South West London and St George's NHS
Mental Health NHS Trust

COMPLAINTS POLICY AND PROCEDURE TWC7

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3.0	July 2011	FINAL	Amended to reflect governance changes and learning from previous policy
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5.0	February 2014	FINAL	Amended to reflect changes of practice in the Patient Experience (Complaints) Department and learning from previous policy.
6.0	March 2014	FINAL	Amended changes in procedures in the Patient Experience Department.

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Executive Summary

This policy has been reviewed to reflect Quality Governance and departmental structure changes. It sets out the complaints handling process to take account of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 ("the 2009 Regulations") which came into effect from 1 April 2009 which this policy formally adopts. This policy also formally adopts the NHS Constitution and the Parliamentary and Health Service Ombudsman's ("the Ombudsman") Principles of Complaints Handling, Administration and Remedy.

1. INTRODUCTION

1.1 This policy sets out the Trust procedure for complaints handling: listening, responding to and learning from complaints from service users and carers or from third parties acting on their behalf or any person who is affected by or likely to be affected by the action, omission, or decision of the Trust.

1.2 The Trust aims to provide a high standard of care but accepts that sometimes things go wrong and there will always be improvements we can make to our services. Good complaints handling is vital to ensure that services are changed for the better. For this reason all complaints will be listened to and taken seriously and viewed as a positive means of gaining feedback. We will endeavour to respond to all complaints in a way that is consistent, open, fair and timely with a focus on resolution and service improvements.

1.3 The Trust is committed to the early resolution of complaints either by an immediate informal response from front line staff, or by subsequent investigation and conciliation by staff empowered to deal with complaints.

1.4 The Trust will handle all complaints in accordance with the NHS Constitution, the 2009 Regulations and the Ombudsman Principles of Complaints Handling being:

(1) Getting it right
(2) Being customer focussed
(3) Being open and accountable
(4) Acting fairly and proportionately
(5) Putting things right
(6) Seeking continuous improvement

1.5 This procedure also adopts the Ombudsman's Principles of Administration and Remedy.

2. Purpose

2.1 The purpose of the Complaints Policy is provide a framework to achieve four key aims:

(1) Listen carefully and compassionately to the person making the complaint, treating them with respect and courtesy and do everything reasonably possible to resolve that complaint;

(2) Respond in a timely, open and transparent manner;

(3) Learn from what has happened and make improvements where appropriate; and

(4) Ensure that complaints information is reported on.

3. Duties

3.1 Trust Board

- Responsible for making arrangements for dealing with complaints in accordance with the 2009 Regulations and to publicise those arrangements
- Identify an Executive Lead for complaints
- Be informed of key themes and significant issues arising from complaints

3.2 Chief Executive

- Is the "responsible person" for ensuring compliance with the arrangements made under the 2009 Regulations and that action is taken in the light of the outcome of complaints
- Is the signatory to all written complaint responses or shall delegate as appropriate

3.3 Executive Lead for Complaints

- Present Complaints Reports to the Trust Board or its Committee
- Arrange or delegate for the handling of any media interest arising from a complaint or subsequent investigation with the Trust public relations service.

3.4 Service Directors and their delegates

In respect of complaints arising in their respective boroughs:

- Support complainants and support and guide staff who are the subject of a complaint
- Support and guide staff regarding the complaints policy with a focus on early resolution
- That staff escalate complaints where appropriate
- Ensure that identified actions, recommendations and learning from complaints are disseminated and acted on in their service areas and reported to their appropriate governance structures.

3.5 Operational Managers (and their delegates)

- Support complainants and support and guide staff who are the subject of a complaint
- Support and guide staff regarding the complaints policy with a focus on early resolution
- That staff escalate complaints where appropriate
- Ensure that identified actions, recommendations and learning from complaints are disseminated and acted on in their service areas and reported to their appropriate governance structures.

3.6 Head of Quality Governance

- Provide Quality Governance strategic direction that impacts on complaints handling
- Escalate to the Board or its committees key strategic themes arising out of complaints handling
- Provide quality assurance for complaint responses

3.7 Patient Experience Manager

- Shall be the designated Complaints Manager under the 2009 regulations.
- Provide strategic direction for complaints handling and have oversight of the Complaints Policy for the Trust in accordance with the 2009 Regulations, the Ombudsman Principles.

- Escalate to the Board, and/or its committees and groups, key themes arising out of complaints received and their handling
- Provide reports to the Board, Executive Management Committee (EMC), Quality Assurance and Safety Committee (QSAC), Serious Incident Governance Group (SIGG), Risk Intelligence Group, Clinical Governance Groups or other related committees or groups about complaints
- Provide quality assurance for complaint responses
- Where unclear, decide whether a communication is a complaint or not and whether is should be investigated under another procedure (such as the Safeguarding Adults at Risk Policy)
- Support Complaints Officers, reviewers and other staff by providing advice and guidance about complaint handling
- Ensure that complainants receive support in making a complaint
- Ensure that staff have appropriate support and training to enable them to respond positively to complaints, concerns and comments.
- Maintain up to date knowledge about emerging Government policy, Inspection body requirements and best practice concerning complaints handling, recommending changes as required in Trust policy in order to comply with these.
- Ensure that complaints are graded in according to Trust risk management procedures.
- Inform the Claims Manager of any potential claims arising from complaints
- Inform the Head of Quality Governance and SIGG if a complaint or subsequent investigation reveals a possible criminal offence or incident that may require referral to a professional regulatory body has occurred.
- Ensure a database and record of complaints is maintained
- Make any required statutory returns
- May delegate certain functions
- Inform the police, coroner, professional regulatory body or other agency as appropriate should a complaint or subsequent investigation reveal that a criminal offence or other serious incident has occurred.

3.8 Lead Investigator

- Provide clinical guidance to the Patient Experience Manager and Complaints Officers regarding complaints
- Escalate clinical issues to clinical and managerial staff

3.9 Complaints Officers

- Complaints Officers shall mean Serious Incidents and Complaints Officers.
- To consider whether any other policy or procedure requires to be considered such as the Safeguarding Adults at Risk procedure (and if an alert needs to be made under that procedure) and/or whether the Serious Incident Policy needs implementation
- Listen compassionately to complainants and conduct investigations and draft proposed responses appropriately and thoroughly ensuring that they are evidence based and in accordance with this policy and with a focus on resolution.
- Seek clinical advice where appropriate from the Lead Investigator
- To maintain good communication with the complainants keeping them informed throughout the complaints process and focussed on resolution.
- Endeavour to reach local resolution for all complaints and to find conclusions to the complaint and recommend whether any action is taken as a result of it. If an action plan or recommendations are made to ensure they escalated and reported to the Patient Experience Manager, Service Director and Clinical Governance Groups
- Ensure that learning from complaints is disseminated and acted upon by reporting to the Clinical Governance Groups and considering Trustwide learning on a monthly basis.
- Support and guide staff who are the subject of or involved in a complaint
- Undertake all specific duties allocated to them as part of this policy

3.10 Emergency teams relevant to the Borough

- Provide support for staff to respond to complaints received out of hours.
- Decide where necessary to inform the on-call Operational Manager

3.11 On call Operational Manager

- Provide support for staff to respond to complaints received out of hours
- Decide where necessary to call the on-call Director, Police, Coroner or other appropriate agency should a complaint be of a sufficiently serious nature

3.12 All staff:

- Treat complainants supportively with compassion, respect and courtesy
- Take steps to ensure that service users and carers are not treated adversely as a result of making a complaint
- Develop an understanding of the Complaints Policy and where to get further advice and support Ensure all service users and their carers have access to the Complaints Policy and to support them to use it
- Escalate complaints where appropriate
- Try and resolve concerns fully and quickly as they arise
- Co-operate fully and promptly in complaints investigations
- Be adaptable to learn from complaints and to put that learning into practice in their work

4. Ratification process

Key Area	Lead Director	Working Group	Ratification Body
Complaints	**Director of Nursing and Quality**	**Clinical Practice Compliance and Standards Group**	**Integrated Governance Group (IGG)**

5. DEFINITIONS

A complaint

5.1 A complaint is an expression of dissatisfaction about our services and/or facilities however made, by an existing or former service user (or their representative) or by any person affected by or likely to be affected by the action, omission, or decision of the Trust, requiring a response.

5.2 A complaint is not:

- a request for a service
- a petition or circular letter
- a request for clarification
- an isolated incident immediately resolved by the following day to the satisfaction of the complainant
- a staff grievance or disciplinary issue
- a request for access to health records

5.3 Advice from the Patient Experience Manager must be sought if there is uncertainty about whether an issue should be dealt with (and recorded) under the Complaints Policy or at which stage it should enter this procedure.

5.4 If a communication is received from a service user that lacks clarity and appears to require clinical input, the Patient Experience Manager shall refer the communication for

clinical advice to the Lead Investigator. They shall jointly decide whether it is appropriate to open a complaint at that stage or to wait until the service user is better able to engage in the complaints process at a later stage. In reaching this decision, consideration shall be given as to whether any remedial action needs to be taken including liaison by the Lead Investigator with the clinical team.

5.5 Members of staff can raise their concerns or grievances via the Raising Concerns or Grievance procedures that can be found on the Trust's bulletin board under Human Resources policies and procedures or can be obtained in hard copy from the Human Resources Department.

A *service user*

5.6 A service user is anyone who is currently or who was formerly in receipt of Trust services.

A third party acting on behalf of a service user

5.7 A third party may refer to:

- Relatives/carers (a partner, relative or friend who provides practical or emotional support)
- Individuals with parental or statutory responsibility for children receiving care from the Trust (e.g. parents, carers, teachers, social workers, health visitors)
- Advocacy Services
- Service Users' Forum
- Carers Forum
- General Practitioner
- Care Quality Commission
- Members of Parliament
- Legal representative

A Person Affected

5.8 A person affected or likely to be affected could include a complaint made by carers concerning services they received from the Trust in respect of their role as carers (e.g. carers assessments).

Decision

5.9 If a person is unsure whether a communication is a complaint that falls within the 2009 Regulations and whether it should be treated under this policy, the matter should be referred to the Patient Experience Manager who will make the determination.

6. EQUALITY AND DIVERSITY

6.1 All service users should have equal access to the complaints system. This may require providing additional assistance and support such as help to prepare or express the complaint or through provision of an interpreter or advocate. Communication needs should be assessed for all service users as part of the care planning process and where support is needed it should be provided both to ensure all service users know about the complaints system and to help them use it.

7. SCOPE

7.1 A complaint can be made orally, in writing or electronically.

7.2 Any complaint that falls within the definition at paragraph 5 above will be subject to the complaints process unless it has been excluded (see below), dealt with as a concern or

comment or other direction has been given by the Patient Experience Manager such as it being investigated under another procedure (e.g. Safeguarding Adults at Risk Policy).

7.3 A complaint should normally be made within twelve months of the date on which the matter which is the subject of the complaint occurred or within twelve months of the date on which the matter which is the subject of the complaint came to the notice of the complainant. The Trust has discretion to extend this time limit where it is satisfied that the complainant had good reason for not making the complaint within that time and notwithstanding the delay it is still possible to investigate the complaints effectively and fairly.

7.4 The following matters are specifically excluded from the scope of this policy by virtue of the 2009 Regulations:

(1) a complaint made by a local authority, NHS body or primary care or independent provider; or

(2) a complaint made by an employee of a local authority or NHS body or primary care or independent provider about any matter relating to their contract of employment; or

(3) a complaint which is made orally and is resolved to the complainants satisfaction not later than the next working day after the day on which the complaint was made; or

(4) a complaint the subject of matter of which has previously been investigated under the 2009 Regulations (or their predecessor regulations); or

(5) a complaint which is being or has been investigated by the Health Service Commissioner or Local Commissioner; or

(6) a complaint arising out of an NHS body's alleged failure to comply with a request for information under the Freedom of Information Act 2000; or

(7) a complaint which relates to any scheme established under s10 or s24 of the Superannuation Act 1972 or to the administration of those schemes the subject matter of which has already been investigated under the NHS Complaints Regulations.

7.5 Where a complaint is specifically excluded, the Trust will not consider it but will write to the complainant as soon as is reasonable to inform them of the decision and the reasons for it.

7.6 The Trust has procedures for complaints received regarding the Data Protection Act 1998 and the Freedom of Information Act 2000. The Trust may consult with the Information Commissioner regarding these complaints.

7.7 Access to health records should not be confused with access to the 2009 Regulations, which are both separate processes. However, it will often be the case that a complaint will relate to a clinical issue and will therefore require disclosure of health records to the service user or their representative. Requests for access to records should be handled in accordance with the Trust's Subject Access Policy.

7.8 If the representative for a service user competent to consent wishes to have access, or discuss any aspect of their health records, they must supply a written statement from the service user authorising the hospital and the medical/nursing staff to reveal to, or discuss with, the representative any and all clinical information.

7.9 Complainants also have a right to request access to their complaints file. These requests should also be handled in accordance with the Trust's Subject Access Policy.

8. COMPLAINTS INVOLVING SERVICES PROVIDED BY AGENCIES OTHER THAN THE TRUST

Complaints received and sent regarding other parties

8.1 Where complaints are sent to other NHS bodies, Local Authorities or Primary Care Providers but relate to the exercise of the functions of the Trust, they shall be handled under these procedures once it has been received. The Trust shall handle the complaints as if it had been received directly.

8.2 If a complaint is received by the Trust but relates to the another NHS body, Local Authority or Primary Care Provider the Patient Experience Manager shall seek the consent of the complainant to pass the complaint on to the third party for dealing. Once that consent has been received the Patient Experience Manager or delegate shall pass on the complaint to the third party and inform the complainant of doing so. If consent is not received then the complainant will be informed that the Trust is not able to investigate the complaint.

8.3 Where complaints are received which involve shared Social Service Care provisions, the Patient Experience Manager or delegate shall liaise with the appropriate Local Authority on investigating and producing a response. On receipt of a complaint of this kind the Trust must seek to obtain permission from the complainant prior to sending details of the complaint to the Local Authority. If consent for information sharing is withheld then the Trust must advise the complainant on the parts of the complaint that it is able to deal with adding that should the complainant wish to pursue the Local Authority for part of the complaint, they should approach the Local Authority directly. If consent is received there is a clear duty for all parties to fully co-operate in the investigation of the complaint. This includes:

- Sharing relevant information
- Attending joint meetings to consider the complaint
- Ensuring a comprehensive and appropriate response is sent
- Coordination of the complaint procedures
- Keeping the complainant informed throughout the process

8.4 The two bodies should seek to agree which organisation should take the lead in co-ordinating the handling of the complaint and dealing with the complainant. The lead body's Complaints Manager or delegate must:

- Coordinate the handling of the complaint by working closely with all those involved;
- Ensure a comprehensive and appropriate response is sent, and
- Ensure that they keep the complainant informed and, where possible, coordinate a single reply.

8.5 The bodies should consider a joint meeting with the complainant if this will facilitate a more effective outcome.

8.6 The coordinated response must identify which parts relate to the relevant aspects of the complaints letter. The response should advise the complainant of their right to pursue the complaint further and provide details of which regulatory organisation would deal with each aspect of the complaint.

8.7 Notwithstanding which body is the lead agency, the Trust's Chief Executive should sign the response, except where there are good reasons for them not being able to do so. Further, each body retains its duty of care to the complainant and must handle its part of the complaint in accordance with its own regulated procedures.

Safeguarding children and vulnerable adult procedures

8.8 Local authorities have a key role and legal powers in safeguarding children and vulnerable adults. The Trust also has procedures in place for dealing with concerns about safeguarding children and protection of vulnerable adults.

8.9 The Patient Experience Manager and Complaints Officers should be aware of the need to identify any safeguarding children or vulnerable adult issues arising out of complaints and to liaise with relevant staff and agencies, and to work to the relevant procedures. They shall separate out complaints that should be dealt with under other procedures and cases where joint action is required and seek advice from the Lead Investigator and Safeguarding Lead where appropriate.

8.10 If the complaint raises safeguarding issues then it should be subject to the Safeguarding and Promoting the Welfare of Children Policy or the Safeguarding Adults at Risk Policy and not the Complaints Policy. If the complaint is partially a safeguarding issue then that part will be subject to the relevant safeguarding policy and the remaining complaint be subject to the Complaints Policy. If a safeguarding alert is raised but is found not to meet the criteria of a full investigation under the safeguarding policies then that issue will be returned to the Complaints Policy for investigation as a complaint.

The independent sector

8.11 Where the Trust makes arrangements for the provision of services with an independent provider, it must ensure that the independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of services as if the 2009 Regulations applied to it.

Care Quality Commission

8.12 Where complaints are made that might relate in part to a matter for the Care Quality Commission (CQC), the Patient Experience Manager and Complaints Officers should advise the complainant of the ability to complain to the CQC.

9. COMPLAINTS ABOUT THE CHIEF EXECUTIVE

9.1 The Chief Executive shall be the Responsible Person in respect of all complaints received but this can be delegated. If a complaint is received about the conduct or actions of the Chief Executive, the role of Responsible Person shall be delegated to the Trust Chairman for that complaint.

10 RECORD KEEPING

10.1 The Patient Experience Manager and Complaints Officers should ensure that all information relevant to the investigation of the complaint is recorded and kept in a case file. They should always bear in mind that should the complaint progress to an independent review; the Ombudsman will request a copy of the case file and will expect it to be delivered to them without unnecessary delay.

10.2 All complaints should be sent to the Patient Experience Team.

11. THIRD PARTY COMPLAINTS AND CONSENT

11.1 It is necessary under the Data Protection Act 1998 to obtain the service user's consent to use or exchange personal or clinical information as determined by the requirements of the Data Protection Act. Care must be taken when a third party makes the complaint and the response may involve disclosure of such information. When seeking consent a letter in the form at Appendix 4 will be sent.

11.2 Where written consent is not supplied (or not in the appropriate form) by the third party or the service user at the time the time the complaint has been submitted, the Patient Experience Manager or delegate shall arrange for consent to be sought in writing.

11.3 If the local clinical or management team are assisting a service user to complete a Data Protection Act consent form, the assistance must not be provided by someone who has been complained about in the complaint. The assistance must be provided by a person who is impartial to it.

11.4 If no consent is received within 3 weeks of it being sought, it shall be assumed that consent has not been granted and a response shall be sent to the third party complainant tailored so that it does not breach the service user's confidentiality.

12. PRINCIPLES IN COMPLAINTS HANDLING

Introduction

12.1 This section sets out the general principles the Trust will apply in responding to complaints and are in conjunction with the Ombudsman's Principles that have been adopted at paragraph 1 above. This section should be read with the case examples at Appendix 12.

(1) An open, honest, transparent and flexible approach that supports listening compassionately and learning from experience

12.2 All problems, difficulties and complaints must be listened to with care and compassion and handled in an open, honest, transparent and constructive manner. Actions taken should be of benefit to the person or people making the complaint, to the staff involved and to the Trust as a whole. An open and learning approach is of particular importance if service users, relatives and families are to have confidence in the organisation. Openness and transparency of staff is integral when handling complaints by discussing aspects of the complaint promptly and fully. Openness when things go wrong is fundamental to the partnership between service users and those who provide their care.

12.3 Directorates and Corporate Services within the Trust must take follow-up action to improve services based not only on individual complaints but on trends that emerge. Information about these improvements will be included in reports to the Trust Board or its committees.

(2) Providing ease of access

12.4 Complaints can be raised to any member of staff, by email to **complaintsmanager@swlstg-tr.nhs.uk** , in writing to the Trust or by feedback systems Care Connect and Patient Opinion which are linked on the Trust website: www.**swlstg-tr.nhs.uk** There is no need to complete a form but one is available in the complaints leaflets on Trust sites and Complaints Record Forms (Appendix 2) can be obtained by staff to help service users.

(3) Impact of actual or intended litigation

12.5 Actual or intended litigation shall not be a barrier to the processing or investigation of a complaint and the complaints process shall be entirely separate from the considerations of litigation.

(4) Providing high standards of assistance

12.6 Those wishing to make a complaint should be assisted in doing so. Staff need to ensure that they have an up to date knowledge of the Complaints Policy and that they are able to supply service users with appropriate information and literature about how the Complaints Policy operates. Staff can complete a Complaints Record Form (Appendix 2) on behalf of

anyone making a complaint over the phone or in person and also assist. Trust staff should adopt a sensitive and compassionate approach when handling complaints, giving help and assistance in a constructive way treating all complainants with respect and courtesy.

12.7 Particular attention needs to be given by staff to those who may have difficulty making a complaint. For example, interpreters should be provided to assist people with limited or no English or who are Deaf and would prefer an interpreter or those with limited literacy skills to confirm details of the complaint verbally.

12.8 Staff should resolve complaints as speedily and efficiently as possible to prevent matters escalating, since delays will lead to frustration and lack of confidence. The Trust's performance on the speed with which it substantively responds to complaints is carefully monitored for this reason.

12.9 Where services have failed to reach the required standards a clear apology should be given and other remedies considered.

(5) Support for those making a Complaint

12.10 Making a complaint can be a daunting task, particularly when it involves matters of personal health and care. People who make a complaint should be encouraged to seek support if they feel it would help. Support from family, friends, Trust staff, Patient Experience Team, and Advocacy services should be encouraged.

(6) No adverse treatment

12.11 Any service user, carer or representative making a complaint are to be reassured as appropriate that making a complaint will not have any adverse consequences to service user's or carer's care. To support this principle, complaints and their responses will not be held with service users' medical records (unless they specifically request that it is done so, in which case it can be considered).

12.12 If a service user or carer wishes to raise an issue regarding adverse treatment this will be handled as a separate complaint and investigated in accordance with this Policy.

(7) Arms-length Independent Investigations

12.13 All complaints shall be investigated by the Patient Experience team, a team that is clinically and managerially within the Corporate Directorate and is managerially separate and independent from the borough reporting structures where clinical care is provided. This offers a level of arms-length independence for complainants in all investigations.

12.14 Any complaints about the Patient Experience team shall be investigated by the Head of Quality Governance.

12.15 If it is considered appropriate by the Patient Experience Manager that an investigation should be conducted by an investigator external to the Trust, this shall be facilitated.

(8) Access to Advice in Complex or Complicated cases

12.16 The Patient Experience team has a clinician working within the team and is supported by a Lead Investigator with clinical expertise who can advise on cases. If complaints advocacy services identify a need for expert advice this can be provided by the Lead Investigator or facilitated by them.

(9) Supporting Staff

12.17 Being involved in a complaint can be stressful for staff, especially if they are being personally criticised. Staff should receive support from their manager, the Patient Experience Manager or Staff Support Advisory Network. Staff may also wish to obtain support from their Professional Organisation or Trade Union.

12.18 Staff should be advised that this Complaints Policy is quite separate from the Trust Disciplinary Procedure and that the process of considering whether the disciplinary procedure should be invoked is also quite separate.

(10) Training

12.19 Training in complaints handling will be provided within the Trust as part of its training programme. All new members of staff will be given guidance about the Complaints Policy as part of their mandatory induction.

(11) Training Needs Analysis

12.20 In order to ensure the health, safety and wellbeing of our service users and staff, the Trust aims to address the needs and impact of its corporate, mandatory and statutory training with a comprehensive and robust training needs analysis procedure. To this end, all Trust policies which have risk management training needs for permanent staff are included in the ‘’Training and development policy” which includes comprehensive Training Needs Analysis for all staff as managed by the Training and Development Department. This document is available on the Trust intranet, under ‘Training and Development’.

Policy Author Responsibility:	To inform the Training and Development Department of amendments to policy training needs.
Management Responsibility:	To ensure all permanent staff are adequately trained as appropriate to the employees duties and work location and to follow up on refresher training needs.
Staff Responsibility:	To ensure that they attend all relevant training as detailed in their induction and annual Performance Appraisal and Development Review (PADR).
Training and Development Department Responsibility:	To provide access to training for all permanent staff. To maintain monitoring, reporting and review systems via the Training and Development Policy.

(12) Effectiveness

12.21 Staff who are involved in all aspects of complaints handling must be thorough in their approach. They can demonstrate this by, for example, carefully analysing letters of complaint, ensuring that investigations are carried out that involve all the appropriate areas of the Trust, offering to meet or speak with the complainant early on in the investigation and responding with the right level of detail and openness and ensuring that appropriate actions are taken and that learning is developed.

12.22 Where staff need to develop skills to achieve this then this should be identified in their personal development plans with their line managers and appropriate training given.

(13) Listening, Learning and Improving from complaints

12.23 The Trust is committed to listening and learning from Complaints and that those lessons lead to service improvement.

12.24 It is the role of the Complaints Officer to find conclusions to the complaint and recommend whether any action is taken as a result of it. If an action plan or recommendations are made it is to be reported to the Service Director and Clinical Governance Group and it is their responsibility that the actions or recommendations are taken.

12.25 All Trust-wide learning from complaints and service improvements are to be reported to the SIGG every month for monitoring and any outstanding actions yet be taken. Local learning from complaints and service improvements will be responded to by service directorate's local performance structures. A summary of the lessons learned and service improvements are to be reported bi-annually to QSAC.

(14) Reporting

12.26 It is important that complaints information is escalated and reported to the appropriate level in the Trust. Complaints reports shall be submitted to the Serious Incidents Governance Group, Integrated Governance Group, Quality Safety Assurance Committee and/or the Trust Board reporting on numbers of complaints, key performance indicators, themes and trends arising from categories of complaint, learning and feedback from the Ombudsman. The Trust Board shall be submitted with an Annual Complaints Report in accordance with the 2009 Regulations, and ad-hoc complaints reports or analyses and complaints shall be sourced as potential Patient Stories outlining experiences as told by services users and carers as set out in their complaints.

13. COMPLAINTS RESOLVED BY THE FOLLOWING DAY (THE 24 HOUR RULE – VERBAL COMPLAINTS)

13.1 Many complaints will be raised to front-line staff and can be resolved immediately. If it is a straightforward verbal complaint and it can be resolved by no later than the following day (to the satisfaction of the complainant) there is no need to proceed to full investigation. The recipient of the complaint is to ensure that the complaint is dealt with as quickly as possible in an informal and sensitive manner to resolve the issue. Once resolved, the form at Appendix 1 is to be completed and sent to the Patient Experience Team immediately.

13.2 Examples of early resolution are complaints about a particular aspect of care might be resolved promptly through organising a review of the Care Plan, involving the Ward Manager and Care Co-ordinator and any other relevant members of the clinical team. Concerns of a more general nature (e.g. ward environment) might be resolved quickly through ward community meetings or discussion with the Ward Manager.

13.3 Young people in the Child and Adolescent Mental Health Service, as well as their parents or carers, should be encouraged to discuss complaints with the appropriate member of the clinical team in the first instance (e.g. Care Co-ordinator, Key Worker, Consultant Psychiatrist).

13.4 Complaints made by clients living in the community are often about particular aspects of care and treatment and might be resolved promptly through setting up a case review meeting with the clinical team.

13.5 The Manager of the service should be contacted where this might assist in deciding the most appropriate approach to dealing with a complaint.

13.6 Examples of when it is not possible to resolve the complaint adequately can include. For example:

- When it is not possible to give the assurances that the complainant is looking for.

- Where the severity of the complaint requires formal investigation and especially where disciplinary action should be considered (e.g. accusations of verbal or physical abuse by a member of staff, accusations of theft).

- Where the complainant remains, or appears to remain, dissatisfied, or where the nature of the complaint requires further investigation.

- Where there is any doubt as to how to proceed.

13.7 If the complaint is not capable of resolution by the following day or it has not been resolved to the complainant's satisfaction the complainant should be provided with any necessary assistance to pursue a complaint through the normal process and the complaint passed to the Complaints Manager. This may also include practical assistance and help with contacting an appropriate advocacy service.

13.8 If the complaint cannot be resolved the complainant should be offered the choice of sending their concerns in writing to the Chief Executive or the Patient Experience Manager or help given to them to complete a Complaint Record Form (Appendix 2) which, if completed by a member of staff should be checked with the complainant for accuracy. This must then be **faxed immediately** to the Patient Experience Team **within 1 working day**.

14. COMPLAINTS HANDLING PROCESS

Receipt and Triage

14.1 Any complaint that has been received by the Trust within it's services it is to be sent to the Patient Experience Team within 1 working day. If a complaint is received orally, a written record of that complaint shall be made a copy provided to the complainant.

14.2 Upon receipt of any complaint the Patient Experience Team shall triage the complaint and assess whether it should, in whole or in part, be reported as a Serious Incident. If this is the case or it has already been reported it shall be referred to the Serious Incident Governance Group who will consider whether a Root Cause Analysis (RCA) investigation should be carried out. If it is decided that a RCA should be carried out the complaint shall be answered in an appendix to the RCA. If it is decided that the complaint should be in part RCA investigation and part Complaints Policy investigation then the complaint shall be divided accordingly.

Acknowledgement and Seeking Consent

14.3 A complaint should be acknowledged by the Patient Experience Team on behalf of the Chief Executive **within 3 working days** from the date received by the Trust (in the form of Appendix 3) reflecting any reference to, or decision by, the Serious Incident Governance Group if it has met or is due to meet within that time. If it is to be investigated under the Complaints Policy the Patient Experience Team shall also seek consent form the service user in the form of Appendix 4 if appropriate.

Initial Steps and 7 day rule

14.4 Upon receipt of the complaint a Complaints Officer shall be allocated to investigate and shall:

(1) consider whether any immediate remedial action needs to be taken and action if appropriate (this would include, for example, raising a safeguarding alert under the Safeguarding Adults at Risk procedure or a recorded as an incident under the Serious Incidents Policy);

(2) pass on the complaint to all those relevant including the person (s) named in the complaint;

(3) **The 7 day rule** The Complaints Officer shall endeavour to telephone the complainant within 7 days of the acknowledgment letter to discuss how the complaint is to be handled, when the investigation is to be completed, when a response is likely to be sent and whether independent advocacy support is needed (and if so signposted). The Complaints Officer should take proactive steps at this stage to establish what the complainant is looking for in terms of resolution and complete the Initial Contact Sheet/7 Day rule (Appendix 5) after the call.

If the Complaints Officer is unable to make contact with the complainant and/or has left messages for the complainant which have not been returned they shall record on the Initial Contact Sheet/7 Day rule (Appendix 5) detailing the attempts at making contact and proceed to investigation.

The Investigation

14.5 The Complaints Officer will commence and conduct the investigation in accordance with the Guidance for Investigations at Appendix 6, Guidance on Meetings at Appendix 7 and request that all relevant documents are provided, including statements in the form set out in Appendix 8. Statements will need be gathered from all relevant staff members and provided to the Complaints Officer promptly, **within 5 days** of the request (unless greater urgency is indicated), together with any relevant supporting documentation (e.g. care plans, nursing notes, incident forms).

14.6 The investigation shall be carried out in time to aim for a response to be sent to the complainant within 25 working days of receipt of the complaint. If there is a delay in meeting the time frame the Complaints Officer shall endeavour to agree a new time frame (explaining reasons for delay and apologising if appropriate) and a letter will be sent to the complainant setting out an alternate timescale. The Complaints Officer should keep the complainant informed during the investigation process as far as is reasonably practicable.

14.7 When concluding the investigation the Complaints Officer shall ensure that the investigation is evidence based, cogent and supports the response. In drafting the proposed response (Appendix 9) the following points should be taken into account:

- the details of the complainant, such as name and address, must be checked for accuracy. If the complaint is in respect of being detailed on a section under the Mental Health Act, information regarding pursuing a complaint to the Care Quality Commission should be given.

- all issues in the complaint should be responded to. A description of the investigation, including any interviews and statements, should be set out and any action resulting from the investigation should be explained.

- the response should be in plain English and grammar and spelling accurate. It should be free of jargon, with any technical terms fully explained.

- an apology or other redress or remedy should be included in the response where appropriate.

- the response should offer the opportunity for the complainant to discuss the final response with the relevant Complaints Officer (and member(s) or the clinical team, where appropriate).

- if the complainant is still dissatisfied, s/he should be advised in the response how they can pursue their complaint further. The response letter should therefore include details on how to contact the Ombudsman.

14.8 When considered satisfactory the proposed response and complaint file will be sent to the Chief Executive for consideration and to sign the response. If any amendments are recommended by the Chief Executive they are to be taken in by the Patient Experience Manager or Complaints Officer. Once the response is finalised and sent to the complainant, a copy will be sent to the Borough for dissemination to all those involved in the complaint and the service user's consultant if appropriate. All responses shall be sent to the complainant within the Trust key performance indicator prevailing at the time.

14.9 If during the process any communication is to be sent electronically to the complainant, consent should be obtained from them in writing and it should be checked that consent has not been withdrawn.

14.10 Once the investigation has been completed, the Complaints Officer shall ensure that all associated documentation is kept securely and that any learning or follow-up action identified in the response is reported to the Borough's Clinical Governance Group.

Follow up complaint

14.11 If the complainant is not satisfied happy with the response and contacts to the Trust setting out their concerns or further complaint, the Complaints Officer is to reconsider the investigation and response together with the additional issues raised by the complainant. A further meeting should be considered. Advice should be sought from the Patient Experience Manager as this stage as whether a referral to the Ombudsman would be appropriate or further work on the complaints is needed.

Summary

14.12 A summary of the investigation process is at Appendix 10.

15. AGGREGATION ANALYSIS AND IMPROVEMENT

15.1 The Risk Intelligence Group (RIG) meets weekly to review risks identified by serious incidents, complaints and claims and the Serious Incident Governance Group (SIGG) meet monthly to review serious incidents, complaints and claims. A quarterly report on serious incidents, complaints and claims is presented at the Quality and Safety Assurance Committee (QSAC) and/or the Trust Board. This report includes an identification of themes and lessons learned shared Trust-wide with staff responsible for providing patient care and ensuring patient safety. Further information about analysis and learning is outlined in the Trust Learning from Experience Policy.

16. CONCILIATION AND MEDIATION

16.1 Conciliation should be considered throughout the course of the investigation and advice from the Patient Experience Manager should be sought as to whether a conciliator independent of the service complained of could be used to resolve any outstanding concerns. The Conciliators role is to talk to both parties, either separately or together, in order to identify areas of conflict, ensure that all issues are fully discussed and aired, and help bring the situation to a satisfactory conclusion and resolution.

16.2 The Patient Experience Manager may, in any case where he/she thinks it would be appropriate to do so (taking into account any cost considerations) and with the agreement of the complainant, make arrangements for external mediation for the purposes of resolving the complaint.

16.3 Whether mediation or conciliation is used, all those involved in conciliation need to be made aware of what such a process involves. Inevitably it will mean that both parties will need to enter such a process willing to compromise.

16.4 Confidentiality must be strictly observed during the conciliation or mediation.

17. OUT OF HOURS ARRANGEMENTS FOR COMPLAINTS HANDLING

17.1 Most complaints can be dealt with during normal working hours. When a person makes a complaint out of working hours and it cannot be resolved at the time, staff should tell the complainant that the complaints response process will start on the next working day. If unsure what to do, the person receiving the complaint should contact the On Site Nurse Advisor for the relevant site for advice.

17.2 Occasionally a complaint may be of such a serious nature that immediate action needs to be taken. Examples might include an allegation of assault or other criminal act. In this case the person receiving the complaint should call the on call Operational Manager.

18. COMPLAINTS REVIEW MEETING

18.1 A Complaints Review Meeting considers complaints and summaries on a weekly basis. The impact on the Care Quality Commission outcomes are considered, their risk rating and reporting categorisation. The Head of Quality Governance and Patient Experience Manager provide direction as to their handling and also make any declaration regarding vexatious complaints.

19. VEXATIOUS COMPLAINTS

19.1 Staff are expected to respond to all complainants with patience and understanding. However, in exceptional circumstances, there may be times where nothing further can be reasonably done to assist complainants to rectify a real or perceived problem. In such circumstances staff should refer to the Appendix 11 guidance for responding to vexatious complainants

20. COMPLAINTS GRADING AND ROOT CAUSE ANALYSIS

20.1 In accordance with Trust risk management procedures, complaints are to be categorised and graded according to the Trust risk matrix (see Appendix 13) and the relevant CQC rating to be considered by the Complaints Review Meeting.

20.2 All complaints graded Red (15 or above) will be taken out of the Complaints process and subject to full root cause analysis and be subject to the Serious Incident procedures.

20.3 Root cause analysis is a process that aims to discover the root cause of the incident resulting in a complaint. The root causes of complaints usually lie in the organisational and management systems and processes that support the delivery of care. The primary purpose of investigating is to identify and address the root causes and to improve systems and processes (where this is indicated) to reduce the likelihood of the events leading to the complaint recurring. Investigations will focus on identifying the following:

- what happened (or nearly happened)
- Where, when and to whom it happened
- Persons involved
- The root cause(s) of the events (systems, policies, procedures, processes)
- Any lessons which can be learnt which might prevent a reoccurrence or
- Reduce the impact

20.4 The use of root cause analysis is essential in ensuring that whilst not detracting from personal accountability, a just culture is established which acknowledges the importance of identifying the systemic factors which can lead to complaints and acts to remove or mitigate these factors to improve care. Further details of the use of root cause analysis and triggers for using root cause analysis can be obtained from the National Patient Safety Agency website: http://www.nrls.npsa.nhs.uk

21. WHERE A COMPLAINT INDICATES THE NEED FOR INVESTIGATION UNDER THE DISCIPLINARY PROCEDURE

21.1 The Complaints Policy is concerned with resolving complaints and not with investigating disciplinary matters, the disciplinary process is separate. Where a complaint reveals the need for disciplinary action, this need not prevent investigation under the Complaints Policy of other aspects of the complaint provided it does not prejudice or compromise the concurrent investigation. If disciplinary action is taken as a result of a complaint this will not necessarily be disclosed to the complainant.

22. COMPLAINTS REQUIRING FURTHER INVESTIGATION AND FOLLOW-UP BY OTHER BODIES

22.1 Some complaints will require further investigation under other procedures. These would include complaints requiring disciplinary action, a serious issue that should be reported to a professional body for further investigation or an allegation of a criminal offence. These issues will be referred to the appropriate body if that action is agreed by the Chief Executive or delegate.

23. CORONER'S INQUESTS

23.1 Where a complaint is also subject to a Coroner's inquest, the Trust will continue to investigate the complaint and respond as per these procedures.

23.2 However, where a complaint relates to the cause of death, the Trust will only formally respond in writing after the Coroner has delivered its verdict. Complaints investigations should also be extended if the Coroner so requests.

23.3 Where the Coroner's Court requests statements from staff, it is advised that the Trust use these statements as the basis for any internal complaints investigation.

23.4 The Patient Experience Manager should consult with the Coroner's Office as appropriate.

24. SECOND STAGE REVIEW BY THE OMBUDSMAN

Referral

24.1 If the complainant is not satisfied they can ask for the Ombudsman to investigate the case for them. Before the Ombudsman will look into a complaint, they will expect that the Complaints process has been exhausted, unless it is assessed that in the particular circumstances this would be unreasonable to do so.

24.2 The Ombudsman is independent of the NHS and the government and there is no charge for the service. The Ombudsman's office can investigate complaints about:

- poor service

- failure to provide a service that a patient has a right to receive
- administrative failures such as, avoidable delay, not following proper procedures, rudeness or discourtesy, not answering a complaint fully and properly, including refusing to set up an Independent Review Panel
- complaints about the care and treatment provided by a hospital doctor, GP, nurse, dentist or other health professional, providing that the events complained about occurred after 31st March 1996.

Initial Action

24.3 If the Ombudsman contacts the Trust of a potential referral, the Patient Experience Manager shall consider whether the complaints process has been exhausted or not and notify the Ombudsman.

24.4 If the Chief Executive receives a letter from the Ombudsman, enclosing a summary of the complaint referral, he/she will delegate responsibility for dealing with issues arising from the letter to the Patient Experience Manager. Documents requested by the Ombudsman will be collated and sent to the Ombudsman together with any comments about the investigation as appropriate.

Report and Subsequent Action

24.5 Once the Ombudsman's investigation is complete, a draft final report to the Chief Executive is usually received. This will be considered and factual information and comments may be provided to the Ombudsman.

24.6 On receipt of the Final Report from the Ombudsman, the Chief Executive will delegate the responsibility of collating the necessary action to implement the recommendations in the report. Ombudsman learning outcomes will be reported to the Serious Incidents and Governance Group, Quality Safety Assurance Committee and/or the Trust Board and the Borough Clinical Governance Groups.

25. PUBLICITY

25.1 Information about this Complaints Policy is available to the public on the Trust website: www.swlstg-tr.nhs.uk and a hard copy shall be provided by the Patient Experience Team on request. The website also summarises key features of this Complaints Policy and has electronic copies of complaints posters and leaflets which are available in hard copy within Trust services.

26. MONITORING COMPLIANCE AND EFFECTIVENESS WITH THIS POLICY

26.1 For the purposes of monitoring the arrangements of this Complaints Policy the Trust shall maintain a record of each complaint received, the subject matter and outcome of each complaint and whether the outcome of the investigation was sent to the complainant within the agreed or amended period of response.

26.2 To monitor effectiveness the following audits shall be carried out.

Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Acting on recommendation and Lead(s)**	**Change in practice and lessons to be shared**
That all complaints are acknowledged within 3 working days of receipt	*Patient Experience Manager*	*Appendix 14*	*Every two years*	*Report to Quality and Safety Assurance Committee (QSAC) and/or Board*	*Required actions will be identified by the Executive Lead for Complaints and completed in a specified*	*Required changes to practice will be identified and actioned within a specific time frame. A lead*

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendation and Lead(s)	Change in practice and lessons to be shared
					timeframe.	*member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholder*
That all complaints are responded to within 25 working days	*Patient Experience Manager*	*Appendix 14*	*Every two years*	*Report to Quality and Safety Assurance Committee (QSAC)*	*Required actions will be identified by the Executive Lead for Complaints and completed in a specified timeframe*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholder*

Element to be monitored	*Lead*	*Tool*	*Frequency*	*Reporting arrangements*	*Acting on recommendation and Lead(s)*	*Change in practice and lessons to be shared*
That complaints received and responses sent are not placed on the patient's medical record (unless specifically requested by the patients and agreed to)	*Patient Experience Manager*	*Appendix 14*	*Every two years*	*Report to Quality and Safety Assurance Committee (QSAC)*	*Required actions will be identified by the Executive Lead for Complaints and completed in a specified timeframe*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholder*
That responses from relating to joint handling of complaints is co-ordinated appropriately	*Patient Experience Manager*	*Appendix 14*	*Every two years*	*Report to Quality and Safety Assurance Committee (QSAC)*	*Required actions will be identified by the Executive Lead for Complaints and completed in a specified timeframe*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholder*
That the Trust aims to improve as a result of complaints being raised	*Patient Experience Manager*	*Appendix 14*	*Every two years*	*Report to Quality and Safety Assurance Committee (QSAC)*	*Required actions will be identified by the Executive Lead for Complaints and completed in a specified timeframe*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholder*

27. COMPLIMENTS AND GENERAL FEEDBACK

27.1 In order to obtain a more balanced picture of how the Trust's services are received, it is important to also collect data about the compliments received within the organisation. All

compliments must therefore be copied to the Patient Experience Department for logging on a compliments register and reported on.

27.2 Service users and carers from time to time also provide feedback (positive and negative) stating explicitly that they do not want this to be viewed as a complaint. This should also be forwarded to the Patient Experience Department as such feedback may enable other services to improve.

28. REVIEW

28.1 This policy will be next reviewed in 2016 unless new regulations or changes in practice require amendments prior to that date.

29. ASSOCIATED DOCUMENTATION

- Explanatory Memorandum to support implementation of the 2009 Regulations
- The Ombudsman's Principles of Complaints Handling, Administration and Remedy
- Trust complaints leaflet and website as amended from time to time
- Safeguarding and Promoting the Welfare of Children PolicyTWC03
- Safeguarding Adults at Risk TWC40
- Reporting, Investigating and Learning from Serious Incidents TWC10
- Disciplinary Policies and Procedure
- Consent Policy (TWC13)
- Being Open: Sharing Information with Patients and their Relatives following a Patient Safety Incident (TWC16)
- Risk Management Strategy (7.8.3)
- Administration of Clinical Negligence Liability and Property Expenses Claims
- Safety Incidents with Patients and their Carers. London – NPSAClaims Handling Procedure (Clinical Negligence, Liabilities to Third Parties and Property Expenses Scheme Claims) TGP 006 2011
- Learning from Experience Policy (Incidents, Complaints and Claims)
- Subject Access Policy IG5
- Data Protection Policy IG4
- Information Governance Policy IG1

30. REFERENCES

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (SI no 309) Available at www.opsi.gov.uk
- The Parliamentary and Health Service Ombudsman. *Principles for Remedy (2007).* Available at: www.ombudsman.org.uk
- The Parliamentary and Health Service Ombudsman. *Principles of Good Administration (2007)*. Available at: www.ombudsman.org.uk
- The Parliamentary and Health Service Ombudsman. *Principles of Good Complaint Handling.* Available at: www.ombudsman.org.uk
- Department of Health (2009): Listening, improving, responding: a guide to better customer care. Available at www.dh.gov.uk
- The Healthcare Commission. *Complaints Toolkit – Handling Complaints within the NHS (2008).*
- National Patient Safety Agency (2005): Being Open – Communicating Patient
- Data Protection Act 1998. Available at www.opsi.gov.uk
- Freedom of Information Act 2000. Available at www.opsi.gov.uk

APPENDIX 1

South West London and St.George's NHS
Mental Health NHS Trust

THE 24 HOUR RULE

COMPLAINTS RESOLVED BY THE FOLLOWING DAY
(Verbal complaints only)

Name of complainant:	
Staff Name and Title who received and handled the complaint:	
Date/time complaint received	**Date/time Complaint resolved**
Complaint details	
How was it resolved (and resolution communicated to the complainant) 1. 2. 3. 4	
Is the complainant satisfied with the outcome? Y/N*	
*If no please provide assistance to the complainant to send in a complaint to the Chief Executive's Office or Patient Experience Team	

*****ONCE COMPLETED PLEASE SEND FORM TO THE PATIENT EXPERIENCE TEAM by FAX to 020 3513 5519*****

APPENDIX 2

South West London and St.George's NHS
Mental Health NHS Trust

Complaint Record Form

Date Of Complaint:	
Time Complaint Taken:	
Complaint Taken By (NAME):	
(POSITION):	
Name Of Team/Service/Ward:	

Complainant Details

Name:

Address:

Relationship To Patient:

Patient Details (Where Different)

Name:

Address:

Details Of Complaint

Please provide clear details of the complaint (and continue on a separate sheet if necessary)

Resolution Required

Please provide clear details of how the complainant would like to see their complaint resolved

***** Please now fax this form to the Patient Experience Team 020 3513 5519*****

APPENDIX 3

ACKNOWLEDGEMENT LETTER

Mr David Bradley
Chief Executive
South West London and St Georges
Mental Health NHS Trust
Springfield University Hospital
61 Glenburnie Road
London SW17 7DJ
Direct Line: 020 3513 6385
Fax: 020 3513 6703
E-mail: david.bradley@swlstg-tr.nhs.uk

[date]

Strictly Private & Confidential
[name and address]

Our Reference: xxxx

Dear [name]

Thank you for your complaint which was received on [date] regarding the [summary of issue]. This matter has been brought to my attention and your concerns will be investigated through the Trust's Complaints Procedure [*or Given the details of your complaint it has been referred for consideration by the Trust's Serious Incident and Governance Group on [x] who will decided whether it is more appropriate to undertake a Root Cause Analysis investigation under the Trust's Reporting, Investigating and Learning from Serious Incident Policy. We shall inform you of the decision by [x]]*

An Investigating Officer will be appointed to conduct an investigation. That person will contact you within 5 working days of your receipt of this letter, to discuss your complaint, agree a way forward and offer to meet with you. If the Investigating Officer cannot get through to you we will still work towards sending a response to you within 25 working days.

If you would like independent support or advice regarding your complaint, please contact the NHS Complaints Advocacy organisation on 0300 330 5454. Their email address is nhscomplaints@voiceability.org and their website is www.nhscomplaintsadvocacy.org

[As your complaint is about your detention under the Mental Health Act, you have the right to refer it to the Care Quality Commission (CQC). The CQC can be contacted on: CQC National Customer Service Centre, Citygate, Gallowgate, Newcastle-Upon-Tyne, NE1 4PA or call on 03000 616161. www.cqc.org.uk]

If you have any queries or wish to discuss this further please contact the Patient Experience Team on 020 3513 6150.

Yours sincerely
[name]
[Title]

On behalf of
[name]
Chief Executive

APPENDIX 4

OBTAINING CONSENT LETTER

[name and title]
South West London and St Georges
Mental Health NHS Trust
Springfield University Hospital
61 Glenburnie Road
London SW17 7DJ
Direct Line: 020 3513 6385
Fax: 020 3513 6703
E-mail:

[date]

Strictly Private & Confidential

[patients name and address]

Our ref:

Dear [patient name]

You may be aware that we have received a complaint involving your care.

So that the Trust can proceed with investigating and responding to the issues raised it is necessary for us to receive your consent to disclose information about to your [relative/representative][name].

If you agree to this, please find enclosed a copy of the consent form, to be returned to me at the Patient Experience Team, Building 14, Entrance C, Springfield Hospital, 61 Glenburnie Road, London SW17 7DJ in the stamped addressed envelope provided as soon as possible.

Yours sincerely

[name]
[Title of Patient Experience Team staff]

Encs.

APPENDIX 5

INITIAL CONTACT SHEET
THE 7 DAY RULE

- This form should be used by the Complaints Officer at the time of making contact with a complainant on or before day 7 to try and resolve the complaints and/or to agree how their complaint is going to be handled in the future

Name of Complaints Officer:	
Name of Complainant and Case No:	
Date of contact (s):	
Attempts at contact (where not successful)	

Summary of issues raised by complainant in addition to the existing complaint

What outcome does the complainant want to resolve the complaint? (e.g. apology, explanation, redress)

1.

2.

3.

I have discussed with the complainant:

- How the complaint will be handled Y/N
- When the investigation is likely to be completed Y/N
- When the complainant is likely to receive a response Y/N
- Independent advocacy support signposted Y/N

Date of form completion:

APPENDIX 6

GUIDANCE FOR INVESTIGATIONS

1. Investigating Complaints

This section is intended as a guide for staff who may need to handle or investigate complaints it should be used in conjunction with the Trust's Complaints Policy and the Ombudsman's Principles of Complaints Handling, Administration and Remedy.

Advice is available to staff on any aspect of complaints handling from the Complaints Manager during standard office hours. Out of hours staff may call the on-call manager for advice and support.

2. Verbal Complaints

Any member of staff who is approached by a service user or their representative with a complaint should endeavour to resolve the matter straightway or by the end of the following day to the complainant's satisfaction. If the matter is serious or cannot be resolved by then it should be referred to the Patient Experience Team by writing down the complaint on the form attached at Appendix 1 and assistance should be given to complainant to do this. If the complainant does not wish to do this they should be directed to contact the Patient Experience Team.

3. The Investigation

General Principles

The investigating Officer must investigate the complaint appropriate to resolve it speedily and efficiently and keep the complainant informed as far as reasonably practicable as to the progress of the investigation.

Things to consider that define your investigation are: what happened? What should have happened? What are the differences between those two things?

Scoping

As part of the initial stages of the investigation, the Complaints Officer shall scope of the investigation from the complaint and understand the precise nature of the complaint being raised (It is important that the investigating officer reads and understands the complaint from the perspective of the complainant). The complaint should be broken down into individual issues if it is complex or lengthy and this should then be agreed with the complainant if contact is possible and form the headings of any proposed response

The Complaints Officer should at least consider the following:

- Who are the key people involved? (e.g. service user/carer, staff, other witnesses)
- What documentation do I need to review? (e.g. clinical records, incident reports, staff statements, policies//procedures/guidelines)
- Are there any other factors I need to consider? (e.g. physical environment, equipment, custom and practice)
- Do I need any support/assistance to undertake the investigation?
- Whether any remedial action needs to be taken?

Immediate Remedial Action

The Complaints Officer should consider whether any immediate remedial action needs to be taken by the Trust and facilitate that action and report on them in the Investigation Report.

Contact with the Complainant

The Complaints Officer should make personal contact with the complainant, by telephone if possible and offer a meeting. This can be helpful in terms of confirming the details of the complaint, assessing the feelings of the complainant and establishing what they are looking for as an outcome of the investigation. In many cases, it can lead to the swift resolution of a complaint.

It is important that accurate notes are made of any discussions that take place so that records give a true picture of the contents of those discussions.

The following should be recorded:

- The names of all who took part, together with the date, time and place of the discussions.
- The purpose of the discussions
- Key facts
- The main points made by those making the complaint
- Comments from senior staff about those points.
- Apologies for any failures in service
- Details of any follow up action that has been taken or will be taken
- Any details on how the matter is being taken forward, especially in the context of the Complaints Procedure.

If any meeting is arranged with the complainant then the guidance on meetings at Appendix 9 should be followed.

4. Documentation and collating evidence

All aspects of the investigation should be clearly recorded and all documentation, (including staff statements that must be obtained within 5 working days of their request or earlier), incident reports, copies of clinical records etc) should be carefully reviewed. Staff should be aware that, should the matter proceed to litigation, all complaints documentation is subject to disclosure.

Copies of complaints correspondence must **not** be held on the service user's health and social care records (to help ensure that the complainant is not prejudiced by the complaint) unless the complainant specifically requests this and such request must be in writing to the Complaints Manager.

When you review the documentation you may consider it necessary to conduct an interview to get the evidence you need. To conduct a successful interview it is important to:

- understand the needs of the person and the background of the complainant
- know the questions you want to ask in advance
- know when specialist support is needed
- let the interviewee know in advance what you are likely to ask so they can prepare and explain that you would like to record the conversation with their permission

- hold the interview in a private place and avoid interruptions

5. Continuing care

The complainant will of course continue to receive care from the Trust. Complaints Officers should exercise sensitivity both from the point of view of the team or services that is the subject of a complaint and the complainant and consider whether it is appropriate to offer a change of named nurse, care co-ordinator or consultant etc while the complaint is being investigated and to facilitate those changes.

The Investigating Officer should also ensure that any urgent remedial action is taken, particularly with complaints about patient safety, and ensure that any incidents highlighted by the complaint are reported appropriately.

6. Holding response for delay

If the investigation is unlikely to be completed within the **25 day target** or the date otherwise **agreed with the complainant**, a letter shall be sent to the complainant explaining the reason for the delay and providing a new time frame.

7. On completion of the Investigation

Having completed the investigation, the Complaints Officer should ensure that all relevant documentation gathered or reviewed (e.g. statements, incident reports, copies of clinical notes, meetings etc.) are stored securely.

The Complaints Officer must carefully check the completeness of the investigation, the quality of the response, to ensure that all the issues raised in the complaint have been addressed and subject it to line management review before sending it to the Chief Executive.

8. The Proposed Response

The template for preparing the proposed response letter is attached at Appendix 12. Whilst answering the complaint as fully as possible the response should be clear using simple language and avoiding jargon.

Overtly legalistic responses should be avoided and clear distinctions made between fact and opinion. Where it has not been possible to answer the complainants allegation in full this should be stated, as well as the reasons for it.

Finally, an apology is not an admission of guilt and especially where the service has clearly failed the complainant this should be included. An apology should also be given to recognise the complainant's distress, even where the Trust is not at fault.

9. Support/Feedback to Staff

Staff who may be the subject of a complaint can be anxious about the process and their position. It is important that they are kept informed about progress with the investigation by the Complaints Officer and that they are offered the opportunity to discuss the matter with a professional colleague or the staff advisory service. They should also be encouraged to contact their union or professional body.

Staff subject to a complaint shall be shown a copy of the final response to make them aware of its content.

It should be made clear to all staff that the complaints process is separate from the disciplinary process.

10. Vexatious Complaints

There may be occasions when staff encounter a complainant who is potentially vexatious (see Appendix 15). If it is considered that a complainant is becoming vexatious, the Investigating Officer should discuss the matter with the Complaints Manager who will advise on the procedure to be followed in such circumstances.

APPENDIX 7

Guidance on Conducting Complaint Meetings

This guidance is based on Good Practice from the Healthcare Commissions Complaints Handling Toolkit (2008).

1. In the event that the complainant or their representative wishes to have a meeting to discuss the complaint, outstanding concerns or as part of the process of resolution, this should be facilitated. It is essential to have the relevant people in attendance and a clear idea of the areas the complainant or their representative wish to explore.

2. When setting up the meeting, ascertain who will accompany the complainant and whether any additional support is required, e.g. advocate, interpreter etc.,

3. Appropriate staff from the division and/or the Patient Experience Team should be in attendance.

4. Meetings can, of course, take place at any stage in the process and do not have to wait until after a written response. It can be good practice to arrange an early face-to-face meeting with a complainant so that all of the issues can be talked through in depth and resolution may be possible at this stage. At whichever stage of the process a meeting takes place, the better the preparation; the more likely it is that a satisfactory outcome will be achieved.

5. It is important to engage the complainant in the process of arranging a meeting to ensure that the time and venue are convenient; all of the issues are included in the meeting agenda; all relevant parties attend; anybody the complainant reasonably does not want to see is not in attendance; and any special support is arranged, for example an interpreter. Complainants should be encouraged to bring an ICAS advocate or a friend or relative for support. The agenda should be clear and comprehensive and include details about who will be present, when and where the meeting will be and what will be discussed.

6. The date and time meeting, agenda and venue along with attendees should be confirmed in writing at least five days before the meeting is due to take place.

7. With regard to advance preparation, it is vital that people in attendance are familiar with the complaint and its background. Good practice would indicate that, where possible, a case conference should be held in advance of the meeting so that all staff members concerned are sufficiently familiar with the background to the complaint and the issues involved.

8. Essential things to record include:

    - the response to the desired outcomes, in particular, reasons for non-agreement; timeframes for implementing any changes to training, orientation, policy, etc;

    - how the complainant will be advised of completion of agreed-upon tasks;

- any apology offered; and any significant agreement or disagreement on facts. Reading notes at the end of the meeting will allow everyone present to reach agreement on their content.

- Meetings should not be adversarial and a conciliatory approach is preferred. You should make efforts to fully involve the complainant in the process and, where it is decided that remedial action must be undertaken, include the complainant in the discussions about how this needs to take place.

10. After the meeting, you should follow up and write to the complainant to confirm the nature and outcome of the discussions. The timescale for this should be agreed with the complainant at no longer than 5 -10 days after the meeting. This is particularly important where follow-up work has been agreed and should include timescales and detailed proposals. It may be worthwhile to involve the complainant in the change process. He or she may be able to provide feedback on any proposed guidelines or policy, or participate in or attend training sessions, if this is considered appropriate.

11. In seeking to resolve the complaint either during correspondence or at a local resolution meeting, complaint handlers need to consider carefully the range of remedies that are potentially available. Remedies can take a variety of forms, including (alone or in combination):

- apologies, explanations and acknowledgements of responsibility
  remedial action, such as reviewing or changing a decision on the service given to a complainant, revising published material, revising procedures to prevent the same thing happening again, or training staff

- financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, or distress

12. The Ombudsman's Principles for Remedy set out the approach that should be taken when determining remedies. The Principles can be found at www.ombudsman.org.uk/improving_services/rmedy/index.html

13. Every possible attempt should be made to resolve the complaint locally including the options for reinvestigation and external review. However, if the complainant or their representative remains dissatisfied at the conclusion of all attempts at local resolution, they must be informed of their right to contact the Parliamentary and Health Ombudsman for an independent review.

APPENDIX 8

Guidelines for Writing a Statement

Context

In order that a comprehensive reply can be provided in response to a complaint, it is often essential that written statements are obtained from relevant members of staff.

This allows those members of staff the opportunity to provide their account of the key facts in response to allegations or issues raised by a complainant, particularly where there may be insufficient information available from other sources (e.g. case notes, incident forms). Whilst a request to provide a written a statement may cause some degree of anxiety, it is important to recognise that statements are used to ensure that the investigation process and response to the complainant can be clear, accurate, balanced, simple, fair and easy to understand and that all points raised in the complaint are addressed.

Your statement should be

Timing

1. provided to the Complaints Officer no later than 5 working days from the date of the request or sooner of greater urgency is required

Content

2. honest and open and full

3. in chronological order and make sure you are clear about what you are to comment on (if you are not, ask the Complaints Officer who requested the statement).

4. stick to the facts and make clear which parts are from clinical records/other records and which parts are from memory. When you are referring to records please be specific and reference and attach them to the statement. Also, provide copies of relevant additional information

5. Avoid opinions or judgements and do not respond with a defensive or hostile tone

6. Be as detailed as possible: giving dates, times and locations.

7. Include dates and times of the relevant event(s)/incident(s).

Format

7. Address your statement to the Investigating Officer (including their title) who requested the statement and ensure that it is typed.

8. Date the statement.

9. Start with an introduction or heading (e.g. “This is a statement of events in connection with the allegations made by Mr X in his complaint letter of X”).

10. Use full names and titles of any professionals referred to in the statement.

11. Answer all relevant allegations/questions/issues raised by the complainant and respond to the concerns in the same order as the complainant has detailed; list, if helpful (e.g. 1, 2, 3 etc).

12. Sign and print your name and grade/title at the end of the statement. You may wish to ask your line manager to check your statement before sending it to the Complaints Officer.

APPENDIX 9

COMPLAINT RESPONSE TEMPLATE

[
Mr David Bradley
Chief Executive
South West London and St Georges
Mental Health NHS Trust
Trust Headquarters, Building 15
Springfield University Hospital
61 Glenburnie Road
London SW17 7DJ
Direct Line: 020 3513 6385
Facsimile: 020 3513 6703
E-Mail: david.bradley@swlstg-tr.nhs.uk

Date

Private & Confidential

Name
Address
Address
Address
Postcode

Our Reference: XXXX

Dear (Name),

I am writing in response to your recent complaint dated (INSERT DATE OF THEIR COMMUNICATION), regarding (INSERT BRIEF OVERVIEW OF COMPLAINT). I am sorry that you have needed to raise these concerns and would like to begin by apologising for any ensuing distress we may have caused you. (IF THE RESPONSE IS OVERDUE, SEPARATE OUT AND ENHANCE THE APOLOGY TO REFLECT THE DELAY).

In order to consider the details of your complaint, I asked Mr Darren Langridge/Ms Jacqueline Ewers/Ms Jane Healey/Ms Angela Evans (DELETE AS APPROPRIATE), Serious Incidents and Complaints Officer, to conduct an investigation on my behalf in accordance with the Trust's formal complaints procedure. In summary, the concerns you raised were as follows:

1. Concern 1;

2. Concern 2; and

3. Concern 3.

As part of the investigation, (IO) (SAY WHAT THE INVESTIGATION INVOLVED, FOR EXAMPLE A REVIEW OF THE COMPLAINANTS ELECTRONIC CLINICAL RECORDS AND INTERVIEWS WITH STAFF – IF THE LATTER, GIVE STAFF NAMES AND JOB TITLES). (IO) has now concluded (HIS/HER) investigation and I would like to take this opportunity to respond to each of your concerns in the order above for ease of reference:

1. Response 1

2. Response 2

3. Response 3

(PLEASE MAKE SURE THE RESPONSES ADDRESS THE CONCERNS RAISED USING EMPATHIC LANGUAGE AND CLEARLY IDENTIY ACTIONS TAKEN TO ADDRESS THE COMPLAINT/LEARNING IDENTIFIED)

Please let me take this opportunity to reassure you that as part of our commitment to delivering the best standards of care possible for service users, families and carers, we take all complaints received very seriously. They provide us with opportunities to review and reflect upon current practices, and allow us to consider changes that will enhance the standards of care we strive to achieve.

In closing, I hope this letter has addressed the concerns you raised. If you would like to discuss any aspect of this letter by telephone or a face-to-face meeting, then please do not hesitate to contact Mr Darren Langridge/Ms Jacqueline Ewers/Ms Jane Healey/Ms Angela Evans (DELETE AS APPROPRIATE), Serious Incidents and Complaints Officer, on 020 3513 6150.

If you are not satisfied with my response, you have the right to take your complaint to the Health Service Ombudsman. The Ombudsman is independent of government and the NHS. Her service is confidential and free. There are time limits for taking a complaint to the Ombudsman. You can contact their helpline on 0345 015 4033, email phso.enquiries@ombudsman.org.uk or fax 0300 051 4000. Further information about the Ombudsman is available at www.ombudsman.org.uk.

You can write to the Ombudsman at:

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

If you need any help or advice to make your complaint to the Ombudsman you can contact the NHS Complaints Advocacy organisation. They can be contacted as follows:

NHS Complaints Advocacy
VoiceAbility
United House
North Road
London
N7 9DP
Helpline: 0300 330 5454
Fax: 0330 088 3762
E-Mail: nhscomplaints@voiceability.org
Website: www.nhscomplaintsadvocacy.org

OR (FOR SUTTON RESIDENTS)

Healthwatch Sutton
Granfers Community Centre

73-79 Oakhill Road
Sutton
Surrey
SM1 3AA
Helpline: 020 8644 2867

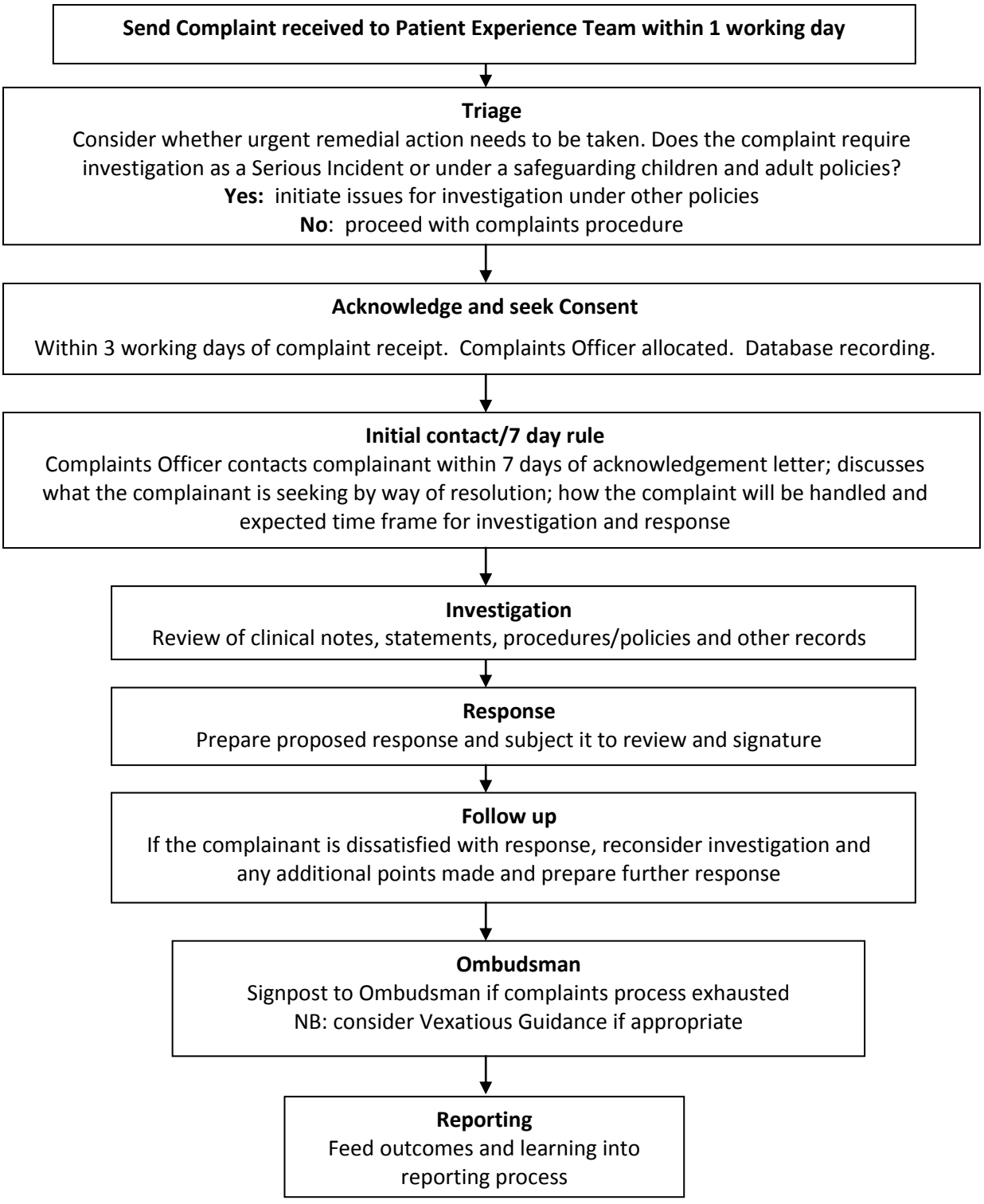
[As your complaint is about your detention under the Mental Health Act, you have the right to refer it to the Care Quality Commission (CQC). The CQC can be contacted on: CQC National Customer Service Centre, Citygate, Gallowgate, Newcastle-Upon-Tyne, NE1 4PA or call on 03000 616161. www.cqc.org.uk]

Yours sincerely,

[name]
Chief Executive
Encl.

APPENDIX 10

COMPLAINTS INVESTIGATION FLOW CHART



APPENDIX 11

VEXATIOUS COMPLAINANTS: GUIDANCE AND POLICY

1. INTRODUCTION AND CONTEXT

Complaints received within the Trust are a form of feedback on our services form service users and the public. It is important, therefore, that robust processes are in place to investigate appropriately and respond in timely and constructive way. It is therefore imperative that service users who choose to do so are not subsequently discriminated against or made to feel guilty for having raised their concerns.,

However, complainants who display unreasonable behaviour put a strain on time and resources and cause stress to staff. Whilst staff endeavour to respond to complainants with patience and sympathy there are times when unreasonable behaviour is extreme or persistent and there is nothing further which can be reasonably done to assist the complainant or to rectify a real or perceived problem.

The aim of this policy is to help identify situations where a complainant may legitimately be regarded as behaving unreasonably and to outline ways of responding in such situations. The decision to deem a complainant's behaviour unreasonable should only be made after all appropriate steps have been taken to try and resolve the complaint through the Trust's normal Complaints Procedure. Where appropriate the complainant should have been encouraged to contact an Advocacy Service for help and advice and to seek their support and to provide liaison with the Trust.

Staff concerned should ensure that there is a complete record of the steps that have been taken. Judgment and discretion will be needed in deciding the action to be taken in specific cases.

2. CRITERIA FOR DEEMING A COMPLAINANT VEXATIOUS

Complainants (and/or anyone acting on their behalf) may be deemed to be vexatious where previous or current contact with them shows that they meet one of the following criteria:

2.1 **Persist in pursuing a complaint** when the Trust's complaints procedure has been fully and properly implemented and exhausted, or is not within the Trust's remit to investigate; or

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

2.3 Are **unwilling to accept documented evidence** of treatment given as being factual, e.g. drug records, manual or computer records, nursing records; or

2.4 **Deny receipt** of an adequate response in spite of correspondence specifically answering their questions; or

2.5 **Do not clearly identify the precise issues** which they wish to be investigated, despite reasonable efforts of Trust staff and, where appropriate, the aid of advocacy services to help them specify their concerns. Or the concerns identified are not within the remit of the Trust to investigate but they continue to be raised; or

2.6 **Focus on a trivial matter** to an extent that is out of proportion to its significance and continue to focus on this point. *(It is recognised that determining what is a "trivial" matter can be subjective and careful judgement must be used in applying this criteria);* or

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

2.8 Have **harassed,** threatened, or used actual physical violence, been personally **abusive or verbally aggressive, racist or homophobic** towards staff dealing with their complaint or their families or associates.

(This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter only be pursued through written communication. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They must document all incidents of harassment using the Trust's incident reporting system).

3. PROCEDURE FOR DECLARING A COMPLAINANT VEXATIOUS

3.1 Staff that have been dealing with the complainant are to provide to the Patient Experience Manager evidence of potentially vexatious behaviour (such as notes of conversations, correspondence etc).

3.2 The Head of Quality Governance and/or Patient Experience Manager is to

(1) consider whether the complaints procedure has been **correctly implemented so far as possible and that no material element of a complaint overlooked** (even habitual or vexatious complaints may have aspects which contain some genuine substance; ensure that an equitable approach has been followed); and

(2) prepare the evidence of meeting the vexatious criteria above to the Complaints Review Meeting which shall meet from time to time to consider such cases.

3.3 The Complaints Review Meeting, on behalf of the Chief Executive, shall consider the complaint and any response(s) to it together with evidence presented regarding the complaints process or vexatious criteria and any other relevant information and shall declare or otherwise whether the vexatious criteria has been met and provide direction as to the nature of any future communication of the Trust with the complainant and others. Such decision and direction is subject to the approval of the Chief Executive and if approved the recommended or amended steps shall be implemented.

4. Complaints Review Meeting

4.1 The approved decision must be recorded in writing with its reasons for the decision for the decision and, once approved, a copy provided to the complainant and their representative together with any direction as to communication and copy to others already involved in the complaint (such as practitioners and clinicians, conciliators, advocacy services, Member of Parliament)

4.2 The Complaints Review Meeting has discretion on how it may decide to deal with its consideration this may include, but not limited to, directing the following:

(1) try to resolve matters by drawing up a signed "agreement" with the complainant (and if appropriate involving the relevant clinician in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action; and/or

(2) decline contact with the complainants either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained. (If staff are to withdraw from a telephone conversation with a complainant the following statement or other alternative may be used: I'm sorry I am unable to deal with your complaint. I understand your complaint is being dealt with by ....., please contact telephone number .....); and/or

(3) restrict communication through a third party (e.g. advocate) by negotiation; and/or

(4) notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered (other than a request for Independent Review, if applicable (NB: before this action is taken, the Complaints Manager must ensure that the complainant has been informed of their right to request an Independent Review by the Ombudsman); and/or

(5) inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors; and/or

(6) temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Strategic Health Authority or other relevant agencies; and/or

(7) time limit the declaration or make it subject to its review or reconsideration;

5. Effect of declaration

Subject to the terms of the Complaints Review Meeting's decision, a complainant who is declared vexatious does have the right to make new complaints if they wish and they shall be considered on merit (if they fall outside the Complaints Review Meeting's direction) by the Patient Experience Manager. The complainant should be treated fairly during the investigation of new complaints however the complainant should conduct themselves in an acceptable and courteous manner and not verbally harass or cause offence to Trust staff and other service users or be breach of any direction of the Complaints Review Meeting decision.

6. Victims of Harassment

Where staff have been assaulted, verbally abused or harassed the Trust will consider whether it is appropriate to report the facts to the police with a view to criminal prosecution. If the police and the Crown Prosecution Service decide not to prosecute, the Trust will advise its staff to consider the commencement of a private prosecution. (The Trust will also advise its staff as to the commencement of appropriate civil action such as an injunction if appropriate. The Trust will provide the member of staff with the appropriate support in taking such action).

7. Withdrawing Vexatious Status

Once complainants have been determined as vexatious, the Complaints Review Meeting may determine at a later stage that the complainant is no longer vexatious if, for example, complainants subsequently demonstrate a more reasonable approach.

APPENDIX 12

CASE EXAMPLE 1

A patient, Mrs A, was admitted to Jasper ward from St Helier Hospital on 16 December 2008, where she had been treated for injuries sustained by a fall from a third-floor balcony, and was displaying psychotic symptoms. Mrs A had had previous contact with the mental health services.

Mrs A was placed on 10 minute observations when she was admitted. The next day, she was found on the floor by her bed on two occasions, and was placed on continuous observations. At 4pm, Mr A visited and found his wife being nursed on the floor by her bed and in pain, and asked for a doctor to examine her. At approximately 6pm, Mrs A was examined by a doctor and found to have severe bruising to her left eye and forehead, and she was incoherent. An ambulance was called and she was taken to A&E at St Helier Hospital, and subsequently admitted.

On 28 December 2008, the Trust received a complaint from Mr A. Mr A complained about the care and treatment that his wife received on Jasper Ward, and about the attitude of nursing staff.

Mr A stated that the situation was traumatic and raised serious questions. He wanted a positive answer to his complaint so that they could resolve the matter without contacting a solicitor.

The Trust acknowledged the complaint on 30 December, and stated that a response would be issued in four weeks. The Investigating Officer failed to telephone Mr A and agree a way forward and no letter was sent to him in this regard.

However, on 18 January, the Trust wrote to Mr A to offer a meeting. A meeting was held on 6 February. On 2 March, Mr A contacted the Patient Experience Team, angry that he had not received a response to his complaint.

On 3 March the Trust decided to investigate the complaint under the Critical Incident procedures, and advised Mr A that this would be completed by 7 April, but subsequently informed him that there would be a delay until 24 April.

On 25 April the Trust wrote to Mr A, enclosing a draft RCA report and offering a meeting to go through it. The report stated that the Trust had not yet been able to interview all the nursing staff who were responsible for keeping Mrs A under continuous observations on

17 December, and was not able to locate the continuous observation sheets, and it was therefore not possible to determine the exact events and reasons for the bruising.

On 26 April, Mr A contacted the Trust, stating that he did not wish to meet, and would be pursuing litigation.

Comment:
It seems that in this case, not contacting Mr A at an early stage and the delays incurred in investigating the complaint exacerbated the situation, and may have prevented there being any chance of achieving successful resolution.

This complaint illustrates the importance communicating effectively with the complainant and of obtaining all relevant evidence as quickly as possible. On receipt of the complaint, the Trust should have contacted Mr A quickly and initiated a full investigation, and secured all relevant documentation. Statements from staff who were on duty on 17 December should have been gathered.

Unfortunately, the Trust did not contact Mr A until three weeks after receiving his complaint, and did not initiate a full investigation for over two months. By the end of April, some staff had still not been interviewed, and even if they had, would be unlikely to provide an accurate recollection of an incident that took place in December. In these circumstances, the frustration felt by Mr A, and his decision to pursue litigation, is understandable.

CASE EXAMPLE 2

On 2 October 2008, the Trust received a complaint from Mrs B, regarding her admission to Tolworth Hospital in July 2008. Mrs B complained that she was subject to inappropriate physical restraint, and was forcibly cleaned whilst naked, in front of a male nurse. Mrs B stated that she felt humiliated and ashamed and was looking for an apology, and action taken to ensure that a similar incident did not happen again.

The Trust acknowledged the complaint on 2 October and forwarded it for investigation. The Investigating Officer telephoned Mrs B and acknowledged her distress and agreed a timeframe within to respond and set up a meeting. The Investigating Officer gave Mrs B her direct line if she wanted to discuss any issue. Statements were immediately requested from the staff who were involved in the incident. An investigation report, action plan and draft response was forwarded to the Patient Experience Team within the set timescales, and a comprehensive response issued within the timeframe agreed with Mrs B.

The response apologised to Mrs B for the feelings that she experienced, and assured her that the Trust takes such matters very seriously. The response outlined the investigation process and then addressed each part of Mrs A's complaint in detail. The response explained the chronology of events, and explained the actions of staff. The investigation did not uphold the main aspects of Mrs B's complaint, but found some areas where the care provided could have been of a higher standard. The Trust apologised for this, and outlined the action it was going to take to address this.

Comment:

This is an example of very good complaints handling. The Trust immediately initiated a full investigation and the urgent collection of evidence from staff, as well as from the complainant, provided the investigating officer with full and accurate information which informed the investigation report and draft response. The response was excellent in tone and content; it provided appropriate apologies and sought to give Mrs B assurance that the Trust takes such complaints very seriously, and seeks to learn from them.

Grading Categories

Risk Scores

This information classifies all incidents for future analysis, and helps identify the scope of any further investigation and remedial action. This scoring is used in grading complaints.

The table below should be used to provide a simple assessment of the degree of risk associated with the incident. All reported incidents are graded according to the actual impact on the patient(s) and the potential future risk to patients and to the organisation, and reviewed to establish stakeholder-reporting requirements.

Who grades incidents/complaints?

Because of the subjective nature of the grading process, it is essential that the person, or persons, designated with authority to grade adverse patient incidents have been trained to do so, and that their performance is periodically audited.

Process:

a. Score consequence first

b. Consider use of modifiers

c. Score likelihood – based on past information – (has it happened before) and knowledge of future events / context

d. Calculate risk score

e. All risks of 15 and over should be reported to the Director of Nursing & Governance for inclusion on the Corporate risk register

Very Low risk – 1 – 4

Low Risk – 5 – 8

Medium Risk – 9 – 12

High Risk – 15 and above

Table 1a: Consequence Score

	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Tragic
Injury	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	RIDDOR reportable	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care – short term effects	Mismanagement of patient care – long term affects	Totally unsatisfactory outcome or experience
Complaint / Claim Potential	Locally resolved complaint	Justified complaint peripheral to clinical care	Below excess claim. Justified complaint involving lack of appropriate care	Claims above excess level. Multiple justified complaints	Multiple claims of single major claim
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget schedule slippage. Minor reduction in quality / scope	5 – 10% over budget / schedule slippage. Reduction in scope or quality requiring client approval	10 - 25% over budget / schedule slippage. Doesn't meet secondary objectives	>25% over budget / schedule slippage. Doesn't meet primary objectives
Service / Business Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality (<1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training	Non-delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training
Financial	Small loss (>£100)	Loss > £1,000	Loss > £10,000	Loss > £100,000	Loss > £1000,000
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with core standards	Prosecution. Zero rating. Severity critical report
Adverse Publicity	Rumours	Local media – short term	Local media – long term	National media < 3 days	National media > 3 days. MP concern (Questions in the House)

Table 1b: Consequence Modifiers

Consequence Modifiers (up to a maximum score of 5)		
Modifiers	Number Affected	Importance
Plus 2	**More than the whole organisation (>3000)**	**Critical objective / project / service**
Plus 1	**More than one team or department (>50)**	**Important objective / project / service**
Minus 1		**Minor objective / project / service**

Table 2 : Likelihood Score

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	**Not expected to occur for years**	**Expected to occur at least annually**	**Expected to occur at least monthly**	**Expected to occur at least weekly**	**Expected to occur at least daily**
Probability	**<1%**	**1 – 5%**	**6 – 20%**	**21 – 50%**	**>50%**
	Will only occur in exceptional circumstances	**Unlikely to occur**	**Reasonable chance of occurring**	**Likely to occur**	**More likely to occur than not**

Likelihood	**Consequence**				
	1 Insignificant	**2 Minor**	**3 Moderate**	**4 Major**	**5 Tragic**
1 – Rare	1	2	3	4	5
2 – Unlikely	2	4	6	8	10
3 – Possible	3	6	9	12	15
4 – Likely	4	8	12	16	20
5 – Almost Certain	5	10	15	20	25

Level of Risk

VERY LOW	LOW	MEDIUM	HIGH (Unacceptable)

APPENDIX 14

Patient Experience Team
*** Data Collection Tool ***
(Please use one tool per standard)

Date of Audit:	Auditors Initials:
Audit Tool Code:	

Standard	Met	Not Met	N/A	Comments
That all That All complaints are acknowledged within 3 working days of receipt				
That all complaints are listened to responded to				
That complaints received and responses sent are not placed on the patient's medical record (unless specifically requested by the patients and agreed to)				
That responses from relating to joint handling of complaints is co-ordinated appropriately				
Actions are taken as a result of complaints and learning reported				

APPENDIX 15

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	NO	
	• Ethnic origins (including gypsies and travellers)	NO	
	• Nationality	NO	
	• Gender	NO	
	• Culture	NO	
	• Religion or belief	NO	
	• Sexual orientation including lesbian, gay and bisexual people	NO	
	• Age	NO	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	NO	
2.	**Is there any evidence that some groups are affected differently?**	NO	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NO	
4.	**Is the impact of the policy/guidance likely to be negative?**	NO	
5.	**If so can the impact be avoided?**		
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NO	
7.	**Can we reduce the impact by taking different action?**	NO	

If you have identified a potential discriminatory impact of this procedural document, please refer it to Victoria Gregory, Complaints Manager, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Claire Alexander, Clinical Governance Manager