The Rotherham NHS
NHS Foundation Trust

Ref No: 221

MANAGEMENT OF COMPLIMENTS, COMMENTS, CONCERNS AND COMPLAINTS POLICY

SECTION 1
PROCEDURAL INFORMATION

Version:	3
Ratified by:	Trust Document Ratification Group
Date ratified:	March 2014
Title of author:	Quality Improvement Project Manager
Title of responsible committee/individual:	Patient Experience Group
Date issued:	March 2014
Review date:	March 2017
Target audience:	All staff

Document History Summary

Version	Date	Author	Status	Comment
1.1		Brigid Reid	Draft	Flow chart to be added
1.2		Brigid Reid	Draft	Stage 1 Level 2 non exec
1.3	31/3	Brigid Reid	Draft	HMB changes
1.4	17/4	Brigid Reid	Final version 1	Policy Ratification feedback re flow chart
1 b	11/9	Brigid Reid	Amend	Non Exec request to QA 7.2.11
1c	23/10	Brigid Reid	Amend	Feedback from Sept Policy Ratification Group re format
1.d	08/11	Sarah Taylor	Amend	Organisational structure change
2	09/11	Sarah Taylor	Ratified	Amended following feedback from policy ratification group. Ratified.
3a	10/12	Sarah Taylor	Draft	New format and amended to meet NHSLA requirements
3b	03/14	Anna Downward-Fletcher	Draft	Full review
3c	03/14	Anna Downward-Fletcher	Approved	
3	03/14	Anna Downward-Fletcher	Ratified	

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1. INTRODUCTION

The Rotherham NHS Foundation Trust (RFT) is committed to listening and responding to services users and encouraging a culture that seeks and uses people's experiences to improve our services. The Trust recognises the need for a clear and accessible process for patients, their carers and their families to provide feedback about their experience.

This Policy and Procedures relates to the full range of patient experience feedback, the '4Cs'; compliments, comments, concerns and complaints.

The 4Cs can help the Trust identify what's working and what isn't, potential service problems, risks and opportunities for improvements.

This Policy reflects the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 which came into force on 1st April 2009.

Under these Regulations, the Trust should be providing a patient-focussed complaints service. We should be:

- **listening** to what the complainants are saying
- **responding** to the issues they raise and
- **improving** our services subsequent to the lessons learnt from our investigations into their concerns.

The Healthcare Commission 2007 suggested that if an NHS organisation receives no complaints then it is most likely that they are not operating a patient focussed/friendly/accessible complaints process.

The Trust is committed to handling complaints in an open, honest and fair manner and making all reasonable efforts to achieve a satisfactory resolution and to reassuring anyone making a complaint that any future care they receive will not be negatively affected as a result of having made a complaint.

The following principles of Good Complaint Handling endorsed by the Health Service Ombudsman have been incorporated into this policy and related procedures.

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

This Trust recognises and accepts its responsibilities outlined by The Care Quality Commissions Essential Standards; outcome 17.

The recommendations following the final report into the Mid Staffordshire NHS foundation Trust inquiry by Robert Francis QC and the review of the NHS Hospitals Complaints system Putting Patients back in the Picture, Clwyd and Hart 2013 have been considered in the development of this policy.

This policy supersedes and replaces The Management of Concerns and Complaints Policy.

2. PURPOSE & SCOPE

2.1 Purpose

The purpose of this policy is to provide an open, fair and accessible process for handling compliments, comments, concerns and complaints received by the Trust.

The policy emphasises the importance of early resolution of concerns and complaints, details the individual roles and responsibilities of staff involved, set out the performance standards and the reporting and assurance processes in place.

Application of this policy and its procedures will ensure;

- Patients and their representatives are aware of ways to provide Feedback to the Trust.
- The Trust can identify where it is doing well and celebrate successes.
- Patients and their representatives have easy access to the best and earliest resolution of their concerns and complaints and the process is flexible and responsive to individual needs and are provided with support where needed.
- Complainants are treated with respect and courtesy.
- Patients who raise concerns or complaints are not disadvantaged as a result of making a complaint.
- Concerns and complaints are dealt with efficiently, investigated promptly and thoroughly, honestly and openly.
- Complainants are kept informed of the progress, receive a timely and appropriate response and outcome of the investigation.
- Staff involved in complaints are given support.
- Actions to rectify the cause of the complaint are identified, implemented and evaluated.
- Learning from complaints is shared and informs service development and improvement and the personal and professional development of staff
- Identification of complaint themes and trends.

2.2 Scope

The policy applies to all departments and areas within the organisation; and applies to all staff working within the Trust.

The policy deals with the handling of compliments, comments, concerns and complaints regarding Trust services, buildings or the environment received from patients; patient relatives, carers or visitors; and other service users.

The complaints excluded from the scope of this policy are;

- a complaint made by a local authority, NHS body, primary care provider or independent provider.
- a complaint made by an employee of a local authority or NHS body about any matter relating to employment.
- a complaint which is the same as a complaint that has previously been made and resolved.
- a complaint which has previously been investigated under the 2004, 2006 or 2009 regulations.
- a complaint that has been reviewed by the Parliamentary Health Service Ombudsman (PHSO).
- a complaint which is or has been investigated by a Health Service Commissioner under the 1993 Act.
- a complaint that alleges a failure to comply with a request for information under the Freedom of information Act 2000 or failure to comply with a data subject request under the Data Protection Act 1998.
- Complaints about privately funded care.

3. ROLES & RESPONSIBILITIES

Roles	Responsibilities
Board of Directors	The Board of Directors is ultimately accountable for ensuring a complaints policy is in place and effective controls are in place to support the policies purpose and aims. The Board will; Ensure that there is appropriate expertise and resources available to enable the policy to be effectively discharged. Provide scrutiny of complaints via the Non Executive Directors; Directors will review a random sample of complaints files on an annual basis.
Chief Executive (CEO)	The CEO is the 'responsible person' for ensuring compliance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and that action is taken if necessary in the light of the outcome of the complaint. The CEO or nominated deputy in his/her absence will read and review all complaints responses and provide a signed cover letter.

Chief Nurse (CN)	The CN is responsible for providing the Board with a monthly report regarding complaints activity and the action taken and an evaluation of the effectiveness of the action. The CN or nominated deputy in his/her absence will read all complaints and provide a written acknowledgement of the complaint. The CN or his/her nominated deputy in his/her absence will quality assure all complaints responses for complaints risk rated red.
Deputy Chief Nurse (DCN)	The DCN is responsible for ensuring detailed procedures are developed, agreed, implemented and monitored. Ensuring key performance indicators are monitored and reported to Directorates, Patient Experience Group, Quality Assurance Committee and Trust Board. Will consider and approve requests for an extension to complaint response timeframes. The DCN or his/her nominated deputy in his/her absence will quality assure all complaints responses for complaints risk rated amber. The DCN is responsible link person with Healthwatch Rotherham.
Patient Experience Lead	The Patient Experience Lead is responsible for: Day to day management and provision of a patient advice and support service in relation to the 4Cs. Managing the procedures for handling and considering complaints and acts as a 'complaints manager' under the complaints regulations. Interpretation of NHS Complaints Procedure and developing and reviewing associated local policy and procedures. Execute his/her duties as described in the associated procedural documents. Providing quality assurance of complaint responses for complaints risk rated yellow or green.

	Managing the administrative process for Parliamentary Health Service Ombudsman investigations. Providing training in relation to the management of complaints. Monitors concerns and complaints key performance indicators (KPI) and analyses complaints information and provide data and information for directorate, Patient Experience Group, Quality Assurance Committee and Board reports. Escalate issues to the Deputy Chief Nurse as required. Inform the Communications Manager of Potential Media interest.
Patient Advisors	Patient Advisors will provide day to day advice and support to services users and their representations in relation to the 4Cs. Execute his/her duties as described in the associated procedural documents. Ensure the Patient Experience Lead is kept apprised of any complaints investigations that are not going to meet the timescales within the complaints procedure. Deputise for the Patient Experience Lead as appropriate and as instructed.
Directorate Complaints Leads (Head Nurses/Head of Midwifery/Head of Clinical Professions	Are accountable for the management of complaints within his/her directorate in liaison with the Business and Service Manager and Clinical Director as required. Ensure that this policy and associated procedures are implemented within his/her directorate. Allocate an investigator to complaint investigations within his/her directorate and inform the Patient Experience Team. Ensure complaints investigations are undertaken within the required timeframes. Quality assure all complaint responses and ensure all aspects of the complaint have been addressed and the response has been written in line with the guidance on writing response letters at appendix 4.

	Make a judgement regarding whether the complaint is upheld or not. Disseminate complaints information as appropriate to front line staff within the directorate. Ensure individual complaints and trend data are considered at Directorate Governance Groups. Inform the Directorate Governance groups of performance in relation to complaints management KPIs. Ensure that complaints action plans are monitored at Directorate Governance Groups and ensure all learning is identified and implemented. Provide the Patient Experience Lead with monthly updates on progress with action plans and lessons learned.
Clinical Directors	The Clinical Directors are responsible for investigating complaints relating involving a senior member of his/her medical team.
Business and Service Managers	Inform the Patient Experience Lead of any changes to services with a potential impact on patient experience/concerns and complaints.
Investigators	Ensure a full investigation of each aspect of the complaint (in line with the Trust's Reporting, investigation, management and analysis of incidents, complaints, concerns and claims policy) and provide the Patient Experience Team with the information required as set out in the complaints management plan within 20 working days of receipt of the letter of complaint. Conduct a complaints investigation following the guidance at appendix 2. Discuss any delays or complications encountered during the investigation with the Directorate Lead for Complaints.
Matrons/Lead Nurses/Ward/Departmental Managers	Ensure every effort is made to informally resolve concerns/complaints which arise locally. Provide advice to patients regarding the process for

	making a complaint. Report the number of comments and compliments received to the Patient Experience Team on a monthly basis. Act as an investigator or assist with a full investigation of the concern/s and complaints/s and provide the investigator with the information required electronically within the timescale requested. Ensure feedback to the staff involved regarding complaints and ensure key learning points are disseminated Assist with the development of improvement strategies and their implementation.
Communications Manager	The Communications Manager will ensure that media interest is managed if they are alerted to its potential by the Patient Experience Team. S/he will decide, in collaboration with the designated Executive, on whether any information will be disclosed to the press, the content of a press statement, who will answer press enquiries and whether media access to the area will be given.
Claims Manager	Will review complaints responses in cases where there is a possible claim for negligence.
Associate Director of Patient Safety and Risk	Will review complaints responses for cases subject to an inquest.
Corporate Secretariat	Responsible for opening and date stamping all written complaints received by the Chief Executive Office and placing in the Patient Experience Teams post tray on a daily basis.
All Staff	All staff must make every effort to deal with concerns as they arise, informally and promptly and inform senior staff of any issues raised. Where local resolution of a concern has failed and/or the individual wishes to make a complaint then staff should ensure that they are given the appropriate information about how to do this and the Patient Experience Team be advised of the complaint immediately. An incident report should be completed where

	appropriate. All staff must ensure that any associated correspondence should not be kept in the patient's Medical record and no reference to the complaint should be documented in the patient's clinical record. Comply with any complaints investigation, including providing a statement within defined timeframe.

4. POLICY INFORMATION

In addition to the information contained within this section; procedures and guidance that support the implementation of this policy are listed below;

- Standard Operating Procedure for the Management of Concerns and Complaints. (link)
- Appendix 1 Guidance for the Management Vexatious and persistent complaints
- Appendix 2 Guidance on conducting an investigation into a complaint
- Appendix 3 Guidance for staff on preparing statements
- Appendix 4 Guidance on preparing a complaints response letter.
- Appendix 5 Guidance for meetings with complainants
- Appendix 6a Guidance for the recording and reporting compliments
- Appendix 6b Capturing compliments and messages of thanks

4.1 Methods of providing feedback.

Feedback can be made in a number of ways so the individual can choose the most convenient way for them.

Patients and their representatives can provide compliments, comments or raise concerns and complaints via a number of methods;
Verbally in person or via the telephone to staff on duty or the Patient Experience Team.
in writing via letter
in writing via email
In writing via the links on the Trust Internet.

The Trust will raise awareness of all methods through promotion verbally and visually through the use of leaflets, posters and the Trust internet.

4.2 Handling and management of feedback

Patients and their representatives must be asked how they wish an issue they have raised to be dealt with. However, any feedback received which suggests cause for concern must be investigated and responded to whether or not the informant has indicated a desire to have the matter dealt with. Such matters

should be dealt with as a concern following the Standard Operating Procedure for the Management of Concerns and Complaints.

4.3 Who can make a complaint?

A complaint can be made by any person who receives or has received services from an NHS organisation, primary care provider or independent contractor/provider or by a person who is affected, or likely, to be affected by the action, omission or decision of the responsible body which is the subject of the complaint.

A complaint can also be made by a representative acting on behalf of a person who receives or has received services from the above or who:

- is a child (an individual who has not attained the age of 18). The Trust must be satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child.
- is unable to make the complaint themselves because of physical incapacity or lack of capacity within the meaning of the Mental Capacity Act 2005;
- has died; or
- has requested the representative to act on their behalf.

If the Trust is satisfied that a representative is **not** conducting the complaint in the best interests of a child or a person that lacks capacity then the Trust must not consider the complaint and inform the representative and the reason for the decision.

4.4 3rd Party Complaints and Consent

If a complaint is made on behalf of an individual then the Trust will need to seek consent from the individual so that an investigation can be carried out.

If an individual is unable to provide consent for a person making the complaint on their behalf (for example, they are incapable by reason of physical or mental incapacity or they are a child) then their legal guardian or parent or other verified appropriate representative will be accepted to act on their behalf.

Where a complaint has been made on behalf of a patient by a Member of Parliament (MP) it will be assumed that implied consent has been given by that patient. If however, the complaint relates to a third party, consent will need to be obtained from the patient prior to the release of personal information.

If a patient is deceased, the relationship of the complainant to the deceased patient must be clarified and confirmed as the next of kin or Executor of the Estate.

In the event that consent or sufficient evidence cannot be made available confirming the relationship between the complainant and the patient, or the complainant does not have sufficient interest in the person's welfare, the Trust

will notify the complainant in writing confirming that they will not receive any details relating to the patient or any information obtained via health records.

If the complaint is made on behalf of a child, the complainant must be a parent, guardian or other adult person who has caring responsibilities for the child.

4.5 Confidentiality

Individuals should be assured that concerns and complaints will be handled in the strictest of confidence. Disclosure of information collected as part of an investigation or contained within an investigation report and / or written response, which identifies individuals, must be confined to those with a justifiable and demonstrable need to know. Disclosure of information from health records to persons involved with an investigation will be handled in accordance with the requirements of the Data Protection Act 1998 and the Caldicott Principles, 1997.

Correspondence about complaints will not be included in patient's records and reference to the complaint should not be entered in the patient's medical record.

4.6 Time limits for making a complaint

Normally a complaint should be made to the Trust within twelve months of the event or within 12 months of first becoming aware of the matter.

Where a complaint is made after this time, the complaint may be investigated if the complainant had good reasons for not making the complaint within the above time limits e.g. if circumstances prevented the complainant expressing their dissatisfaction any earlier (i.e. ongoing treatment) or the complainant was unaware that there was cause for complaint.

Complaints will not be investigated if the time lapsed prevents the Trust from conducting a full and factual investigation. A decision not to extend the twelve month period will be made by the Patient Experience Lead in discussion with the Deputy Chief Nurse and confirmed in writing providing a concise explanation.

4.7 Support in providing feedback/making a complaint

Making a complaint can be daunting and evidence confirms that many people who might wish to complain do not because they do not know how to or they find the process too intimidating. The Trust therefore loses valuable feedback from its patients.

The Patient Experience Team will offer assistance to those individuals with specific needs, e.g. interpreting services, to enable everyone who wishes to give feedback to be able to do so.

The Patient Experience Team will offer support to complainants throughout the complaints process and will provide details of Healthwatch Rotherham. See Standard Operating Procedure for the Management of concerns and complaints

Complainants must not be led to believe either directly or indirectly that they may be disadvantaged because they have raised a concern or complaint.

4.8 Supporting staff

The Trust is committed to ensuring staff are adequately supported. It is important to remember that it can be distressing to receive a complaint or be involved in a complaint. Staff involved in a complaint should be fully supported by their line manager. Please refer to the Policy for supporting employees involved in an incident claim or complaint for further advice on how to support a staff member.

4.9 Media interest

In cases where a complainant expresses their intention to contact the media, the Head of Communications will be informed and take appropriate action on media handling.

4.10 Possible Claims for Negligence

If a review of a complaint reveals a prima facie case of negligence, or if it is thought that there is a likelihood of legal action being taken the Patient Experience Lead with notify the Claims Manager and the Claims manager will review the response letter before it is sent to the complainant.

4.11 Reference to External Agencies

If a review of a complaint reveals a possible case of criminal activity or other serious matter, the Patient Experience Lead or Deputy should ensure the Deputy Chief Nurse is notified.

In such cases it will be necessary to refer the matter/s raised to an external agency or agencies e.g. Police, Strategic Health Authority, Her Majesty's Coroner, etc. The Deputy Chief Nurse will be responsible for triggering such a referral.

4.12 Joint Handling of Complaints

Where a complaint involves a second provider, health, or social services the Patient Experience Lead will inform the second provider. The relevant managers will:

- Determine how the complaint will be handled jointly and which provider will be responsible for sending the joint response.
- Advise the complainant accordingly and inform other contacts as necessary.

In circumstances where The Rotherham NHS Foundation Trust has taken the lead on a complaint involving more than one provider and our reply is available but the other organisation has not supplied their information within the prescribed time limits The Rotherham NHS Foundation Trust will provide its information to the complainant within the timescale agreed and a reminder will be sent to the Complaints Officer of the other organisation. In the event that information is still not received the Chief Executive of the other organisation will be advised. In the event that this still does not elicit a response we will close our files. The complainant will be advised that as the only matter that remains outstanding relates to the other organisation the matter has been transferred to them for completion. Named contact details will be provided to the complainant. The second organisation will be advised that our files are closed and that they now have whole responsibility.

In circumstances where The Rotherham NHS Foundation Trust has taken the lead on a shared complaint and the complainant is dissatisfied with the response but this relates wholly to the other organisation the further management of this complaint will be handed to the other organisation. The complainant will be advised of this and the rationale. They will be provided with named contact details.

If a complaint is received that relates wholly to another NHS organisation, the complaint will be referred to the appropriate organisation by the Patient Experience Lead and the complainant advised accordingly, including the contact name and address.

4.13 Complaints Analysis, Learning and Reporting

Information from comments, concerns and complaints will be used to improve the quality of care, treatment, services and facilities provided by the Trust, and reduce risk.

Analysis will include;

- Performance on KPIs
- Number of complaints, subject of complaints, location of complaints and risk grading.
- Identification of trends.
- Complainant satisfaction

On a weekly basis the Patient Experience Lead will provide the Directorate Complaints Lead with a report on the target dates for complaints investigations and responses and a status update on all open complaints within their Directorate.

On a monthly basis the Patient Experience Lead will provide the Directorate Complaints Lead with a report to show performance against the key performance indicators.

Complaints information will be reported monthly to board via the Chief Nurse Integrated Quality Report, quarterly to Patient Experience Group and Quality Assurance Committee and annually via the annual complaints report.

Complaints provide us with valuable information and the Trust aims to have learning points agreed, where appropriate prior to the response being sent to the complainant. An action plan will be produced for those complaints where corrective actions are identified as being necessary.

Lessons must be learned from individual complaints. This learning needs to translate into improvement strategies that are developed and monitored through governance arrangements from wards/departments to Board level.

A sample of complaints files will be reviewed by a Non-executive Director on a quarterly basis.

An anonymised summary of each upheld complaint relating to patient care as agreed with the complainant/patient will be published on our website. Where the complainant/patient is not happy to share information, summaries will be shared confidentially with commissioners and the CQC.

Trust wide systematic analysis of incidents, complaints and claims takes place on a quarterly basis as described in the Policy for Reporting, investigation, management and analysis of Incidents.

4.13.1 Complainant Satisfaction

Complaints handling satisfaction questionnaires are sent with the response letter to obtain feedback on the handling of the complaint by the Patient Experience Team.

5. DEFINITIONS AND ABBREVIATIONS

5.1 Definitions

Comment
Suggestion of improvement or an observation or expression of personal opinion. There is no expectation from the person making the comment that action is required.

Compliment
Positive feedback or an expression of gratitude from service users, carers, families and friends for the Trust or its employees.

Concerns
Are issues of importance, interest or worry raised by a patient, carer or service user which they wish to be dealt with on an informal basis. Concerns do not require a formal investigation as the issues raised should be able to be resolved locally and quickly (within 10 working days).

Complaint

A complaint is defined as “an expression of dissatisfaction” received from a patient, carer or service user about any aspect of care/service provided. Complaints that are not resolved by the end of the next working day will be dealt with under the NHS complaints regulations.

Local Resolution
Is the first stage of the complaints procedure. This is the procedure followed by the Trust to try and resolve the complaint.

Parliamentary & Health Service Ombudsman Review is the second stage of the complaints procedure. It will normally only be requested by the complainant after all attempts to resolve the complaint through Local Resolution. The request is made (by the complainant) direct to the Ombudsman who will consider the request.

5.2 Abbreviations

CEO	Chief Executive Officer
CN	Chief Nurse
DCN	Deputy Chief Nurse
CD	Clinical Director
ICAS	Independent Complaints Advocacy Service
TRFT	The Rotherham NHS Foundation Trust

6. REFERENCES

Principles of Good Complaint Handling (Parliamentary & Health Service Ombudsman 2008)
Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
Listening, Responding, Improving – a guide to better customer care (Department of Health 2009)
Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry, 2013
Good practice standards for NHS Complaints Handling, Patients Association 2013
A review of the NHS Hospitals Complaints System, Putting Patients Back in the Picture, 2013.
Care Quality Commission

7. ASSOCIATED DOCUMENTATION

Trust Patient Experience Strategy
Trust Policy for the reporting, investigation, management and analysis of Incidents, complaints, concerns and claims Including the Management of Serious Untoward Incidents
Trust Standard Operating Procedure for the Management of concerns and complaints
Trust Being Open Policy
Supporting employees involved in an incident claim or complaint
Trust Claims Handling Policy
Trust Risk Management Strategy

Appendix 1

Guidance for the Management of Vexatious and Unreasonably persistent Complainants

Vexatious and unreasonably persistent complainants are those that raise the same or similar issues repeatedly, despite having received a full response to all the issues they have raised. Each circumstance must be considered carefully. It is emphasised that it is expected that this guideline will only be used as a last resort and when all reasonable measures have been taken. See Standard Operating Procedure for the Management of Concerns and Complaints.

Examples would include complainants that:

- Display unreasonable demands or expectations and fail to accept that these may be unreasonable.

- Have excessive contact and/or inappropriate contact with the Trust, placing unreasonable demands on its staff

- Persist in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted

- Are unwilling to accept documented evidence of treatment given as being factual, or deny receipt of an adequate response or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the Trust staff, or other body to try and assist them specify their concerns and/or where the concerns identified are not within the remit of the Trust to investigate

- 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. Care must be taken not to disregard new issues which are significantly different from the original complaint. Any new matter must be considered on its merits

- Fail to engage with staff in a manner which is deemed appropriate: e.g. repeatedly using unacceptable language; secretly recording telephone calls or meetings without consent (in contravention of the Data Protection Act 1998); refusing to adhere to previously agreed communication plans or behaving in an otherwise threatening or abusive manner on more than one occasion, having been warned about this. Where complainants are violent or aggressive, staff should refer to the Trust's Violence and Aggression Policy.

The Patient Experience Lead in agreement with the Deputy Chief Nurse will determine the point at which a complainant is considered to be unreasonably persistent and will decide what course of action to take. Below are some possible courses of action that may help to manage complainants who have been designated as persistent and/or unreasonable.

- Requiring contact to be made with a named member of staff.
- Requiring contact to be made through a third person, such as an advocate.
- Limiting the complainant to one mode of contact e.g. in writing only.
- Requiring any personal contact to take place in the presence of a witness.
- Advising that the organisation does not deal with correspondence that is abusive or contains allegations that lack substantive evidence. Request that the complainant provide an acceptable version of the correspondence or make contact through a third person to continue communication with the organisation.
- Notify the complainant in writing that the Trust has responded fully to the points raised and considers that all methods of resolving the complaint have been exhausted and either there is nothing more to add or continuing contact on the matter will serve no useful purpose. Further, explaining that correspondence is at an end and that any further letters etc on the specific or closely related matter that are received will be read and placed on file but not acknowledged and no further action will be taken.

Once a course of action has been determined. The Patient Experience Lead will draft a letter informing them of the decision and the reasons for the decision. The letter will be reviewed by and signed by the Chief Executive.

Appendix 2

Guidance on conducting an Investigation into a Complaint

A comprehensive investigation should be carried out in accordance with the process detailed within the Trust's reporting, investigation, management and analysis of Incidents, complaints, concerns and claims policy.

Note; Independent investigation will be initiated where any one of the following apply;

- A complaint amounts to an allegation of a serious incident.
- Clinically related issues cannot be resolved without an expert clinical opinion.
- A complaint raises issues of professional misconduct or the performance of senior managers.
- A complaint involves issues about the nature and extent of the services commissioned.

The timeframes for an investigation as detailed in the Standard Operating Procedure for the Management of Concerns and Complaints must be adhered to.

It is important that one person is responsible for the conduct of the investigation – 'the investigator'.

- Before starting the investigation it is important to understand all the elements of the complaint and to clarify what the complainant's expectations are. The Patient Experience Team will have contacted the complainant and documented this information on the Complaints Management Plan.

- Understanding all the elements of the complaint is essential in developing an investigation action plan. Throughout the investigation, the investigator must keep in mind what the complainant is looking for and what is a reasonable, achievable outcome.

- It may be appropriate to construct a timeline of events to help in the development of the investigation action plan, particularly if the complaint is complex.

Example complaint investigation action plan

Action/information required	Lead	Timescale	Progress

- In order for the investigation to be efficient, the investigator needs to decide;
  - what needs to be done and what questions need to be answered
  - consider what information is required to establish the facts this could include;
    - -Health records
    - -Booking systems
    - -Lab results

-Reference to local and national policies and guidance-Site visits

- who needs to be approached for information/statements on each issue for example any named individual or clinician complained against, line management or witnesses. It is good practice, where possible, to have clinical responses verified by senior clinicians not involved in the care that is the subject matter of the complaint.
- gather sufficient clinical, factual and other information to identify what has occurred and what action, if any, is required.

- In some circumstances it may be necessary to conduct an interview. This may a serious complaint where conflicting accounts have been provided by staff and 3rd party witnesses. Interview notes must include, date, time, venue, duration of interview, name of the interviewee and job title/relation to complainant and the name and job title of the interviewer.

- Where the complaint relates to serious harm or death, opinions from outside of the Trust are likely to be required. This should be discussed and agreed with the Directorate lead for complaints and Deputy Chief Nurse.

- Other people beside organisation staff may be useful witnesses who can be interviewed or provide statements e.g. friend, relative, carer. The investigator should seek permission from the complainant for 3rd party witnesses to be contacted. Patient Services can help with this.

- When asking for responses from anyone involved make sure your request is clear about the issues to which you want a response. It is not sufficient to merely ask for comment – you need to pose specific questions which will help build a complete understanding of what happened. You should advise people to refer to the guidance for staff on the preparation of statements at appendix 3.

  Emphasise that all responses, be they correspondence, emails statements or interview notes may be disclosable under Data Protection and Freedom of Information legislation and must include; responses must address all the issues and be factual and be dated and signed.

  Staff providing statement should be made aware that documentary evidence, including statements, obtained in the course of an investigation may be used as evidence in any resulting disciplinary proceeding.

- Any contact made with the complaint, staff or anyone else during the investigation must be logged on the complaints management plan. If an investigator has been unable to obtain a statement or information from a key member of staff, the reasons why must be recorded. Contact with ex-employees may be appropriate if they are a crucial witness, this must be discussed and agreed with the directorate complaints lead.

Evaluation of findings

- After information has been gathered, the investigator must analyse all relevant facts and opinions.

- The investigator must identify points of agreement, difference of opinion e.g. differing views from clinicians on the appropriateness of patient treatment and any dispute of facts e.g. where there are different accounts of events.

- Where a difference of opinion has been found during the investigation, the investigator must highlight any evidence which suggests one opinion to be more reasonable; this may include highlighting key aspects of best practice guidance or independent opinion if obtained and the credibility of witnesses.

- Where there is a dispute of facts, the investigator must identify any evidence which indicates the more likely version of events; this may include highlighting relevant aspects of the health record, corroborating parts of statements or interviews, highlighting the credibility of witnesses.

- The investigator should then indicate their preliminary conclusions they have reached for each aspect of the complaint.

Reaching a judgement

- Ideally the investigator and decision maker should not be the same person.

- The investigator should write a succinct and comprehensive report that summarises the investigation, the evidence gathered and the preliminary conclusions reached. The purpose of this report is to enable the Directorate complaints lead to make a decision regarding each aspect of the complaint without needing to go back through the entire investigation in detail.

- The report, a draft response letter and a draft action plan (where required) should be sent to the Directorate Complaints Lead who will review the findings of the investigation and the preliminary conclusions and decide whether a complaint are justified (upheld) and which are not (not upheld) and whether there are aspects where no conclusion could be made e.g. there is a conflict of accounts about what was said during a consultation and there is no clear evidence to be able to establish fact. They must detail why they have reached their view on the complaints management plan.

- The Directorate Lead for complaints will then quality assure the response letter and action plan.

- All investigation documentation must be sent to the Patient Services department as detailed in the procedure for the management of concerns and complaints.

Appendix 3

Guidelines for staff on preparation of statements

This guidance will help you to write a full and thorough statement. Statements may include accounts of events but also opinions on the appropriateness of treatment or the conduct of an individual.

You may take advice from your manager, the Directorate complaints lead or the Patient Services Team.

Although the majority of statements stay within the Trust, your statement is disclosable and may be released to the complainant/family, the Parliamentary and Health Service Ombudsman, the Coroner or be used as evidence in defending a legal claim.

Dos

- Use chronological order
- Note all the points complained of and give a response to each point.
- Be factual, honest objective. Make clear what part is from memory, what part from the notes and what part from your recollection of your standard practice at that time.
- If you don't recall particular details and there is no written account say you do not recall.
- You should give enough information about clinical terms or issues so that it can be understood by someone who is not clinical.
- Try to avoid abbreviations but if you need to use one, you should explain it immediately after the first time you use it and continue to give abbreviation in full
- Comment on any allegations made concerning your involvement
- Point out any factual inaccuracies with the allegations which are being put forward in the complaint and explain how you know they are incorrect.
- If you wish to support the reasons for a decision made/action taken refer to policies/procedures/guidelines in use (if appropriate) and explain the reasons for deviating from these guidelines
- Identify other staff involved, names and job titles.
- Avoid ambiguous statements
- Provide as much detail as possible, giving dates, times, locations and amounts (if appropriate e.g. drugs).

Don'ts

- Do not simply re-write your entry/entries in the notes. The investigator will already have access to this information.
- Speculate on what others were doing or thinking unless you know something as a fact
- Give opinions on the care given or actions taken by other staff or blame other staff or departments.
- Attempt to write the statement without access to all the medical records

- Be hostile, rude or unnecessarily defensive to the complainant (remember that complainants may request sight of your statement, which they are entitled to).
- Be subjective
- Relate conversations that you were told by someone else
- Anticipate evidence of another witness or questions which may arise
- Use abbreviations
- Comment on the aftermath rather than the incident itself

What you will need
A copy of the complaint
Clinical notes

Personal Information
The statement should include:
Your full name, job title and department
Reference number of the case
Your professional qualifications and grade
The post held at the time of the incident if different.

Your statement should conclude with the phrase:
“The contents of this statement are true to the best of my knowledge and belief”.

Print, sign and date the end of your statement.

You should retain a copy of your statement for your information

Appendix 4

Guidance on preparing a complaints response letter

It's important to appreciate that all letters of complaint are feedback of **the patient's personal experience** of the service they have received. Whether a person is justified in complaining or their viewpoint appears unreasonable; all complaints give us an insight into what our patients are thinking and provide an opportunity to change the actual service if something is not working, or to provide appropriate information to change public perception, if that's the problem.

Many complaints can be resolved through the provision of an explanation, detailed information and an apology where needed. Responses should be thorough, clear, honest and open and should include what has been changed or any planned changes in relation to the complaint. The complainant should not have to ask further questions to be satisfied that the response is comprehensive.

If the letter needs to be in an alternative language/format, to meet the needs of the recipient, advice can be sought from the Patient Experience Team.

This provides guidance regarding the content all response letters, however you should always bear in mind that each complaint is unique. A template letter can be found in the Standard Operating Procedure for the Management of Concerns and Complaints

Content

1. Complaints Regulations state that "complainants are treated with respect and courtesy". The letter should demonstrate sincerity and where appropriate compassion. The letter should never contain rude or dismissive comments and the tone should match the seriousness of the complaint.

2. The style and language of the response letter should be appropriate. The letter should be written in a style that is easily understood. Avoid jargon and abbreviations. The language used should not be overly formal or overly casual and should show some consideration of the style and the language used by the complainant. Ideally, not use bullet points, numbered points or titles. The letter should be personal and not read like a report. The exception to this rule is if the complainant has used this style and it would be beneficial to respond likewise.

3. Follow the principles of plain English. Technical language must be explained so a lay person can understand it and terminology used by the Trust e.g. winter pressures, discharge plan should be avoided or explained.

4. Confirm that the investigation has now been completed. Explaining the steps taken to investigate the complaint and stating what evidence you have taken into account, including:

   the complainant's account of events;

the account of events by the person(s) complained about (if relevant);
relevant documentation, including medical records;
relevant law, policy, guidance and procedures (quote when appropriate); and
any independent clinical or professional advice taken.

5. Summarise what the complaint was about. Include a summary or statement of the complaint that mirrors the complainant's original complaint letter. Do not go into great detail but the complainant must be confident that we have understood the essence and context of the complaint. E.g. "Further to my letter of 15 July 2009, I am now able to respond to your complaint about the delay in your surgery following your admission to ward X on the (insert date).

6. If the date of the response is outside the timescale that was originally agreed with the complainant, include a specific apology for the delay in the reply, e.g. "I am sorry for the delay in responding to you".

7. After the introduction, offer an apology or an acknowledgment of how the complainant is feeling. This acknowledgement is important and helps to set the tone of the letter. Even if the Trust has acted entirely appropriately it is clear that the complainant did not see it that way at the time. Possible responses could be something like –
"I would like to apologise for the distress which this incident has caused you."

"I am very sorry that you were dissatisfied with your experience when you attended day surgery".

"I was saddened to hear that your mother has died and I do appreciate that this must be a very difficult time for you. Please accept my condolences".

8. Respond to each part of the complaint and explain the findings of the investigation. This can be complex so it is advisable to break it down into smaller sections. Dealing with the issues chronologically can be a useful approach. If the complainant has used a particular format for summarising their concerns, use this as a guide to compiling your response.

9. Avoid telling the complainant something that they know and have experienced. Rather than saying "On Monday 5 May 2009 you were admitted for your hysterectomy", better to say, "I understand that you were admitted for your hysterectomy on Monday 5 May 2009".

10. If the complainant has used the actual names of members of staff, use them yourself. Include the job title when you refer to a member of staff by name for the first time.

11. Use active, direct but personal language. Use "I", "you", "we" as much as possible. Rather than passive "It was considered…" say "We / The doctor / Sister Smith considered…"

12. Double check that you have covered every point made in the complaint, no matter how trivial. Answers should be forthcoming and not skirt around the

issues. There should be no unsatisfactory events or findings uncovered by the investigation that are deliberately not shared with the complainant. The explanation of the findings should be in a level of detail that the complainant wanted.

13. Where the findings of an investigation have led to disciplinary proceedings, the complainant will not be given explicit information regarding the proceedings or the outcome.

14. State your conclusions based on the evidence. Address any conflicting evidence or lack of evidence. Make sure that the decision is clear. Take into account any discrepancies or omissions that cannot be reconciled and be honest about these in your response.

15. Acknowledge when a mistake has been made, apologise for it and explain what we are doing to prevent it happening again, or that we do not accept the complaint and give the reason why. Avoid apologising indirectly. Try and avoid phrases like “we are sorry that you *felt* the organisation or an individual did something wrong”. Apologise for it going wrong instead

16. Refer to national guidance or Trust Policies when claiming that our care was appropriate. If a firm conclusion could not be drawn about some or all of the issues raised in the complaint, an explanation of the reason why must be given.

17. One of the Principles of Good Complaint Handling published by the ombudsman advises that the Trust should be looking favourably at any request for reimbursement for a financial loss incurred due to an error by the Trust. Patient Experience Team will provide advice with regard to this.

18. Be thorough and honest about what the Trust can or cannot do to prevent the same thing happening again. If we need to take remedial action, state when this will be completed and how we will monitor the improvements. The more specific personalised and timed the plans for improvement, the more credible they will be.

19. All complaints response letters include that the complainant can contact the Patient Services department if they are unhappy with the response or wish to discuss the response. However, the investigator may also wish to provide their contact details to discuss the outcome or it can be helpful to offer a meeting with the complainant. This is particularly the case when there has been a bereavement or if there are a lot of medical issues involved. Face to face meetings, where complex issues can be discussed openly and sensitively, and in language which is understandable can often resolve issues and is time well spent. The Patient Experience Team will arrange meetings. Please refer to the Guidance for meetings with complaints.

20. Always get the latest information about the patient. It is professional to demonstrate that we know the patient's current situation. For example, we

may have arranged or changed an appointment, or perhaps a patient included if the complaint has died.

21. When you have dealt with all the issues, make the last paragraph positive.
    • "In conclusion, I very much hope that this helps to explain why …… Please accept my apologies for the distress and anxiety that you experienced."
    • "I was very pleased to learn that your wife has fully recovered and has now returned home."
    • "I understand that you now have a date for your surgery. I hope this goes well and that you are soon fully recovered".
    • "I understand you had an appointment with Dr …….. on (insert date). I trust the outcome was satisfactory and you are now making a good recovery."

22. The following are also useful examples of how to conclude a letter
    • If not upheld
    "In summary, I am confident that, based on the results of our investigation, the care you received was appropriate. However, I am sorry that you feel your care was not to the standard that you would have expected, and would like to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services."

    • If partially upheld
    "In summary, I believe that certain aspects of your care did not reach the high standard of care that we aim to provide to all patients. I apologise for this, and would like to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving."

    • If upheld
    "In summary, I believe that your care did not meet the high standard that we aim to provide to all of our patients. I would like to apologise for the shortfalls we have identified, and to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving."

23. Empathise with the complainant and consider how you would feel if you received the proposed response letter. Is there anything in there that would cause further distress or aggravation? Can anything be misinterpreted? Is there anything left unanswered? Is the answer rather vague? Would you feel satisfied with this response and believe that the Trust had taken your complaint seriously? Would you feel comfortable about engaging in further resolution if necessary?

24. The Directorate complaints lead should quality assure the draft letter.

25. The final draft should be sent to the Patient Experience Team

Please do not be discouraged or annoyed if the Patient Experience Team makes some changes. They are seeing it with a fresh pair of eyes. Also, it is most likely that they have been in verbal contact with the complainant and have an understanding of what the patient will be expecting in a letter of response.

Occasionally, the team will return letters to the investigating officers advising that some elements have not been addressed. Please accept that this is a benefit of having someone outside the service to review the responses – the Patient Advisors will not know exactly what the service can/should offer so they will read the response with the limited knowledge that a complainant may have.

Similarly, sometimes the responses may read as too defensive of the staff in question so the Patient Experience Team will suggest amendments to redress the balance.

The Patient Experience Team will check all response letters meet Complaints Regulations and Trust requirements and make necessary amendments and additions.

Appendix 5

Guidance notes for meetings with complainants

Meetings can be a particularly effective way of diffusing a potential complaint, resolving an ongoing complaint or providing clarification following a final response to a complaint. It is sometimes easier to discuss issues and avoid misinterpretation through verbal communication rather than correspondence.

Before the meeting

- Agree the issues for discussion and who will be attending with the complainant.
- Agree a venue, date and time (It may be best in some cases to meet at an off site, neutral, venue at a time negotiated between both parties).
- In difficult cases you may wish to set a deadline at which the meeting will end.
- Meeting should be chaired by the Clinical Director, Matron or Head of Service/Department or person nominated by them.
- The Patient Experience Team will confirm all arrangements and send a letter of invitation.
- Review the complaint and investigation findings with staff who will be at the meeting, to maintain honesty and consistency.
- Ensure staff who attend the meeting are briefed and offered support; they should not be left to take the full brunt of a complainant's anger.
- If you feel the complainant or their family may be intimidating to a staff member you may take the decision not to have that staff member at the meeting.
- Ensure drinks and tissues are available in the meeting room.

The meeting

- If recording equipment is to be used, read out the recording of meetings agreement contained within the Standard Operating Procedure for the Management of Complaints and Concerns.
- Begin with introductions and your understanding of the reasons for the meeting.
- Have a note-taker (a member of the Patient Services team) at the meeting so that you can concentrate on the issues at hand.

- Have the complaint letter, response letter and action plan with you for reference.

- Listen – ask the complainant to outline their key issues. Clarify outstanding issues from those that might already have been addressed.

- Acknowledge mistakes and apologise if necessary. Avoid apologising indirectly. Try and avoid phrases like “we are sorry that you *felt* the organisation or an individual did something wrong”. Apologise for it going wrong instead.

- At the end of the meeting summarise the key points and any actions agreed/who will undertake them. Tell the complainant what will happen next and when.

Appendix 6a

Guidance for the recording and reporting of compliments

The Trust logs and reports concerns and complaints and it is also important to log and report compliments from across the Trust to help provide a more complete picture regarding people's views of the services the Trust provides.

Compliments provide an opportunity to learn from good practice and to recognise the excellent work that staff do.

The number of verbal compliments, cards, letters, token gifts etc received by wards and departments should be logged on the capturing compliments and thank you form.

Heads of Service/Departments and Matrons are asked to ensure all departments and wards log their compliments on a monthly basis using the new form. Completed forms should be sent electronically to the compliments email; compliments@rothgen.nhs.uk by the 5th of each month.

Heads of Service/Departments and Matrons should share compliments information with their staff.

The Patient Experience Team will collate all compliments received Trust wide and report to the Patient Experience Group on a monthly basis.

Appendix 6b

The Rotherham NHS
NHS Foundation Trust

CAPTURING COMPLIMENTS AND MESSAGES OF THANKS

Please populate the table below for your area for each calendar month. This information should be forwarded by email to compliments@rothgen.nhs.uk for collation and inclusion in a monthly report to the Board of Directors **no later than the 5th day of the following month.**

Division……

Ward/department……. **Month and year…….**

Number of verbal compliments, cards, letters* or other messages of thanks and gifts received

Verbal	Cards	Letters	Copy of publication e.g. newspaper article	Chocolates/ biscuits/ sweets	Tea/coffee/ non alcoholic beverage	Other gifts

*Whilst we cannot possibly view all cards/letters received if they are particularly articulate in identifying what it is that we did so well please scan and email as well. Please **do not send** hard copies of cards, letters etc to the Patient Services department.

Gifts

Staff must refuse gifts, benefits, hospitality or sponsorship of any kind which might reasonably be seen to compromise their personal judgement or integrity, and to avoid seeking to exert influence to obtain preferential consideration. All such gifts must be returned and hospitality refused.

It is recognised that gifts are commonplace and often deserved, and in some cases can be accepted. However moral judgement should be exercised, especially when dealing with vulnerable people. Staff must declare and register gifts, benefits, hospitality or sponsorship of any kind, *(*using SoBC declaration form*)* if they are worth £50 or more, whether refused or accepted. Similarly a declaration must be made if several small gifts, benefits, hospitality or sponsorship of any kind are offered totalling over £200 from the same or a closely related source in a 12-month period. A declaration is required when:

- items have been refused or returned; or
- approval is required to accept the item(s) being offered

Gifts of money or alcohol should ALWAYS be refused. Staff could suggest the money is instead donated to the hospital charity or the alcohol is donated to the hospital charity as a raffle prize.

The Standards of Business Conduct (SoBC) and declaration form can be found on the intranet

MANAGEMENT OF COMPLIMENTS, COMMENTS, CONCERNS AND COMPLAINTS POLICY

SECTION 2
DOCUMENT DEVELOPMENT, COMMUNICATION, IMPLEMENTATION AND MONITORING

8. CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

This document was developed in consultation with:

Interim Chief Executive
Chief Nurse
Deputy Chief Nurse
Medical Director
Lead Nurses/Heads of Service/Departments
Clinical Directors
Patient Services Team

9. APPROVAL OF THE DOCUMENT

This document was approved by:

Patient Experience Group

10. RATIFICATION OF THE DOCUMENT

This document was ratified by the Trust Document Ratification Group.

11. EQUALITY IMPACT ASSESSMENT STATEMENT

An Equality Impact Assessment has been carried out in relation to this document using the approved initial screening tool; the EIA statement is detailed at Appendix 1 to this section of the document.

The manner in which this policy impacts upon equality and diversity will be monitored throughout the life of the policy and re-assessed as appropriate when the policy is reviewed.

12. REVIEW AND REVISION ARRANGEMENTS

This document will be reviewed every three years unless such changes occur as to require an earlier review.

The Patient Experience Lead is responsible for the review of this document.

13. DISSEMINATION AND COMMUNICATION PLAN

To be disseminated to	Disseminated by	How	When	Comments
Quality Governance Team via policies email	Author	Email	Within 1 week of ratification	Remove watermark from ratified document and inform Quality Governance Team if a revision and

				which document it replaces and where it should be located on the intranet. Ensure all documents templates are uploaded as word documents.
Communication Team (documents ratified by the document ratification group)	Quality Governance Team	Email	Within 1 week of ratification	Communication team to inform all email users of the location of the document.
All email users	Communication Team	Email	Within 1 week of ratification	Communication team will inform all email users of the policy and provide a link to the policy.
Key individuals Staff with a role/responsibility within the document Heads of Departments /Matrons	Author	Meeting/E mail as appropriate	When final version completed	The author must inform staff of their duties in relation to the document.
All staff within area of management	Heads of Departments /Matrons	Meeting / Email as appropriate	As soon as received from the author	Ensure evidence of dissemination to staff is maintained. Request removal of paper copies Instruct them to inform all staff of the policy including those without access to emails

14. IMPLEMENTATION AND TRAINING PLAN

Ad hoc training aimed at staff responsible for conducting investigations into complaints and writing complaint response letters will be delivered by members of the Quality Governance Team and Patient Experience Team.

15. PLAN TO MONITOR THE COMPLIANCE WITH, AND EFFECTIVENESS OF THE TRUST DOCUMENT

15.1 Process for Monitoring Compliance and Effectiveness

Audit/Monitoring Criteria	Process for monitoring e.g. audit, survey	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Duties	PDR process	Line Managers	Annual	Line manager	Line manager
How the Trust listens and responds to concerns and complaints from patients, their relatives and carers	Internal Audit	Patient Experience Lead	Annual	Patient Experience Group	Patient Experience Group
How the Trust makes sure that patients, their relatives and carers are not treated differently as a result of a concern or complaint	Complainant satisfaction survey	Patient Experience Lead	Annual	Patient Experience Group	Patient Experience Group
How the Trust makes improvements as a result of raising a concern concerns or complaint	Internal audit	Patient Experience Lead	Annual	Patient Experience Group	Patient Experience Group
How joint complaints are handled between organisations	Internal audit	Patient Experience Lead	Annual	Patient Experience Group	Patient Experience Group
Key performance indicators	Internal audit	Patient Experience Lead	Monthly	Directorate Complaints Lead	Directorate Governance Group/ Patient Experience Group

Note – any issues with compliance will be escalated to higher groups or committees as decided by the Patient Experience Group.

15.2 Standards/Key Performance Indicators (KPIs)

Measure	KPI %
Complaints will be acknowledged within 3 working days	95%
Directorates will be informed of a complaint and sent the complaints management plan within 2 working days of receipt.	95%

Complainants will receive a Healthwatch leaflet with their acknowledgment	100%
Patient services contact lead investigator for progress update at day 15	95%
Response reviewed by contributors - Day 16-17	90%
Responses QA – Day 18-19 Yellow and green - directorate complaints lead. Amber - DCN Red – CN	90%
Final response due by Patient Services – Day 20/Day 35 for complex complaints	90%
Response and cover letter sent to CEO – Day 21/Day 36 for complex complaints	90%
Response sent to complainant – Day 24/Day 39 for complex complaints	90%
Extensions to complaints responses will be agreed by the Deputy Chief Nurse	100%
Extensions to complaints responses will not exceed 10 days	100%
Extensions to be discussed/agreed with the complainant	90%
Extension agreed - Extension letter sent to all complainants	100%
All complaints to be risk graded	100%
All sections of the complaints management plan will be completed for all complaints	100%
All complaints will have a completed action plan or it will be documented that no action plan is required.	100%
All complaints will be logged on Datix	100%
Complainants will be sent a complaints handling survey	100%
Number of Re-opened complaints	≤ 4% of all complaints received annually.
Concerns will be responded to within 10 working days.	95%

The Rotherham NHS
NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

Document Name:	Management if concerns, complaints, comments and compliments policy.			Date/Period of Document:	March 2014
Lead Officer:	Patient Experience Lead	Directorate:	Chief Nurse Directorate	Reviewing Officers:	Patient Experience Lead

❑ Function	☑ Policy	❑ Procedure	❑ Strategy	❑ Joint Document, with whom?
Describe the main aim, objectives and intended outcomes of the above:				

*You must assess **each** of the 9 areas separately and consider how your policy may affect people's human rights.*

1. Assessment of possible adverse impact against any minority group				
How could the policy have a **significant** negative impact on equality in relation to each area?		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	**Age**?		✓	
2	**Sex** (Male and Female?		✓	
3	**Disability** (Learning Difficulties/Physical or Sensory Disability)?		✓	
4	**Race** or Ethnicity?		✓	
5	**Religion and Belief**?		✓	
6	**Sexual Orientation** (gay, lesbian or heterosexual)?		✓	
7	**Pregnancy and Maternity**?		✓	
8	**Gender Reassignment** (The process of transitioning from one gender to another)?		✓	
9	**Marriage and Civil Partnership**?		✓	

You need to ask yourself:

- Will the policy create any **problems** or **barriers** to any community of group? **No**
- Will any group be **excluded** because of the policy? **No**
- Will the policy have a negative impact on **community relations**? **No**

If the answer to any of these questions is yes, you must complete a full Equality Impact Assessment

2. Positive impact:				
Could the policy have a **significant** positive impact on equality by reducing inequalities that already exist? Explain how will it meet our duty to:		**Response**		**If yes, please state why and the evidence used in your assessment**
		Yes	**No**	
1	Promote **equal opportunities**		✓	
2	Get rid of **discrimination**		✓	
3	Get rid of **harassment**		✓	
4	Promote **good community relations**		✓	
5	Promote **positive attitudes** towards disabled people		✓	
6	Encourage **participation** by disabled people		✓	
7	Consider **more favourable treatment** of disabled people		✓	
8	Promote and protect **human rights**		✓	

3. Summary On the basis of the information/evidence/consideration so far, do you believe that the policy will have a positive or negative adverse impact on equality?						
Positive	*Please rate, by circling, the level of impact*					**Negative**
HIGH	**MEDIUM**	**LOW**	**☑NIL**	**LOW**	**MEDIUM**	**HIGH**
Date assessment completed: March 2014	Is a full equality impact assessment required?		❑ Yes (documentation on the intranet)		☑ No	