University Hospitals Bristol and Weston NHS Foundation Trust

Complaints Policy

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What is in this policy?
This policy explains how University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) will fulfil its statutory obligations for the timely and effective handling and investigation of complaints made by patients and those who care for them. The policy enshrines the Trust's commitment to making its complaints service open and accessible to all, and to the use of complaints as a key source of organisational learning.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
Unspecified	1.0	Director of Nursing	Unspecified	Unspecified
September 2007	2.0	Chief Nurse and Director of Governance	Unspecified	Unspecified
12 February 2009	3.0	Assistant Director of Governance and Risk Management	Major	Factual update to include strengthened compliance with Healthcare Standards C14a, b and c.
14 May 2009	4.0	Assistant Director of Governance and Risk Management	Major	Policy changed to include the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
18 November 2010	4.2	Assistant Director of Governance and Risk Management	Minor	Factual update to include organisational changes and strengthened compliance with CQC Outcome 17 and NHSLA Risk Management Standards.
1 February 2011	4.3	Assistant Director of Governance and Risk Management	Minor	Minor amendments to clarify process.
19 March 2012	5.0	Assistant Director of Governance and Risk Management	Major	Amendments to clarify process and change to format of policy.
23 July 2012	5.1	Assistant Director of Governance and Risk Management	Minor	Amendments to process to provide further clarity to process.
8 July 2013	5.2	Head of Quality (Patient Experience and Clinical Effectiveness)	Minor	Head of Quality (PE/CE) now has lead responsibility; ICAS replaced by SEAP; changes to Divisional management structure; introduction of validation reports for breaches of complaints indicators; text phones no longer provided in Patient Support and Complaints Team (no demand); removal of examples in financial remedy section; addition of recognition of overlap with Child Death Review process; changes to monitoring table.
17 June 2014	5.3	Head of Quality (Patient Experience and Clinical Effectiveness)	Minor	Requirement for Divisions to provide draft complaints responses at least four working days before the deadline agreed with the Complainant;

				expectation that Patient Support and Complaints Team will review draft responses and send for Executive approval within 24 hours of receipt; escalation of delayed complaints responses; clarification of relationship between complaints and possible related legal action; updates to monitoring table.
11 August 2014	5.4	Head of Quality (Patient Experience and Clinical Effectiveness)	Minor	Minor amendments further to Patient Experience Group review in June 2014 and subsequent discussion: 5.23 (learning process); 5.1 (expectations for acknowledgement of complaints); 4.7g (logging informal complaints). Associated updates to monitoring table.
2 August 2016	6.0	Head of Quality (Patient Experience and Clinical Effectiveness)	Major	The following themes within the policy have been added or significantly amended: • Escalation of high risk complaints • Consent • Independent review • Linking complaints with patient safety incidents and serious incidents • Duty of Candour • Involving complainants in improvements • Hearing about and learning from people's experience of the complaints process • Persistent user protocol Previous complex flow charts describing processes for responding to complaints have also been removed from the policy document.
30 September 2019	7.0	Head of Quality (Patient Experience and Clinical Effectiveness)	Major	Removal of detailed processes (for standard operating procedures), reflecting the fact that this is a policy document. Addition of full Equality Impact Assessment. Title change to 'Complaints Policy'.

Sign off Process and Dates	
Groups consulted	**Date agreed**
UH Bristol Involvement Network	21/10/2019
Patient Experience Group	21/11/2019
Policy Assurance Group	16/03/2020
Clinical Quality Group (approved by Chief Nurse as lead Executive Director in the absence of CQG meetings due to COVID-19 outbreak)	31/03/2020

- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.
- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

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Do I need to read this Policy?

All staff responsible for coordinating, investigating or responding to a complaint, or required to provide input into a complaint investigation

Must read the whole policy document

All staff responsible for one or more departments/services, or a registered health professional accountable for managing patient care

As a minimum, should read sections 1-3 and 6

All staff who have direct contact with patients verbally or in person

Must be aware:

- of the expectation that concerns raised by patients, their families and those who care for them, should be addressed at the point of care wherever possible
- that this policy exists for reference in instances where concerns cannot be satisfactorily addressed at point of care
- of the principle of Being Open which underpins the policy

1. Introduction

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) is a large and complex organisation, offering a wide range of services to a culturally diverse population. However diligent and skilful our staff are, there will inevitably be circumstances where patients' expectations have not been met. We encourage patients to tell us when they are unhappy about any aspect of their care and treatment as soon as possible, so that we have the opportunity to investigate and put things right.

The Trust wants to learn from the experience of patients and to ensure that services are improved and developed accordingly. Complaints provide the Trust with an understanding of how our patients experience and feel about the services that they access from us. We will use this feedback constructively to improve their and others' experiences in the future.

We want the people who use our services to be able to feed back their views, both positive and negative, about the treatment and services the Trust provides, in the knowledge that their concerns will be taken seriously, investigated thoroughly, and that they will receive timely, understandable and clear responses to all of their questions. We will also explain what action we have taken to minimise the risk of the same issues recurring in the future.

This policy is consistent with the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), introduced 1st April 2009 and the Parliamentary and Health Service Ombudsman's Principles of Good Complaints Handling 2009, namely:

(a) Getting it right

(b) Being customer focused

(c) Being open and accountable

(d) Acting fairly and proportionately

(e) Putting things right

(f) Seeking continuous improvement

The policy also supports the Trust in maintaining compliance with Care Quality Commission Fundamental Standards Regulation 16 – Receiving and acting on complaints.

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-16-receiving-acting-complaints

In the event that anyone reading this document considers that the Trust has not adhered to the principles of this policy, or the guidance laid out within it, they should in the first instance raise their concerns in writing for the attention of the Chief Executive.

2. Purpose

The purpose of this policy is:

- To ensure that there is an easily accessible mechanism through which patients can raise issues of concern and/or make a complaint.
- To ensure that all complaints received are thoroughly investigated and that a full, honest fair and transparent reply is provided within the time frame agreed with the Complainant, and that action is taken where appropriate.
- To ensure that the patient's/complainant's care is not adversely affected as a result of having made a complaint.

The complaints policy is not designed for staff to raise a complaint against another member of staff, except where a member of staff is making a complaint as, or on behalf of, a patient about services provided by the Trust.

This policy is not about apportioning blame, but understanding and prevention.

This policy explains the expectation of transparency and openness at all stages of the complaints process for everyone involved.

The complaints policy is not designed for staff to raise a complaint against another member of staff, except where a member of staff is making a complaint as, or on behalf of, a patient about services provided by the Trust.

3. Scope

This policy relates to the handling of complaints by all permanent and temporary employees, volunteers, agencies and agency staff working for and on behalf of the Trust.

The Trust will aim to resolve complaints at the point of contact wherever possible. This policy applies to concerns that cannot be resolved at the point of contact.

4. Definitions

4.1 Complaint

An expression of dissatisfaction about an act, omission or decision by the Trust, or those acting on its behalf, either verbal or written and whether justified or not, where the person (or persons) expressing dissatisfaction requires or expects a response, and falls within the scope of NHS Complaints Regulations.

4.2 High risk complaint

A complaint which meets one or more of the following criteria:

- A complaint involving the death of a child;
- A complaint involving the unexpected death of an adult;

- A complaint containing serious allegations about a specific member of staff;
- A complaint where serious harm to a patient is alleged;
- A complaint where the Complainant is threatening to contact a third party such as the press, media, or a healthcare regulator;
- A complaint which involves a possible legal claim;
- A complaint where the Complainant is dissatisfied with both the Trust's initial response via formal resolution and the Trust's second attempt to address the issues raised in the complaint.

4.3 Informal complaint resolution

Complaints which can be investigated through an informal resolution process are generally recognised as:

(a) Complaints about non-complex matters, which can be resolved within a short time period (usually up to 10 working days). This includes letters of complaint received directly by Divisional Management/Clinical teams which can be resolved easily by a telephone call or letter. For example, appointment cancellations, reasons for surgery cancellations, communication problems.

(b) Complaints which are current and occurring on a ward and department, which will impact on patient care if they remain unresolved.

4.4 Formal complaint resolution

Complaints which require investigation through a formal resolution process are generally recognised as:

(a) Complex complaints about issues such as:

(i) Lack of capacity / service not available;

(ii) System failures;

(iii) Staff attitude;

(iv) Patient safety incidents; and

(v) Complex clinical issues.

(b) Multi-department or organisational complaints.

(c) Complaints which do not involve the current immediate care of a patient, i.e. where there may be a particular need for rapid resolution.

The usual timescale for investigating and responding to complaints via formal resolution is 30 working days. However, this may increase if the complaint is particularly complex and/or involves more than one Division or organisation. A longer timescale may also be needed where the Complainant requests a local resolution meeting rather than a written response.

4.5 Patient Support and Complaints Team (PSCT)

The Trust's integrated complaints and 'PALS' service[1].

4.6 Independent Complaints Advocacy

If a patient/relative/carer feels that they have not received the service they expected from the NHS and wants to make a complaint, the law states that they have the right to have the support of an advocate.

A health complaints advocacy service is completely independent of the NHS and can offer a complainant the following help:

- Support with an NHS complaint either in person or over the telephone;
- Help the complainant to understand the NHS complaints process;
- Refer the complainant to other agencies where appropriate;
- Support the complainant in preparation for and attendance at complaint meetings; assist the complainant with referring cases to the PHSO.

The Patient Support and Complaints Team will routinely provide every complainants with leaflets from local NHS complainant advocacy services, including seAp Advocacy and Swan Advocacy.

4.7 Incident

Any unintended or unexpected event which could have led to, or did lead to, harm for one or more patients receiving NHS care.

5. Duties, Roles and Responsibilities

5.1 Trust Board of Directors

(a) Ensures that there are clear policies and procedures for the handling of complaints and that appropriate expertise and resources are available to enable its responsibilities to be effectively discharged.

(b) Receives and reviews monthly information on complaints via the Trust's Quality & Performance Report, including:

(i) Total number of complaints received;

(ii) Response time performance; and

(iii) The percentage of complainants dissatisfied with their response.

(c) Delegates authority to the Quality and Outcomes Committee to receive and review a detailed quarterly analysis of complaints themes and associated learning.

[1] Many NHS Trusts have a Patient Advice and Liaison Service, known as 'PALS', offering confidential advice, support and information on health-related matters. UH Bristol's Patient Support and Complaints Team encompasses the function of PALS.

(d) Receives and reviews the Annual Complaints Report. Complaints performance data will also be included in the Trust's annual Quality Report (Quality Account).

5.2 Chief Executive

(a) Has overall accountability for how complaints are handled.

(b) Delegates the role of executive lead for complaints to an appropriate executive director.

(c) Will sign or designate the signing of written complaints responses to all complaints investigated through a formal investigation process (all formal response letters will bear the Chief Executive's name).

5.3 Chief Nurse

(a) Is the designated executive lead for complaints, responsible for ensuring organisational compliance with the complaints regulations.

(b) Will act as signatory, supported by other executive team members on behalf of the Chief Executive for all complaints investigated through a formal investigation process.

(c) Will be responsible, with the Medical Director, for reviewing all complaints escalated by the Patient Support and Complaints Manager in accordance with the standard operating procedure for the escalation of high risk complaints.

(d) Line manages the Head of Quality Patient Experience and Clinical Effectiveness (see below).

5.4 Other Executive Directors

(a) Will be responsible for advising on any complaints assigned to them in respect of the process described in the standard operating procedure for the escalation of high risk complaints.

(b) Participate in the rota of signatories for formal complaints responses, particularly in the absence of the Chief Nurse.

5.5 Clinical Chairs and Divisional Directors

(a) Ensure that complaints procedures are applied in their respective Divisions of the Trust.

(b) Responsible for ensuring the quality of draft complaints responses leaving their divisions.

(c) Ensure that Divisional Boards receive regular reports of complaints activity and identify a divisional quality/governance committee to receive more detailed reports.

(d) Ensure that action plans arising from complaints are implemented and lessons learned.

5.6 Heads of Nursing and Midwifery

(a) Hold divisional lead responsibility for the effective handling and resolution of complaints.

(b) Ensure that complaints are investigated thoroughly, fairly and within timescales agreed with Complainants.

(c) Ensure that Divisional Boards receive monthly information on complaints via the Trust's Quality & Performance report, including:

(i) Numbers of complaints received

(ii) Response time performance.

(iii) The number of Complainants dissatisfied with their response.

(d) Discuss any breach of performance thresholds with Board Executives via Divisional Performance Review meetings and identify how performance will be improved.

(e) Ensure that the staff in their Divisions are aware of the complaints procedure and participate in complaints training appropriate to their role and responsibilities.

(f) Ensure that responses are drafted in accordance with the Trust's 'Investigating and Responding to Complaints' training and using the agreed template/format.

(g) Ensure that draft complaints responses are sent to the Patient Support and Complaints Team at least seven working days before the response deadline agreed with the Complainant.

(h) Ensure that final response letters/meeting notes are copied to all the staff appropriate to receive them, i.e. staff involved in the investigation and/or those who have provided statements and to the senior divisional management team.

(i) Ensure that incidents are reported when identified in the course of a complaint investigation.

(j) Ensure financial redress is included, where appropriate, as part of fair and proportionate remedies for Complainants.

(k) Assess (with the Patient Support & Complaints Manager) thematic learning via detailed quarterly analysis of complaints received, and respond to these themes either by explaining what actions have already been taken to address the concerns, or by proposing new improvement actions on behalf of the division.

(l) Ensure the Division is represented at the Trust's Patient Experience Group (PEG) and that learning from PEG is shared with divisional boards, including learning from other divisions where common themes are identified.

5.7 Head of Quality (Patient Experience and Clinical Effectiveness)

(a) In consultation with the Chief Nurse, determines organisational strategy towards complaints handling and resolution.

(b) Monitors progress against the Patient Support and Complaints Team annual work plan, and performance against board-reported performance targets.

(c) Routinely reviews all dissatisfied responses prior to Executive sign-off, and performs random checks of other draft complaints letters from the Trust to ensure a high quality of response is maintained.

(d) Line manages the Patient Support and Complaints Manager (see below).

5.8 Patient Support and Complaints Manager

(a) Manages the Trust's corporate Patient Support and Complaints Team, with responsibility for the Trust-wide management and co-ordination of complaints procedures.

(b) Responsible for the production of letters, responses, and Trust-wide reports.

(c) Leads on the design and delivery of complaint training for staff.

(d) Produces monthly data for Trust and Divisional Board Reports and quarterly reports to the Patient Experience Group, routinely producing a summary of any significant complaint activity, themes arising out of complaints, and action taken.

(e) In consultation with the Head of Quality, produces an annual work plan setting out improvement goals in complaints handling.

(f) Writes an annual report to the Board describing and quantifying the Trust's performance in handling complaints for the preceding 12 months, to include comparison with previous years' performance.

(g) Advises Divisions and managers on the effective handling and investigation of complaints, including writing response letters.

(h) Ensures that the receipt of complaints is acknowledged within timescales laid down in the NHS Constitution.

(i) Where a complaint indicates that a patient may have come to harm, liaises with the corporate Patient Safety Team and/or Legal Services Team to confirm whether a complaint is also the subject of a reported incident or a potential claim.

(j) Escalates high risk complaints to the Chief Nurse (or Medical Director) in accordance with the standard operating procedure for this purpose.

(k) Liaises with Complaints / PALS Managers from neighbouring NHS trusts and Local Authorities to agree the management of any joint complaints / enquiries received, ensuring that wherever possible a single response is drafted.

(l) Ensures that draft complaints responses received from Divisions are reviewed by the Patient Support and Complaints Team and sent for Executive approval within 24 hours of receipt.

(m) Escalates delayed complaints responses or actions on behalf of the Chief Nurse to Heads of Nursing, Divisional Directors and Clinical Chairs.

(n) Alerts the Trust Communications Team to any situation that has potential for press interest.

(o) Liaises with the Parliamentary and Health Service Ombudsman (PHSO) in respect of complaints which have been raised directly with them by the Complainant.

5.9 Divisional Complaints Co-ordinators

(a) Responsible for the administration processes relating to the management of complaints within their Division.

(b) Communicate regularly with the Patient Support and Complaints Team regarding any areas of concern or potential delays during the investigation of a complaint.

(c) Ensure that the Datix database is updated to include all actions taken during the investigation of a complaint by the Division.

(d) Ensure that all complaints investigated and resolved directly by the Division are input onto the Datix database as 'Concerns'.

(e) Ensure that the Patient Support and Complaints Team, and the Datix database, is kept updated on the progress of action plans produced following the investigation of a complaint.

(f) Contact Complainants to explain and agree any extensions that are required to the deadline agreed by the Patient Support and Complaints Team, in line with the standard operating procedure for the extension of deadlines.

(g) Review and confirm validation reports received in respect of breaches of complaints targets (delays in responses, or dissatisfied Complainants).

5.10 Trust Services Divisional Management Board

(a) Monitors compliance with targets for the timely acknowledgement of all complaints (which is a constitutional standard which sits within the Division).

5.11 Patient Experience Group

(a) Receives a quarterly complaints report summarising complaints activity, themes and learning arising out of complaints and performance in complaints management.

(b) Monitors compliance with Care Quality Commission Fundamental Standard (Regulation) 16.

(c) Ensures learning from complaints is shared with Divisions via Heads of Nursing.

5.12 All Front line staff

(a) Frontline staff need to be aware of their role in handling complaints at the time of occurrence.

Further information is proved in a staff information leaflet.
http://nww.avon.nhs.uk/dms/Download.aspx?r=2&did=10993&f=ComplaintsALeafletForStaff-1.pdf

5.13 Parliamentary & Health Service Ombudsman (PHSO)

(a) The Parliamentary and Health Service Ombudsman manages the second stage of the NHS complaints procedures by assessing complaints which have not been

resolved locally and, where appropriate, commissioning independent investigations into complaints about the NHS in England.

(b) The Ombudsman, who is independent of the Government and the NHS:

(i) Will require that the Trust has made all possible attempts at local resolution of the complaint before accepting their need to investigate.

(ii) Can pass information to a professional regulatory body.

(iii) Can make recommendation to the Trust for additional remedy should local resolution be found to be insufficient.

(c) All Complainants whose complaints are pursued through the Trust's formal resolution process are routinely provided with information about the PHSO.

6. Policy Statements and Provisions

6.1 General principles

Any person wishing to make a complaint, but who is unable to do so without support, will be given appropriate assistance. To this end, the Trust will employ a dedicated team of staff to help and guide people who want to make a complaint about its services.

Clear and accessible information about how to raise a concern or make a complaint, either verbally, in writing or electronically will be provided in all wards and departments, in major public areas of the Trust and on its website.

Complainants will be offered a range of choices for how they would like to make a complaint at a time which is convenient for them.

The Trust expects that the language of complaint responses demonstrates compassion and empathy.

The Trust will observe the principles of Being Open as set out in its Staff Support and Being Open Policy (Duty of Candour) by offering full and honest explanations to people who raise concerns and complaints. Being Open involves:

- Acknowledging, apologising and explaining when things go wrong – saying sorry is not an admission of liability and is the right thing to do.
- Conducting a thorough investigation and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.

6.2 Situations in which the complaints procedures do not apply

The following complaints will not be dealt with under this policy:

- A complaint made by another NHS organisation or a private or independent provider or responsible body.
- A complaint made by an employee about any matter relating to their employment.

- A complaint, the subject of which has previously been investigated under current or previous NHS complaints regulations
- A complaint which has already been investigated by the Parliamentary and Health Service Ombudsman (PHSO)
- A complaint arising out of an alleged failure by an NHS body to comply with a data subject request under the Data Protection Act 1998 or a request for information under the Freedom of Information Act 2000.
- A complaint where solicitors have served papers on the Trust to progress with a case of litigation against the Trust.
- A complaint where the Trust has been notified that criminal proceedings have been commenced in relation to the substance of the complaint where there is a risk that a complaint investigation may prejudice those criminal proceedings.
- Complaints about private medical treatment provided in an NHS setting if the service is delivered totally by privately employed staff and the NHS premises are being privately leased at the time. The policy does cover any complaints made about Trust staff delivering medical care to private patients under their NHS contract of employment and/or facilities provided whilst receiving private medical care delivered by NHS staff in Trust premises. The policy also covers the delivery of medical treatment and care funded by the NHS in private facilities.

6.3 Who can complain?

Anybody can complain to the Trust, including young people aged 12 and above, as long as:

- They have received or are receiving services from the Trust, or
- They are someone who is affected by or likely to be affected by, the action, omission or decision of the Trust.

A complaint may be made by the person who is affected by the action, omission or decision of the Trust, or it may be made by a person acting on their behalf in a situation where the person affected:

- Is a child under the age of 12
- Has died
- Has physical or mental incapacity (within the meaning of the Mental Capacity Act 2005)
- Has given consent to a third party acting on their behalf which may include an advocacy service
- Has delegated authority to act on their behalf, for example in the form of a lasting power of attorney which covers health affairs
- Is an MP, acting on behalf of and by instruction from a constituent
- Is the patient's GP

If a complaint is raised in relation to the care of a child under 16 years by anyone other than a parent or legal guardian, consent will always be sought from a parent or legal guardian before any information is released to the Complainant.

In many circumstances it will be an 'interested other person' such as relative, friend, carer or advocate who complains on behalf of a person who is or has been a patient. If this is the case, it is essential that permission is obtained from the patient for the 'interested other person' to act on their behalf.

If a patient has died, the complaint can be accepted from a close relative, friend, carer, organisation or individual suitable to represent the patient. This arrangement also applies if a patient is unable to act for themselves. If the patient lacks capacity to consent to the complaint being made, the complaint should where possible be brought by the patient's personal representative in law, such as a lasting power of attorney giving legal authority to act in the patient's best interests.

6.4 Making a complaint

In the event that a patient/relative/carer is unhappy with the care they have received, they should initially speak to the nurse in charge on the ward or the manager for the department/clinic at the time. If they do not wish to discuss their concerns with the staff or manager, or they have tried this approach and remain unhappy with the response received, they should contact the Patient Support and Complaints Team, who can be contacted in the following ways:

- By telephone on 0117 342 1050;
- By email to PSCT@UHBristol.nhs.uk;
- In writing to University Hospitals NHS Foundation Trust, Patient Support and Complaints Team, A201, Welcome Centre, Bristol Royal Infirmary, Upper Maudlin Street, Bristol, BS2 8HW;
- By completing a form attached to the Patient Support and Complaints Team's leaflet;
- By completing an online form on the Patient Support and Complaints Team page on the Trust's website;
- By completing a general online feedback form on the main Trust website;
- By calling at the Patient Support and Complaints Team's office located in the Welcome Centre at the main entrance to the Bristol Royal Infirmary.

6.5 Time limit for making a complaint

Complaints should be made to the Trust within 12 months of the events taking place, or of becoming aware of the events that have given rise to the complaint. Where a complaint is made after the 12 month time limit, the Trust will exercise discretion as to whether it accepts the complaint. In doing so, the Trust will consider in particular whether a) there is good reason for the time delay and b) it is still possible to investigate the complaint fairly and effectively in view of the length of time that has passed (for example, staff may have left the organisation, etc.).

6.6 Supporting people who make a complaint

All complaints managed by the Patient Support and Complaints Team will be allocated to a caseworker, who is responsible for the management of the complaint and all communication with the Complainant whilst the investigation is underway.

The method of resolving the complaint will be decided in discussion with the Complainant and should be proportionate to the complexity of the issues raised.

All Complainants will be notified of how to contact an independent advocacy service (such as seAp, Swan Advocacy, etc.) for assistance and support in relation to the resolution of their complaint, and of the option of subsequent independent review by the Parliamentary and Health Service Ombudsman (PHSO) should they remain dissatisfied.

6.7 Equality of access and non-discriminatory practice

The Trust will provide easy access to people who want to raise concerns and complaints about its services. Information about how to access the Trust's complaints service will be made widely available in a range of formats, including translating complaints guidance into the most commonly used languages in our local communities; this will include 'easy-read' materials for patients with a learning disability. We will provide, upon request, access to interpreters to support non-English-speaking patients in making a complaint; similarly, we will provide access to BSL interpreters to support D/deaf patients in making a complaint.

The Trust recognises that patients and their relatives have a right to raise concerns about the services they receive. It is expected that staff will not treat patients or their relatives unfairly as a result of any complaint or concern raised by them. Any complaints about unfair treatment because of having made a complaint will be investigated and appropriate action will be taken as necessary. Discrimination against people who make complaints or raise concerns is unacceptable and will not be tolerated.

More specifically, no patient, or any other person involved in the investigation and resolution of a concern or complaint will receive unfair treatment as a result of raising a complaint or on the grounds of their age, race, colour, ethnic or national origin, religious or equivalent belief system, political beliefs, gender, marital or partnership status, sexual orientation, disability, gender reassignment, pregnancy/maternity status, or any other condition or requirement which cannot be justified and which causes them disadvantage.

Nobody who makes a complaint will be treated differently by the Trust as a result of doing so. To support this process, the Trust will hold complaint documentation separately to the patient's medical records. The details of a complaint should only be made known to those directly involved in investigating or responding to the issues raised i.e. on a "need to know" basis.

The Trust will actively gather data on equality themes identified from complaints and will routinely report this information to its Patient Inclusion and Diversity Group for purposes of monitoring and learning.

6.8 Forms of remedy

The Trust is committed to a full, open and honest investigation of complaints relating to the services it provides. Where it is found there has been maladministration or poor service, the Trust will take steps to provide an appropriate and proportionate remedy. This remedy may include one or all of the following:

- An apology and a full explanation.
- Remedial action. This may include: reviewing or changing a decision on the service given to an individual Complainant; revising published material; revising procedures to prevent the same thing happening again; training or supervising staff; or any combination of these.
- Financial remedy. The Trust will consider proportionate financial remedy for Complainants who have incurred additional expenses as a result of poor service or maladministration by the Trust, for example as a result of a recommendation by the Parliamentary and Health Service Ombudsman (PHSO). This does not include requests for compensation involving allegations of clinical negligence or personal injury where a legal claim is indicated.

6.9 Resolution meetings

The majority of complaints result in a written communication to the Complainant explaining what the Trust's findings are. However, face-to-face meetings are often the best way of achieving a satisfactory resolution. In situations where the Complainant would prefer to meet, a suitable date and time to meet will be negotiated with the Complainant and relevant staff members. The Trust will normally expect resolution meetings to take place within standard office hours, i.e. broadly 9am – 5pm, however in the event that a Complainant is unable to meet at this time, the Trust will do its best to accommodate reasonable requests, whilst respecting staff's contracted hours.

The Trust is increasingly adopting the process of recording resolution meetings and sending a copy of the recording to the Complainant as part of the resolution process. This arrangement will always be with the consent of the Complainant. It should be noted that the recording of meetings or face-to-face/telephone conversations without the prior knowledge and consent of the parties involved (i.e. the Complainant and the Trust) is in contravention of the Data Protection Act 1998.

6.10 Complaints involving other NHS organisations and Social Services

If a complaint is received that includes issues relating to another NHS organisation, the Patient Support and Complaints Team will, with the agreement of the Complainant, liaise with the other organisations to obtain responses in relation to the issues raised. However wherever possible, attempts will be made to provide the Complainant with one written response that covers all of the issues raised. Similarly, in cases where the complaint received includes issues relating to Social Services, the Patient Support and Complaints Team will request consent from the Complainant to liaise with the appropriate Local Authority to ensure that, wherever possible, the Complainant receives a fully coordinated response.

6.11 Complaints about matters which are the subject of other parallel investigatory processes

It is recognised that sometimes the same issue will be addressed through multiple processes, for example as a complaint, an incident, or a Child Death Review. Where this occurs, the Trust will ensure that these processes work together in a way which Complainants and their families can understand and which provides a single coordinated point of contact with the Trust.

In instances when a complaint and a legal claim are brought at the same time, the complaints process will still apply unless contrary to the advice of the Trust's legal advisors or insurers.

6.12 Staff disciplinary concerns

The complaints policy is not designed for staff to raise a complaint against another member of staff, except where a member of staff is making a complaint as, or on behalf of, a patient about services provided by the Trust.

The Trust is committed to ensuring that the complaint process is fair to all parties, i.e. both Complainants and staff. The purpose of the complaints procedure is not to apportion blame: the Trust investigates complaints to establish **what** went wrong and **why**, rather than **who** did wrong. During the course of an investigation, if it is identified that there are concerns regarding the performance, capability or competence of any member of staff, the appropriate manager will consider an internal investigation under the relevant Trust policy, however this is not a matter for the complaints process.

6.13 Staff support and training

The Patient Support and Complaints Team will provide training in the effective handling and resolution of complaints. The training is targeted at three levels outlined in Appendix F of this policy. Staff who have responsibility for investigating complaints or chairing resolution meetings with Complainants are expected to attend relevant training.

Staff who are required to give a statement following a complaint should be supported throughout the investigation by their line manager using the range of staff well-being tools made available by the Trust.

Members of staff complained about in a complaint will not normally be asked to attend resolution meetings with Complainants, unless this is felt appropriate and agreed by all parties involved.

6.14 Unresolved complaints

Where the Complainant is dissatisfied with the Trust's response and further investigation or explanation is required, the Trust will do its best to provide the outstanding answers that the Complainant is seeking, ideally via a meeting, which is the Trust's preferred method of resolution.

The PHSO will be the primary route by which Complainants may seek an independent review of their complaint if they remain unhappy following the Trust's attempts at local resolution.

In exceptional circumstances, the Trust may employ the services of an expert advisor or external mediator to help resolve complex or unresolved complaints.

6.15 Unacceptable and unreasonable behaviours by complaints

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

The following Complainant behaviours are never acceptable:

- Harassing or being personally abusive or verbally aggressive towards staff dealing with their complaint.
- Threatening or using actual physical violence or intimidatory behaviour towards staff at any time.
- Being racially abusive or showing any other kind of discrimination.
- Using unacceptable language (whilst taking into account that some people do use swear words as part of their everyday conversation).

In the event of these behaviours applying, the Trust will act in accordance with its procedure for Management of Unacceptable Behaviour.

The following Complainant behaviours may also be deemed unreasonable by the Trust:

- Repeatedly not identifying the precise issues to be investigated, despite reasonable efforts of Trust staff and, where appropriate, advocacy services.
- Changing the substance of a complaint or continually raising new issues or seeking to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed.
- Raising the same or similar issues repeatedly, despite having received a full response to all the issues that have been raised.
- Repeatedly insisting on the complaint being dealt with in ways which are incompatible with this policy and NHS Complaints Regulations.
- Repeatedly displaying unreasonable demands and failing to accept that these may be unreasonable, such as demanding staff dismissal or setting “penalties” if demands are not met by the Trust.
- Having excessive contact with the Trust.

In the event of these behaviours, the Trust’s ‘Protocol for supporting Complainants who contact the Trust prolifically or who behave unreasonably’ will apply (see Appendix E). The abiding principle in these circumstances is that the Complainant needs support from staff to resolve their issues. The Complainant may also have underlying needs which explain their unreasonable

behaviour and/or persistence. The Trust's policy is not to label Complainants as "persistent" or "unreasonable" but to seek to understand the reasons for those behaviours.

6.16 Learning from complaints

Complaints are a key source of organisational learning. In respect of learning, our experience over many years suggests three things:

- Learning from the majority of complaints is for the individual members of staff involved, and often in the area of communication.
- Where specific patterns of complaints are identified, this will generally confirm/validate issues that are already known to the organisation and in respect of which remedial action has already been taken.
- Nonetheless, a complaint may also identify points of learning which indicate the need to change practice in a team, ward or department, or very occasionally the need for a wider change in a clinical Division or across the Trust.

Actions to be taken in response to a complaint will be explained clearly to the Complainant, either in writing in writing or in person, as agreed. Those actions will be recorded on the Trust's Datix risk management system and monitored to ensure they are completed. Each quarterly complaints report produced by the Trust will also include a section describing changes in practice made in response to learning identified from complaints.

7. Standards and Key Performance Indicators

The Trust is required by law to act in accordance with the NHS Complaints Regulations (2009) and the Care Quality Commission's Fundamental Standard 16 as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Trust is also committed to handling complaints in accordance with the Patients Association's 'Good Practice Standards for NHS Complaints Handling' (September 2013), namely:

(a) We will provide publicised, accessible complaints information and processes which is easily understood by all those involved in a complaint.

(b) We will display information about how to raise a concern or make a complaint in all wards, departments and in major public areas.

(c) We will conduct investigations which are consistent, evidence-based and directed by the Complainant's concerns and responses.

(d) We will respond sympathetically to complaints and concerns within appropriate and agreed timeframes.

(e) We will involve Complainants as much as they want to be in the complaints process. We will provide support and guidance throughout the complaints process, and at the outset of the complaint, we will ask the Complainant the extent to which they wish to be involved in the complaints process and any actions arising from it.

(f) We will provide a level of detail in our response appropriate to the seriousness of the complaint.

(g) We will identify the causes of complaints and take action to prevent recurrences.

(h) We will use lessons learnt from complaints as a driver for change and improvement.

(i) We are committed to hearing about and learning from Complainants' experience of our complaints system and will routinely survey our Complainants at an appropriate time after their complaint has been responded to by the Trust. As part of this survey, we will routinely ask Complainants whether they would be interested in receiving information about different ways of getting involved with improving services at the Trust.

(j) We will ensure that the care of Complainants is not adversely affected as a result of making a complaint.

The following key performance indicators shall apply:

All complaints received by the Trust will be acknowledged within three working days.

Timescales for completing a complaints investigation will be agreed between the Patient Support and Complaints Team (PSCT) and the Complainant; however, the following timescales will normally apply:

In cases where complaints are investigated through the informal resolution process, the Trust will contact the Complainant with its findings within 10 working days of the date when the Trust sends the complaint to the appropriate Trust Division for investigation. The Trust will send the complaint for investigation once a conversation has taken place with the Complainant (this could be by letter, email, phone call or in person) to confirm how the investigation will proceed, e.g. formal or informal.

In cases where complaints are investigated through the formal resolution process, the Trust will write to the Complainant with its findings within 30 working days, calculated from the same starting point described above (if a resolution meeting is required, we will seek a mutually convenient date and time for this to take place – see section 6.8).

8. References

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, Statutory Instrument, February 2009

Ombudsman's Principles, (2009) Parliamentary and Health Service Ombudsman.

NHS Constitution (2008) Department of Health.

Listening, Responding, Improving: A guide to better customer care, Department of Health, February 2009

Complaints handling in NHS Trusts signed up to the CARE campaign, Patients Association, 2013

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Websites:

Parliamentary and Health Service Ombudsman – www.ombudsman.org.uk

Care Quality Commission – www.cqc.org.uk

Patients Association – www.patients-association.org.uk

9. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table.

Objective	Evidence	Method	Frequency	Responsible	Committee
Complaints are acknowledged in a timely fashion: within three working days	Monthly complaints data extracted from Datix	Report	Monitored and reported on a quarterly basis.	Patient Support and Complaints Manager	Patient Experience Group; Trust Services Divisional Board
Complaints will be investigated within timescales agreed with the Complainant	Monthly complaints data extracted from Datix	Report	Monitored and reported on a monthly basis. Also quarterly complaints report.	Divisions	Quality and Outcomes Committee; Trust Board; Patient Experience Group
Complaints will be investigated carefully, comprehensively responses made in line with PHSO's principles. Response letters will explain what action the Trust is taking at either individual, Divisional or organisational level to make improvements and avoid recurrence.	PSCT and designated executive review of draft response letters to ensure we have responded fully to the concerns raised by the Complainant. Head of Quality (PE/CE) also reviews randomly selected draft responses. Monitor rates of dissatisfaction with complaints	Draft response letters are referred back to Division for further consideration where necessary. Report	Ongoing Monitored and reported on a monthly basis. Also quarterly complaints report.	Divisions; PSCT; Head of Quality; Executive Directors	Quality and Outcomes Committee; Trust Board; Patient Experience Group

Objective	Evidence	Method	Frequency	Responsible	Committee
	responses.				
Learning from complaints.	Actions are listed on the Datix system for all formal complaints and are monitored through to completion. Where there are no actions, the reason for this will be recorded.	Thematic learning and notable changes in practice following complaints are reported to PEG via quarterly complaints reports (also reported to Senior Leadership Team; Quality and Outcomes Committee; Trust Board). Learning is also summarised in the Trust's Annual Complaints Report.	Quarterly and Annual	Monitored by Patient Experience Group	Divisions (governance groups); Patient Support & Complaints Team; Patient Experience Group; Senior Leadership Team; Quality and Outcomes Committee; Trust Board

10. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Patient Support and Complaints Manager
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	A
If answer above is B: Alternative documentation this policy will replace (if applicable):	[DITP - Existing documents to be replaced by]
This document is to be disseminated to:	Please refer to Policy Dissemination Plan
Method of dissemination:	Please refer to Policy Dissemination Plan
Is Training required:	Not Applicable
The Training Lead is:	N/A

Plan Elements	Plan Details
Additional Comments	
Policy implementation will be managed through the Patient Support & Complaints Manager, by completing the following actions: (a) Presenting the policy to the Senior Leadership Team for approval. (b) Updating the policy and procedures on the Document Management Service (including intranet links). (c) Placing an alert to the updated policy in Newsbeat. (d) Emailing the Patient Support & Complaints Team, Divisional Directors, Heads of Nursing / Midwifery and Complaints Co-ordinators, highlighting key changes. (e) Ensuring the availability of the policy and all other documentation in alternative formats (large printing, Braille, other languages) upon request.	

11. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:
http://nww.avon.nhs.uk/dms/download.aspx?did=17833

Query	Response
What is the main purpose of the document?	This policy explains how University Hospitals NHS Foundation Trust (the Trust) will fulfil its statutory obligations for the timely and effective handling and investigation of complaints made by patients and those who care for them.
Who is the target audience of the document? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ **Staff Patients Visitors Carers Others**

Could the document have a significant negative impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		√	There is no reason to suppose that the existence of this policy document could have a negative impact in relation to any of these specific characteristics. All patients and their families should have access to the complaints process.
Disability (including physical and sensory impairments, learning disabilities, mental health)		√	
Gender reassignment		√	
Pregnancy and maternity		√	
Race (includes ethnicity as well as gypsy travelers)		√	
Religion and belief (includes non-belief)		√	
Sex (male and female)		√	

Sexual Orientation (lesbian, gay, bisexual, other)		√	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		√	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		√	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

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

Could the document have a significant positive impact on inclusion by reducing inequalities?	**YES**	**NO**	**If yes, please explain why, and what evidence supports this assessment.**
Will it promote equal opportunities for people from all groups?	√		The policy makes it clear that the Trust's complaints service must be open and accessible to all
Will it help to get rid of discrimination?	√		
Will it help to get rid of harassment?	√		The policy is clear about unacceptable behaviours by complainants towards staff.
Will it promote good relations between people from all groups?	√		Yes, if the policy enables all parties to have a better understanding of their roles and responsibilities when a complaint is made.
Will it promote and protect human rights?	√		Yes, in the sense that basic human right are based on shared values like dignity, fairness, equality and respect.

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
Significant	**Some**	Very Little	NONE	Very Little	Some	Significant

Is a full equality impact assessment required?

NO

However, due to the nature of the policy in question, we have completed a full EIA.

Date assessment completed: 23/12/19

Person completing the assessment: Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness), UH Bristol

12. Appendix D – Equality Impact Assessment (Full)

FULL EQUALITY IMPACT ASSESSMENT (Form B)

This form should only be completed where it has been identified (by completing the Equality Impact Assessment Screening Tool) that a strategy, service development or change, policy, procedure, consultation or committee document may have a negative impact on people from a protected group.

Name of Proposal : Complaints Policy

(***strategy, service development or change, policy, procedure, consultation or committee document***)

Areas of concern

From the information in the Screening Tool, what are the concerns about the impact on different groups?

There are no specific concerns arising from the screening tool, however, in response to a point of challenge from a Complainant, the Trust undertook to carry out an engagement exercise to seek feedback on the redrafted policy document.

Consultation

What have service users / employees / others said about the Proposal and any negative impacts? (Say who has been consulted with and how.)

The Trust shared the draft policy with more than 30 stakeholder groups, including representative groups that make up its Involvement Network (which is a mechanism via which the Trust engages with and consults its local communities). Stakeholders were asked to review and comment on the draft policy. In doing so, they were asked to consider what was most important to them in the process of making a complaint and whether our policy gave them confidence that we would provide an open, accessible and inclusive service. Stakeholder feedback can be summarised as follows: - Define terms clearly and carefully throughout the document - Be clearer about what our commitment to equality of access means – examples? - Review the section of the policy that talks about unreasonable behaviours by Complainants and match the tone of this section with the protocol in the appendix - Say more about learning from complaints.

Do you need to carry out further consultation? If so, who will you consult with and how?

No

Evidence and Evaluation

What evidence (for example workforce or service user monitoring information) was examined when the Proposal was being developed? What did it show?

N/A

If there is a lack of evidence, what information is needed and for which groups? How will this be found?

N/A

EQUALITY ACTION PLAN

Using the information already gathered, summarise your findings in the table below. If you have identified that any group is experiencing or is likely to experience a negative impact – particularly if this could be unlawful discrimination or if it is unintentional – action must be taken to address this.

Remember that any policy/strategy or function which could unlawfully discriminate must be changed, unless it can be objectively justified (shown that there is a genuine reason for the provision). Even if the negative impacts would not amount to unlawful discrimination, ways to remove or reduce them must be identified. (For example: change the policy or procedure; change how it is put into practice; find alternative ways of achieving the aims of the Proposal.)

If no actions are taken to change the provisions of the Proposal when adverse impacts for any groups have been identified, or where an adverse impact for any group is unavoidable, double-check that this could be justified legally. Major changes would need to be reported to the Proposal author/owner, highlighting the findings of the EIA and setting out any recommended actions.

Identified Impact on Equality (i.e. problem/barrier identified using consultation/evidence, etc.)	Potential impact on Protected Group(s) *	Action identified to mitigate / resolve	Who will action	When by
N/A – no specific concerns identified from screening tool. Feedback received from the stakeholder engagement exercise has been discussed at the Trust's Patient Experience Group and various amendments have been to the draft policy. These changes seek to address the four broad themes identified above.				

* Age / Disability / Gender reassignment / Pregnancy & Maternity / Race / Religion & Belief / Sex / Sexual Orientation / Groups at risk of stigma

13. Appendix E – Protocol for supporting Complainants who contact the Trust prolifically or who behaved unreasonably

13.1 Introduction

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

Examples of prolific/persistent and unreasonable behaviours are set out in the Trust's Complaints Policy.

In these circumstances, the abiding principle which shall apply is that the Complainant needs support from staff to resolve their issues. The Complainant may also have underlying needs which explain their unreasonable behaviour and/or persistence.

The Trust's policy is not to label Complainants as "persistent" or "unreasonable" but to seek to understand the reasons for those behaviours.

13.2 Guidance for staff

Staff should always:

(a) Identify the patient/service user's needs.

(b) Approach all concerns/issues objectively and without making assumptions.

(c) Identify the key concerns/issues raised.

(d) Give clear explanations using language that the patient/service user can understand

Possible courses of actions that may help support the Complainant include:

(e) Requiring all contact to be made via a nominated member of staff.

(f) Placing time limits on telephone conversations and personal contacts.

(g) Restricting the number of calls, letters or emails that will be taken or made.

(h) Limiting the Complainant to one mode of contact e.g. in writing only

(i) Requiring contact to be made through a third person, such as an advocate.

(j) Requiring any contact takes place in the presence of a witness.

(k) If necessary, clearly and politely explaining that the Trust will not be entering into further correspondence about matters where the complaints resolution process has already been exhausted.

(l) Informing the Complainant that future correspondence will be read and placed on file, but not acknowledged. In this case the Complainant should receive a letter from the Chief Executive stating they have responded fully to all points raised and have tried to resolve the complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose.

13.3 Unacceptable behaviours

Examples of unacceptable behaviours are set out in the Trust's Complaints Policy. Such behaviours should be addressed in accordance with the Trust's procedure for Management of Unacceptable Behaviour.

14. Appendix F – Training in complaints handling and resolution

Training on complaints is addressed at three levels:

Level	Staff Group	Training method	Objective
1	All staff	Quality and Governance session in Day 1 corporate induction	New staff will understand the responsibility of all staff to responding to complaints, resolve where possible and escalate appropriate.
The local induction checklist will include a prompt for the line manager to identify if a new employee requires a higher level of complaints training than level one provided at corporate induction.			
2	Front line nursing and administrative staff dealing with local resolution only.	Within Trust Values training and through workshops arranged by the Patient Support & Complaints Team.	Front line nursing and administrative staff will be supported to resolve complaints locally and manage locally escalated complaints.
3	Staff with lead responsibility for complaints management e.g. Matrons, Heads of Nursing, Divisional Directors, Assistant Divisional Directors, Senior Managers	Complaints investigation, analysis and improvement training for Senior Managers e.g. how to investigate complaints and write effective complaint responses. Written complaint response training Leadership for Leaders training Preceptorship Training Division specific update training	Senior Managers will be able to lead a complaint investigation and write high quality response letters. They will also ensure that, through analysis, lessons learned are identified and that service improvements are implemented as a result.