent, the complaint is closed.

9.9 Anonymous Complaints

9.9.1 Occasionally anonymous complaints are received and where there is sufficient detail, the complaint, Should be investigated in accordance with this procedure. The Issues will be brought to the attention of the senior team in the CMG and report of findings and action taken will be retained on the electronic complaint system.

9.10 Withdrawn Complaints

9.10.1 If a complainant wishes to withdraw a complaint, it is important to know why. Discreet efforts should be made to find out the reasons for withdrawal of a complaint. However, significant complaints will continue to be investigated even though withdrawn, as a matter of good practice. In all cases, the case manager will decide whether to proceed with an investigation of a complaint that has been withdrawn dependent on the issues involved.

10. CONCERNS RAISED ABOUT SAFEGUARDING

10.1 On occasions, members of the public may use the complaints process to raise concerns about procedures followed to safeguard children or adults. These could include concerns about the investigations undertaken to rule out child abuse, circumstances relating to the death of or serious injury to a child and the approach by staff involved in the investigation of suspected abuse cases. In these circumstances the Head of Safeguarding for UHL must be contacted and involved in any decision making regarding how a response will be made and the formation of the response.

11. MEETING WITH COMPLAINANTS

11.1 Listening to complainants concerns and expectations is fundamental to good complaints handling. A face to face meeting will enable the clarification of all issues from the complainant's point of view and identify what outcome they are wanting.

11.2 In order to reach a satisfactory resolution there may need to be an offer of a face to face meeting as appropriate. All staff employed by UHL must attend meetings with complainants if requested to do so and will be fully supported by their line manager within this process, including joint attendance at the meeting as appropriate. Few people find these meetings easy but they are usually a positive experience that helps to achieve resolution. Whilst attendance at a complaints meeting is part of any UHL staff members job, it is recognised that this can cause some anxieties on occasions. If this is the case, staff should seek the support and advice of the CMG or Corporate Patient Safety Team with responsibility for complaints handling.

11.3 Attendance at meetings by complainants is entirely voluntary and it is their right to decline an invitation. However, UHL must clearly identify to the complainant that, should a meeting be absolutely declined, that written responses cannot be provided indefinitely and that local resolution will have to be drawn to a close.

11.4 UHL will ensure that complainant meetings are conducted in a supportive and open manner for both complainants and staff.

11.5 See Good practice for Complaints Meetings guidance – **Appendix D**

12. REOPENED COMPLAINTS

12.1 Initial responses to complaints do not always achieve resolution for complainants, despite all best efforts.

12.2 On-going concerns will be received, logged and acknowledged by the PILS and forwarded to the appropriate CMG/s for further review, investigation and response.

12.3 Every endeavour will be made to respond within 25 working days.

12.4 If a meeting has not previously been held this must be considered and encouraged. Even if a meeting has been held this should be considered again with the most appropriate staff in attendance.

12.5 The Trust must document clearly to the complainant once they feel all opportunities to resolve complaints locally are exhausted and give information to enable them to appeal to the Parliamentary Health Service Ombudsman (PHSO).

13. COMPENSATION

13.1 Complainants sometimes request via their complaint letter financial compensation/recompense.

13.2 It is not possible to obtain financial compensation through the NHS Complaints Procedure for the following:

- Personal Property Losses (teeth, clothing, jewellery etc.).
- Clinical Negligence.

  These must be forwarded to the Head of Legal Services, Corporate and Legal Affairs Department at UHL for on-going management as per Clinical Negligence Reporting Guidelines.

13.3 However, remedying injustice and hardship is a key aspect of the Ombudsman Principles. Following thorough investigation within the complaints process, should it be proven that maladministration or poor service has resulted in injustice or hardship the CMG may consider whether financial compensation is appropriate to achieve satisfactory resolution for the complainant or refer the complainant onto the Ombudsman for independent review.

14. CASES SUBJECT TO LITIGATION

14.1 The Department of Health's position in relation to complaints that are also the subject of litigation is laid out in its consultation document "Reform of Health & Social Care Complaints: Proposed changes to the Legislative Framework" (December 2008).

14.2 In such cases where legal action is being taken or the police are involved, if a complaint is also received it is expected that discussions will take place with the relevant authority (e.g. Trust legal advisors, NHS Resolution, the police, Crown Prosecution Service, Safeguarding Team, H.M. Coroner) to determine whether progressing the complaint might prejudice subsequent legal or judicial action. If so, the complaint will be put on hold, and the complainant must be informed of this fact.

14.3 All cases must be considered and discussed, and decisions made on an individual case basis. Wherever possible the Trust will seek to continue to resolve the complaint unless there are clear legal reasons not to do so.

15. MEDIATION ANDCONCILIATION

15.1 Independent mediation and conciliation arrangements can be made available on a case by case basis.

15.2 Independent clinical review may be considered appropriate as part of any investigation or to support resolution.

15.3 Funding for any of the above would need to be met by the appropriate CMG, usually the lead investigating CMG. Each case would need to be considered individually. In cases of dispute, the Director of Safety and Risk would consider the issues and make a final decision regardingfunding.

16. UNREASONABLE PERSISTENT COMPLAINANTS AND UNREASONABLE COMPLAINANT BEHAVIOUR

16.1 The Trust is committed to treating all complaints equitably and recognises that it is the right of every individual to pursue a complaint. However, in a minority of cases, individuals pursue their complaints in a way which can either impede the investigation of their complaint or can have significant resource issues for the Trust.

16.2 It is acknowledged by the Trust that certain complaints can be difficult to resolve and can cause anxiety and distress to both complainants and staff. Staff will do their utmost to respond sympathetically to all complaints and will, whenever possible, try to find a way toresolveissues.

16.3 However, it is accepted that there are a relatively small number of complaints where it is extremely difficult to achieve local resolution. Despite the best efforts of the Trust and having demonstrated/evidenced thorough investigation and holding meetings, that all efforts have been made.

16.4 Many complaints but not all, falling in to this category arise directly as a consequence of a patient's medical condition, or may be driven by bereavement. It is also important that consideration be given to complainants suffering mental health illness or learning difficulties.

16.5 The full procedure for unreasonably persistent complaints or unreasonable complainant behaviour can be found at **Appendix F.**

16.6 Should any member of staff believe that the complainant can be defined/classified (in line with criteria included in Appendix F) as unreasonably persistent or using unreasonable complainant behaviour, they must inform the relevant Patient Safety Lead and contact the Local Security Management Specialist for advice.

16.7 A case review will be arranged including the CMG Patient Safety Lead for the complaint, the Patient Safety Co-ordinator and the Senior Patient Safety Manager.

16.8 The outcome of the above review must be documented. Should it be considered that the complainant is unreasonably persistent or using unreasonable complainant behaviour, a letter will be sent by the Director of Safety and Risk informing the complainant of the decision and why all attempts at local resolution are now exhausted. It will also inform them of their right to take their concerns to the Parliamentary and Health ServiceOmbudsman.

17. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

17.1 If a complainant is dissatisfied with the handling of their complaint by the Trust they can ask the Ombudsman to undertake a review of their case. Information on how to do this is included in the complaint response. This should occur within 12 months of receiving the Trust's finalresponse.

17.2 The Ombudsman investigates complaints about the National Health Service and is completely independent of the NHS and the Government. The Ombudsman will consider cases where the complainant is not satisfied with the trust's efforts to resolve their concerns at a local level. The Complainant has to send their complaint to the Ombudsman no later than a year from the date of when they became aware of the events, which are the subject of complaint. The Ombudsman can sometimes extend the time limit but only if there are specialreasons.

17.3 The Ombudsman **can** investigate complaints about hospitals or community health services which are about:-

- A poor service.
- Failure to purchase or provide a service a complainant is entitled to receive.
- Mal-administration – that is administrative failures such as unavoidable delay, not following proper procedures, rudeness or discourtesy, not explaining decisions or not answering the complaint fully and promptly.
- Complaints about the care and treatment provided by a doctor, nurse or other health care professional.
- Other complaints about family doctors (GPs) or about dentists, pharmacists or opticians providing an NHS service locally.

17.4 The Ombudsman **cannot** look into:-

- Complaints which one could take to court or an independent tribunal – unless the Ombudsman does not think it reasonable for the Complainant to do so.
- Personnel issues such as appointments of staff pay or discipline.
- Commercial or contractual matters, unless they relate to services for patients provided under an NHS Contract.
- Properly made decisions an NHS authority or other body or individual providing NHS services has a right to make, even if the Complainant does not agree with thedecision.
- Services in a non-NHS hospital or nursing home, unless they are paid for by the NHS.
- Complaints about government departments, such as the Department of Health.

17.5 The Ombudsman will decide whether or not an investigation will be carried out. If the Ombudsman cannot look into a complaint or decides not to, the complainant will be told why. If the Ombudsman decides to investigate, the complainant and the Trust will be sent a statement of complaint, which sets out what matters the Ombudsman, will look into. The Corporate Patient Safety Team will provide the Ombudsman with the complaint file and arrange medical records to be shared if required. At the end of the Investigation, a draft report will be sent to the complainant and the Trust for comments prior to the final report being published. If the complaint is found to be justified, the Ombudsman will seek for the complainant an apology or other remedy. Sometimes that may include getting a decision changed, or a repayment of unnecessary costs to patients or their families. The Ombudsman does not recommend damages. The Ombudsman may also call for changes to be made so that what has gone wrong does not happen again. Where the Trust tells the Ombudsman that it needs to make such changes, the Ombudsman checks that it has done so.

17.6 Following receipt of the Ombudsman's draft report, this will be circulated to the relevant staff involved in the case for their comments. The Trust must confirm to the Ombudsman that the content is accurate and state whether it accepts the Ombudsman'sdecision.

Further to receipt of the final report, if recommendations are made the CMG must convene a meeting of the relevant senior staff to review the recommendations and carry out the necessary actions. Clear action planning must be carried out. It is likely that the Ombudsman will wish to review actions taken as a result of their recommendations three months later. The Senior Patient Safety Manager will oversee this process but this will be led by the relevant Patient SafetyLead.

A summary of the Ombudsman's report will be included in the next monthly Complaint report by the Senior Patient Safety Manager for consideration at Executive Quality Board and Quality Outcomes Committee. The full report, finding and recommendations will be discussed at the Adverse Events Committee, where themes from these are triangulated with other patient safety data.

A complaint to the Ombudsman represents the final stage in the procedure for pursuing a complaint. The Ombudsman's decision on a complaint is final.

18. LEARNING FROM COMPLAINTS

18.1 A key objective of the Trust is the willingness to listen and to change and improve services in response to complaints and concerns, along with other forms of feedback and outcomes from incident investigations.

18.2 Triangulation of data from various forms of feedback including complaints, concerns, Friends and Family Test, NHS Choices is undertaken quarterly

19. RECORDS MANAGEMENT

19.1 Excellent documentation is an essential component of good complaints handling. A complaint file should include all documents relevant to a complaint, including information gathered during the investigation, statements, notes from interviews and telephone conversations, copies of letters, notes of meetings and actions taken. These should be retained in accordance with Retention

Schedules as per NHS Digital Appendix 3 https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016

19.2 All investigation documentation must be securely filed within the Complaint case files. The final response, investigation material and action plan must be forwarded electronically to the Patient Safety and Complaints Officer for filing on the Datix system.

19.3 No documentation in relation to complaints must be filed in the patient's medicalrecords.

19.4 All documentation may be requested for inspection at any time by the Care Quality Commission, Parliamentary and Health Service Ombudsman, Clinical Commissioning Groups (CCGs) and National Health Service Resolution, Her Majesty's Coroner, Nursing and Midwifery Council (NMC) and General Medical Council (GMC).

19.5 All email communication with patients complies with the UHL policy Email and Internet Usage Policy (A9/2003).

20. EDUCATION AND TRAINING REQUIREMENTS

20.1 Training on complaints is provided in the form of an E-learning module within the Trust training system (HELM) and as face to face training as part of the Patient Safety Essentials and Complaints Intermediate training programmes.

20.2 The Corporate Patient Safety Team will, on request, consider providing customised ad-hoc training to meet the particular needs of staff groups.

21. PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Number of complaints reported and reason for complaint – Datix coded categories	Senior Patient Safety Manager (SPSM)	Datix	Monthly	Monthly and annual reports
% Complaints responded to within 10, 25 and 45 working days	Corporate Patient Safety Team	Datix	Monthly	Monthly and annual reports
Number of complaints referred to the PHSO and outcome of complaints referred to PHSO	Corporate Patient Safety Team	Datix	Monthly	Monthly and annual reports

22. EQUALITY IMPACT ASSESSMENT

22.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

22.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

23. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

23.1 The following is a list of associated policies or documents that may be relevant to or helpful in the application of this policy document:

- Duty of Candour (Being Open) Policy (B42/2010)
- Policy for the Management of Patient and Staff Safety (A10/2002)
- Protocol for the Handling of Local Inter-Organisation Complaints
- UHL policy Email and Internet Usage Policy (A9/2003)
- Incident and Accident Reporting Policy (Including the investigation of serious, RIDDOR and security incidents) (A10/2002)
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 http://doh.gov.uk
- The Parliamentary and Health Service Ombudsman (PHSO) Principles at www.ombudsman.org.uk
- The Patients Association ' Good Practice Standards for NHS Complaints Handling' (2013)
- Healthwatch, PHSO LGO 'My Expectations for Raising Concerns and Complaints' (2014)
- 'Saying Sorry' National Health Service Resolution (NHSR) leaflet
- Policy for the Support of Staff Involved in Incidents, Inquests ,Complaints and Claims (B28/2007)
- Management of Violence, Aggression and Disruptive Behaviour Policy (including Restraint Guidance) (B11/2005)
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC 2013
- Parliamentary and Health Service Ombudsman's 'My expectations for raising concerns and complaints' www.ombudsman.org.uk
- Data Protection Act 2018 (DPA18)
- General Data Protection Regulation (GDPR) 2016

24. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

24.1 The availability of an updated policy will be communicated by the Trust's Senior Patient Safety Manager to clinical CMGs and corporate directorates via email to directors and managers.

24.2 An electronic version will be stored on the *'UHL Insite Documents'* to allow ease of access. Wards and departments are encouraged to print out a paper copy for reference in those areas where a PC is not always available.

24.3 The policy will be reviewed every three years unless there is reason for earlier review. Document review will be the responsibility of the document author.

24.4 Previous electronic versions held on the UHL 'InSite Documents' will be archived automatically. Paper copies of previous versions will be destroyed by departments in which they are held.

Appendix A – Verbal Complaints form

VERBAL COMPLAINTS / CONCERNS FORM

THIS FORM MUST BE COMPLETED BY A MEMBER OF STAFF AND FAXED THROUGH TO 8661 IMMEDIATELY AFTER COMPLETION

Date: Time: Telephone: ☐ In Person ☐

COMPLAINANT'S DETAILS (IF NOT PATIENT)

Name: Female ☐ Male ☐

Ethnic Origin:

Address:

Post Code: Telephone Number:

Complainant's relationship to patient:

Is patient aware of complaint? Yes ☐ No ☐ Unsure ☐

Note: Concerns can be taken but the complainant must be informed that consent may be required from the patient to allow a response to be made to them

PATIENT DETAILS

Name: Female ☐ Male ☐

Ethnic Origin:

Hospital Number: D.O.B.:

Address:

Post Code: Telephone Number:

Inpatient ☐ Outpatient ☐

Consultant

Hospital

CMG

Ward/Clinic/Department

BRIEF SUMMARY OF COMPLAINT
SUMMARY OF ACTION TAKEN
Note: Use extra paper and attach if necessary
Completed By: **Signature:**
Date: **Time:**
CONCERNS / COMPLAINT RESOLVED?
Yes ☐ No: ☐
If NO, what further action has been agreed?
Further investigation and response by CMG within 72 hours (will be logged as **verbal**) ☐
Further investigation and response by CMG within 10 working days (will be logged as **concern**) ☐
Furhter investigation and written response by CMG within formal process ☐

Appendix B

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
CORPORATE STATEMENT TEMPLATE

STAFF DETAILS

NAME:	
ROLE:	
PROFESSIONAL QUALIFICATIONS:	
PROFESSIONAL REGISTRATION NO. :	
PROFESSIONAL ADDRESS:	
PROFESSIONAL CONTACT NO:	

DETAILS OF PATIENT STATEMENT RELATES TO

NAME:	
DATE OF BIRTH:	
DATE OF DEATH:	
DATE OF INCIDENT:	

INCIDENT ☐ **COMPLAINT** ☐ **INQUEST** ☐

Please provide your response/account of what happened on the back of this form and use additional sheets if required. (Please see appendix G for further information).

The statement should be factual, not opinion. The statement may be shared with other parties e.g. Police, Coroner, Solicitors, patient/family. Please be aware that you may seek advice and support in its completion via your CMG, Corporate Patient Safety team, Corporate Health and Safety Team, Corporate Claims and Litigation Team, Research & Development, or professional body or union.

PLEASE DATE, SIGN AND PRINT YOUR NAME AT THE BOTTOM OF EACH SHEET OF PAPER USED

Appendix B

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
CORPORATE STATEMENT TEMPLATE

DATE: ……

SIGNATURE ……

PRINT YOUR NAME……..

Do Not:-

- Make reference to statements by other witnesses
- Go beyond your recollection of events and never base the statement on hearsay
- Seek to blame others
- Report facts of which you do not have direct knowledge
- Use abbreviations
- Include your home address

Tips

- It is helpful to recall others who were working at the time of the incident/accident/adverse event/near miss
- Try to have your statement typed
- Always keep a copy of the statement for your own records
- Seek advice from a more experienced person if you wish

Advice and Support

- Line Manager
- Corporate Patient Safety Team
- Corporate Health and Safety Team
- Corporate Legal Team
- Trade/Professional Union

And Finally

Your statement may be disclosed to the patient or their next of kin (if the patient is deceased), their legal representative or H.M. Coroner. It is not normally necessary to seek the advice of your professional union before submitting your statement, but if you wish to do so, you must ensure that you comply with the appropriate deadlines. If, however, your statement has been prepared for the Trust's solicitor, in anticipation of legal proceedings against you or the Trust, your statement will be "legally privileged", which means it will be treated as confidential and will not be disclosed to a third party without your prior notification.

University Hospitals of Leicester NHS Trust

Stating the Facts

Your Guide to preparing and writing a witness statement in relation to a Patient Safety Incident (PSI), Staff Accident (SA), Complaint, Claim or Inquest

Writing a Statement

Having an effective incident reporting system/complaints management means that you may be asked to provide a statement. This should be viewed positively as it means that vital information is gathered whilst it is fresh in your mind, and if a complaint or claim arises the evidence is available to inform the investigation process.

It is important to write a statement as near as possible to the event as memories will fade.

There is a UHL NHS Trust Corporate Template available on the Document Management System (DMS) for the writing of a statement which should be used. However, if this is difficult to access for any reason, the following information should be followed:-

Staff Details:-

- Full Name
- Role
- Professional Qualifications
- Professional registration number
- Professional address
- Professional contact number

Details of Patient statement Relates to:-

- Name
- Date of Birth
- Date of Death (if appropriate)
- Date of Incident

The Statement must:-

- Indicate if it is in relation to a Patient Safety Incident, Inquest, Complaint or Claim
- Be a clear, straightforward narrative dealing with events in *chronological order*
- Simply relate to the facts of the event and not state opinions
- Be complete, thorough and honest
- Be as detailed as possible
- Contain only material facts
- For inquests and claims it may be required to document a supportive opinion.
- Should state whether you are writing the statement from memory, from the notes or both, or simply your recollection from your standard practice at that time
- Include the following declaration:- "The contents of this statement are to the best of my knowledge and belief"
- Be signed and dated with name printed on each sheet of paper used.

Appendix D

THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

GOOD PRACTICE GUIDANCE FOR COMPLAINTS MEETINGS

1 Preparation for the Meeting

1.1 Whilst attendance at a complaints meeting is part of any UHL staff members job, it is recognised that this can cause some anxieties on occasions. If this is the case, staff should seek the support and advice of the Corporate Patient Safety Team.

1.2 Attendance at meetings by complainants is entirely voluntary however, and it is their right, to decline the invitation.

1.3 Possible dates for meetings should be secured and held in diaries as soon as possible and offered to complainants.

1.4 A clear agenda will be agreed with the complainant. This will be forwarded to the personnel expected to attend so that everyone is aware of what the meeting will cover during the meeting, along with all correspondence relevant to thecomplainant.

1.5 For all complaint meetings a pre-meeting chaired by a senior member of staff from the Corporate Patient Safety Team will be arranged.

1.6 Staff attending meetings should ensure they are familiar with all the issues they are expected to provide a response to, and have to hand any documentation that they feel might help the complainant for example medical records.

1.7 Any requirement such as language support or access should be agreed prior to the meeting so that suitable arrangements can bemade.

2. Who Should Attend

2.1 The number of staff present at meetings should be kept to a minimum but it is important that those that who do attend, can deal with the issues raised and are appropriately supported.

2.2 Complainants may be supported by an advocate, and this should be encouraged. They provide a vital role in assisting complainants who may feel vulnerable to raise concerns in an appropriate way, and to understand the explanations given.

2.3 There are occasions when a complainant requests the attendance of their solicitor. The following points should be noted:-

- Solicitors may attend, but in the capacity of an advocate, not a legalrepresentative.
- The purpose of the meeting must be clearly described to the complainant and the solicitor before it begins.
- The solicitor's presence is to advocate on behalf of the complainant and should therefore be given every opportunity to speak for and tothecomplainant.
- Solicitors are not there to make legal challenges to clinical decision making and service delivery and this must be made very clear to all attendees before the meeting commences.

- If the solicitor continues to obstruct the true process of the meeting by persisting with such challenges, the chair of the meeting should adjourn for a short time and, outside of the meeting, explain again its purpose and the conductexpected.

- Should the solicitor or complainant not accept this decision, or continue to conduct themselves in a way that obstructs the purpose of the meeting, the chair will bring the meeting to a close, explaining clearly why.

3. Scheduling Meetings

3.1 A letter confirming the date, time, length and venue for the meeting should be sent by the Patient Safety and Complaints Officer to the complainant at the earliestopportunity.

3.2 Letters should also inform the complainant who will be attending the meeting, and asking the complainant to inform the Trust, via the Patient Safety and Complaints Officer, who will be attending with them. The letter should also include the suggested issues for discussion with a request for the complainant to confirm their agreement to this as it will form the meeting agenda and any particular requirements they mayhave.

3.3 The Corporate Patient Safety Team should ensure that all professionals attending the meeting are informed of the arrangements.

4. Venues

4.1 The venue for a complaint meeting will depend on the number of attendees, and often the clinical commitments of the professional staff.

4.2 Consideration should however be given to the physical and psychological needs of the complainant and their advocate/s. For example, they may find it very difficult to attend a venue that is close to an area where a loved one haddied.

4.3 Rooms should be tidy and comfortable. Chairs should be spaced slightly apart and placed in a circle or around a table as this aids communication, inhibits exclusion and engenders a sense of equality.

4.4 Water and tissues should be available for all attendees.

5. Punctuality and Conduct

5.1 Meetings should start on time and all professionals involved should aim to be present from the start. Latecomers should apologise for their lateness and explain the reason for it.

5.2 Meetings will have an identified chairperson from the Corporate Patient Safety Team who welcomes the complainant and others, introduces themselves and asks for all attendees to introduce themselves.

5.3 Professionals should expect to remain at the meeting for its duration. However those who have a limited amount of time available for the meeting should inform the chair of this at the pre meet so that it is clear from the start and this can be explained to the complainant.

5.4 Mobile phones should be switched off except for staff who may be required in an emergency. This should be explained to the complainant.

5.5 Meetings should proceed according to an agreed agenda and complainants should be given the opportunity to ask questions both during the meeting and at theend.

5.6 Meetings should be conducted with openness and honesty and apologies offered without hesitation. The complainant and their advocate/s should feel included in discussions and that their concerns are being treated seriously.

5.7 All attendees should conduct themselves in a calm, respectful, constructive and sensitive manner and this should be outlined at the start by the chair. Any deviations from this by any attendee should not be allowed to continue and must be dealt with by the chair.

5.8 It must be recognised that a complainant may feel vulnerable and experience some distress during a meeting. It may be necessary to adjourn for a short time to allow them to regain composure.

5.9 The chair person will conclude the meeting by thanking all attendees for their contribution and summarising any actions agreed.

5.10 The chair person will inform the complainant of their options should they remain dissatisfied with the outcome of the meeting and actionstaken/proposed.

6. Administration

6.1 The meeting must be audio recorded.

6.2 If any notes are to be taken, the chair person will inform attendees that notes, not minutes, will be taken.

6.3 Any notes will be typed up at the earliest opportunity to ensure accuracy. They should then be circulated to all professionals for their comments/amendments before forwarding to the complainant within ten working days.

6.4 A covering letter thanking the complainant for their engagement, highlighting what issues were discussed, any agreed actions and outlining their options should they remain dissatisfied, should be signed by the CMG and forwarded with the audio recording and any meeting notes. This can be translated if required. Contact the Equality Team on 0116 258 4382 / 0116 258 2959 or via email, equality@uhl-tr.nhs.uk.

7. Individuality, Equality and Diversity

7.1 People's backgrounds, beliefs, and values differ enormously and as professionals we must exercise an understanding and respect of a complainant's views, when if they are different from our own.

7.2 Specific needs of individuals must be acknowledged and discussed so that complainants get the best they can at a meeting. Issues to consider when arranging meetings may include:-

- Language
- Hearing
- Physical disability
- Mental disability

7.3 Support and advice is available from the Equality Team on 0116 258 4382 / 0116 258 2959 or via email, equality@uhl-tr.nhs.uk.

Appendix E

INDEPENDENT COMPLAINTS REVIEW PANEL

TERMS OF REFERENCE

PURPOSE:

1. The Independent Complaints Review Panel is established to provide independent oversight of randomly selected closed complaints and re-opened complaint files considering their management from beginning to end, including timelines, plain English, communication, identified actions and complainant satisfaction.
2. The ICRP is further invited to provide feedback on their observations of the UHL complaint's process and any improvements which should be considered.

AUTHORITY:

This panel will report to the Director of Safety and Risk, who will provide updates in her monthly complaints report to the Executive Quality Board and Quality Outcome Committee.

DUTIES & RESPONSIBILITIES:

i. To meet every three months (four times per year).

ii. The panel (six members) to split in to two groups. Each group to review three to four complaint files.

iii. Each file review to consider to be undertaken against the agreed template considering the following aspects;

- Triaging.
- Acknowledgement.
- Allocated timescale.
- Consent
- Staff management of complaint.
- Quality of response.
- What was done well?
- What could have been done better?
- Are there clear actions described?

iv. Provide an anonymous summary report each quarter identifying common themes and trends of complaints management to the Director of Safety and Risk.

MEMBERSHIP:

1. Membership to the ICRP is as follows:-

   - HealthWatch members x 2
   - POhWER Member x 2
   - UHL Patient Partners x 2

2. Each body will appoint their own representative based on the following criteria:-

   - Must have an objective outlook.
   - Must not have had recent personal experience of the complaints process.
   - Must be able to work constructively within a team.

- Must adhere to the rules of confidentiality in line with the Data ProtectionAct
- 2018 (DPA18) and General Data Protection Regulation (GDPR) 2016.
- Must declare any conflict of interest in any case beingreviewed

3. The initial appointment will be for two years.

4. The Senior Patient Safety Manager and allocated Patient Safety and Complaints Officer will assist the Review Group by retrieving the complaint files and preparing the files forreview.
5. Before each review meeting commences, the Senior Patient Safety Manager or their representative will advise of any updates / changes with the NHS Complaints Regulations. They will then leave the meeting but be available to the Review Panel should any queries or issues arise that may need managing or clarifying.

QUORUM:

The Review Panel will be deemed to be quorate when four members are present. If there are less than six members present, the number of reviews undertaken may have to be adjusted.

ATTENDANCE:

Members are expected to attend 75% of meetings.

FREQUENCY OF MEETINGS:

Meetings will be held quarterly and four times per year.

MINUTES:

No minutes will be taken but a template will be completed for each individual case.

REPORTING ARRANGEMENTS:

A summary of cases will be provided quarterly to the Director of Safety and Risk, who will include the information within the complaints report to Executive Quality Board and Quality Outcomes Committee.

MONITORING COMPLIANCE AND EFFECTIVENESS:

Review of Annual Report though Executive Quality Board and Quality Outcomes Committee.

REVIEW:

The Terms of Reference will be reviewed on an annual basis.

VERSION CONTROL:

VERSION 3	**DATE: SEPTEMBER 2018**

APPENDIX F

PROCEDURE FOR HANDLING UNREASONABLE PERSISTENT COMPLAINANTS AND UNREASONABLE COMPLAINANT BEHAVIOUR

1.0 Introduction

1.1 Generally, dealing with a complaint is a straightforward process, but in a minority of cases people pursue their complaints in a way which can either impede the investigation of their complaint or can have significant resource issues for NHS bodies. These actions can occur either while their complaint is being investigated, or once an authority has concluded the complaint investigation.

1.2 In such cases the following procedure will apply:

2.0 Definition

2.1 Unreasonable and unreasonably persistent complainants are those complainants who, because of the frequency or nature of their contacts with the Trust, hinder the consideration of their or other people's complaints.

3.0 Actions and Behaviours of Unreasonable and Unreasonably Persistent Complainants

3.1 These include:

- Refusing to specify the grounds of a complaint, despite offers of assistance with this from complaints staff.
- Refusing to co-operate with the complaints investigation process while still wishing their complaint to be resolved.
- Refusing to accept that issues are not within the remit of a complaints procedure despite having been provided with information about the procedure'sscope.
- Insisting on the complaint being dealt with in ways which are incompatible with the adopted complaints procedure or with good practice.
- Making what appear to be groundless complaints about the staff dealing with the complaints, and seeking to have them replaced.
- Changing the basis of the complaint as the investigation proceeds and/or denying statements he or she made at an earlier stage.
- Introducing trivial or irrelevant new information which the complainant expects to be taken into account and commented on, or raising large numbers of detailed but unimportant questions and insisting they are all fully answered.
- Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved.
- Adopting a 'scattergun' approach: pursuing a complaint or complaints with the Trust, at the same time, with a Member of Parliament/a councillor/the Care Quality Commission /NHS England/solicitors/Independent Advocacy services, the Ombudsman's office.

- Making unnecessarily excessive demands on the time and resources of staff whilst a complaint is being looked into, by for example excessive telephoning or sending emails to numerous members of staff, writing lengthy complex letters every few days and expecting immediate responses.
- Submitting repeat complaints, after complaints processes have been completed, essentially about the same issues, with additions/variations which the complainant insists make these 'new' complaints which should be put through the full complaints procedure.
- Refusing to accept the decision – repeatedly arguing the point and complaining about the decision.
- Using abusive language, being abusive and/or threatening towards members of staff in respect of their complaint(s) or using any other form of unacceptable behaviour. This may then be managed under the Management of Violence, Aggression and Disruptive Behaviour Policy (including Restraint Guidance) B11/2005).
- Combinations of some or all of these.

4.0 Deciding that someone is an unreasonably persistent complainant

4.1 Before deciding that someone is an unreasonably persistent complainant, the Trust must be satisfied that:

- The complaint is being or has been investigated properly;
- Any decision reached on it is the right one;
- Communications with the complainant have been adequate; and
- The complainant is not now providing any significant new information that might affect the Trust's view on the complaint.

4.2 Where the Trust is satisfied that someone is an unreasonably persistent complainant, the manager of the complaint will notify the complainant, identify the behaviour that is considered to be unreasonable and ask the complainant to behave reasonably in future.

4.3 If the complainant is unable or unwilling to comply with this request then a plan will be developed for all future contacts with the complainant. This may then be managed under the Management of Violence, Aggression and Disruptive Behaviour Policy (including Restraint Guidance) B11/2005).

5.0 Handling Unreasonably Persistent Complainants

5.1 It is essential that any restrictions placed on the complainant should be as a result of fair and consistent policy. Therefore any request to cease or limit contact with a complainant who is considered to be unreasonably persistent needs to be made to the Director of Safety and Risk and can be considered after what is felt to be a reasonable period of time given the unreasonableness and persistency displayed.

5.2 The plan for dealing with unreasonably persistent complainants could include all or some of the following:

- Placing time limits on telephone conversations and personal contacts. Restricting the number of telephone calls that will be taken (for example, one call on one specified morning/afternoon of any week).
- Limiting the complainant to one medium of contact (telephone, letter, email etc.) and/or requiring the complainant to communicate only with one named member of staff.

- Requiring any personal contacts to take place in the presence ofawitness.
- Refusing to register and process further complaints about thesamematter.
- Where a decision on the complaint has been made, providing the complainant with acknowledgements only of letters, faxes, or emails, or ultimately informing the complainant that future correspondence will be read and placed on the file but not acknowledged. A designated officer should be identified who will read future correspondence.

5.3 A copy of the plan and the procedure on unreasonably persistent complainants will be sent to the complainant along with details about how to appeal the decision and/or the details of the plan.

5.4 The plan will specify how long it will apply to the complainant and when it is to be reviewed.

5.5 When unreasonably persistent complainants make complaints about new issues these should be treated on their merits, and decisions will need to be taken on whether any restrictions which have been applied before are still appropriate andnecessary.

5.6 The use of an advocate to assist the complainant should be considered, as well as mediation services.

6.0 Review

6.1 The plan will be reviewed every 12 months or earlier if circumstances change.

6.2 The plan will be reviewed by the Director of Safety and Risk.

6.3 The Director of Safety and Risk will notify the complainant that the plan has been reviewed and the outcome of the review with reasons for the decision and the date of the next review.

7.0 Appeals

7.1 The complainant may appeal either the decision or the details of the plan or the review decision in writing or orally.

7.2 Appeals will be considered by the Director of Safety and Risk and the complainant informed in writing of the decision with reasons.

8.0 Recording

8.1 All contacts with persons considered to be unreasonably persistent will be recorded in progress notes section of the electronic complaints file.