West Hertfordshire Hospitals NHS
NHS Trust

**ANNEX 3**

# Complaints Policy and Procedure

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| Author | Lynn Hill |
| Author's Job Title | Trust Quality Manager |
| Division | Corporate Nursing, Midwifery, Quality & Risk |
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| Manager responsible for review | Lynn Hill |
| Manager Job Title | Trust Quality Manager |
| E-mail address of Manager | Lynn Hill@whht.nhs.uk |

West Hertfordshire Hospitals NHS
NHS Trust

# Complaints Policy and Procedure

## Contents

**Appendices:**

## 1. Policy Statement

West Hertfordshire Hospitals NHS Trust acknowledges the importance of an effective and efficient Complaints Policy and Procedure. It also recognises that complaints provide useful management information and learning opportunities about the quality of services from the perspective of patients, their families, friends, carers, the wider general public and staff.

We are strongly committed to a **Listening, Acting and Improving** approach to concerns and complaints that is honest and thorough. This policy seeks to ensure that any concerns raised, or complaints made are handled without delay and with the aim of satisfying the complainant whilst being fair, open and honest with all those concerned.

By resolving complaints quickly and efficiently the Trust will be able to consider lessons learnt and improve services.

This Policy and Procedure describes to the complaints process (See Appendix 1 for summarised procedure). Please refer to Trust's Procedure for the Investigation and Root Cause Analysis of Incidents, Complaints and Claims for guidance for practical advice on effective investigation.

This Policy is based on national legislation and guidance (See Appendix 2), as an interim measure until the NHS Complaints Reform becomes available.

## 2. Definition of a Complaint

A complaint may be defined as an expression of dissatisfaction with some aspect of service(s) (including staff performance) by a patient, visitor, carer, representative group, or member of the general public or staff.

Complaints may be lodged verbally or in writing (by letter, fax or email) and may be addressed to any level of the organisation.

## 3. Who the Complaints Policy and Procedure is for

Any member of staff could come into contact with a patient or carer or organisation that wants to make a complaint to the Trust. It is essential that this policy is read by all staff and should be made available to patients and complainants on request.

**This policy and procedure covers complaints made by:**

- Patients
- Former patients or visitors using the Trust's services and facilities

- Someone acting on behalf of existing or former patients advocate, for example a Member of Parliament (MP), providing they have obtained the patient's consent
- Any appropriate person in respect of a patient who has died e.g. the next of kin or their agent
- General Practitioners
- External organisations

**This policy is patient centred, however it cannot cover the following areas:**

- Complaints from staff. Internal staff complaints will continue to be handled separately using the relevant policies and procedures obtainable from Human Resources and on the Trust's Intranet. E.g. Grievance Procedure and Raising Concerns Policy and Procedure.
- Complaints that relate to the Trust's partners. E.g. Hertfordshire Partnership Trust, Social Services, General Practitioners, Private Healthcare providers and Primary Care Trusts.
- Complaints about the Ambulance Service.

## 4. Policy Objectives

- To resolve complaints as quickly and effectively as possible, through an informal response by a frontline member of staff. If this is not possible then through a more formal investigation and conciliation in an open and non-defensive way.
- To ensure that all complaints are dealt with in accordance with the Trust's Complaints procedure (See Flowchart, Appendices 3 &4).
- To ensure that staff, patients and relatives/carers are aware of the policy and procedure.
- To improve quality of service by identifying lessons learned from complaints locally and nationally and by implementing improvements in service using the lessons learnt.
- To uphold even-handedness for both staff and complainant alike.

## *5.* Policy Principles (NHS Review Committee: Wilson, May 1994)

- Easy, accessible and well publicised
- Simple to understand and use
- Allows speedy handling, within established time limits and keep people informed of progress
- Ensures a full and fair investigation
- Respects confidentiality and upholds the Caldicott principles of confidentiality (See Appendix 5)
- Addresses all the points at issue and provides an effective response and appropriate redress
- Provides information for the improvement of health services

## 6. Trust Accountability

The Chief Executive is the designated officer in accordance with Department of Health Circular HC (88) 37 and is accountable for thorough investigation of complaints within the Trust.

The Trust has in place an effective complaint system and processes supported by regular monitoring by maintenance of data on a database (Datix) that is reviewed at Divisional and Trust Board level.

In the event that an accumulation of similar complaint occurrences are detected across the Trust, Divisions or Departments, a report must be prepared by the Quality Manager for submission to the Trust Risk Management Committee and which will be filtered into the Trust Board.

The Trust will demonstrate overall accountability by sharing complaints statistics in the Clinical Governance Reports with all departments and by monitoring and sharing investigation findings and implementation of actions.

The Trust will have simple, readily available, written information about the right to complain, advice about how to use the complaints procedure and the help available to complainants from staff, Patient Advice & Liaison Service and other users of the service. This can be made available in languages other than English. (See Appendix 6 for contact information for interpreting, advocacy and advice). The Trust also has produced the information booklet “Making Your Voice Heard, Comments, Compliments and Complaints” a copy of which is provided to anyone making a formal complaint within 48

hours of a letter being received. The booklet is widely available in all departments of the Trust and explains the processes available to them.

The Trust will not suspend the complaint procedure if a death is referred to the Coroner's Office/Inquiry is established.

The complaint procedure will be stopped if legal action is started.

## 7. Roles and Responsibilities (In Relation to Complaints)

**Chief Executive:**

Holds overall responsibility for all areas of complaints as part of Risk Management within the Trust.

**Medical Director:**

Holds executive responsibility for the medical aspect of complaints handling and provides advice and guidance with the medical aspect of complaint responses. The Medical Director (or nominated clinical colleague) also chairs Local Resolution Meetings and Independent Review Panel/Health Service Ombudsman report action planning meetings.

**Director of Nursing, Midwifery, Quality and Risk**:

Holds executive responsibility for the day-to day management of the Quality department, clinical and non-clinical risk, patient, public and staff involvement.

**Director of Operations**:

Holds executive responsibility for the complaints performance within the Trust's Clinical Divisions and manages the Assistant Director of Operations and the Divisional Managers for Acute Medical Care, Surgery & Anaesthetics, Specialist Services, Clinical Support Services & Women's & Neonatal Services.

**Director of Planning:**

Holds executive responsibility for the complaints performance within the Facilities Division and manages the Divisional Manager for Facilities

**Director of Finance:**

Holds executive responsibility for the complaints performance within the Clinical Informatics Division and manages the Associate Director of Clinical Informatics.

**Quality Manager:**

Holds day-to-day responsibility for guiding and facilitating the implementation of the complaints policy and procedures, complaints training, linking complaints with clinical incidents, litigation claims and audit and providing advice. The Quality Manager reports to the Deputy Director of Nursing, Quality & Risk.

**Deputy Quality Manager:**

Holds day to day responsibility for collecting and disseminating complaints management data, guiding and facilitating the complaints department staff, implementing and monitoring the complaints processes, complaints and induction training, managing clinical negligence claims and providing advice. The Deputy Quality Manager reports to the Quality Manager and line manages the Quality Assurance Team.

**Patient Advice and Liaison Service Manager (PALS):**

Holds day-to-day responsibility for resolving informal concerns and complaints and that complaints are graded and recorded appropriately. The PALS Manager reports to the Deputy Quality Manager.

**Quality Assurance Manager:**

Holds day-to-day responsibility for ensuring formal complaints are acknowledged and answered in an effective and timely way and that complaints are graded and recorded appropriately. The Quality Assurance Manager reports to the Deputy Quality Manager.

**Trust Risk Manager:**

Holds day to day responsibility for guiding and facilitating the implementation of risk management policies and procedures, ensuring collection and dissemination of risk management data and providing risk management advice including advice relating to risk/non clinical incidents. The Trust Risk Manager reports to the Deputy Director of Nursing, Quality and Risk.

**Clinical Governance Manager:**

Holds the day-to-day responsibility for ensuring that the information generated from complaints handling is incorporated into the Trust Clinical Governance Reports in order to highlight the emerging themes and trends. The reports are then used to address areas of concern throughout the Trust, in order to improve the level of services provided.

**Divisional Managers**:

Divisional Managers are responsible for ensuring that staff within their areas of management are aware of and comply with the Complaints Policy and Procedure. They are additionally responsible for ensuring timely nomination of an appropriately trained investigator and that where appropriate, complaints are thoroughly investigated using Root Cause Analysis, statements and notes are taken and, must provide accurate and timely responses for complaints to the Quality Assurance Department. Their nominated Service Managers must also maintain accurate, full and consistent records of the complaints relating to their area of work, the investigation, final response and action plans. The Action Plan implementation and progress must also be monitored and documented.

**Heads of Nursing and Midwifery**:

Are responsible for ensuring timely nomination of an appropriately trained investigator and that complaints are thoroughly investigated using Root Cause Analysis, statements and notes are taken and, must provide accurate and timely responses for complaints to the Complaints Department. Heads of Nursing and Midwifery must also maintain accurate, full and consistent records of the complaints relating to their area of work, the investigation, final response and action plans. Action Plan implementation and progress must be monitored and documented.

**Ward Managers/Modern Matrons:**

Are responsible for ensuring that appropriate action is taken concerning informal resolution through to PALS and customer care training is provided and staff attitude monitored and addressed as appropriate, to avoid potential complaints.

**All staff:**

Are responsible for treating patients, carers, visitors and colleagues with empathy, dignity and respect. All staff must familiarise themselves with the Complaints Policy and Procedure and ensure that complainants are given the correct advice on how and to whom to complain. Complainants must not be pushed 'from pillar to post'. All verbal complaints must be recorded on the Trust's Single Incident Reporting Form.

## 8. Complaints Involving More Than One Organisation

Where a complaint concerns more than one organisation, the organisation receiving the complaint must ensure that the complainant receives a full

response. In such cases the complainant's written permission should be sought before the complaint is passed on to the other organisations.

When complaints span more than one Trust, a protocol must be agreed that identifies how the investigation is to be undertaken, who the lead officers are and which Trust is responsible for keeping complainants informed at all times. The organisation receiving the complaint would normally also be expected to lead joint internal reviews.

## 9. Complaints Procedure Overview

The complaints procedure is built around the processes of Informal Local Resolution, Local Resolution and Independent Review and is based upon National Health Service Guidance. For more information go to www.doh.gov.uk/complaints .

Where possible and appropriate, **Informal Local Resolution** is offered. In these instances PALS should be the first point of contact for the complainant, if the Ward or Department in question cannot resolve the complaint immediately. PALS will 'Triage' the complaint to decide who should handle it. When appropriate, PALS will act as facilitators to help resolve the concern or complaint quickly, efficiently and fairly. If PALS cannot help resolve the complaint informally, they must explain the options available to pursue the complaint formally. All complaints that cannot be resolved immediately must be recorded on a verbal complaint form and passed on to PALS.

The principal objective of **Local Resolution** is to provide the fullest opportunity for investigating and resolving concerns and complaints in an open, fair, flexible and conciliatory manner. These complaints are dealt with, within the Trust.

**Verbal complaints** must be recorded and graded on the Trusts Single Incident Reporting Form. Where the risk is graded at yellow or red, the complainant should validate the verbal complaint.

**Conciliation** is a way of dealing with complaints that helps to avoid adversarial situations. By bringing the two sides together with a neutral conciliator, it aims to facilitate a satisfactory conclusion for both the complainant and the Trust. There is a statutory requirement to provide conciliation as an option during the complaint's procedure, for the benefit of both those complaining and those being complained about. This is an independent and confidential service open for referrals from all agencies.

Either a complainant or the organisation that is being complained about can ask for conciliation, but both must agree to the process of conciliation taking

place. If conciliation is the agreed and adopted approach the Trust must contact the Complaints Support Service for Primary Care Trusts.

The conciliator is not an advocate for either party their role is to give impartial support to both parties working through an issue. The conciliator will adopt procedures that are most appropriate for conducting the conciliation process.

The conciliator's first step is to hear what has happened from each individual perspective. The conciliator has no advisory or decision-making role - they are purely facilitating the parties to find their own solutions. The conciliator has to behave impartially and is there to support everyone to try to achieve what for them would be a successful resolution ~ without agreeing with a particular viewpoint.

The conciliator must confirm that all discussions, the meeting (and any agreements made at it) are confidential and without prejudice. Parties are required not to repeat the detail of the discussion. This helps to ensure safety for all involved to speak openly. The complaints procedure regulations require that a conciliator report the outcome of a meeting i.e. 'resolved' or 'not resolved'.

N.B. Included in this Policy is sections for **handling intractable (habitual and/or vexatious) complainants** and **anonymous complaints**. These complaints are handled within Local resolution procedures.

Complainants who remain dissatisfied with the response they receive as a result of Local Resolution may request an **Independent Review** of their continuing concerns.

Complainants can also complain to the **Health Service Ombudsman** if there is dissatisfaction with the outcome of Local Resolution and Independent Review.

## 10. Time-limits

Complaints should be made **as soon as possible** after the event to which they relate. Generally the Trust will investigate complaints that are:

- Made within 6 months of the event; or

- Made within 6 months of the complainant realising that they have cause for complaint, as long as that is no more than 12 months after the event itself.
- If the complainant was not aware of that there was cause for complaint, then the complaint must be made within 6 months of the date of awareness or 12 months from the date of the event whichever is earlier.

The Trust has discretion to extend these time limits where it would have been unreasonable for the complaint to be made earlier and where it is still possible to investigate the facts. If this discretion is rejected, the complainant may appeal to the Chief Executive and, if again refused, to the Trust Convenor.

## 11. Management of Complaints

Many potential formal complaints may be prevented from arising if the initial contact is handled personally with understanding, sensitivity, empathy and respect. If required, PALS should be used to help resolve concerns raised at this stage.

### 11.1 Complaint Grading/Classification

Staff responsible for coordinating investigation of the complaint must grade all complaints in accordance with the Trusts Risk Scoring Matrix (Appendix 7) and recorded in the Trusts complaints database (Datix). Following investigation, if required complaints must be reclassified accordingly. Links between complaints and incident reports must also be made.

### 11.2 Record keeping

The Quality Assurance Department and PALS are required to maintain an up to date and accurate record and database of all complaints and suggestions that they handle, including investigation notes and signed and dated statements.

Information handling that includes person identifiable information must be in accordance with the Data Protection Act 1998 and Caldicott requirements.

### 11.3 Performance indicators

- All staff must be made aware of their responsibility concerning formal complaints and relevant timescales;

- Acknowledgement letter to the complainant within two working days of receipt of complaint;

- Full response to the complaint within 20 working days of receipt of complaint;

- All clinicians are required to make themselves available to participate in investigation interviews if asked to do so.

### 11.4 Referral and escalation

Written complaints and verbal complaints that are graded as yellow or red must be referred immediately to the appropriate Executive Director. The Quality Assurance Department keep the Quality Manager fully informed concerning complaints that are graded as yellow or red or that may escalate to a claim.

### 11.5 Investigation, resolution and recommendations

Suitably trained staff in accordance with Trust guidance must carry out complaints investigation. Root Cause Analysis must be used for complaints that are graded as yellow or red to establish the active and latent factors that gave rise to the complaint and must be crosschecked with incident reports. Refer to the Trust's Procedure for the Investigation and Root Cause Analysis of Incidents, Complaints and Claims, which can be found on the Trust's Intranet front page under "Policies".

All options to assist local resolution must be explored, including, meetings with appropriate managers/senior clinicians responsible for the patient's care, conciliation, referrals to ICAS (Independent Complaints Advocacy Service) to help complainants through the complaints process.

Sustainable recommendations and an action plan to address the issue of the complaint must be developed, documented and monitored, overseen by the Divisional Manager. The Clinical Governance Committee must review complaint trends, recommendations arising from trends and subsequent actions.

## 12. Complaints about Trust Executive Directors

Complaints made concerning an Executive Director should be made in writing to the Chief Executive who will investigate the allegations and respond. Complaints concerning the Chief Executive and non Executive Directors should be made in writing to the Trust's Chairperson who will investigate the allegations and respond.

## 13. Closing a Complaint

The response from the Chief Executive or their representative will offer a meeting with senior staff where appropriate, in the event of complaints

associated with clinical care. These will be established as quickly as possible. Once a meeting has been convened this will be seen as the close of the local resolution procedure.

Providing the Trust finds no other issues to investigate and is satisfied that no further action can be taken, the complainant must be advised, in writing of how to proceed to Independent Review and who may assist them in this action. (Please refer to the booklet "Making Your Voice Heard" for further details).

## 14. Independent Review

The Commission for Health Audit & Inspection (CHAI) will carry out Independent Reviews (subject to Legislation). Until this change is implemented, if the complainant continues to remain dissatisfied s/he should be advised or his/her right to refer the matter to the Convener for Independent Review. Conveners will have received appropriate training and follow national guidance.

The Convener (Non-Executive Director of the Trust) will expect the complainant to write to them with their remaining concerns. If the complainant cannot write in then they must tell the Convenor's office their remaining concerns and these must be clarified before the process can continue. The Convener will ascertain whether all opportunities for satisfying the complainant has been fully explored and also whether due care was given and if not, were the systems, processes and procedures at fault. It must be decided within 20 working days of receipt of request (in consultation with a Lay Chairperson) whether an Independent Review Panel should be established.

The complainant must be sent a letter informing them of the decision to establish a panel, or not and the reasons and the complainant must be informed of their right to take their complaint to the Health Service Ombudsman.

The Chief Executive must also receive a copy of the written statement from the complainant and the Conveners response.

Actions must be taken based on the Independent Review panel's recommendations.

All Independent Review reports and the Trust's action plan will be received and approved by the Trust Board.

**Summary Timetable for Independent Review Panel Process:**

The target timetable is as follows:

- Convenor's acknowledgement following receipt of request: 2 working days
- Convenor's decision to set up Panel, or not, following receipt of request: 20 working days
- Appointment of Panel members following decision to set up a Panel: 20 working days
- Draft Panel report following formal appointment of Panel: 50 working days
- Final Panel report following draft report: 10 working days
- Response to complainant by Chief Executive after receipt of final report: 20 working days

## 15. Final Stage: Health Service Ombudsman

Following an Independent Review Panel report, the Chief Executive should provide information about the complainant's right to take their grievances to the Health Service Ombudsman if they remain dissatisfied.

All complainants have the right to refer complaints to the Ombudsman but unless the circumstances of a particular case indicate to him that such a course would be unreasonable, he may not undertake investigations unless he is satisfied that the Local Resolution and Independent Review processes have been exhausted. It must therefore be made perfectly clear to the complainant when the NHS complaints processes are considered to have been completed.

Leaflets explaining the Ombudsman's procedures are available from the Quality Assurance Department or by accessing www.ombudsman.org.uk

## 16. Complaints and Negligence Claims

Even if a complainant's initial communication is via a solicitor's letter it cannot be assumed that the intention is to take legal action.

Complaints correspondence and accident/adverse incident reporting information is not regarded as privileged by the Courts, (although there continues to be some uncertainty about the legality of a claim of privilege in respect of documents created in the course of an internal Trust investigation into an adverse outcome). This means that all correspondence and papers generated in the course of a complaints investigation, including staff statements etc, will have to be disclosed to a claimant if they later pursue a claim for negligence through the courts.

The Data Protection Act 1998 classifies complaints and untoward incident documentation as personal data. Patients are able to request copies of complaints and risk management files in the same way as they do their health records.

If investigation of a complaint reveals a possibility that there may have been negligence on the part of the Trust, the Investigating Officer should immediately contact the Quality Manager and agree the way forward. The existence of negligence does not prevent a full explanation being given and if appropriate, an apology. An apology is not an admission of liability.

If at any time it becomes clear that the complainant is intending to take formal legal action, the complaints procedure should be brought to an end and the complainant and the complained against advised appropriately in writing in a letter signed by the Chief Executive. The papers should then be passed to the Litigation and Claims Manager for reporting to the NHS Litigation Authority.

## 17. Requests for Copies of Health Records and X-Rays

Where a complainant requests copies of the Health Records and/or x-rays under the complaints procedure these will be released in accordance with the Data Protection Act 1998 or the Access to Health Records Act 1990 (for deceased patients). The Litigation and Claims Administration Assistant will be responsible for organising the release of the relevant records and x-rays within 40 working days of receipt of request and ensuring relevant charges are calculated and requested.

## 18. Out-of-Hours Procedure

Written complaints are opened on the first working day received. The out of hour's procedure relates to verbal complaints received in person or by telephone.

The definition of an escalated complaint is where the consequence to the Trust of any delay would be major or catastrophic and it is felt that immediate remedial action must be taken.

Out of hours procedures and contact points for when verbal complaints escalate are:

**Telephone**: Switchboard must contact the on-call Manager.
**In person**: Staff must refer the complainant to the on-call Manager.

The-on call Manager must take an accurate record of the complaint and grade it in accordance with the Trusts Risk Scoring Matrix. The complaint must be referred on to the on-call Divisional Manager, who will refer it to the on-call Executive Director if it is felt that due to the severity of the complaint, it cannot wait to be processed on the first working day available. The Quality Manager must be notified of such complaints as soon as possible.

## 19. Training

Complaints management must be included in staff induction and staff update training. There is an in-house training manual called “How to Deal With Complaints”. This is available from the Quality Assurance Department and is also available on the front page of the Trust Intranet under “Policies”.

Training needs analyses must be carried out by Divisional Managers/line managers to identify gaps in core skill set requirements for investigators and other staff likely to receive a formal complaint:

- Communication skills training requirements (all staff).

- Risk Scoring (Risk Manager, Risk Leads, Divisional / Senior Managers, Quality Manager, Ward/Department Managers/Investigators, Complaints Officers and PALS staff).

- Root cause analysis and investigation skills (Risk Manager, Divisional & Service Managers, Quality Manager, Deputy Quality Manager, Heads of Nursing & Midwifery, Ward & Department Managers, Quality Assurance Manager, Litigation & Claims Manager and PALS Manager).

- Linking incidents and complaints with risk assessments and risk registers (Risk Manager, Divisional Risk Leads, Quality Manager).

- Statement and summary discussion writing (Divisional & Service Senior Managers, Quality Manager, Deputy Quality Manager, Quality Assurance

Manager, Complaints Investigators, Litigation & Claims Manager, PALS Manager).

- Letter and report writing (Divisional & Service Managers, Quality Manager, Deputy Quality Manager, Quality Assurance Manager, Litigation & Complaints Manager, Complaints Investigators).

- Interviewing skills (Divisional & Service Managers, Quality Manager, Deputy Quality Manager, Complaints Investigators, PALS Manager).

All complaints training must be prioritised according to need targeted and formally evaluated and improvement based upon staff feedback.

Complaints management must, where appropriate be included within the Trust's appraisal process and personal development plans should reflect training needs concerning complaints.

## 20. Recruitment

The following statement must be introduced into all job descriptions:

'Ensure that all staff consciously review mistakes, complaints and incidents/near misses as well as successes to improve performance and the level of customer care.'

## 21. Patient Consent

Complaints made on behalf of patients must be made with the patient's consent. This is to comply with the Data Protection Act 1998 and Caldicott Requirements (refer to the Trusts Caldicott for Beginners leaflet). Exceptions to this are if the patient is:

- **A child.** If in the course of investigating a complaint it becomes clear that the child is mentally emotionally and physically capable of pursuing a complaint themselves (Gillick Competent) then their consent must be obtained to allow someone to act on their behalf.

- **Is incapacitated or has died.** If a patient is incapacitated either mentally or physically, consent is not needed. If the Chief Executive is of the opinion that the person acting on behalf of an incapable individual or in respect of someone who has died is not a suitable person, he/she may refuse to deal with that person and nominate another person to act. This discretion will be exercised in only exceptional circumstances.

- **Third party**. Where a complaint is received from **a third party** in respect of a capable adult or child, the Quality Assurance Department must obtain that person's consent for the Trust to:

- Accept and respond to the complaint from a third party; and
- Access personal health information, to the extent necessary to investigate and respond to the complaint.

## 22. Intractable complaints

There are exceptional circumstances when a person may pursue a complaint to the point where it becomes unreasonable, despite every effort by the Trust to try and resolve the issues or the perceived issues by:

- Ensuring that the Trust's Complaints Policy and Procedure has been correctly implemented as far as is possible; and
- No material element of a complaint has been overlooked or inadequately addressed.

A complainant may be regarded as unreasonable if, during previous or current contact with the Trust, one or more of the following criteria is met:

- Threaten/use physical violence towards staff. Harassment, personal abuse or aggressiveness towards staff.
- Persistence in pursuing a complaint where the procedure has been fully and properly implemented and exhausted.
- Have unreasonable demands or expectations and fail to accept that these may be unreasonable.
- Constantly raises new issues or changes the focus of the original complaint to seek to prolong correspondence.
- Unwillingness to accept factual documented evidence e.g. medical records and charts or do not accept that facts can sometimes be difficult to verify when a very long period of time has elapsed.
- Focus on the trivial, which is out of proportion to its significance and is repeated during all communication.
- Unreasonable demands upon staff by making an excessive number of contacts.
- Is a relative, friend or carer of a patient, where the patient does not have a personal complaint (assuming that there are no capability issues concerning the patient).
- Unauthorised recording(s) of meeting(s) or face to face/telephone conversation(s) without the prior knowledge or consent of the parties involved.

Intractable (including habitual or vexatious) complaints must be assessed by the Quality Manager and referred for review to the Medical Director who will decide whether the complaint is unreasonable and should be classified as such.

The Director of Nursing, Midwifery, Quality and Risk will notify the Chief Executive and the Quality Manager of the decision and if the complaint is classified as unreasonable, will write to the complainant stating;

- The Trust has fully considered and responded to the concerns raised in the original complaint.
- Despite efforts by the Trust to answer/resolve the complaint to the complainant's satisfaction, there is nothing more to add and therefore the correspondence is at an end.
- Further letters from the complainant concerning the issues raised will be acknowledged but not answered.

## 23. Complaints Made by Children

If a child has a complaint he or she should be asked whom they would like to talk to about it.

Complaints made by children should be handled where possible by the staff on the Ward, who are trained to talk to children in an age appropriate and child friendly way. The Trust Child Protection Advisor should be notified without delay.

Children should be encouraged to express their concerns without prompting or 'leading' questions. It should be recognised that a child may need to express their complaint through drawing or other media.

PALS, an interpreter or Link worker may be needed to support communication and resolution of the complaint.

All complaints should be recorded and if not resolved informally, it should be processed through the usual procedures. The response should be conveyed to the child in an accessible format/way. Where appropriate, liaison with the named Paediatric Consultant and appropriate personnel from Hertfordshire Partnership Trust will quality assure and validate the response to the child to ensure it answers the concerns in a way that will be understood.

## 24. Anonymous Complaints

Anonymous complaints or allegations must be forwarded to the Trust's Quality Assurance Department should be recorded in the Datix database under 'anonymous complaints'.

The Quality Assurance Manager must bring to the attention of the Quality Manager, who will in turn advise the appropriate Divisional Manager of the anonymous complaint or allegation. The decision and reasons should be recorded in the Datix database.

If the complaint is investigated, the final report recommendations and final actions must be submitted to the Quality Manager and then filed in the Datix database for reference.

## 25. Staff Complaints

Members of staff making a complaint should approach their line manager in the first instance. If this is not possible or appropriate, they should approach a Senior Manager or Executive Director responsible for the area of work in question. Alternatively the member of staff can use the Zero Tolerance Policy, Grievance Procedure or Raising Concerns Policy, (The Raising Concerns Policy provides a framework for staff to raise concerns about the delivery of care to patients, or about fraud or corruption).

Human Resources must record staff complaints via any channel within the Trust on a centralised database. The investigation and resolution process must be carried out using similar principles to that of the Complaints Policy and Procedure.

## 26. Complaints and the Disciplinary Procedure

It is the view of the Board that disciplinary action should NOT form part of the complaints process except in certain cases where one or more of the following applies:

- Where, in the view of the Trust and/or any professional registration body, the action causing the complaint is malicious, criminal or constitutes gross or repeated misconduct.
- Where there is a failure to report an incident that was raised as a complaint, in which the member of staff was either involved or about which they are aware.
- Where there is a repetition of repeatedly reported complaints/incidents involving the same staff.

- Failure to undertake remedial action as advised from a previous similar complaint or incident.

In these cases, the member of staff concerned will be managed through either:

- An investigation under the Disciplinary Procedure;
- One of the professional regulatory bodies due to for example, possible professional misconduct;
- A Serious Incident Inquiry; or
- An investigation of a criminal offence.

The issues discovered by the investigator, must be passed immediately to the Divisional Manager for referral to the Chief Executive.

If a decision is taken to embark upon a referral, the complaint should continue to be investigated as usual.

## 27. Service Improvement

The information originating in complaints must be used to improve the quality of the service provided by the Trust. Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint.

- Careful monitoring of all complaints must be undertaken by the Quality Assurance Department and detailed reports must be provided to the Clinical Governance Manager on a monthly basis. In addition information must also be supplied to Divisional Managers, the Complaints Advisory Group and the Strategic Health Authority on a quarterly basis in conjunction with information on the status of legal claims and clinical and non-clinical incidents.
- Each Divisional Manager is expected to monitor complaints and incident trends within the Division.
- Each Division is expected to provide a plan of action taken to improve the service through systems of policy, process or practice changes and training to reduce the risk, as far as possible, of similar situations occurring. A mechanism for monitoring the improvements must be included in the plan.

The action plan, trends and monitoring reports concerning complaints (and other quality and risk issues) must be subsequently provided to the Clinical Governance Manager on a quarterly basis.

## 28. Reporting Requirements

The Clinical Governance Department is required to provide monthly complaints reports to Clinical Governance Committee outlining:

- Number of formal complaints received, number of formal complaints open and overdue responses.
- Performance monitoring statistics (acknowledgement and response times).
- Complaint trends by Division.

For the local complaints handling procedure (See Appendix 8).

**Appendix 1**

# Flow Chart for NHS Complaint's Procedure

The current NHS Complaint's Procedure came into effect on 1 April 1996. It was designed to make it easier for patients to access, quicker and more openly. The procedure operates in broadly the same way, irrespective of which part of the NHS is complained about. The overall approach of the complaints process is to be honest and thorough, with the main aim of resolving problems and satisfying the concerns of the complainant.

Below shows in brief the procedure for making a complaint if Informal Resolution fails:

| | |
|---|---|
| **Stage 1 ~ Local Resolution**<br><br>A complaint will usually be made to the person or organisation that provides the service being complained of. | **Stage 1**<br><br>▪ The Chief Executive ensures a full investigation and response to the concerns of the complainant. |
| **Stage 2 ~ Independent Review**<br><br>▪ If a complainant is not satisfied with the outcome of Local Resolution, they may ask for an Independent Review | **Stage 2**<br><br>▪ The Convener decides, in consultation with an independent layperson if an independent review panel is appropriate.<br><br>▪ An Independent Review Panel will comprise of 3 members: A lay Chairman, the Convener and a third lay member.<br><br>▪ Complaint is investigated and a written report is provided, detailing any recommended actions to be taken by the organisation |
| **Stage 3 ~ Health Service Ombudsman**<br><br>▪ If the complainant remains dissatisfied with the response from the NHS, they may refer the matter to the Health Service Ombudsman | **Stage 3**<br><br>▪ Independent of both the NHS and Government<br><br>▪ Looks at all aspects of NHS care<br><br>▪ Normally expects complainants to have tried to resolve their concerns through the NHS<br><br>▪ Complaints procedure needs to have been followed first |

**Appendix 2**

## Legislation and Guidance

The West Hertfordshire Hospitals NHS Trust policy draws on guidance issued under the legal framework for the NHS complaints procedure. It is set out in Directions made under powers conferred on the Secretary of State by Section 17 of the National Health Service Act 1977, Section 1A of the Hospital Complaints Procedure Act 1985, and paragraph 6(2)(e) of Schedule 2 to the NHS and Community Care Act 1990.

Separate Directions were issued in 1996, and subsequently in 1998, to cover the arrangements for making a complaint in different parts of the NHS. Following changes to the structure of the NHS following enactment of the NHS Reforms and Health Care Professions Act 2002 (*Shifting the Balance of Power*) it has been necessary to clarify the complaints role of primary care trusts and to reflect the abolition of health authorities in the complaints Directions. Duties on health authorities for operating parts of the complaints procedure transferred to primary care trusts on 1st October 2002. The Department of Health will be carrying out a separate exercise to update the existing Directions so that they take account of the Amendment Directions and reflect the post 1st October 2002 roles and responsibilities. Other guidance used to develop this policy include:

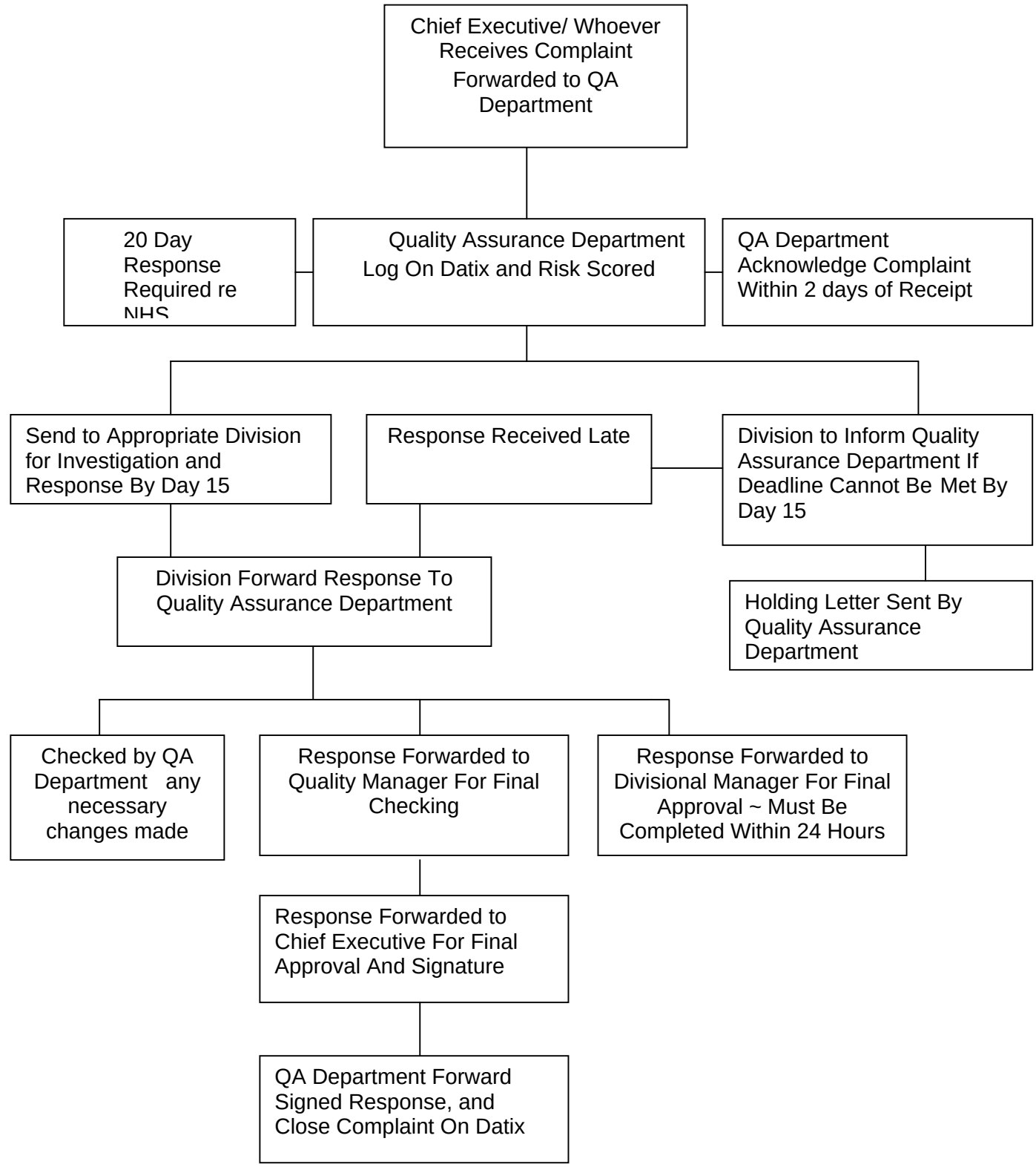
- NHS Complaint Procedure" Acting on Complaints" (NHS Executive March 1996) which was developed following the publication of "Being Heard" (Willis Report 1994)
- Acting on Complaints March1995
- NHS Complaints Procedure Revised Guidance for Family Health Service Hospital and Health Board Complaints
- Reforming the NHS Complaints Procedure: A listening Document (Sept 2001)
- NHS Complaints reform: making things right. March 2003
- Data Protection Act 1998
- Human Rights Act
- Caldicott Principles
- Clinical Negligence Scheme for Trusts/Risk Pooling Scheme for Trusts
- The NHS Complaints Procedure Revised Guidelines ~ May 1999 provides specific guidance for dealing with the intractable (habitual and /or vexatious) complainant.

**Links to Trust Policies:**

Risk Management Policy and Strategy
Guidance on Risk Scoring Matrix and Risk Register
Incident Reporting Policy (incorporating the Serious Untoward Incident Policy)
Grievance Procedure
Raising Concerns Policy
Serious Untoward Incident Procedure
Zero Tolerance Policy
Procedure for the investigation and root cause analysis of incidents, complaints and claims
How to Deal with Complaints

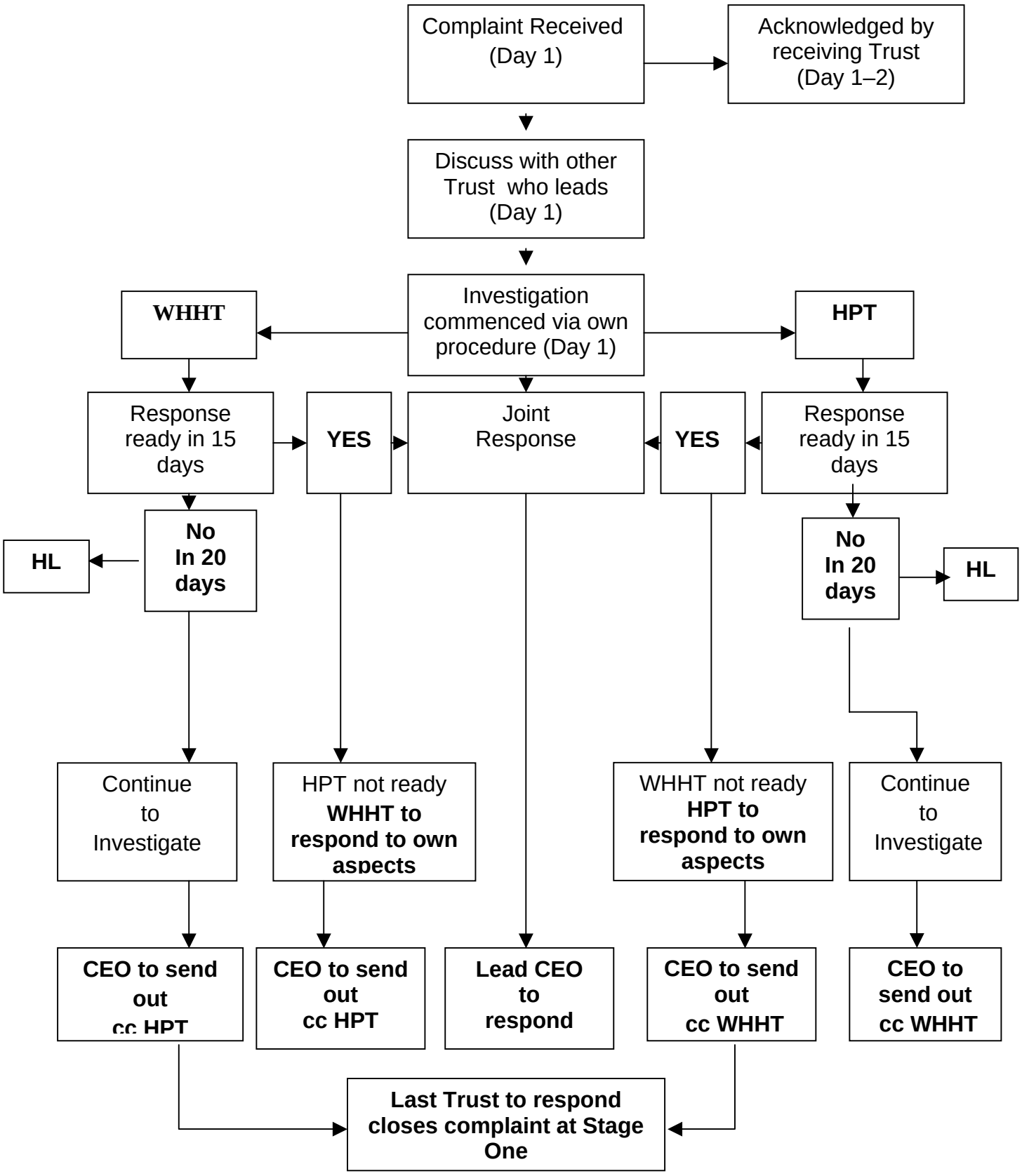
**Appendix 3**

## West Hertfordshire Hospitals NHS Trust Complaints Procedure Flow Chart



**Appendix 4**

## WHHT & HPT Joint Complaint Response Flowchart



**Appendix 5**

## The Caldicott Principles of Confidentiality

### Principle 1 ~ Justify the purpose

Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

### Principle 2 ~ Don't use patient-identifiable information unless it is absolutely necessary

Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

### Principle 3 ~ Use the minimum necessary patient-identifiable information

Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

### Principle 4 ~ Access to patient-identifiable information should be on a strict need-to-know basis

Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes. Do not send unsecured emails via Yahoo, Hotmail etc containing patient identifiable information. Documents should be password protected if there are no alternative means of transmitting the information.

### Principle 5 ~ Everyone with access to patient-identifiable information should be aware of their responsibilities

Action should be taken to ensure that those handling patient-identifiable information - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

### Principle 6 ~ Understand and comply with the law

Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

The Trusts Caldicott Guardian is: Mr Howard Borkett-Jones, Medical Director
For information on Data Protection, contact Mrs Nicola Bateman, Data protection Manager

**Appendix 6**

## Contacts for Support and Interpreting Services

### Patient Advice & Liaison Service (PALS).

The Patient Advice Liaison Service is an independent service offering confidential advice, information and support to patients, their families and their carers. They will act as facilitators to negotiate with the appropriate personnel to forward your complaint to the appropriate department. The Trust provides this service as a gateway for patients, their carers and families so that we can improve our quality of care. PALS can be contacted through the Hospital Switchboard. or by use of the dedicated Mobile Telephone Number 07790 550718

### Patients' Representative Forum.

The Patients' Representative Forum is a voluntary body of patients and ex-patients who visit all wards, clinics and outpatient departments in the hospital on a regular basis to talk to patients. They are very keen to help any one who has a problem. They may be contacted through the Hospital Switchboard.

### Independent Complaints Advocacy Service (ICAS)

ICAS is not connected with the Trust, and offers complainants independent support through the complaints process. ICAS can be contacted on: 0845 456 1082. The Commission for Patient and Public Health Improvement (CPPIH) monitors ICAS.

### Link workers for people whose language is not English

Link workers are available to help people whose first language is not English. They provide advocacy and interpreting services. This service can be accessed through People of Hertfordshire Want Equal Rights (POhWER), the Bedfordshire and Hertfordshire ICAS provider on the number above.

### Further Advice and support

Complainants can telephone NHS Direct on 0845 4647 for information on complaints.

### Health Service Ombudsman

**www.ombudsman.org**

If there is dissatisfaction with the outcome of Local Resolution and/or Independent Review write to: Health Service Ombudsman, 11th Floor, Millbank Tower, Millbank, London SW1P 4QP

# Risk Scoring Matrix

**Appendix 7**

## Qualitative Measures of Consequence of Risk

| Level | Descriptor | Injury/Harm | No. of people affected at one time | Actual or potential impact on Trust | Quality | Potential Cost | Potential for claims / Complaint | Reputation/ Publicity |
|---|---|---|---|---|---|---|---|---|
| 1 | Negligible | No injury or adverse outcome | One - None | No loss to the organisation - no interruption of non-critical service | Negligible non-compliance of standards | No loss | Complaint ~ possible litigation ~ remote | Within unit only |
| 2 | Minor | First aid treatment/ short term injury/ damage (e.g. injury resolved within a month) | One | Minimal risk to the organisation/ Minor loss of non-critical service | Minor non-compliance of standards | <£100 - £5,000 | Complaint ~ possible Litigation ~ unlikely | Within unit Local press <1 day coverage |
| 3 | Moderate | Medical treatment required, semi permanent injury / damage (e.g. injury that takes up to 1 year to resolve) | Small numbers 3 - 10 | RIDDOR reportable MDA reportable Short term sickness Loss of services in any critical area | Repeated failures to meet internal standards or follow protocols | £5,001K - £100K | Complaint ~ highly Litigation ~ possible but not certain | National media >2 day coverage Department Needs PR management |
| 4 | Major | Permanent disability requiring lifelong care Multiple injuries/unexpected death RIDDOR reportable injury* | Moderate numbers | Service closure RIDDOR reportable Long term sickness | Failure to meet national standards | £100,001 – £5m | Litigation expected / certain | National media >3 day of coverage MP concern Questions in the House |
| | Catastrophic | Multiple fatalities | Many (e.g. cervical screening disaster) | Loss of multiple essential services in critical areas | Failure to meet professional standards | >£5m | Litigation expected / certain | Full public enquiry |

***For comprehensive listing of events, refer to Appendix 1 in the Trust's Risk Scoring Matrix and Risk Register**

**Appendix *7 Cont.***

## Qualitative Measures of Likelihood of Risk (Prospective analysis)

| Level | Descriptor | Description |
|---|---|---|
| 1 | Rare | The event **may** occur only in **exceptional circumstances** |
| 2 | Unlikely | The event **could** occur at **some time** |
| 3 | Possible | The event **will** occur at **some time** |
| 4 | Likely | The event **will** probably occur in **most circumstances** |
| 5 | Almost Certain | The event is **expected** to occur in **most circumstances** |

## Qualitative Risk Assessment for Evaluation of Severity and Prioritisation of Risk (Prospective analysis)

| Consequence | Descriptor | Rare - 1 | Unlikely - 2 | Possible – 3 | Likely - 4 | Almost Certain – 5 |
|---|---|---|---|---|---|---|
| 1 | Negligible | 1 | 2 | 3 | 4 | 5 |
| 2 | Minor | 2 | 4 | 6 | 8 | 10 |
| 3 | Moderate | 3 | 6 | 9 | 12 | 15 |
| 4 | Major | 4 | 8 | 12 | 16 | 20 |
| 5 | Catastrophic | 5 | 10 | 15 | 20 | 25 |

**Legend:** Blue - Low risk; Grey - Moderate risk; Yellow – Significant risk; Red - High risk

***Adapted from: AS/NZS 4360:1999 : Risk Scoring Matrix –Risk Management Department July 03***

**Appendix 8**

## Local Complaints Handling Procedure

### 1. Approach

This new staff procedure has been prepared to facilitate the speedy resolution of complaints by the local resolution process. Often the complainant wants an informed explanation about the cause of the complaint and if it is justified, reassurance that the complaint is being treated seriously and that practice will be changed to help prevent it happening again.

Complaints are rarely straightforward, and often, poor communication hinders resolution. This procedure places resolution as close to the issue as possible with the Divisional Manager leading the investigation. Complex complaints across more than one Division are co-ordinated by the Quality Assurance Manager. The need to communicate effectively with the complainant or representative body such as the Independent Complaints Advisory Service (ICAS) or Conciliators is paramount as is the need to keep the Quality Assurance Manager fully informed.

This procedure works in conjunction with the booklet, “Making Your Voice Heard” and the “Independent Review Panel Procedures”.

### 2. Definitions

The Trust encourages staff to think in terms of the categories below to assess when problems or criticism should be dealt with through a formal process.

A problem or criticism may be defined as ‘an expression of dissatisfaction with the care or services, which the patient or carer wants to be resolved’.

A complaint is ‘an issue which remains unresolved despite previous efforts and/or requires further investigation by an objective third party’.

### 3. Screening

Many of the problems or difficulties, which trouble patients and carers can be and are successfully resolved by front line staff beginning with the Patient Advice and Liaison Service (PALS). The Divisions must make explicit their local arrangements for this to take place and staff should make every effort to achieve this.

However, some patient or carers prefer to relay criticism or complaints directly to a named person such as the Chief Executive, Trust Chairman, Consultant, or Manager.

In this case, that named person must ensure (usually through the Quality Assurance Department) that the patient or carer is contacted to clarify:

- The issues and what the complainant hopes to achieve.
- Whether the matter is a complaint (i.e. is an unresolved issue).

Experience shows that where contact is face to face, a significant number of problems or difficulties can be resolved. Additionally, many complaints can be resolved with a telephone call. This approach is encouraged wherever possible and guidance is available within the booklet "How to deal with Complaints" for clinical staff planning to meet with complainants. The matter may then be dealt with informally or, in accordance with the formal complaints procedure.

## 4. Support Available from the Quality Assurance Team

The Quality Assurance Team primarily based at Hemel Hempstead General Hospital (with a permanent presence at Watford General Hospital) holds the responsibility for the recording of all formal complaints. In support of the principle of devolved complaints handling i.e. investigation and drafting of final responses, the team will provide the following:

- Staff development & training on complaint handling
- Conciliation/meeting facilitation
- Acknowledgment of the receipt of a complaint
- Weekly complaints tracking analysis by Division on the status of complaints being investigated
- Monthly complaints analysis information on a Divisional basis for the purposes of Clinical Governance reporting
- Advice regarding the compilation of final responses
- Corporate performance returns regarding complaints handling
- Expertise for the resolution of ongoing complaints
- Expertise for the return to local resolution following a request for an Independent Review

- An effective consistent link with relevant ICAS providers

## 5. Stage 1: Formal Procedure – Local Resolution

### Registration

A record of the discussion with the complainant and original copies of any correspondence and notes should be faxed or sent to the Quality Assurance Team at the appropriate site either Watford General Hospital or Hemel Hempstead Hospital.

On receipt, the Quality Assurance Team will log details of the complaint onto the Complaints database and will send an acknowledgement within two working days of receiving the complaint. All acknowledgements must include a copy of the revised leaflet "Making your Voice Heard". The Quality Assurance Team will also set up a Complaints file on behalf of the investigating manager and enter the details onto the weekly tracking under the appropriate sub speciality.

### Third Party Complaints

If consent is required, the Quality Assurance Team will send an additional letter at the time of acknowledging the complaint. Once consent has been received the formal complaint process will begin.

### Circulation

Simple complaints i.e. about care or services provided by one professional group, e.g. Nursing, Physiotherapy, should be directed immediately to the investigating manager of that group or service, who will then disseminate the complaint for comments from the personnel involved and the deadlines for the written reply to the complainant.

Complaints about medical care or more complex and multifaceted complaints, i.e. those concerning more than one department or professional group should be directed to the identified lead investigating manager. The Investigating Manager will then circulate the paperwork to those involved, specifying the points requiring comment, and the deadlines for both comments and for the written reply to the complainant.

It may also be necessary to copy in other staff, who are not directly involved, but need to be aware that a complaint has been made. The Medical and Nursing Directors should be made aware immediately of any significant complaint regarding medical or clinical practice respectively. The Clinical Director should receive a copy of the complaint for information concerning their Division.

If for any reason, the Investigating Manager is unlikely to be able to complete the investigation within the time-scale, support may be available from the Quality Assurance Team and the Division should nominate another member of staff to co-ordinate the investigation and to prepare a reply on their behalf.

**Complaints Received via a Solicitor**

A solicitor can act as an advocate for a complainant if legal action has not commenced and this must be ascertained before a complaint is investigated under the NHS Complaints Procedure. However, queries or criticisms sent via a solicitor clearly carry a higher risk or follow up litigation. These cases should always be referred to the Claims and Litigation Manager initially for advice.

**Communication Received about Lost Property**

All such communication should be passed immediately to the Claims and Litigation Manager for investigation, response, and reimbursement if appropriate.

**Investigation**

If a written report from the staff involved is not forthcoming within the deadline, then the identified Investigating Manager should contact their Divisional Manager or Clinical Director as appropriate, who will then be responsible for securing a timely response.

It may be quicker and more effective for the Investigating Manager to meet the staff concerned to discuss the case rather than to receive a written report. Such discussions should be summarized in writing and included within the complaints file.

**Managing Delays**

If the investigation is delayed because of the complexity of the complaint or unavailability of staff due to leave, the Investigating Manager is responsible for ensuring the Quality Assurance Team are kept informed of any delays. The Quality Assurance Team should be contacted to indicate those complaints requiring an interim letter to be issued on their behalf if the deadline is not going to be met. Additionally the Quality Assurance Team will contact all Investigating Managers to ascertain the progress of the drafting of the response and identify delays.

The Quality Assurance Team will keep informed, those to whom the complaint was initially directed (e.g. Trust Chairman, or MP) with respect to lengthy investigations, so they can respond appropriately to any subsequent enquiries.

## Reply to Complainants

Having discussed the case, referred to the clinical notes and considered the various reports, the Investigating Manager will then draft a reply.

This should then be sent to the staff involved to check content is accurate. It is however the Investigating Manager's responsibility to ensure the final letter meets the Trust's agreed standards for content and style.

Letters to complainants must be written in plain English in a style, which will not convey defensiveness or blame, and clarify who conducted the investigation.

They must specifically include:

- An acknowledgement of how the complainant feels or felt.

- An apology where one is due or an apology for the effect the perceived/actual situation had on the complainant and/or other family members.

- A full and honest explanation of all points raised.

- A report on what preventive or remedial action the Trust will take or has already been taken.

- A final paragraph inviting the complainant to contact the Trust if they have any continuing or new concerns should be included.

- Within 28 calendar days/20 working days of the compliant being logged, the finalized reply (with the letter of Complaint) should be sent to the Chief Executive for signature. Once signed, the Quality assurance Team will circulate a signed copy to the Division and update the status of the complaints file. The complaint is then removed from the weekly tracking as completed.

## Ongoing Complaints

Where the complainant remains dissatisfied and reactivates a complaint, a member of the Quality Assurance Team will contact the relevant Manager to undertake further investigation and review the complaint. The complaint is re-logged as a reactivated complaint on the weekly tracking in green to indicate that it is reactivated. In such cases where a more detailed investigation is required, the Trust has eight weeks/40 working days to respond in accordance with the NHS Complaints Procedure.

Other avenues for resolution, such as conciliation interview might also be pursued at this stage if they have not taken place earlier. Specialist conciliation skills are accessible through West Hertfordshire/Hillingdon Health Authorities.

If at six weeks/30 working days, the Investigating Manager is not confident that the matter is going to be resolved or there are still unresolved issues, then they should ask the Quality Assurance Team, Director of Nursing, Clinical Director or Medical Director to review the paperwork and advise on the appropriateness of a second opinion and the content of the proposed reply.

**Second Reply to Complainant**

The Investigating Manager is responsible for ensuring that a second letter is sent within a maximum of eight weeks/40 working days.

The second response should:

- Answer any additional questions, explain any unresolved points or summarize the outcome of any meetings.

- Advise the complainant that if they remain dissatisfied, they can now ask for meeting to discuss issues or they now have the right to ask for their complaint to be referred to an Independent Review Panel.

All notes or correspondence relating to a complaint will be keep by the Quality Assurance Team and not copied or held in the patient's health care record.

**Local Resolution Meeting**

If a complainant remains dissatisfied with the written responses the next step would be to offer a local resolution meeting with the complainant and relevant Trust personnel to discuss the outstanding concerns.

If Trust personnel are unable to attend the meeting or have since left the Trust a written statement can be submitted to the meeting to address the concerns relevant to them. Alternatively, in the case of junior Medical Staff, they should be represented by the Consultant to whom they were contracted at the time.

- Any statements or information provided for the meeting will only be circulated to the Quality Assurance Department and the relevant Trust

personnel substituting for the absent member of staff. The statement will then be read at the meeting.

- The meetings will be taped and minutes/notes will be taken at the meeting and circulated to all present for factual amendment only, a time scale will be established for return of amendments.

- Following the meeting a letter and a non-verbatim transcript will be sent to the complainant who will also be given the opportunity of making minor factual amendments. Should they disagree with the content of the transcript, a complainant should be given the opportunity to come to the Trust to listen to the tape. Copies of the tape are not given to complainants as the equipment used to record the proceedings is speed sensitive, and tapes recorded on this system are not compatible with domestic equipment. The final letter once all parties are agreed on the content should advise them of the options available to them should they wish to continue to pursue their complaint,

**This marks the end of the Local Resolution Stage**

The handling of unresolved complaints is the responsibility of the Trust's Quality Manager based at Watford General Hospital. A paper copy of the Trust's Complaints Procedure and procedure for Independent Review is available upon request.

**Local Resolution Meeting Joint Guidance**

West Hertfordshire NHS Hospitals Trust, Hertfordshire Partnership Trust, Bedfordshire & Hertfordshire Health Authority, Luton & Dunstable and East & North Hertfordshire Trust have agreed to work together, taking a joined up approach to complaint resolution.

The primary objective of handling complaints both informal and formal is to achieve resolution of issues aiming to satisfy the complainant. This objective may be achieved through correspondence and meeting with the complainant when appropriate. The process needs to be fair to all and create the opportunity for an explicit, robust and formal process for evaluating every complaint, the outcome of which is properly documented.

The underpinning message for staff meeting with complainants is to listen actively and communicate in a non-defensive manner.

**Before the Meeting:**

- An agenda will be agreed with the complainant and ICAS representative regarding the issues to be discussed and resolved.

- Agree who is to attend

- Agree who will chair the meeting, which will usually be a senior manager for the Trust. In any event it must be somebody to whom those complained against can be held to account.

- The date, time and venue for meeting will be finalised with the complainant and ICAS representative.

- Time frame will be given for meeting and agreed with complainant and ICAS representative.

- Relevant paperwork will be circulated to relevant Trust personnel by the Quality Assurance Department.

- A Pre-meeting with Trust personnel will be held at an appropriate time for briefing on the nature of the complaint.

- A Checklist of arrangements to be completed by the Quality Assurance Department to ensure no omission of details (See Appendix 8a).

- Conciliators can be involved to chair a meeting if agreed by all parties.

**At the Meeting:**

- The Chair will welcome visitors and ask everyone to introduce him or herself.

- The Chair will explain the meeting will be following the pre-arranged agenda.

- The complainant will be allowed to articulate their concerns and clarify issues to be addressed, through discussion, with a view to resolving issues.

- Clear (no jargon) and complete (open and honest) answers will be provided by the Trust representatives, with a commitment to provide further information after the meeting if required.

- Confidentiality will be observed at all times. Once the final meeting follow up letter has been sent, the tape recording will be destroyed.

- At the end of the meeting the Chair will summarise agreed actions, in response to the issues raised to ensure that all points have been covered. Where issues have not been resolved, further information will

be obtained and forwarded, or the Trust will state the reason why it is not possible to answer the issues raised.

- Before the meeting is closed the Chair or the Quality Manager will explain the next stage of the NHS Complaints Procedure, which will later be confirmed in writing.

**After the Meeting:**

- It is helpful for both parties to be given the opportunity to debrief and reflect. It is important that staff and the complainant do not feel demoralised and/or distressed by the meeting.

- In the event of outstanding issues, the Chief Executive will write and formally close the complaint, advising that if the complainant remains dissatisfied, to write to the Convener requesting an Independent Review within 28 days of the date of the letter.

- All correspondence relating to the complaint will be held on the complaint file, and not within clinical notes.

- Once the Complaint has been closed the Tape recording of the discussion will be destroyed.

**Other Information:**

- Clinical Directors and all relevant Consultants will be informed of all meetings with complainants and may be asked to attend the meeting when this is appropriate or requested by the complainant.

- As part of local resolution, it is not appropriate for legal representation to be made at any meeting. If the complainant requests this, they should be informed that as per NHS Complaints Procedure Guidelines the complaints procedure must cease.

- At no point during the meeting should discussion be entered into with regard to Ex-Gratia payment or compensation. If this is the outcome required by the complainant, the complainant should be advised of the appropriate course of action and asked to contact the Litigation & Claims Department, who will be able to clarify the due process.

**Complaints Policy Comments and User Feedback**

- Should you wish to comment on any aspect of this policy, please complete the feedback (See Appendix 2a) at the end of the policy.

**Appendix 8a**

## COMPLAINT MEETING

## CHECKLIST OF ARRANGEMENTS

Complainant Name …… Datix Number ……..

| | Yes | No | Date | Checked by A N Other |
|---|---|---|---|---|
| Meeting request received | | | | |
| Acknowledged | | | | |
| Agenda requested | | | | |
| Relevant staff contacted | | | | |
| Proposed meeting date checked with complainant | | | | |
| Proposed meeting date checked with ICAS if attending | | | | |
| Meeting room booked | | | | |
| Letter of confirmation sent to complainant including: | | | | |
| • Room details | | | | |
| • Time of meeting | | | | |
| • Day & Date of meeting | | | | |
| • Those attending | | | | |
| • Where to report to | | | | |
| Papers filed in chronological order and checked | | | | |
| Summary completed | | | | |
| Chase agenda if not received two weeks prior to meeting | | | | |
| Memo of confirmation and papers sent to members of staff attending the meeting (see list below) | | | | |
| Any additional papers received prior to the meeting circulated | | | | |
| Confirmation received from the following attendees including complainant.<br>1.<br>2.<br>3 | | | | |
| Follow up Action from the Meeting | | | | |

**Appendix 9**

# Complaints Policy and Procedure

### User Feedback

We would welcome your comments on this policy now or in the future, so that it can be improved. Areas you may wish to feed back on could include:

- Sections you did not understand.
- Sections that are unclear about what West Hertfordshire Hospitals NHS Trust expects from you in relation to policy, procedure and guideline production, approval and implementation
- Sections that you would like to see added or changed.
- Problems you are having keeping to this Policy.
- Other

| COMMENTS: |
| --- |
| |

Your Name (optional):

Your Department (optional):

Date:

Please email or post this form to: The Quality Assurance Department, Watford General Hospital or Hemel Hempstead General Hospital or, quality.assurance@whht.nhs.uk