Homerton University Hospital NHS
NHS Foundation Trust

Complaints & Concerns Policy

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Background

1.1. In 2006, the white paper 'Our Health, Our Care, Our Say', made a commitment to implement a single complaints procedure across health and social care. In April 2009 a new two-stage complaints process; 'Listening, Responding, Improving: a guide to better customer care' replaced the existing system[1]. Following the Francis report (2013) the need for openness, transparency and candour throughout the healthcare system was identified. The report highlighted the way complaints from patients and families were responded to as a specific issue and included a number of recommendations (most of which were accepted by the Government) and a further report was commissioned 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' (Clwyd and Hart 2014).

1.2. The Local Authority Social Services & National Health Services Complaints (England) Regulations 2009 places an emphasis on personal contact with complainants so that the complaint can be fully understood and to ensure that the response sought by the complainant can be identified. However, any agreed resolution must be proportionate to the content of the complaint, realistic and achievable.

1.3. This policy supports complaints handling that is comprehensive, accessible and patient-focused, using local resolution to respond flexibly and quickly to individual cases. It will also ensure compliance with the requirements of the Care Quality Commission (CQC) and the Parliamentary and Health Service Ombudsman (PHSO) in proving complaints are investigated in a supportive, timely and accessible way are met.

1.4. The Trust's vision for a successful complaints procedure is that it meets the need of our patients, staff and the organisation and follows the six principles of good complaint handling as set out by the Parliamentary & Health Service Ombudsman:

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

The Trust's main objective is to respond to and remedy complaints as soon as possible ensuring the individual is satisfied with the response and feels that they have been fairly treated. The Parliamentary and Health Service Ombudsman's '*Principle for Remedy'* states that all appropriate remedies should be considered for complaints that have been upheld and this includes financial remedies.

2. Introduction

The Patient Complaints Resolution Team is led by the Head of Patient Response & Resolution. The Chief Nurse & Director of Governance is the Executive Director responsible for complaints. The Patient Advice & Liaison Service (PALS), Complaints Office and Head of Patient Experience are at the forefront of gaining feedback and being a point of contact for our patients and their carers to seek advice and give their views.

Homerton University Hospital NHS Foundation Trust encourages compliments, comments, complaints and suggestions from patients, carers and members of the public. Should patients, carers or the public be dissatisfied with the care they receive, they have a right to be heard and for their concerns to be dealt with promptly, efficiently and courteously The Trust is committed to ensuring that there is a culture where under no circumstances should patients, relatives or carers be treated negatively as a result of making a complaint or raising a concern.

We welcome all forms of feedback and use this to improve the service we provide.

The Complaints Office under the leadership of the Head of Patient Response & Resolution works to identify lessons learned from complaints and disseminate them through the organisation as part of 'shared learning'. All complaints are entered on the Datix system which generates reports that are shared on a weekly and monthly basis through the Complaints, Litigation, Incident and PALS (CLIP) meetings. Recommendations and actions arising from complaints are shared with each Division for discussion and action at Operational Team Meetings and Patient Safety and Quality Meetings to ensure learning from all complaints occurs across the organisation.

2.1. The NHS Constitution on complaint and redress states:

2.1.1. **You have the right** to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

2.1.2. **You have the right** to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

2.1.3. **You have the right** to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

2.1.4. **You have the right** to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

2.1.5. **You have the right** to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

2.1.6. **You have the right** to compensation where you have been harmed by negligent treatment.

2.2. The NHS also commits:

2.2.1. **to ensure** that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);

2.2.2. **to ensure** that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and

2.2.3. **to ensure** that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

2.3. The new two-step (local and national) process applies to:

2.3.1. All NHS bodies, including Clinical Commissioning Groups (CCG's), NHS England, all statutory providers of NHS care, including Foundation Trusts.

2.3.2. Voluntary and Independent sector organizations that provide services under contract to the NHS.

2.3.3. Local authorities that provide adult social services.

2.3.4. All these should work together to ensure coordinated handling and to provide the complainant with a single response that represents each organisations final response.

2.3.5. You should make your complaint as soon as possible. The time limit for a complaint is normally 12 months from the date the event happened, or 12 months from the date you first became aware of it. Previously the time limit was 6 months.

3. The Trust key principles are:

3.1.1. Concerns/Issues and Complaints should be seen as part of the continuum of feedback from patients and should be welcomed as an opportunity to improve.

3.1.2. Openness and Honesty forms part of the Duty of Candour and is a key component of the Trust Values and Behaviour's which staff are required to work according to.

3.1.3. The Complaints process itself will be transparent and open.

3.1.4. A complaint will not be investigated/responded to by any individual involved directly in the complaint. However, individuals involved will be asked to provide statements or be interviewed.

3.1.5. The PALs service will support patients to resolve issues and concerns and to advocate for them if a more formal complaint is required. They will develop a more pro-active approach in identifying and supporting patients/visitors who have concerns or issues in order to achieve early resolution.

3.1.6. Responses to Complaints will be led by the Executive team and all responses to complaints signed off by the Chief Executive, in conjunction with either Medical Director or Chief Nurse if appropriate.

3.1.7. Information on the complaints process will be provided in agreed key languages including details of the Interpretation and Advocacy service.

3.1.8. Lessons learnt from complaints will be shared across professions and divisions

3.1.9. All patients and public will feel 'safe' when making a complaint and can be assured that they will not be penalized in any way as a result of their complaint.

4. Scope

4.1. This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff'.

5. Roles and Responsibilities

5.1. The **Chief Executive** is the 'Responsible Person' (as per the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009) and is accountable for ensuring effective management of complaints across the Trust and is the responsible signatory for written responses to Formal Complaints. This role is designated to a nominated deputy in their absence to ensure that the process continues.

5.2. The **Chief Nurse & Director of Governance** has the delegated responsibility for ensuring the efficient and effective implementation of the Complaints Policy and for monitoring the effectiveness of Patient Experience for Homerton University NHS Foundation Trust. The Head of Patient Response & Resolution is accountable for overseeing the operational management of the Patient Complaints Response Team, responsible for the day to day management of complaints; ensuring principles and policy are achieved.

5.3. The **Medical Director** is the executive lead for clinical and medical concerns raised in complaints.

5.4. The Complaints office consists of two Complaints Officers under the guidance and management of the Head of Patient Response & Resolution. The role of the Complaints office is to act as a point of contact to advise patients and their carers on the complaints process and to facilitate the administrative processes laid in statute within the complaint regulations. The Head of Patient Response & Resolution has been given delegated authority by the Chief Executive (as the responsible Officer) to oversee the complaints process on a day to day basis. The Complaints office will liaise with the complainant and Trust staff in regards to complaints received by telephone and email to ascertain if local resolution is attainable or agreed.

5.5. **Response Leads: Divisional Heads of Nursing / Midwifery, General Managers and Associate Medical Directors** across the divisions are the response leads for complaints. This involves coordinating investigations and responses and cascading and implementing improvement plans. A summary of complaints/concerns are collated and shared to the relevant committee at divisional and specialty level.

5.6. The Investigating Officer is identified by the response leads to undertake an investigation into the issues raised by the complainant. They will speak with the complainant where appropriate and relevant staff, obtain information from clinical records and document their findings in the Investigating Officer's report and on Datix. The Investigating Officer will compose a draft letter of response which is to be provided to the Complaints Office within 15 working days. Unless the complaint is complex (eg. crosses several departments or is lengthy and detailed) or a

meeting has been agreed with the complainant when a clock stop will be placed on the response and an appropriate response time is agreed.

5.7. All staff hold the responsibility to be caring and understanding; to respond appropriately, listen and assist and to apologise for complainants' situations, to see what can be done to resolve the complaint immediately or escalate to a senior manager as required.

5.8. Where it has been identified that the complainant or patient is a vulnerable adult or there are concerns around mental capacity, advice should be sought from the Trust Safeguarding Lead.

5.9. PALS officers are responsible for facilitating responses to enquiries and supporting patients and public in resolving their concerns. In the event that a resolution cannot be found the PALS officer will escalate to the complaints department.

5.10. The Complaints, Litigation, Incidents and PALS (CLIP) group in each division is responsible for reviewing all complaints, litigation, incidents and PALS queries. Each divisional group is chaired by either the Head of Nursing or Associate Medical Director (or Deputy) and has representation from the relevant specialty areas in the Divisions. Each divisional group will be responsible for holding a weekly CLIP meeting attending by a member of the Complaints team.

5.11. The Risk Committee is responsible for reviewing Trust wide complaints handling and responses for themes and to ensure lessons are learnt and disseminated across the Trust.

5.12. The Chairman, Non-Executive Directors, Governors and the Trust Board will receive the quarterly complaint report, including complaints which will monitor the effectiveness of the Complaints process.

5.13. Governors provide an important link between the Trust and localities they represent, enabling the Trust to reflect the interest of current and prospective service users. While welcoming ideas, suggestions and general comments, it is not the responsibility of Governors to deal with individual complaints about the Trust, or the care and treatment received. Governors have a duty to inform the Patient Resolution Team of any patient concerns as swiftly as possible.

6. Advocacy Support

The Trust works closely with the providers of the NHS Complaints Service across Homerton. The NHS Complaints Advocacy Service is a free and independent service that complainant's can use to help make a complaint about the NHS. Information on advocacy is provided within the Complaints section of the Trust website, and within the acknowledgement letters to formal complaints.

7. Definition of a complaint and aim of this policy

A complaint is 'an expression of dissatisfaction requiring a response'.

The aims of this policy are to:

- Ensure that our complaints procedure is easy to understand and simple to use.
- Make sure that investigations are thorough, fair, responsive, open and honest.
- Demonstrate that we will learn from complaints and use them to improve the services to patients.

- Ensure that our service is accessible to everyone.
- Enable our staff to answer complaints in a timely manner.
- Demonstrate how we will respect individual's right to confidentiality.
- Ensure that complaint information is shared transparently with the Trust Board who are accountable for improving the quality of services.
- Enable staff to respond positively to complaints and endeavor to resolve issues locally as soon as possible.
- Satisfy complainants by giving our staff the tools to conduct a thorough investigation and provide a full explanation to concerns and complaints in a way agreed with the complainant.
- Ensure that patient's relatives and their carers are not treated differently as a result of making a complaint.

8. Who can complain?

- A person who receives or has received a service from the Trust.
- A person who is affected, or likely to be affected by the action, omission or decision of the Trust.

  A complaint may be made by a representative acting on behalf of a patient or any person who is affected by or likely to be affected, by the action, omission or decision of the Trust, where that person:

- Has died.
- Is a child (refer to consent section re Fraser competencies).
- Is unable by reason of physical or mental incapacity to make the complaint themselves.
- Who has requested the representative to act on their behalf and has given consent for this.
- Is a Member of Parliament acting at the request and on behalf of their constituents.

  Where a patient or person has died or who is unable to raise concerns themselves, the representative must be a relative or other person, who is in the opinion of the Complaints Office, has a sufficient interest in their welfare and is a suitable person to act as a representative.

  If in any case the Head of Patient Response and Resolution is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, that person is to be notified of this in writing and the reasons for decision are to be provided.

  In the case of a child, the representative must be a parent, guardian or other local person who has care of the child and where the child is in the care of a local authority or a voluntary organization, the representative must be a person authorized by the local authority or the voluntary organization.

9. Process for managing complaints

9.1. Timescales

9.1.1. The key national timescales are:

- Quick resolution – 1 working day
- Resolve or confirm complaint – 3 working days
- Resolution or investigation – within 6 months

9.1.2 To ensure complaints are resolved swiftly the following local timescales will apply:

Statutory timescales	Actions	Local timescales
1 day	Resolve immediately if possible.	1 working day
3 days	▪ Acknowledge receipt. ▪ Undertake risk assessment	3 working days
6 months	▪ Agree complaints timescale and plan ▪ Resolve using conciliation, mediation, investigation, review panel or other methods.	3 – 10 working days 30 working days or subject to agreement of complainant, a longer period. (With effect from 1st January 2017).

9.2. Complaints received in writing (including by e-mail):

9.2.1. If the complainant is acting on behalf of someone else then consent must be obtained from the patient themselves. A letter will be sent the next working day explaining the situation and asking for consent to respond to the complainant. A consent form (**Appendix 3**) will be enclosed. Where consent is required the target dates will not start to be measured until this has been received.

9.2.2. Where a patient is unable to give consent the next of kin will be consulted if required.

9.2.3. A ‘complaint plan’ is to be agreed with the complainant once the complaint is received; either an internal investigation and written response or invitation to meet to discuss and resolve.

9.2.4. Depending on the nature of the complaint a meeting will be offered with a Consultant, Senior Nurse or Manager (or combinations thereof).

9.2.5. A letter of acknowledgement will be sent to the complainant within 2 working days of receipt of their complaint (or receipt of consent from person involved). This will outline the next steps to be taken and discuss their complaint plan. The letter (**Appendix 4**) advises the complainant that the complaints officer will call and discuss the preferred option, or alternatively they may call the complaints department themselves.

9.2.6. The complaint will be logged onto the DATIX system and complaints department spreadsheet database and a reference number allocated. This information can be accessed by relevant managers wishing to track action and outcomes against complaints.

9.2.7. A file will be created for the complaint to hold all correspondence and information.

9.3. Investigation & written response:

9.3.1 The following information will be recorded on the front of the complaint file and known as the ‘Complaint Front Sheet’:

- Reference Number.
- Date received.
- Complaint plan agreed (e.g. meeting or written response and target completion date).
- Executive lead for sign off; this will be coordinated by the Head of Patient Response and Resolution in liaison with the Chief Nurse & Director of Governance.
- Response lead (e.g. Head of Nursing / Midwifery or Clinical Director).
- Date draft response due (as per agreed complaint plan or 15 working days)
- Date final response due (as per agreed complaint plan or 25 working days).

9.3.2 The complaint letter and complaint front sheet will then be scanned and e-mailed to the relevant response and executive leads. Where required the patients medical records will be requested and provided by the complaints officer.

9.3.3 The response lead will either take the role of investigative lead for the complaint or delegate to a relevant service manager to undertake the necessary enquiry, collect statements, comments and remedial action.

9.3.4 On receipt of required information the response lead will complete a draft response will be sent to the complaints officer within the target timeframe agreed in the complaint plan or 15 working days.

9.3.5 The draft response will then be forwarded to the relevant executive lead for review and sign off in accordance with the target date or by day 15, as detailed on the Complaints Front Sheet.

9.3.6 Responses must detail lessons learned and actions to be taken as a result of the complainant / patient experience. The complaints officer will upload these actions into DATIX to allow tracking and reporting.

9.3.7 Following their review the executive lead will, (at approximately day 20), forward the final version to the response lead and to key staff involved to allow comment prior to dispatch.

9.3.8 The completed response will be sent to the complainant within 25 working days of receipt or the date agreed in the complaint plan.

9.3.9 Although the regulations state that response and resolution should be within a 'reasonable timescale' there is no formal target set. However the Trust has decided to retain the 25 working days target unless negotiated otherwise with the complainant. The objective is to assist patients to have an efficient and satisfactory outcome to their complaint and not have the situation dragging. Where delays are incurred or anticipated due to the complexity of the investigation or staff being away a holding letter will be sent to the complainant explaining the reason for delay.

9.3.10 Where a delay has been negotiated with the complainant (e.g. to schedule a meeting or because a key member of staff is on leave) the executive lead and Head of Patient Response and Resolution must decide whether to 'stop the clock' on the real time spread sheet. The criteria that must be taken into consideration before we agree to 'stop the clock' on a complaint is as follows:

- The Complainant must be advised by the Trust of the need to extend the time-frame for the purposes of investigating the complaint and the reasons for this. The reasons must be set out at the outset of our investigation by the Lead Investigator appointed by the Divisional Head.

- The Complainant must agree to the time-frame set out by the Trust, and if they are not in agreement with the investigation plan proposed, efforts should be made to find a time-frame that is acceptable to both parties.

- The executive lead or Head of Patient Response and Resolution must give their approval to the extended time-frame once we are in receipt of the divisional response. Such requests may be declined if the rationale provided for the extension is considered inappropriate.

- The Complainant is to be kept updated on a regular basis (at a date and method) agreed between the two parties and reasons given should the Trust anticipate or fail to provide a formal response by the date agreed.

- The following reasons will be deemed acceptable for the approval of granting an extension to a complaint investigation; a local resolution meeting to take place, a key member of staff is on annual leave, a Serious Incident/RCA investigation to be conducted, consent not provided by the Complainant, a 'Complex' investigation to be conducted involving multiple departments/divisions and/or a large cross-section of staff.

- Requests that do not meet the above criteria will be considered on a case by case basis by the executive Lead/ Head of Patient Response & Resolution. (Example includes patient records gone missing or the Executive Lead and Chief Executive are not available to approve the investigation and sign the final response letter.

9.3.11 The final response will be copied to the response lead to use in feedback and improvement processes.

9.3.12 The Complaint officers will compile lists of actions taken and lessons learnt as a result of complaints. These will be disseminated across the Trust to all members of staff and shared with the Improving Patient Experience Forum on a quarterly basis.

9.3.13 Every complaint will be reviewed by the Executive Lead to determine whether an independent investigator from another organisation is required according to the criteria stated in the Clwyd and Hart report.

9.3.14 The Trust Board of Directors will receive themes and lessons learnt from complaints as part of the quality report on a monthly basis.

9.3.15 Themes and lessons learnt will be reported on a monthly basis to CLIP and Divisional Directors.

9.4. Meeting

9.4.1 If the complainant has chosen to have a meeting this will be coordinated by the complaints officer.

9.4.2 A date will be mutually agreed that gives the divisional lead at least 10 days to gather the relevant information to have available at the meeting.

9.4.3 The complaint letter and Complaint Front Sheet will then be scanned and e-mailed to the relevant response and executive leads. Where required the patients medical records will be requested and provided by the complaints officer.

9.4.4 The response lead will either take the role of investigative lead for the complaint or delegate to a relevant service manager to undertake the necessary enquiry, collect statements, comments and remedial action. and to have all relevant information available in time for the meeting.

9.4.5 The meeting will be chaired either by the response lead, Deputy Chief Nurse or Executive Lead and notes will be taken by the complaints officer. Other attendees will be decided by the response lead.

9.4.6 Where necessary assistance will be provided to support the complainant and a friend or relative or independent support they may wish to accompany them, in attending the hospital for the meeting. Meetings will be held in the Education Centre or Trust Offices.

9.4.7 Within 5 working days after the meeting the chair will draft a letter to the complainant outlining the key points discussed in the meeting and actions agreed. This will be sent to the Executive Lead for final sign off.

9.5 Telephone complaints (see 'Getting it right first time').

9.5.1 Telephone calls received to main switchboard will first be directed to the PALS service for initial assessment. The PALS office is open from 09.00 to 17.00 Monday to Friday and if PALS staff are unable to answer the phone immediately will pick up phone messages regularly during the day.

9.5.2 The PALS staff will identify with the caller whether immediate action can be taken to resolve the issue or whether to refer to the complaints department.

9.5.3 Those calls able to be dealt with by the PALS service will follow their normal procedures and also be logged on DATIX. These steps include:

9.5.4 Acting as an intermediary, seeking information, clarification or resolution and calling the complainant back. All staff are expected to respond promptly to such enquiries to assist PALS staff in affecting a swift and satisfactory resolution for the complainant.

9.5.5 Forwarding the call to a relevant member of staff for action or resolution, e.g. matron, senior nurse, doctor.

9.5.6 Call received out of office hours will first be transferred to the Clinical Site Manager on Bleep 117, who will identify with the caller whether immediate action can be taken to resolve the issue or whether to refer to the complaints department. In the case of the latter the Clinical Site Manager will take the complainants details and e-mail the Complaints Officer.

9.5.7 Those calls transferred to the complaints department will be listened to and noted and the next steps explained to the complainant. The Complaints Officer will offer to take the callers number and call them back, or to arrange a face to face or telephone discussion with a relevant manager.

9.5.8 The Complaints Officer will, either by e-mail or letter write to the complainant outlining the key points of the discussion and formally acknowledging the complaint.

9.5.9 In the absence of the Complaints Officer, Trust Offices secretariat are to forward the call or the contact details to either the relevant Divisional Senior Nurse, Clinical Director or the Deputy Chief Nurse.

9.6 Complaints in person.

9.6.1 A patient (or person acting on their behalf) may attend the hospital and state they wish to make a complaint.

9.6.2 If they present to Main Reception they are to be guided to the PALS office, if it is open, where staff will help them. If the PALS office is closed then the Clinical Site Manager will be called who will either attempt to resolve the issue or contact the most suitable person to do so.

9.6.3 If the patient (or person acting on their behalf) present to a ward or department the person in charge will try and resolve immediately.

9.6.4 If local resolution is not possible at either the PALS office or on the ward or department a more senior manager will be called. This could be the Matron, Divisional Senior Nurse, Clinical Director or General Manager. If no-one is available the Complaints

Officer may come to meet with them to take the details of the complaint and ensure follow up as soon as possible.

9.7 Informal complaints via PALS

9.7.1 The PALS service aims to:

- Provide information and support to patients, their families and carers.
- Listen to concerns, queries, suggestions or views.
- Help to sort out problems on behalf of patients, their families and carers.
- Learn from experience about what the hospital gets right and where there is a need for improvement.

9.7.2 Patients and public who attend, call or e-mail the PALS office with a complaint will be assisted to first achieve a swift resolution. This may be immediate through sorting out a problem or obtaining information for them or it may take a little time such as the need to contact a consultant's secretary or see a specific member of staff.

9.7.3 PALS staff will agree with the complainant a reasonable time frame for them to resolve their concern.

9.7.4 If necessary the complaint may be escalated to the formal route.

9.8 Complaints resolved locally within services, wards or departments

9.8.1 Many issues are raised directly with staff and managers during the normal course of interactions with the patients, their families and carers and these may be either verbally or in writing. It is always best that issues and concerns are resolved and recorded locally. Such recording is important for completeness and monitoring purposes.

9.8.2 Service, ward and departmental managers are required to keep a record of minor / informal complaints that have been actioned and resolved. This is to ensure that any themes that require assistance or support to minimise recurrence can be evidenced.

9.8.3 A template for logging local these complaints is provided in Appendix 9.

9.8.4 Service, ward and departmental managers are required to report on their informal complaints as part of the quality performance reports.

9.8.5 A prompt, considerate and proportionate response will boost patient and public experience and promote goodwill and confidence in the Trust. Where appropriate it is good practice to follow up verbal responses in writing detailing the issues and agreements and giving information about the formal complaints process should the person wish to take the matter further.

10.0 Protocol for handling of joint complaints

10.1 There will be occasions when a complaint spans more than one organisation for example (e.g. GP's, dentists, social services). The Trust will liaise directly with other statutory organisations where appropriate and coordinate responses in order to affect a prompt and complete response for the complainant. Should this not be possible then

the complaints officer will discuss this with the complainant and assist or direct them to where further assistance can be obtained.

11.0 Role of the Parliamentary Ombudsman & independent advisers

If everything possible has been done by the Trust to resolve a complaint and the complainant is still not satisfied then they have the right to ask the Health Ombudsman to review the matter or the Trust may seek and independent observer to review and arbitrate.

11.1 The Ombudsman can be contacted by:

11.1.1 visiting: www.ombudsman.org.uk

11.1.2 calling the helpline on: 0345 015 4033 (Mon – Fri 08.30 to 17.30)

11.1.3 e-mailing: enquiries@ombudsman.org.uk

11.1.4 writing to: The Parliamentary and Health Ombudsman, Millbank Tower, Millbank, London SW1P 4QP

11.1.5 After assessing that the complaint is within their jurisdiction the Ombudsman will first check that everything has been done to resolve the issue locally. If they feel more can be done they will refer the issue back to the organisation.

11.1.6 Before taking the matter on the Ombudsman will consider several factors: What has gone wrong, what injustice has been caused and what is the likelihood of achieving a worthwhile outcome?

11.1.7 If the Ombudsman believes there is a case to answer they will instruct the organisation to put things right.

11.1.8 Independent review by an external expert adviser may be sought by the Trust. This decision will be made by the Chief Executive.

12.0 Dealing with unreasonable complainant behaviour and unreasonably persistent complaints.

12.1 **Definition:** It is important to differentiate between 'persistent' complainants and 'unreasonably persistent' complainants. Arguably, some people are 'persistent' on the entirely reasonable basis that they feel the Trust has not dealt with their complaint properly and are not prepared to leave the matter there.

12.2 Unreasonable and unreasonably persistent complainants may have justified complaints or grievances but be pursuing them in inappropriate ways, or they may be intent on pursuing complaints which appear to have no substance or which have already been investigated and determined. Their contacts with authorities may be amicable but still place very heavy demands on staff time, or they may be very emotionally charged and distressing for all involved.

12.3 Raising legitimate queries or criticisms of a complaints procedure as it progresses, for example if agreed timescales are not met, should not in itself lead to someone being regarded as an unreasonably persistent complainant. Similarly, the fact that a complainant is unhappy with the outcome of a complaint and seeks to challenge it once, or more than once, should not necessarily cause him or her to be labelled unreasonably persistent.

12.4 Sometimes the situation between the Trust and a complainant can escalate and the behaviour moves from being unreasonable and unreasonably persistent to behaviour which is unacceptable, for example, abusive, offensive or threatening. Such complainants are in a very small minority, but unfortunately not unheard of. In the event of such behaviour the Trust will consider sanctions in accordance with the Violence & Aggression Policy and may in extreme case consider legal action.

12.5 Examples of unreasonable behaviour

- 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's scope.
- Insisting on the complaint being dealt with in ways which are incompatible with the 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 authority and, at the same time, with a Member of Parliament/a councillor/ independent auditor/the Standards Board/local police/solicitors/the Ombudsman.
- Making unnecessarily excessive demands on the time and resources of staff whilst a complaint is being looked into, by for example excessive contact 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.
- Combinations of some or all of these.

12.6 In the event that unreasonable behaviour is experienced the Head of patient response and resolution, the Chief Nurse / Director of Governance and Chief Executive will meet and review the case. This group will determine:

- That the complaint is being or has been investigated properly and policy followed;
- That any decision reached on it is the right one;
- That communications with the complainant have been adequate;
- That the complainant is not now providing any significant new information that might affect the Trust's view on the complaint.
- If the group is satisfied on these points it should consider whether further action is necessary prior to taking the decision to designate the complainant as unreasonable or unreasonably persistent. Further actions may be:

a. If no meeting has taken place with the complainant and provided that the group knows nothing about the complainant which would make this unadvisable, consider offering the complainant a meeting. Sometimes such meetings can dispel misunderstandings and move matters towards a resolution.

b. If more than one department is being contacted by the complainant, consider setting up a meeting to agree a cross-departmental approach; and designating a suitable senior member of staff as the lead.
c. If the complainant has special needs, an advocate might be helpful to both parties: consider offering to help the complainant find an independent one.
d. Before applying any restrictions give the complainant a warning that if his/her actions continue the Trust may decide to treat him/her as an unreasonably persistent complainant, and explain why.

12.7 The precise nature of any action the group decides to take in relation to an unreasonable or unreasonably persistent complainant must be appropriate and proportionate to the nature and frequency of the complainant's contacts with the authority at that time. The following list is a 'menu' of possible options for managing a complainant's involvement with the Trust from which one or more might be chosen and applied, **if warranted**. It is not exhaustive and often local factors will be relevant in deciding what might be appropriate action.

- 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 of a witness.
- Refusing to register and process further complaints about the same matter.
- 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.

12.8 If a decision is taken to apply the above sanctions the executive lead will write to inform the complainant that:

- the decision has been taken;
- what it means for his or her contacts with the Trust;
- how long any restrictions will last; and
- How the complainant can contact the ombudsman should they not be satisfied.
- A copy of this policy will be enclosed with the letter.

12.9 The Complaints Officer will keep a record of all contacts with unreasonable and unreasonably persistent complainants.

12.10 When unreasonable and 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 and necessary.

13 Making Improvements as a result of a Concern or Complaint

13.1 Complaints/concerns can be a mechanism for identifying where improvements in service provision are necessary. When used this way they are a positive tool for promoting organizational and individual learning, thereby reducing risk to patients, staff and the organisation.

13.2 Divisional Quality/Governance Forums: These forums are responsible for identifying and reviewing complaints, claims, incidents and PALS queries that represent a risk to safety within the divisions. They also act to drive and encourage learning from the above and promote improvements in practice. They will also implement and monitor appropriate risk reduction measures.

13.3 All complaints/concerns are discussed at the CLIP meeting and areas for further action and improvement/s are identified.

13.4 Cumulative complaints and PALS information will be included in reports to the relevant committee and any lessons learnt are captured with the aim of making improvements and reducing the number of future complaints.

14 Training and awareness

14.1 Training will encourage, empower and support staff to take an individualised and person centred approach to complaints.

14.2 This policy will be available on the Trust intranet and internet sites.

14.3 Training will be included within induction training and through in-house customer care training courses.

15 Review

15.1 This policy will be reviewed in 3 years time unless changes indicate otherwise.

16 Monitoring/Audit

Measurable Policy Objective	**Type of Monitoring/Audit**	**Frequency of monitoring**	**Responsibility for performing the monitoring**	**Monitoring reported to which groups/committees, inc responsibility for reviewing action plans**
Complaints response times	Performance review - % responses within agreed times	Monthly	Divisional performance review at Performance meetings	Patient experience delivery group
Complaints themes and lessons learnt	Review of themes, lessons and actions to resolve	Quarterly	Head of Response and Resolution	Patient experience delivery group

17 Sources of Evidence; References / Bibliography

17.1 Department of Health 2009: A guide to better customer care. (including advice sheets; investigating complaints, joint working on complaints and investigating serious complaints.

17.2 Guidance note on 'unreasonably persistent complainants' and 'unreasonable complainant behaviour' Local Government Ombudsman. April 2009.

17.3 Department of Health 2006: Our Health, our care, our say: A new direction for community services.

17.4 Francis R 2013: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

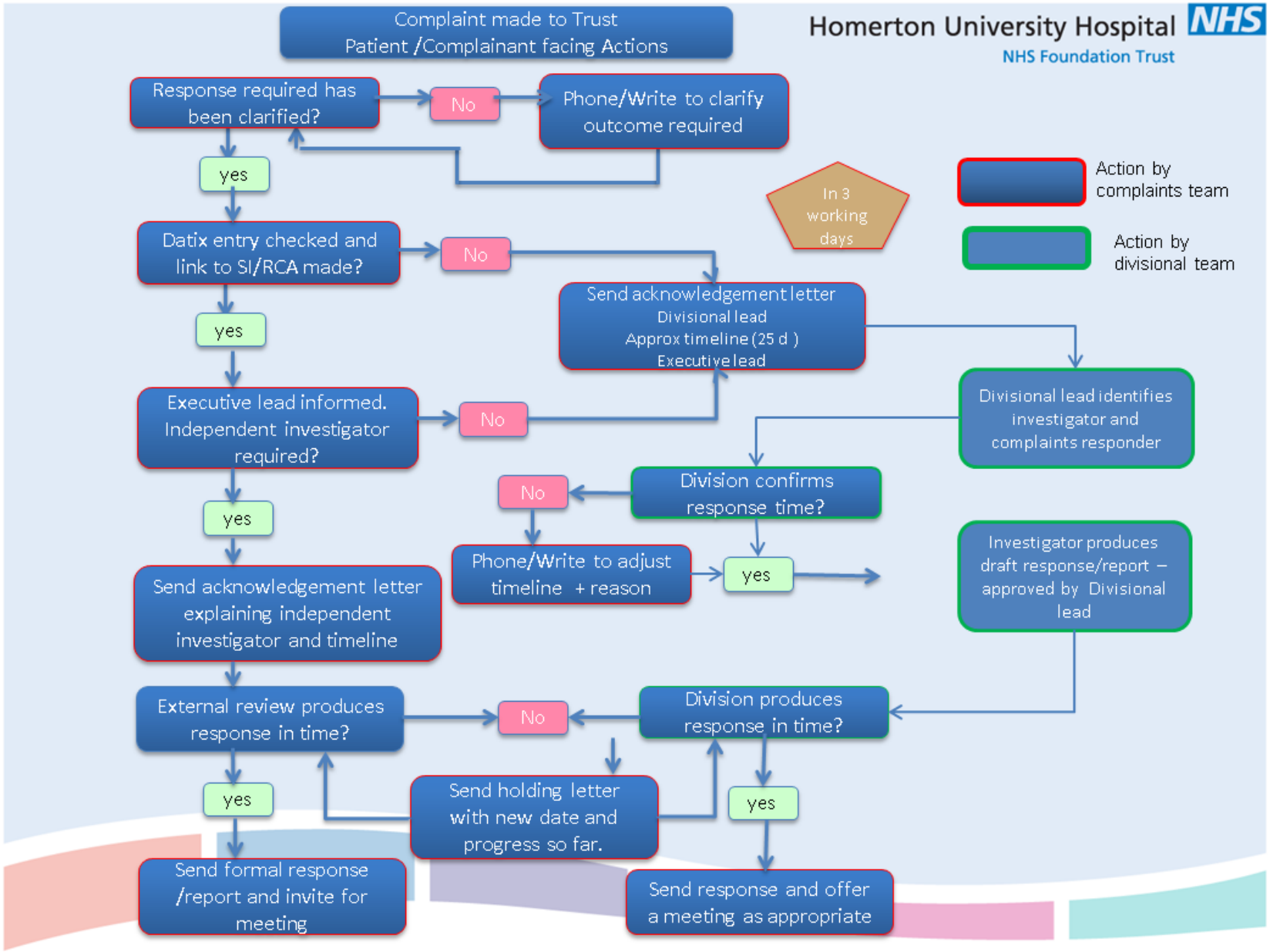
17.5 Clywd, A, Hart, T 2013: A Review of the NHS Hospitals Complaints System Putting Patients in the Picture. Department of Health.

17.6 Department of Health 2013: The NHS Constitution.

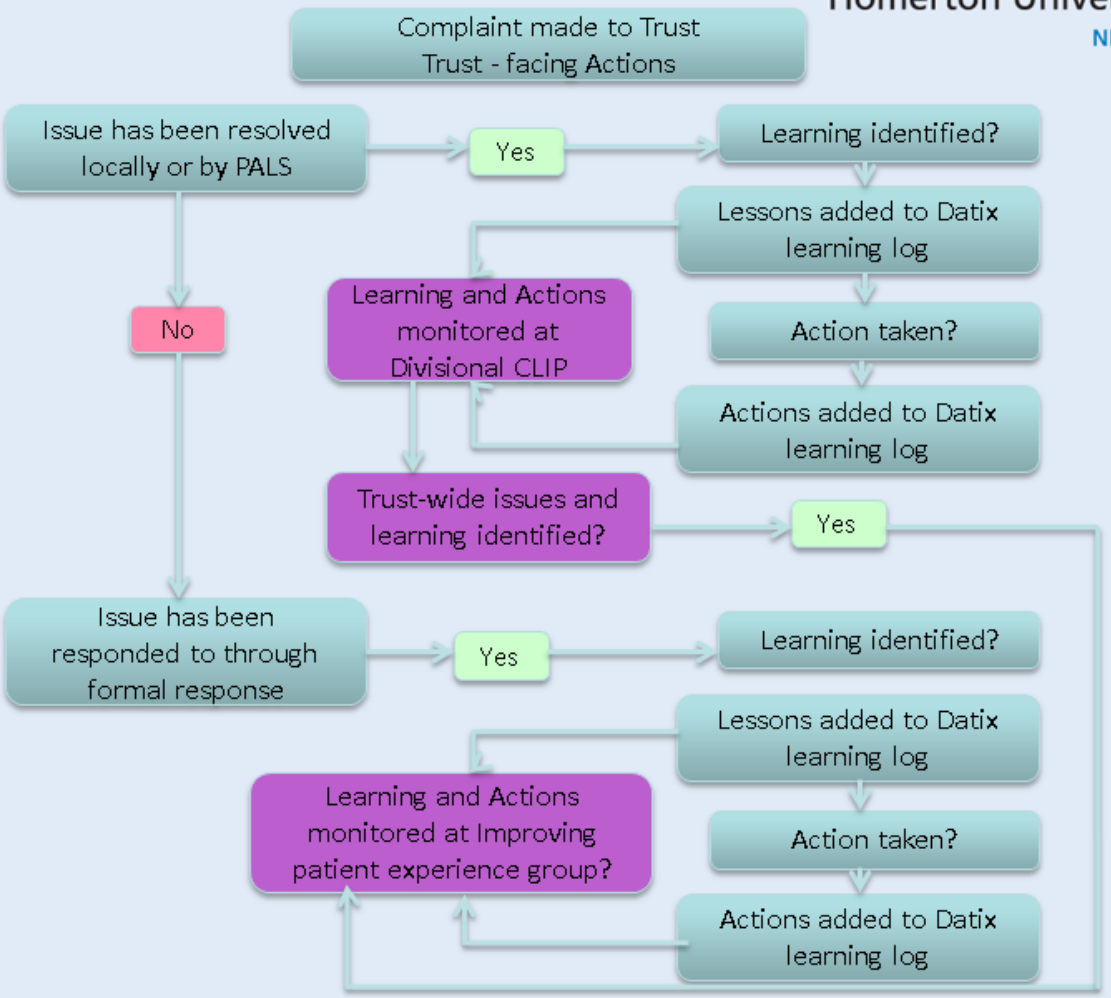
17.7 Fraser Guidelines

17.8 CQC Fundamental Standards

Appendix 1: Process Flowcharts



Homerton University Hospital NHS
NHS Foundation Trust



Learning themes and Trust-Wide Actions monitored at Quality and Safety Board quarterly and shared with Patient experience forum

Appendix 2: - Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	**Complaints policy**
Author:	**Sheila Adam & Damon Broad**
Role:	**Chief Nurse & Director of Nursing-Head of Patient Response & Resolution**
Directorate:	**Corporate**
Date	**May 2015**

Equalities Impact Assessment Question	**Yes**	**No**	**Comment**
1. How does the attached policy/service fit into the trusts overall aims?			Core policy for dealing with complaints, being responsive, open, honest & accountable.
2. How will the policy/service be implemented?			Through corporate induction, customer care training and direct working with divisional complaints leads.
3. What outcomes are intended by implementing the policy/delivering the service?			Dynamic, efficient & thorough approach to managing complaints.
4. How will the above outcomes be measured?			Via complaints monitoring group.
5. Who are they key stakeholders in respect of this policy/service and how have they been involved?			Staff: circulated for consultation. Patients: circulated to governors, PPI & LINks for consultation.
6. Does this policy/service impact on other policies or services and is that impact understood?		No	Not aware
7. Does this policy/service impact on other agencies and is that impact understood?	Yes		Joint protocol agreed.
8. Is there any data on the policy or service that will help inform the EqIA?	Yes		DATIX data available.
9. Are there are information gaps, and how will they be addressed/what additional information is required?		No	
Equalities Impact Assessment Question	**Yes**	**No**	**Comment**

10. Does the policy or service development have an adverse impact on any particular group?		No	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		No	
12. Where an adverse impact has been identified can changes be made to minimise it?		N / A	
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		No	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?	Yes		The new regulations are designed to encourage more people to complain and feedback about their care and treatment who would not have done so before.

EQUALITIES IMPACT ASSESSMENT
FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Appendix 3: Consent form for Third Party Complaint

Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital
Complaints Service
Homerton Row
London
E9 6SR
Tel: 020 8510 7498
Fax: 020 8510 7608
www.homerton.nhs.uk

CONSENT FORM

To the Manager, Complaints & Legal Services Department – Homerton Hospital

Full name

Address:

NHS Number:

I _____ (*patient*), do hereby give my written consent

for ……(*complainant's name*) , my _____

to complain on my behalf.

I agree to the release of any confidential information that may be necessary to answer the complaint.

Signed…… **Date……..**

Appendix 4: Consent Form to Disclose Medical Records

Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital
Complaints Department
Homerton Row
London
E9 6SR
Tel: 020 8510 5113
Fax: 020 8510 7608

CONSENT FORM

MEDICAL RECORDS / CONFIDENTIAL INFORMATION

From: Full name **xxxxxxxxxxxxxxxx**

Address: xxxxxxxxxxxxxxxxxxxxxxxxxxxx

I give my written consent for the release of my medical records / confidential information to the Homerton University Hospital NHS Foundation Trust Complaints Department in order to provide any information needed for the progress of my complaint.

Hospital: xxxxxxxxxxxxxxxxxxxxxxxxxx

My Consultant's name (for this complaint) is: xxxxxxxxxxxxxxxxxxxxxxxxxx,

I understand that the Homerton Hospital will only use the information gathered to assist in the investigation of my complaint.

Signature of complainant ……..……

Date ……..……..

Appendix 5: Acknowledgement letter Requesting Consent

Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital
Complaints Services
Homerton Row
London
E9 6SR

Tel: 020 8510 7498/5113
Fax: 020 8510 7608
www.homerton.nhs.uk

PRIVATE & CONFIDENTIAL

Our Ref:

Date:

Dear

I write to acknowledge receipt of your letter email dated 4th July, which was received the same day. I am sorry that have had cause to complain about the treatment and care provided to your daughter, xxxxx by Homerton Hospital. I would like to reassure you that your complaint has been registered and will be directed to the appropriate staff for investigation.

However, before I can proceed in this way I will require written consent authorising you to act on her behalf. I have therefore attached a consent form for your attention and would ask that you return this to me at your earliest convenience.

Please also find enclosed two leaflets which I hope you find helpful. One explains the Trust's Complaints Procedure, and the other gives details of independent complaints advisory service available to support those who wish to make a complaint about the services provided within the NHS.

We aim to deal with all complaints promptly. To comply with national and Trust standards, our Chief Executive should be able to contact you again within five weeks (25 working days) of receipt of your letter to advise you of the results of our enquiries and any action that has been taken. Occasionally, however, it can take longer to fully investigate a complaint and if this is the case then I will inform you.

Yours sincerely

Complaints Services

Appendix 6: Acknowledgement Letter Outlining Timescale

Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital
Complaints Services
Homerton Row
London
E9 6SR

Tel: 020 8510 5113
Fax: 020 8510 7608
www.homerton.nhs.uk

Dear xx

I am writing to acknowledge receipt of your complaint which you raised with the Patient Advice and Liaison Service (PALS) on xxxxxxxxxx and received by us the same day. I am sorry to learn of your experience, which has led you to complain. I can confirm that your complaint has been registered and forwarded to the Divisional / Service Manager for investigation as well as to the Executive team for review.

We aim to deal with all complaints promptly and to comply with national and Trust standards; our Chief Executive should be able to contact you again within five weeks (25 working days) if not sooner to advise you of the results of our enquiries and any action that has been taken. Occasionally, however, it can take longer to fully investigate a complaint and if this is the case then I will inform you. If you would like to discuss the timescale for responding to your complaint in more detail, please contact the Complaints team on 0208 510 5113/7467

For your information, I have enclosed two leaflets; one explains the Trust's Complaints Procedure, and the other gives details of independent complaints advisory services available to support those who wish to make a complaint about the services provided within the NHS, which I hope you find helpful.

In the meantime, should you have any questions or concerns, please do not hesitate to contact a member of the complaints team on the above number.

Yours sincerely

Elizabeth Metcalfe

Complaints Services

Incorporating hospital and community health services, teaching and research

Appendix 7: Lessons Learned Template

Complaints

Investigation Template

Complaint Ref No:	
Investigating Officer (s)	
Draft Reply Due from investigator (s):	
Date reply received by Complaints team	

Response
Dear _____

I am writing in response to the concerns you raised regarding ***(treatment/care etc.)*** you have received from ***(service area)***. ***(Name and job title)*** was asked to investigated your concerns on my behalf and as part of this investigation ***(delete or add as appropriate - statements have been obtained from those involved/ your records have been reviewed).***
Was a meeting arranged with the complainant as part of this investigation? Was duty of candour complie? If not, who will be responsible for informing patient/responsible person

Summarise your understanding of the complaint/issues

What has the Service learnt from this complaint? (It is essential to write something in this section)

What actions are being taken to reduce the risk of/stop this happening to other patients/clients/family members by the Service:

Action	***By whom***

I would like to thank you for taking the time to bring your concerns to my attention. I do hope that we have been able to answer your concerns to your satisfaction. If however, you feel there are aspects of your complaint that have not been adequately addressed, please do contact me again.

If however you remain unhappy with the outcome then you have the choice of contacting the Health Service Ombudsman who may be able to help you by independently reviewing your case. Further details can be obtained from their website: www.ombudsman.org.uk. They can also be contacted on: 0345 015 4033 or by email: phso.enquiries@ombudsman.org.uk. If you wish to write to them their address is:

The Parliamentary and Health Service Ombudsman
Millbank Tower, Millbank, London, SW1P 4QP

COMPLAINTS ACTION PLAN

Complaint Ref No:_____

Date Complaint Received:_____

Date Final response sent to complainant

Recommendations / Action plan

Recommendation/action	Due Date	Responsible person	How will implement action and how will this be demonstrated?

Evidence that action is complete Complete this section as evidence of lessons learned. Actions recommended and methods of organisational learning or information sharing should be discussed and approved by your division.				
	Action Taken	**Ratified / Approved by:**	**Date**	**Evidence**
1				
2				
3				
4				

Date_____

Appendix 8: Statement of Verbal Complaint

STATEMENT OF VERBAL COMPLAINT

Name of Complainant	
Address:	
Tel No:	
Date Complaint Taken:	
Name of Patient (if different to complainant)	
Address of Patient	
Tel No:	
Complaint taken by	
Service Involved/GP	

DETAILS OF COMPLAINT

Please read, and amend if necessary and sign below to confirm that you agree that this is an accurate account of the concerns you have raised:

Please use this space for any comments you may wish to make:

Signature:	
Print Name:	
Date:	

Appendix 9: Holding letter

Homerton University Hospital NHS
NHS Foundation Trust

Homerton University Hospital
Complaints Services
Homerton Row
London
E9 6SR

Tel: 020 8510 5113
Fax: 020 8510 7608
www.homerton.nhs.uk

PRIVATE & CONFIDENTIAL

Date:xxx
Ref: xxxx

Dear xxxxxxxx

I am writing further to my letter dated xxxxxxx, to inform you that our response to your complaint has unfortunately been delayed as we are still investigating the concerns you raised in your letter.

Ms Tracey Fletcher, Chief Executive, has asked me to inform you that the Trust will be replying to you at the earliest opportunity, but please accept my apologies for any inconvenience this delay may cause.

Yours sincerely

Ruby Daly
Complaints Services

Appendix 10: Guide to investigating complaints

Role of the investigator

The role of the investigator is to ascertain the facts relating to the complaint, assess the evidence, report the findings and make recommendations. As an investigator you should aim to be impartial and examine the facts logically.

Be clear about what you are investigating

The following questions can help you define the investigation:

a) What should have been provided; what was expected?
b) What was provided, what actually happened?
c) Is there a difference between a) and b)?
d) If the answer to c) is yes, why?
e) If the answer to c) is no, why does the complainant think otherwise?
f) What was the impact of d)?
g) What should be done to put it right?
h) What should be done to prevent a recurrence?

Understand from the complainant's perspective

It is a good idea to talk to the complainant as a conversation can often help depth of understanding from the complainants' perspective; that is, the gap between what happened and what should have happened. It can also provide an opportunity to clarify what they would like to see happen and to manage any unrealistic expectations. It is hoped that setting an individual complaints plan soon after receipt of the complaint will assist with this aspect.

- Gather your background information; from the complainant and from within the service.
- What sources of evidence do you have? Documentary, interviews etc.
- What policies or legal requirements need to be considered? Such as guidelines, code of conduct etc.
- Consider using Root Cause Analysis tools if the situation is complex or of high risk.
- Pinpoint areas of disagreement; where there is contention there are usually three choices:
    a) To uphold the view of one party because this is clearly supported by evidence.
    b) To request additional information to explore the matter further.
    c) To decide that the available evidence will never be conclusive.

Conclusions

To develop a conclusion it is a good idea to run through the questions used to define the investigation. Think about failures that have led to the complaint; such as

- Human error or inappropriate behaviour
- Poor application of resources e.g. too late, incomplete, insufficient prioritisation.
- Procedural or administrative problems.

Appendix 11: Getting it right first time; a guide to managing complaints verbally or face to face.

When something goes wrong often all the affected person wants to know is how it happened, that you are sorry and that steps will be taken to prevent it from happening again. The initial contact a person who is unhappy has with the Trust is key. It is crucial to obtain all the information that will allow you to assess someone's concerns correctly and resolve them quickly if you can and build a good relationship with them. Often the reason people give for being unhappy about how their complaint has been handled is poor communication by services.

Things to remember to do when someone says they are unhappy:

1. Listen; let the person tell their story in their own time.
2. Understand it through their eyes.
3. Ask the person how they would like to be addressed, for example: Mr, Mrs., Ms or by their first name.
4. If someone has called offer to call them back and also give them the chance to discuss their concern face to face.
5. Ask them how they wish to be kept informed about how their complaint is being dealt with; by phone, letter, e-mail or perhaps through a third party such as an advocate or support service.
    a. If they say by phone ask them for times that are convenient to call and check that they are happy for messages to be left on an answer machine if they have one.
    b. If they say by post make sure they are happy to receive correspondence at the address they have given.
6. Check if the person has any disabilities that you need to take account of such as being a wheelchair user or whether they are on a medication that may make them drowsy.
7. Discuss the best location at which to meet – it may be for example that they do not want to meet on a ward or in a specific department.
8. Make the person aware that they can have an advocate to support them through the complaints process, even at the first meeting.
9. Systematically go through the reasons within the complaint, it is important to understand why they are dissatisfied.
10. Ask them what they would like to happen as a result of the complaint. For example; an apology, new appointment, reimbursement of cost for lost belongings, compensation etc.
11. Tell them at the outset if their expectations are not feasible or are unrealistic.
12. Agree a plan of action including when and how the complainant will hear back from you.
13. If the matter can be resolved quickly without further investigation then do so, so long as the complainant is happy and there is no risk or impact upon other patients or staff.
14. For a complaint on behalf of a patient remember to check with the patient that consent is provided.
15. Remember to give the complainant contact details for the complaints department or the manager who will be dealing with the complaint.

Patient & Public Rights

The NHS Constitution states that any individual has the right to:

- Have any complaint they make about NHS services dealt with efficiently and have it properly investigated.
- Know the outcome of any investigation into their complaint.
- Take their complaint to the Independent health Service Ombudsman if they are not satisfied with the way the NHS has dealt with their complaint.

- Make a claim for a judicial review if they feel they have been directly affected by any unlawful act or decision by an NHS body.
- Receive compensation where they have been harmed by negligent treatment

Appendix 12: Logging 'informal' complaints

This spreadsheet will be maintained by the ward sisters / department manager and used to provide quarterly data to the Complaints Monitoring Group.

Division	
Ward / department	

Name	Hosp number	Date	Main theme	Immediate action taken / by whom	Lessons learnt	Signature

Appendix 1: Policy Submission Form

Policy Submission Form

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

1	**Details of policy**	
1.1	Title of Policy:	Complaints & Concerns Policy
1.2	Lead Executive Director (job title)	Sheila Adam, Chief Nurse and Director of Clinical Governance
1.3	Author (job title)	Damon Broad, Head of Patient Response and Resolution
1.4	Lead Sub Committee	The Current policy states that we report to the Quality Improvement Committee, but can the TMB decide who which Committee they wish to report to.
1.5	Reason for Policy	To update the Trust policy for the handling of all formal Trust complaints, and to set out the roles and responsibilities for the management of complaints, reflecting recommendations set out by Government.
1.6	Who does policy affect?	All staff/all patients
1.7	Are national guidelines/codes of practice incorporated?	Yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
1.9	Is this a revision of an existing policy?	Yes
1.10	If yes have you identified the changes in the document? – changes should be highlighted for the Policy Group	Yes
2	**Information Collation**	
2.1	Where was Policy information obtained from?	Out-dated policy. Staff, national guidance and publications
3	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	
3.3	If NO explain why	N/A
4	**Consultation Process**	
4.1	Was there internal/external consultation?	Internal

4.2	List groups/Persons involved	Chief Nurse and Director of Clinical Governance Medical Director Heads of Nursing and Midwifery Senior and Lead Nurses and Midwives Heads of Department
4.3	Have internal/external comments been duly considered?	Yes
4.4	Date approved by relevant Sub-committee	TBA
4.5	Signature of Sub committee chair	Signature required
5	**Implementation**	
5.1	How and to whom will the policy be distributed?	Trust Intranet available to all staff
5.2	If there are implementation requirements such as training please detail?	Primarily in practice led by the Head of Patient Response and Resolution and the Chief Nurse and Director of Clinical Governance. Corporate induction needs to be changed to reflect changes to our policy
5.3	What is the cost of implementation and how will this be funded?	N/A
6	**Monitoring**	
6.1	List the key performance indicators e.g. core standards	80% of all formal complaints (excluding clockstops) to be responded to within 25 working days.
6.2	How will this be monitored and/or audited?	An Annual Complaints Report will be presented to the Trust Board of Directors and reported within the Trust's Annual Report. Quarterly KO41A Return
6.3	Frequency of monitoring/audit	As per monitoring section

Date policy approved by Trust Policy Group:

28/4/17

Signature of Trust Board Group chair: