Royal Surrey County Hospital NHS
NHS Foundation Trust

Complaints and Concerns Resolution Policy

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Version Control sheet

Date	Review Type (please tick)		Version No.	Author of Review	Title of Author	Date Ratified	Ratification Body	Page Numbers (where amended)	Line Numbers (where amended)	Details of change	
	Minor amend	[1]Full Review								Inserted	Deleted
2008		√	**1**	**Richard Morgan**	**Senior Manager for Clinical and Risk Governance**	**Nov 2008**	**Trust Board**				
2011		√	**2**	**Linda Wilson**	**Complaints Lead**	**Jan 2011**	**Trust Board**				
2012	√		**2.1**	**Linda Wilson**	**Complaints Lead**	**Jan 2011**	**Trust Board**	**25** **15** **20** **22**		Monitoring details updated Investigation process updated Learning from complaints updated Analysis and improvement section added	

[1] Where there is a full review, amendment details are not required in the version control sheet.

Contents

1. Introduction and Background

At the Royal Surrey County Hospital Foundation Trust (the Trust) we pledge that

'We will be open and conduct a thorough investigation into any complaint or incident to reassure you, your family and carers that any lessons learnt will help prevent recurrence. We will acknowledge, apologise and explain when things go wrong"

We take raised concerns seriously and always aim to resolve arising issues locally within the area and team with which they arose. Our aim to is to ensure patients relatives and carers feel they have been listened to, questions answered, concerns resolved and where necessary appropriate action taken. We have a robust process for answering all concerns raised both via the Patient Advice and Liaison Service (PALS) and via formal complaints, by monitoring process and outcome and making service improvements is set out in this Policy.

The process is summarised in Appendix A. Accountabilities for local management of, and improvements due to, formal complaints in this Policy rests with the SBU management team, Associate and Clinical Director. The Policy will be monitored by the Complaints Monitoring group, and an annual review undertaken.

The author consulted with members of the Complaints Monitoring Group, Legal Service Manager, Head of Patient Safety and Quality and the Head of Non-Clinical Risk in the production /review of this policy.

2. Purpose and Objectives

2.1 Purpose

With effect from 1st April 2009, the Government introduced new legislation for the handling of concerns and complaints made against NHS organisations. The Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, which the Royal Surrey County Hospital is fully committed to implementing.

The legislation aims to ensure that complaints regarding NHS services are responded to quickly, proportionately and in accordance with the Parliamentary Health Service Ombudsman's guidelines on Good Complaints Handling. Current legislation focuses on listening to the concerns of service users and learning from complaints to ensure service improvement to those parts of the service that have not met expectations and to provide an appropriate and prompt remedy or an apology if the Trust has failed to provide a reasonable standard of service.

Within the Trust, the focus will be to act on Comments, resolve Concerns and Complaints and acknowledge Compliments: the 'four C's' approach. The Trust promotes a culture of openness and honesty and expects all staff to share the responsibility for resolving concerns as they are raised.

2.2 Objectives

This Policy sets out a framework for early local resolution of concerns and to provide an effective and open complaints process by:

- Promoting resolution of concerns and complaint
- Demonstrating how the Trust listens to concerns and complaints from service users

- Promoting local and individual accountability for resolving raised concerns
- Ensuring it is easy for patients to raise concerns and complaints
- Ensuring investigating the concern or complaint is an open independent process
- Demonstrating the Trust monitors for emerging themes then learns and implements service improvements as a result of concerns and complaints being raised.

3. Scope

This Policy applies to all substantive and temporary staff who have contractual obligations to the Royal Surrey County Hospital NHS Foundation Trust. It also applies to all patients, their families and carers who have involvement at the Royal Surrey County Hospital NHS Foundation Trust

4. Duties and Responsibilities

4.1 Chief Executive

The Chief Executive has overall accountability for the effective implementation of the Trust's Complaints Policy. It is the responsibility of the Chief Executive or a person acting on his behalf, where for good reason the Chief Executive is not able to do so, to sign the substantive response to all written complaints and all oral complaints, which are subsequently put into writing and signed by the complainant.

4.2 Executive Directors

All Directors are responsible for ensuring this Policy is distributed to their relevant areas. It is the responsibility of Executive Directors to ensure that all relevant staff under their management (including bank agency, contracted, locum and volunteers) are aware of, and meet, their individual responsibilities under this Policy. The Medical Director will be informed directly of complaints graded 'high' concerning medical care and review responses accordingly.

4.3 Director of Nursing and Patient Experience

The Director of Nursing and Patient Experience, or a designated deputy, provides line management to the Complaints Lead and has the responsibility for signing the complaint acknowledgement letter and reviewing responses. Complaints unresolved after the first letters require individual consideration by the Director of Nursing who will discuss with the Medical Director and Complaints Lead to decide the best course of action. Trends in complaints are monitored by the Director of Nursing and reported to the Board monthly, see below.

4.4 Deputy Directors of Operations (DDOs) / Clinical Directors (CD)/ Deputy Medical Directors

- Ensuring staff have a positive attitude to resolving and defusing concerns and complaints, and ensuring that staff are aware of their responsibility to refer to PALS if they cannot resolve a concern.
- Ensuring that documentation concerning formal complaints is distributed to the relevant members of staff to allow an effective response to be written in answer to the complaint.

- Assuming overall responsibility for ensuring that the formal complaint is investigated and responses to the investigation are sent to the Complaints Manager within 15 days of the complaint being received by the AD / CD / Matron
- Ensuring the response is checked and collated as far as possible to ensure the response answers all the concerns raised in the complaint and provides a proportionate amount of clinical detail.
- Ensuring appropriate action plans are produced to improve service delivery in response to issues identified as a result of the concern or complaint raised and subsequent investigation. These should be reviewed at SBU meetings.
- Reviewing the complaints timescales at the SBU meetings (scorecards)
- Ensuring that patients, relatives and carers, having made a complaint are assured that it will not prejudice the treatment and care provided;
- Ensuring that staff are fully assisted and feel fully supported throughout the handling and resolution of any complaint;
- Ensuring staff are released for training in resolving local or formal concerns and complaints.
- In complex complaints, requiring responses from multiple members of staff the AD and CD should decide which issues in the complain should be addressed by which member of staff and should include this information in the memo to involved staff requesting a response
- In complex complaints there should be a designated coordinator who will be responsible for ensuring the medical notes and other documentation is made available to all respondents in a reasonable time frame

4.5 Head of Nursing

The Head of Nursing signs acknowledgements and reviews draft responses in the absence of the Director of Nursing and Patient Experience.

4.6 Head of Patient Safety and Quality

Is responsible for the production of reports that provide the Trust with key intelligence on incidents and its linkages with complaints, claims and PALS enquiries - the ‘Complaints, Claim, Incident and PALS’ report.

4.7 Complaints Lead

The appointed Complaints Lead has the delegated responsibility to manage the complaint procedure and Policy on behalf of the Chief Executive.

The prime responsibilities are

- To oversee this Policy, provide guidance and support, and to provide the Trust with an overview of its complaints.
- The Complaints Lead with the Director of Nursing will grade the complaints (Appendices D and E).
- The Complaints Lead will write reports as directed by the Director of Nursing.

- The Complaints Lead should ensure where external agencies are involved the relevant members of staff communicate with them.
- The Director of Nursing and Patient Experience will meet with the Complaints Lead weekly and review the timescales on all responses.

4.8 Clinical Governance Facilitators / Complaints Officers (The Complaints Team)

The complaints officers are readily accessible to the public. Complainants may refer complaints directly to the Complaints Team if they do not wish to raise issues with the staff directly involved in their care, PALS, or if frontline staff have been unable to resolve the complaint.

The Complaints Team are readily available to members of staff in relation to complaint queries, are responsible for reviewing the complaint and sending it to the appropriate SBU management team for distribution and investigation. The Complaints Team are responsible for:

- Emailing the complaint to the Management Team for appropriate distribution.
- They will request the investigation to be completed and a response returned within 15 working days.
- The Complaints Team are responsible for monitoring timescales closely, and escalating complaints which are not responded to within the set timescales.
- The Complaints Team has the responsibility to further collate a detailed response on behalf of the Chief Executive.
- A draft copy of the response is sent to all staff involved for their comment.
- The Complaints Team will forward the draft final response to the Director of Nursing for review prior to being presented to the CEO.

4.9 Patient Advice Liaison Service Manager (PALS) and Team

The PALS Manager has day-to-day responsibility for overseeing the PALS service provision, investigating and responding to informal concerns, and reporting trends, serious issues, safeguarding concerns to the Director of Nursing and Patient Experience.

The PALS Manager will prioritise the team's caseload to ensure immediate demands are met. The level of need will be assessed on a case by case basis to establish priority and the best way to feedback to the user.

4.10 All Trust Employees

Each member of the Trust has a responsibility for listening to service users concerns and ensuring that complaints received, either oral or written, are resolved in a calm, responsive appropriate manner and aim to resolve the issue locally. Concerns and complaints must be responded to quickly, personally and positively. Escalation to the appropriate person to achieve resolution should occur immediately. When asked to respond to formal complaints, members of staff must respond promptly and, if they need to see the medical notes, formulate a response as soon as the notes are in their

possession. This applies particularly to complex complaints when many respondents will need to have access to notes in a short time scale.

4.11 Risk Management Strategy Group

The discussion, approval and development of actions to address findings concerning the identification of trends in clinical incidents, complaints and claims. These are reported through a six monthly report on combined information on 'Complaints, Litigation, Incident and PALS' (CLIP) (see Analysis section).

4.12 Clinical Quality and Governance Committee

The Clinical Quality and Governance Committee ensures that high clinical standards are delivered and maintained. This is achieved through reports and monitoring results received from The Complaints Monitoring Group, which reports into this committee.

4.13 Complaints Monitoring Group

The Complaints Monitoring Group monitors the effectiveness of the complaints procedure and Policy and provides guidance to improving complaint responses and lessons learnt.

5. Subject Matter of this Policy

5.1. Feedback and Listening to Service Users

The Trust recognises that listening to feedback from service users, both positive and negative, forms an important part of the development of Trust services and optimum quality healthcare. To ensure an effective process for gathering feedback from service users the Trust will provide a PALS and Complaints service that:

- Are identifiable, well publicised and accessible to patients, carers, family and friends.
- Provides compassionate on the spot help whenever possible, with the power to negotiate immediate solutions or speedy resolution of problems.
- Listens and provides accurate information, signposting or referring to other agencies when appropriate.
- Improves the service provided by the Trust by listening to concerns, suggestions and experiences and ensuring that people who design and manage services are aware of concerns raised and improve services accordingly.

5.1.1 How to Raise a Concern via PALS and Complaints

The PALS and Complaints Services are described and contact details given on the Trust website, displayed in poster form outside of the PALS office and in Customer Care leaflets distributed in public areas throughout the Trust.

Both services may be accessed by:

- Calling in to the PALS office
- Letter
- Email
- Telephone

- Through a member of the frontline staff
- Via the Trust's web site
- Patient satisfaction surveys
- Via Foundation Trust Governors
- The ICAS service

5.2. Guidance for Frontline Staff

Complaints are most likely to be raised with front line staff on the wards, in clinics or reception desks in person or on the telephone. Wherever possible concerns should defused and resolved locally in the clinical or service area without reference to the PALS or Complaints Service in the first instance. When necessary it is important that concerns are escalated to a senior member of staff such as a Sister, Matron, Registrar or Specialty Manager. When responding to complaints staff must demonstrate good listening skills and empathy. They should also assure complainants that complaints and feedback are welcome and taken seriously within the Trust.

5.3. Out of Hours Complaints

The procedure for dealing with raised concerns or complaints which occur in the evening and / or weekends is that if immediate assistance is required, escalation to the appropriate Sister bleep holder or Site Nurse Practitioner (SNP) to facilitate resolution should occur.

The Site Nurse Practitioner (SNP) will attempt to resolve the situation but, if necessary and appropriate, they may refer to the relevant on call clinician / manager or the PALS Manager the next working day.

5.4. Non Discrimination – Service Users Must Not be Negatively Affected

5.4.1 It should be emphasised that the Trust welcomes all feedback, positive and negative, as it recognises the importance of service improvement that can be derived when concerns or complaints are raised.

Patients in receipt of care can at times feel vulnerable and may feel that their care will be affected if they complain. This impression should be actively dispelled by seeking the patient's views of their care in an open and responsive manner. It is important to highlight that making a criticism or a complaint will not affect on-going or future care and treatment provided by the Trust, and that all complaints are taken seriously.

5.4.2 Any correspondence in respect of a concern or a complaint must not be filed in the patient's health care records to ensure that the patient is not discriminated against by other clinicians.

5.4.3 The Complaints Lead will provide appropriate training to ensure that Trust staff are aware that patients, their relatives and carers are not treated differently as a result of making a complaint.

5.5. Confidentiality

The requirement to maintain confidentiality is absolute when investigating a complaint or a concern. The Data Protection Act 1998 classified complaint documentation as personal data. Complainants are able to request copies of the complaint file in the same way as they request access to their health

records. Please refer to the Trust's Patient Confidentiality Policy for further guidance.

If a relative, friend or other third party raises a concern with the PALS service on behalf of a patient, the patient must be asked for their verbal consent for PALS to act on their behalf. Only information that the patient has consented to sharing will be discussed or shared with a third party. If a user is unwilling to share certain information, the PALS Manager or Assistant will advise the user that this may impact on achieving resolution of the case.

In cases where a third party raises a formal complaint on behalf of a patient, the hospital must receive signed authorisation for investigation from the patient. The Complaints Team will request that a Form of Authority is completed by the patient and returned to them before any information can be passed to a complainant who is not the patient.

There are occasions when the patient is unable to authorise a complaint, e.g., if the concern or complaint relates to a deceased patient. In these cases the decision on whether the complainant is a suitable representative of the patient rests with the Director of Nursing and Patient Experience. If the complainant has a 'Power of Attorney' this can be copied in place of the Form of Authority.

If the Form of Authority is not returned, the response to the complaint will be prepared but will be kept on file until the form is received. The complainant will be informed of this in writing.

In the case of incapacity, a view of the patient's best interests will be taken. In the event of a concern being raised about the care and treatment of a safeguarding adult, information will be shared with the Trust's Lead for Safeguarding Adults and Social Care as necessary. If there are concerns regarding important decisions about the treatment of an adult that lacks capacity and there is no Next of Kin, the PALS Manager or Complaints Lead will liaise with the Lead Clinician who will appoint an appropriately trained advocate in accordance with the requirements of the Mental Capacity Act 2005.

If the service user has not reached their sixteenth birthday, then the person with parental responsibility must consent on behalf of the child unless the child is judged to be Fraser Competent.

5.6. Patient Advice and Liaison Service

Will inform users about ways of becoming more involved with their own healthcare and local NHS services. To liaise with staff and their managers, other PALS staff and relevant organisations to facilitate a resolution for users.

They will provide information about the Trust's formal complaints procedures and to refer users to advocacy support from local and national sources including the Independent Complaints Advocacy Services (ICAS).

The PALS office is based in the main reception area of the hospital and is easily accessed by users

The office is open to the public from 09.30–16.30 Monday–Friday excluding public holidays. Other opening hours may be trialled and evaluated to determine what is beneficial for users.

PALS staff will ensure that wherever possible, individual needs in accessing and using PALS are met. This includes meeting the needs of people with learning disability, expressive communication disorder or if translation or interpretive services are needed

5.7. Type of Concerns Investigated by PALS

There will be an emphasis on telephone contact and email across the Trust where possible unless it is felt that face to face contact will be more productive. It will be made clear to both service users and Trust staff that PALS cannot undertake a formal investigation and does not offer a detailed written response. Users will be informed that by using an informal process they do not prejudice their option to pursue their concerns formally at a later stage.

5.8. How the PALS Service responds to concerns

Telephone enquiries are answered immediately where possible. An answer phone service gives details of opening times and callers are invited to leave a message. If the office is to be unmanned for a significant period then details of how to access additional help and information will be recorded on to the answer phone message.

Calls will be returned within 2 working days. The answer phone message advises callers of this. Messages left on the answer phone will be logged including the date they are taken.

Staff will be made aware that PALS can be accessed within office hours and the scope of the service. The PALS Manager will maintain close links with senior staff to ensure they can identify situations that may benefit from PALS input

Wherever possible, referrals to the PALS service should be responded to by the close of the next working day following receipt of the enquiry. An extension to this period can occur subject to the agreement of the complainant. Letters both sent and received will be dated and filed.

If the complainant does not agree to an extension or the concern is assessed as having a highly graded clinical risk and/or is complex then an investigation should be commenced as part of the formal complaints process. Otherwise resorting to the formal complaint process should only occur if all efforts to defuse and resolve the concern by either frontline staff or the PALS service have not been successful.

All PALS user documentation is stored in the PALS office which is locked whenever the staff leave. The PALS team documents all information unless it is a very brief request for information or advice.

PALS will record information about referrals to the service on DATIX. This will include the nature of the concern, the Specialist Business Unit affected, a description of the concern and the outcome.

5.9. Responding to Concerns Raised via the Formal Complaints Process

If a concern is raised that:

- Cannot be resolved locally by frontline staff
- Cannot be resolved by PALS by close of the day following it being raised
- Is complex
- Raises significant clinical concerns
- Is specifically requested by the complainant

Then the concern should be investigated as a formal complaint.

5.10. Time limits for making a Formal Complaint

A complaint should be made within twelve months from the date of the incident of concern or date of discovering that there was concern, The Complaints Manager and Director of Nursing and Patient Experience has discretion to extend this timescale depending on circumstances surrounding the event.

If the complaint cannot be resolved through local resolution, the complainant has 6 months from the date of the letter informing the complainant the outcome of local resolution in which to request the Health Service Ombudsman to investigate the concerns. The complainant must take their concerns directly to the Health Service Ombudsman. It is not the responsibility of the Trust to refer complainants to the Health Service Ombudsman.

The complainant may go to the Health Service Ombudsman if the investigation has not been completed within 6 months of the date on which the complaint was made, or if the Trust decided not to investigate the complaint on the grounds that it was not made within the time limits.

5.11. Acknowledging the Complaint

All written complaints will be acknowledged within 3 working days of the receipt date. The acknowledgement will be accompanied by a summary of the Trust's complaints process (Appendix C) and signed by the Director of Nursing and Patient Experience.

Upon receipt of the letter / email the Complaints team will telephone the complainant and offer the opportunity to discuss the complaint over the telephone or face to face. If it is not possible to contact the complainant by telephone, the letter of acknowledgement will invite the complainant to telephone a named member of the complaints team to discuss their complaint. When speaking to the complainant, the complaints officers will confirm the exact nature of the complaint and agree the outcome required with each complainant. A file note will be made on Datix summarising the conversation and the information obtained will be internally distributed.

5.12. Recording the Information on Datix

The complaint will be entered on the Trust database (Datix) by the complaints team. The following information will be recorded:

- Date the complaint is received (as per the date stamp), is to be entered in the first received field.
- name of the patient and a unique reference number
- Primary SBU and Speciality within the SBU

- Sub Type of complaint will be formal
- Closed field will be the date of the final response, which will be the date the complaint is sent for signing by the Chief Executive.
- Risk grading of the complaint (as agreed by the Director of Nursing and Patient Experience (appendices D and E).
- subject(s) of the complaint

5.13. Verbal Complaints or Complaints made in Person

Where a complaint is made orally either by phone or in person; the Complaints Lead must make a written record of the complaint which includes the name of the complainant, the subject matter and the date on which it was made.

The acknowledgement must be accompanied by the written record with an invitation to the complainant to make any changes and return it. This process will not hold up the investigation.

5.14. Risk Assessment of Concerns and Formal Complaints

All concerns and complaints will be risk scored by the Complaints and PALS Teams and reviewed by the Director of Nursing and Patient Experience in accordance with the Trust's Grading Matrix. (Appendices D and E). The grading will be recorded on Datix. The grading will be re-assessed once the full investigation has been completed. A root cause analysis should be performed on complaints which relate to complaint graded high or extreme, in accordance the Trust's Incidents and Serious Incidents Management Policy.

5.15. The Process for Investigating a Complaint

The risk grading of the complaint will determine the depth of investigation in accordance with the following table:

Grade of Complaint	Level of Investigation	Complaint Lead
Low Risk	Basic, seek assurances and actions as reasonable and proportionate	Specialty Manager / Ward Matron / Service Lead
Moderate Risk	Summary of outcome and action plan for learning	Deputy Director of Operations / Specialty Manager / Matron
Significant and High Risk	Liaise with Head of Patient Safety and Quality to consider if SUI or Learning Panel to be declared. Root cause analysis to be provided.	Director of Nursing / Medical Director / Clinical Directors / Head of Patient Safety and Quality.

The depth of investigation should be reasonable and proportionate to the events or concerns raised. Key features of an investigation should include;

- Determination of human error or other factors associated with the event and the processes and systems that led to it

- An understanding of the events / clinical history / processes / normal practice to establish what should have happened and why there may have been a deviation from the normal process.
- Establish any improvements in process, systems or additional training which will decrease the likelihood of such events occurring again.

It is the Complaints Team responsibility to e-mail the complaint to the following: the Deputy Directors of Operations, Clinical Directors, Matrons and Head of Departments who are responsible for the SBU identified in the correspondence.

The Complaints Team will also liaise with the support service managers where appropriate. The Deputy Directors of Operations, Clinical Directors and Matrons are required to undertake an investigation into the issues raised and return their response to the complaints team within 15 working days.

The Complaints Team will send an email to any person whose response is outstanding on day 12 to remind them that their response is due. If the response has not been received by day 15 the complaint will be escalated by the Director of Nursing and Patient Experience to the responsible Deputy Director of Operations (Appendix B). If the response has still not been received by day 19 the complaint will be formally escalated to the CEO.

5.16. Responding to Complaints Involving Other Agencies

When a complaint involves more than one NHS provider, another agency or is solely with another NHS organisation, there should be full co-operation in seeking to resolve the complaint through each "body's" local complaints procedure. The agency receiving the complaint will usually lead on the complaint and collate information received from the other organisation. It needs to be ensured that between them, organisations address all matters of concern to the complainant. The complainant will be informed in writing of arrangements to address their concerns.

If the Trust receives a written complaint that is solely concerned with areas dealt with by another agency, or an organisation outside the NHS, the Complaints Manager will refer the complaint to the appropriate manager within that organisation, subject to the consent of the complainant.

If the Trust receives a written complaint that involves another agency, for example: the Police, the Trust will work jointly with an agreed point of contact, to ensure all matters are fully investigated. The usual timescales will apply.

All cross organisation complaints should be clearly identified in the description field on Datix.

5.17. Complaint Investigation – How to Prepare an Internal Response

All complaint responders should ensure their response is written in the first person singular and addressed to the complainant. The response should be written stating the clear facts and addressing each identified point of concern in the complaint letter chronologically. Questions raised during the acknowledgement telephone call to the complainant should also be

answered directly. Improvements / changes in practice as a result of the complaint should be clearly highlighted together with an appropriate apology. There should not be abbreviations and all clinical terminology should be clearly explained

5.18. Final Response

The complaints team have the responsibility to draft a response to the complainant on behalf of the Chief Executive. As far as possible the internal responses will be used in the final response. All communications to the complainant must be marked “Private and Confidential”.

When responding to the complaint it is important to ensure that:

- All the information required to address each point raised in the complaint has been responded to.
- The information provided is accurate, objective, open, honest and complete with all clinical terminology clearly explained in layman’s terms.
- It will be compassionate and understanding and include the reason for any service failure, and an outline of what action / improvement / change has been taken to prevent it recurring.
- Copies of any relevant Healthcare Records needed to help clarify any complex points are enclosed.
- The response is in accordance with the Ombudsman’s Principles for Remedy
- The response should be proportionate to the complexity and risk grading of the complaint.
- Include an apology where appropriate.

A draft copy of the final response is sent to all staff involved for their comment. The complaints team will present the final draft response to the Director of Nursing and Patient Experience for review prior to it being presented to the CEO for signing. The Director of Nursing and Patient Experience may request further information from the relevant SBU Team(s).

In some cases there may be a delay in responding in which case a “holding” letter detailing the reasons will be sent to the complainant.

5.19. Reopened Complaints

If the complainant is not happy with the response and states that the Trust's response does not address their concerns, a decision will be taken as to the course of action by the Director of Nursing and Patient Experience or deputy. This may result in further investigation to clarify the first response, or the offer of a meeting to discuss and resolve the complaint, as well as discussion with the Complaints Lead to agree what further actions are required to resolve the complaint.

A further investigation, which may include a meeting with relevant personnel, can be arranged if required. A second response should be sent within 25 working days. This is still part of the local resolution process.

If the final response fails to satisfy the complainant they must be informed in writing when this process has concluded.

5.20. Claims for Clinical Negligence Arising from a Formal Complaint

If a complainant has stated in writing that they wish to take legal proceedings the complainant will be informed in writing that the complaints process will continue, and the Complaints Team will communicate with the legal services, to ascertain if responding to the complaint will be prejudicial to the claim.

Reference should also be made to Trust's Claims Management Policy

5.21. A Written Complaint Received by Other Members of Staff (for example a Consultant)

If a member of staff receives a written complaint they must decide if they intend to respond directly themselves or if the complaint should be investigated via the formal complaints procedure. If the letter is to be responded to via the formal complaints process, it must be forwarded immediately to the Complaints Department. If a member of staff e.g. Consultant, wishes to respond directly to a Complainant by meeting them, notification of this should be sent to the complaints office for information. If the Consultant wishes to reply directly to the patient, a copy of the letter and the response should be sent to the Complaints Team for information.

5.22. Archiving of Complaint Information

All documentation of any kind relating to a complaint should be retained for 10 years after the last entry on the record. They should be treated as confidential documents and kept separate from and not form part of the patient's health records.

5.23. Escalation of Complaints

If a concern indicates any of the following, the Complaints Lead or PALS Manager will escalate the issue to the Chief Executive or Director of Nursing and Patient Experience. These concerns are discussed with the Medical Director and Chief Operating Officer at the weekly Patient Safety Meeting.

- An investigation under the disciplinary procedure
- The need for referral to a professional regulatory body
- Issues regarding safeguarding
- An investigation into a Serious Untoward Incident
- Serious concerns or incidents regarding clinical practice
- An investigation of a criminal offence
- The potential for significant adverse publicity
- Potential for a significant claim for clinical negligence

5.24. Local Resolution Meetings

Complex Complaints

When a complaint is assessed as:

- Being complex
- Graded as high or very high risk
- Concerns a deceased patient

The Trust may offer a local resolution meeting to the complainant to allow a full and open discussion of the issues raised, in accordance with the recommendations of the Parliament and the Health Service Ombudsman.

The local resolution meeting will be held with senior members of the Trust staff and will include:

- A Clinical Director or Consultant or Deputy Medical Director
- A Matron or Ward Manager
- Any other appropriate healthcare professional

The Senior Clinician will chair the meeting, whilst a member of the complaints team will be responsible for making a record of the meeting in a digital format and any follow up correspondence. A copy of the recording or meeting notes will subsequently be provided to the complainant.

5.25. Parliamentary and Public Health Service Ombudsman

The Health Service Ombudsman is appointed by the Government to investigate the handling of complaints. They can normally only become involved after a Trust has conducted its own investigation into a complaint. If the person making the complaint remains unhappy with the outcome of the Trust's investigations they can ask for their case to be reviewed by the Ombudsman.

The Ombudsman is accountable to a Parliamentary Select Committee and at such hearings there may be criticism of individuals, which is reported in the press. The officers have powers to obtain case-notes and interview staff during their investigation.

The Ombudsman is able to consider clinical complaints assisted by their own clinical assessors.

Following their investigation of a complaint made against a Trust, the Ombudsman will forward a report of its findings to both the Trust and the complainant, which may include recommendations that the Trust will be required to implement.

The Ombudsman publishes synopses of selected cases in his/her reports. These can include public castigation of named hospitals for their failures in service. In extreme circumstances, the Chairman and Chief Executive of a Trust may be asked to go to meet with the Parliamentary Select Committee.

5.26. Disciplinary

The complaints procedure is concerned only with resolving complaints and not with investigating disciplinary matters. The purpose of the formal complaints procedure is not to apportion blame amongst staff but to investigate the detail of the complaint with the aim of resolution, whilst being fair to staff and to improve service delivery.

Some complaints may identify information about serious matters and the Trust may feel it appropriate to consider disciplinary investigation. Consideration as to whether or not disciplinary action/raising a serious incident/raising a safeguarding alert, is warranted as a separate matter for the Deputy Directors of Operations/Clinical Directors or Executive Team. Further information can be obtained in the Trust's Disciplinary Policy

Information gathered during the complaints procedure may be made available for a disciplinary investigation. Any response sent to the

complainant outlining the outcome of any actions to be taken will be mindful of patient and staff confidentiality at all times.

5.27. Supporting Staff

Support must be available for staff subject to a complaint. They must feel that they are being fairly treated and able to discuss any concerns with an appropriate senior staff member. The Trust acknowledges that staff may find the process of a complaint investigation stressful and recognises it is therefore important that staff are appropriately supported.

The Trust believes that staff do their best to carry out their work in a safe and effective manner to benefit patients and that adverse events are often due to systems errors rather than due to an individual. When a complaint is received about a specific member of staff and where appropriate the member of staff should be offered immediate and on-going support by the operational manager and the complaints team.

The Trust acknowledges that this can be a difficult time and staff are encouraged to make contact with the Complaints Team to discuss the matter. This can be face-to-face or by telephone. This applies equally to staff still employed by the Trust as well as staff who no longer work here.

The Complaints Team will alert the member of staff's manager in circumstances where it is felt particular support is needed from that manager. Staff should be made aware of the support available via Occupational Health. Should a staff member wish to see an Occupational Health Advisor they should discuss this with their line manager, or if appropriate self refer, in accordance with the protocol set out in the Trust's Stress at Work Policy. The Stress at Work Policy sets out managers' and employees' responsibilities in respect of recognizing and responding to a work place stressor. Staff should also be reminded of the Trust's confidential staff counseling service and are encouraged to make use of this where appropriate.

5.28. Habitual and / or Vexatious Complainants

When a complainant repeatedly contacts the PALS Service and the PALS Manager deems that their concerns have been responded to in a reasonable and proportionate manner, then the PALS Manager should invite the complainant to make a formal complaint.

Complainants may be deemed to be habitual or vexatious where they meet two or more of the following criteria:

1. They persist in pursuing a complaint when the NHS complaints procedure has been fully and properly implemented and exhausted.
2. Change the substance of a complaint by continually raising new issues
3. Are unwilling to accept documented evidence
4. Focus on trivial matters
5. Have in the course of addressing a registered complaint had an excessive number of contacts, placing unreasonable demands on staff
6. Have harassed or been personally abusive to aggressive to staff
7. Display unreasonable demands or expectations and fail to accept that these may be unreasonable.

Where complainants have been identified as habitual or vexatious in accordance with the above criteria the Chief Executive will decide what action to take. This may include notifying the complainant that all contact and correspondence with the complainant is at an end and that further letters will be filed but not answered.

Reference should also be made to the NHS Protect document "Unacceptable behavior – Guidance on warning letters and other written communications", for suggestions on the structure and wording of warning letters that may be sent to vexatious complainants.

5.29. Learning and Service Improvements Arising from Complaints

The Trust recognises that lessons can be learnt from the investigation of concerns and complaints which subsequently improve the quality of service we are able to provide. Complaints are an opportunity to improve the service we provide for patients and we will inform individuals of the action we have/are taking as a result of the raised concern or formal complaint.

Complaints can also be used positively at ward or departmental level by discussing at ward and team meetings how individual complaints could have been avoided and identifying if there is any further action that could be taken to avoid a recurrence. Additionally staff can offer personal reflection on how the situation could have been handled differently.

All internal responses to complaints are required to clearly identify to the Complaints and PALS Teams what changes in practice or service improvements have been implemented to prevent the problem arising again and are to be reviewed as part of each Portfolio and SBU governance structure. Changes / improvements will be reviewed on a quarterly basis by the Trust Matrons and Complaints Monitoring Group.

Where appropriate, relevant Trust staff such as Deputy Directors of Operations, Matrons or Specialty Managers will be required to prepare an action plan to address trends and themes that have been highlighted by service users when raising concerns or complaints.

Learning can be demonstrated at organisational level by changes and improvements in process, policy, systems and procedures relating to the quality of care and treatment. Key learning points could include:

- Understanding and identification of the influence of Human Factors
- Solutions to address root causes
- Identification of good practice to cascade across the organization
- Systems and processes that allow early detection or intervention that will reduce the impact of future problems.

Active audits could take place if a specific concern is raised to identify areas for improvement including additional clinical training as well as training in customer care.

5.29.1 Monitoring of Service Improvements Arising from a Complaint

The Complaints Team will keep a record of the actions required to make changes / improvements on a spreadsheet filed on the "G Drive".

Nursing care and attitude complaints are reviewed and changes/improvement actions are monitored quarterly in the Nursing and Midwifery Steering Group Matron Meeting.

Changes / improvements should subsequently be discussed and monitored by the Clinical Quality Governance Committee. For actions that are not implemented the Clinical Quality Governance Committee will request the lead to attend the meeting to discuss barriers to implementation. Alternative solutions to implementation will be identified by the lead and/or the committee.

As and when appropriate the Trust will share improvements in practice and service with external stakeholders such as the Parliamentary and Health Service Ombudsman.

5.30. Analysis and Improvement

5.30.1 How incidents, complaints and claims are analysed: The Complaints, Litigation Incident and Pals (CLIP) Report

The Trust should ensure that they analyse all incidents, complaints and claim to ensure they are aware of any growing trends concerning safety and quality, and appropriate action is taken and monitored to ensure they are resolved.

To achieve this, on **six monthly** basis, the Trust should produce a 'Complaints, Litigation, Incident and Pals' (CLIP) report produced for the following:

- Risk Management Strategy Group (Full report)
- Clinical Quality Governance Committee (Executive Summary, for information only)
- Clinical Quality Risk Management Group (Full report, for information only)
- Portfolio Governance Meetings (Full report, for information only)
- Corporate Services (Full report, for information only)

5.30.2 How the information is combined to provide a risk profile for the organisation

The information in the CLIP report will be organised in such a way, it will provide the Trust with a risk profile. This will be achieved by providing an analysis on the rates and categories of CLIP and will provide a proposed action plan that will be further developed and agreed by the Risk Management Strategy Group. Below is a template of how the information should be presented:

Half Yearly CLIP (Complaints, Litigation, Incidents and Patient Advisory and Liaison Service (PALs) Six Monthly Report

Produced by:
Analysis Performed by:
Executive Sponsor:
Produced on:
Produced for:

- Risk Management Strategy Group (Full report)
- Clinical Quality Governance Committee (Executive Summary, for information only)
- Clinical Quality Risk Management Group (Full report, for information only)
- Portfolio Governance Meetings (Full report, for information only)
- Corporate Services (Full report, for information only)

1.0 Introduction and background
2.0 Methodology
3.0 Findings:
3.1 Quantitative Analysis
3.1.1 Rates on a Trustwide/Portfolio and Specialty Business Unit Level of:
3.1.1.1 Annual rates of CLIP since 2009-to last whole quarter
3.1.1.2 Annual rates of CLIP per grading of severity since 2009 to last whole quarter
3.1.1.3 Annual rates of CLIP per type (actual/near miss) of severity since 2009 to last whole quarter
3.1.1.4 Annual rates of CLIP per type (Clinical/Non clinical) of severity since 2009 to last whole quarter
3.1.1.5 Annual rates of CLIP per type and root cause of serious and major incidents since 2009 to last whole quarter

3.1.2 Combination of Information to Produce Risk Profile for Organisation:

3.1.3 Trust wide/Portfolio and Specialty Business Unit Level of:
3.1.3.1 Rates of categories of CLIP (ordered by high to low so as to see top per year) since 2009 to date
3.1.3.2 Most common categories crossing over CLIP
3.1.3.3 Action plan to address suboptimal areas of performance (including Improvement Activity (e.g. Clinical Audit) currently performed in Trust and direct links to themes identified in CLIP

3.1.4 Monitoring of Implementation of Incident and Serious Incident Policy (annual report only)
3.1.4.1 Incident Reporting Benchmarked to Medium Acute Trusts (from National Reporting and Learning Service)
3.1.4.2 Results of Staff Survey
3.1.4.3 Results of Patient Survey
3.1.4.4 Trust performance on incident reporting

3.1.4.5 Trust performance in incident investigation within 20 days
3.1.4.6 Attendance rates to Adverse Incident Reporting Training
3.1.4.7 Attendance rates to Adverse Incident Investigation Training
3.1.4.8 Audit results of a External reporting of a Random Sample of Major and Serious Incidents
3.1.4.9 Audit results of Depth of Investigation for a Random Sample of Each Grade of Incident
3.1.4.10 Audit results of Sharing Safety Lessons for a Random Sample of Each Grade of Incident
3.1.4.11 Audit results of Action Plans and their Completion for a Random Sample of Each Grade of Incident
3.1.4.12 Results of External Audits (e.g. Deloittes /KPMG and where available)

3.2 Qualitative Analysis

Discussion on themes identified from the rates, combination of information to produce a risk profile and monitoring requirements of the incident policy.

4.0 Action Plan to address key themes:

The CLIP report should contain the following template populated with the relevant information:

Problem	Action	Date for Achievement	Person Responsible	Governance Arrangement
				Risk Management Group and relevant other

5.0 Conclusion

The CLIP report should contain an overall summary of the findings in the report and date for next report.

5.30.3 The CLIP report template (including qualitative and quantitative data)

The CLIP report will contain both qualitative and quantitative data and the template can be read in the section above. The source of this information will be as follows:

- The Datix™ system
- National Reporting and Learning Service
- OLM (Training database)
- Trust Board Quality Report
- Patient 1st Programme
- Clinical Audit Database
- National Staff Survey
- National Patient Survey

- External Audit Reports (as available)
- Solicitors' Risk Management Reports

All CLIP reports will be produced by the Head of Patient Safety and Quality.

5.30.4 Sharing the CLIP Report with the Relevant Individuals/Groups

The Head of Patient Safety and Quality and the Clinical Quality Governance Facilitators will be responsible for sharing this information with the relevant Committees, Groups, Portfolios and Services. It will be disseminated by email. Headline information will also be placed into the Quality Bulletin on a six monthly basis.

5.30.5 How Action Plans are Followed Up

The Risk Management Strategy Group will be responsible for developing and approving the action plan in each CLIP report, and will be required to monitor compliance to the actions at every subsequent quarterly meeting and until the actions are complete. They will be required to identify any barriers to full implementation of the action, and identify solutions or ensure the barrier is risk assessed in accordance with the risk management strategy.

6. Complaints Training

Trust staff are required to undertake training as defined in the Trust's Statutory & Mandatory (SaM) training matrix.

Processes for how the Trust records training completion and for following up those staff who do not complete relevant SaM training are described in the Trust's Statutory and Mandatory Training Policy (Section 5).

7. Implementation

This Policy will be brought to the attention of all staff and monitored in line with the normal assurance processes.

8. Monitoring Compliance & Effectiveness of the Policy

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
CONCERNS & COMPLAINTS					
1. Duties (Section 4.0)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
2. How the organisation listens and responds to concerns and complaints from patients, their relatives and carers (Section 5.1, 5.1.1, 5.9, 5.11, 5.13, 5.18, 5.19)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
3. How joint complaints are handled between organisations (Section 5.16)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
4. How the organisation makes sure that patients, their relatives and carers are not treated differently as a result of raising a concern or complaint (Section 5.4)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
5. How the organisation makes improvements as a result of a concern or complaint (Section 5.29 5.29.1)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
INVESTIGATIONS					
6. Duties (Section 4)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
7. How the organisation trains staff, in line with the training needs analysis (Section 6)	Audit (To be sent to Head of L&D to incorporate into a single annual risk management training report)	Head of Patient Safety and Quality supported by the Head of Learning and Development if necessary	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality Risk Management Strategy Group
8. Different levels of investigation appropriate to the severity of the event (Section 5.15)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
9. How the organisation shares safety lessons with internal and external stakeholders (Section 5.29.1)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
10.How action plans are followed up (Section 5.29.1)	Audit	Complaints Lead	Annually	Complaints Monitoring Group	Complaints Lead Complaints Monitoring Group
ANALYSIS AND IMPROVEMENT					
11.Duties (Section 4)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group
12.How incidents, complaints and claims are analysed (Section 5.30.1)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group

Minimum requirement that is to be monitored	Monitoring Process e.g. review of incidents/ audit/ performance management	Job title(s) of individual(s) responsible for monitoring and for developing action plan	Minimum frequency of the monitoring	Name of committee that is responsible for review of the results and of the action plan	Job title of individual(s)/ committee responsible for monitoring implementation of the action plan
13. How this information is combined to provide a risk profile for the organisation (Section 5.30.2)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group
14. A report template which includes qualitative and quantitative analysis (Section 5.30.2)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group
15. How this information will be shared with relevant individuals or groups (Section 5.30.2 & 5.30.4)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group
16. How action plans are followed up (Section 5.30.5)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group
17. Timescales for minimum requirements 11 to 16 (Section 5.30.1, 5.30.4 & 5.30.5)	Audit	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager	Annually	Risk Management Strategy Group	Head of Patient Safety and Quality, Head of Non-Clinical Risk, Complaints Lead & Legal Services Manager Risk Management Strategy Group

9. Policy Review

The Policy will be reviewed every three years or earlier if national Policy or guidance changes are required to be considered. The review will then be subject to approval and re–ratification.

9.1 Withdrawal and Archiving Arrangements

The author or Central Policy Officer is responsible for ensuring that archive copies of superseded working documents are retained in accordance with the Records Management ;NHS Code of Practice, 2009, refer to Policy Development and Management: Including policies, procedures, protocols, guidelines, pathways and other procedural documents.

10. Dissemination and Publication of this Policy

Dissemination of the final Policy is the responsibility of the author. They must ensure the Policy is uploaded to the Trust's Central Library (TrustNet) either via their Local Policy Officer for submitted directly to the Central Policy Officer.

The Head of Communications and Marketing is responsible for the trust-wide notification of the Policy. Clinical Director's, Deputy Directors of Operations, Specialty Business unit or Supporting Services Management teams, ward managers and heads of department are responsible for distributing the Policy and ensuring that all staff under their management including bank, agency, contracted, locum, honorary and volunteers are aware of the Policy.

11. Equality Impact Analysis

The author of this Policy has undertaken an Equality Impact Analysis (EIA). No adverse impacts were identified. The EIA has been archived and is available via the Central Policy Officer.

12. Associated Documents

- Incidents and Serious Incidents Management Policy
- Being Open Policy (for communicating patient safety Incidents, complaints and claims)
- Induction Policy
- Clinical Audit Policy
- Patient Confidentiality Policy
- Disciplinary Policy
- Policy Development and Management: including Policies, Procedures, Protocols, Guidelines, Pathways and Other Procedural Documents
- Stress at Work Policy
- Statutory & Mandatory Training Policy
- Risk Management Strategy
- Claims Management Policy
- Supporting Staff Involved in Traumatic / Stressful Events Policy

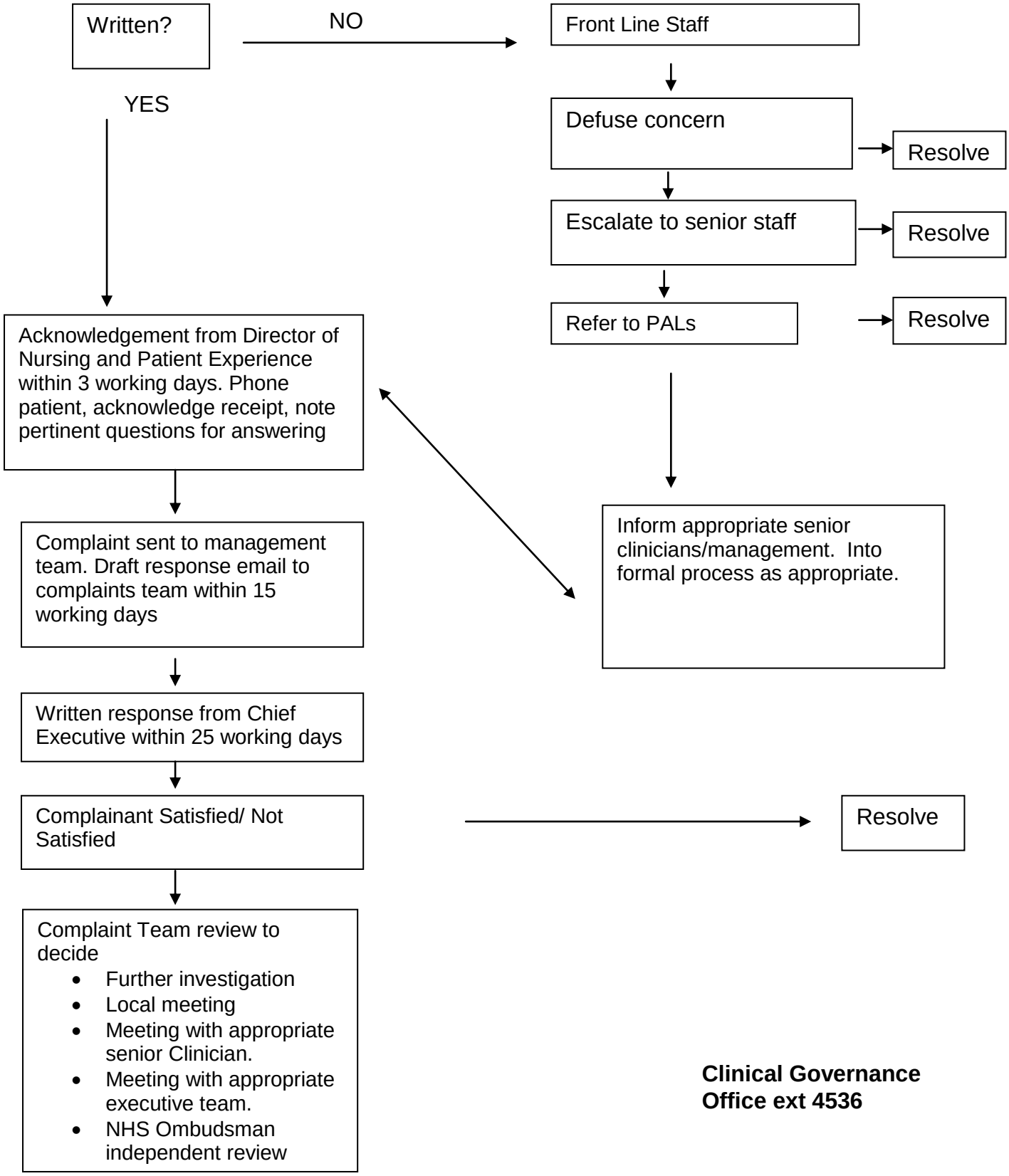
13. References

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

- Parliamentary and Health Service Ombudsman (the Ombudsman) Annual Report on Complaints Handling October 2010.
- Ombudsman's Guidelines on Good Complaints Handling
- Ombudsman's Principles for Remedy
- Data Protection Act 1998
- Mental Incapacity Act 2005
- Records Management: NHS Code of Practice 2009
- The Independent Complaints Advocacy Service

Appendix A: Flow chart

Local Resolution Concern or Complaint



Clinical Governance Office ext 4536

Appendix B: Outstanding Complaint Response Memo

Patients 1st
The Patient's First Choice

Directorate of Nursing & Clinical Governance

MEMORANDUM

From: Director of Nursing and Patient Experience

To: Deputy Director of Operations

CC:

Date:

Re: **Urgent Outstanding Complaint Response**

Regarding the following formal complaint:

Name:

Hosp number:

Date of Complaint:

Date Received:

Date of Memo:

Deadline of staff response:

Deadline of CEO's response:

Number of Days Overdue as of today:

This has now been escalated to you as we are now on day ____. We require the response from _____ urgently.

Please can you arrange for the comments to be sent to _____ in our Clinical Governance Department via e-mail.

With many thanks in anticipation of your support.

Appendix C: Summary of Process for Patients

To be sent with letter.

Royal Surrey County Hospital Complaints Procedure

The Royal Surrey County Hospital is committed to providing a high quality service to all its patients and wider users of our services. As part of this commitment we welcome service user feedback, both positive and negative, as we recognise it is a valuable source of information which can highlight service areas where the patient experience can be improved.

The notes that follow give you a brief guide to our complaints procedure, if you would like more information please do not hesitate to contact our complaints team on 01483 464831.

- We will take your complaint seriously, fully investigate your concerns and advise you of our findings as soon as possible.
- Our response will be objective, open, honest, address all the concerns raised and we will explain any clinical terminology. It will include an explanation of what happened and why.
- Our response will advise you of what actions we have taken to improve our service as a result of your experience and include an appropriate apology.
- We will acknowledge you complaint within 3 working days of receipt, and provide you with a personal contact in our complaints team.
- If you have anything to add to your initial comments, we would appreciate receiving these as soon as possible. Please do not hesitate to contact our complaints team on 01483 464831.
- We will treat your correspondence in confidence, if the complainant is not the patient, we will seek the authority of the patient to disclose their medical information to a third party.
- We will ask for reports from the staff involved to help us investigate your concerns.
- We will provide a written response as soon as our investigation is complete and wherever possible within the agreed timescales.
- If we are unable to meet these timescales we will write to you to explain why and when we expect to provide you with your response.
- Making a complaint whether as an inpatient or outpatient will not adversely affect the care you receive.
- We will not file your complaint correspondence in your medical records.
- We hope our reply will answer your concerns in full. However if you remain dissatisfied with our reply, we would encourage you to contact us again, as we are keen to provide a mutually satisfactory conclusion.
- If you require any independent advice or guidance when making your complaint, we suggest that you contact the Independent Complaints Advocacy Service (ICAS). They can be contacted on 01256 463758, or www.seap.org.uk/icas.

- Should you wish to share your experience with the Care Quality Commission they can be contacted on 03000 616161 or write to:

  Care Quality Commission
  National Correspondence
  Citygate Gallowgate
  Newcastle-Upon- Tyne
  NE1 4PA

- If you still remain dissatisfied with our response you may seek an independent review of the patient's care from the Parliamentary Healthservice Ombudsman at:

  Millbank Tower,
  Millbank
  London SW1 4QP
  Telephone: 0345 015 4033
  E Mail: phso.enquiries@ombudsman.org.uk
  www.ombudsman.org.uk

Appendix D: Risk Assessment Grading Matrix Guidance

Multiply the Consequence Score C with the likelihood score L to obtain the risk rating which should be a score between 1 and 25.

1 Use the table shown below to determine the colour banding for the risk.
R (Risk) = C (Consequence) X L (Likelihood)

Qualitative Measures of Likelihood

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Certain**
Frequency	The event may occur only in exceptional circumstances	The event could occur at any one time	The event will occur at some time	The event should occur in most circumstances	The event is expected to occur in most circumstances

Qualitative Measures of Consequence

	1	2	3	4	5
Descriptor	**Minor**	**Moderate**	**Serious**	**Major**	**Severe**
A Injury Patient/Non patient	Minor injury not requiring first aid	Injury or illness, requiring first aid / medical treatment.	Serious injuries to one or more persons	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
B Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience
C Complaints	Non-clinical I.E. Car parking	Lack of appropriate clinical care and communication	Loss of the Trusts reputation	Patient care compromised	Death or very serious injury of a patient
D Service / Business Interruption	Loss / interruption more than 1 hour	Loss / interruption more than 8 hours	Loss / interruption more than 1 day	Loss / interruption more than 1 week	Permanent loss of service or facility
E Financial	Small loss **< £5000**	Loss more than 0.1% of budget **£5000 - < £25K**	Loss more than 0.25% of budget **£25K - < £100K**	Loss more than 0.5% of budget **£100K - <£500K**	Loss more than 1% of budget **>£500K S**
F External Bodies Inspection	Minor recommendations Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards	Prosecution. Zero Rating. Severely critical report
G Adverse Publicity / Reputation	Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days	National media more than 3 days. MP Concern (Questions in House)
H Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	less than 5% over budget / schedule slippage. Minor reduction in quality / scope	5-10% over budget / schedule slippage. Reduction in scope or quality	10-25% over budget / schedule slippage. Doesn't meet secondary objectives	More than 25% over budget / schedule slippage. Doesn't meet primary objectives

APPENDIX E: Trust Risk Grading Matrix

Qualitative Measures of Consequence

CONSEQUENCE*	Consequence Descriptor	Impact on Person or Trust	No. of Persons Affected	Unfavourable Publicity	Clinical Complaint or Litigation
5	Catastrophic	Death/ Loss of Body Part/ Trust faces serious difficulties and is unable to deliver services on a daily basis/Huge financial loss	More than 50	Certain	Certain
4	Major	Extensive injuries/ Trust faces some major difficulties which are likely to impact on quality service delivery on a daily basis/ Major financial loss	16-50	Likely	Likely
3	Moderate	Medical treatment required/ Prolonged hospital stay/ Trust faces some difficulties which may have a small impact on quality service delivery/High financial loss	3-15	Possible	Possible
2	Minor	First Aid Treatment required/ Trust faces some issues but no impact on quality service delivery/Medium financial loss	1-2	Unlikely	Unlikely
1	Negligible	Minimal/ No injury/No disruption to service delivery/Low financial loss	None	Remote	Remote

***Use the highest number of the four as the consequence score – if in doubt grade UP not down

Qualitative Measures of Likelihood

LIKELIHOOD	Likelihood Descriptor	Likelihood Examples	CONSEQUENCE				
			1	2	3	4	5
1	Rare	Difficult to believe that this will ever happen/ recur	1	2	3	4	5
2	Unlikely	Do not expect it to happen/recur, but it may	2	4	6	8	10
3	Possible	It is possible that it may occur/recur	3	6	9	12	15
4	Likely	Is likely to occur/recur but is not a persistent issue	4	8	12	16	20
5	Almost Certain	Will almost certainly occur/recur and could be a persistent issue	5	10	15	20	25

LEVEL OF RISK

Low Risk 1-3	Moderate Risk 4-6	Significant Risk 8-12	High Risk 15-25

TIMESCALES FOR ACTION(S) AND RISK ELEVATION REQUIREMENTS

High Risk (15-25)	- Immediate action required - Elevate to Head of Non-Clinical Risk (if not available to Head of Patient Safety and Quality) or if outside of working hours to the On-Call Duty Manager - Elevate to SBU/Clinical Support Service/Corporate Service Business Manager - Must be elevated to Risk Management Strategy Group (at RMSG Meeting)
Significant Risk (8-12)	- Action as a priority - Elevate to SBU/Clinical Support Service/Corporate Service Business Manager - Must be elevated to DDO Level (at Portfolio Governance Meeting)
Moderate Risk (4-6)	- Action as soon as possible - Elevate to SBU/Clinical Support Service/Corporate Service Business Manager
Low Risk (1-3)	- Action may be required at some time in the future - Elevate to SBU/Clinical Support Service/Corporate Service Business Manager