



Complaints Policy

(Complaints, Concerns, Comments and Compliments Policy)

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The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative format.

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1. Introduction

The East of England Ambulance Service NHS Trust (hereafter referred to as the Trust) provides a wide range of services to the public such as Emergency and Urgent Care, Patient Transport Services, and Commercial Call Handling Services. The Trust serves the counties of Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk which covers an area of 7,500 square miles and a population of more than 5.9 million people.

With the size of the Trust and the high activity and contact we have with patients and the public, mistakes will sometimes happen or the service delivery we aim to provide will not meet expectations. When this happens the Trust is committed to learn from any mistakes made so that there is a continuous improvement of service delivery to improve patient and public experiences.

Patient and public feedback comes in various forms and is often an expression of dissatisfaction with the service provided by the Trust. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 provides the statutory framework for managing complaints and this is further supported by the Parliamentary and Health Service Ombudsman's (PHSO) principles of good complaint handling as outlined in the PHSO Vision: My expectations for raising concerns and complaints..

This policy provides guidance to managers and staff so that they understand their responsibilities when a patient or member of the public is unhappy with the care or service they have received, how to deal with their dissatisfaction or where appropriate direct them to how they can register the concerns they may have. The policy also informs staff what the complainant can expect from the Trust and the involvement staff will have to help bring the complaint to a satisfactory conclusion, or what further steps may take place if that is not possible.

Equality, Diversity, Inclusion and Human Rights encompass all our aims, objectives and actions addressing inequalities and promoting diversity in healthcare and employment. The key principle of Diversity and Inclusion is that it belongs to everyone and that every individual has the right to be treated with respect and dignity as aligned to our core values.

We will ensure that our services are anti-discriminatory enabling equality of access and provision and meeting the legal requirements under the Equality Act 2010 and the specific elements of the Public Sector Equality Duty. We will use the Equality Delivery System² (EDS²) to ensure that service priorities are influenced and set by the health needs of all our local and regional communities through consultation, equality monitoring and partnership working. We will demonstrate "Due Regard" in all aspects of our business to ensure we remain focused on equality of outcome and equality of opportunity. We will aim to make the Trust a place where all who work and access our services are free from all forms of discrimination and where the diversity of our staff patients, visitors and service-users is recognised as a key driver of our success and is openly valued and celebrated.

1.1 Purpose

The purpose of the policy is to ensure that the Trust meets its legal obligations and focuses on outcomes rather than the process. The Trust will approach any complaint in an honest and open way, with the prime aim of resolving the problem, satisfying the concerns of each complainant and learning from the experience. The Trust will respond to all complaints about the services it

provides or manages including subcontractors such as Private and Voluntary Ambulance Services.

The policy is designed to allow implementation of the Francis Report findings to ensure that complaints handling are more patient centred focus, upheld complaints (anonymous) are published on the Trust website and that we promote and encourage comments and complaints from the regional population. This policy also recognises the Keogh review and this will be monitored to ensure the care we provide is effective, safe and is delivering a positive experience for patients.

EEAST must comply with the NHS Complaints (England) Regulations 2009 and also meet the Care Quality Commission registration requirements as specified in Regulation 19. A number of recommendations regarding complaint handling are contained within the Francis Report (February 2013) and the subsequent review completed by Ann Clwd MP and Professor Hart in October 2013. EEAST acknowledges the recommendations in both reports and complies with the Principles of the Parliamentary and Health Service Ombudsman (PHSO) to facilitate open and transparent complaint handling.

We should also make provision for sharing and receiving complaints from Commissioners and that the Directors and Board are notified of all serious complaints.

1.2 NHS Constitution

The NHS Constitution establishes the principles and values of the NHS. It includes staff pledges, which state what the NHS expects from its staff and what staff can expect from the NHS. The Trust will handle complaints by talking to the complainant, understanding their issues and providing a custom focussed response which addresses the concerns raised. The Trust will provide a full explanation to all its complaints, take action where appropriate and ensure learning is gained and embedded from the feedback.

2.0 Responsibilities within the Trust

2.1 Chief Executive

The Chief Executive is the 'accountable officer' and has overall responsibility for the implementation of the Trust's Complaints Policy, ensuring that lessons are learnt from complaints and, where appropriate, remedial action taken. This function may be performed by any person authorised by the 'responsible body' to act on his/her behalf and periodically may be devolved to other Board Directors.

2.2 The Board

The Board is responsible for receiving and reviewing reports on the effectiveness of the Trust's Complaints Policy and to ensure that action is taken to address complaints and any adverse incidents and trends. The Board will also monitor the effectiveness of complaints handling and compliance with the NHS Regulations through the Quality Governance Committee.

2.3 Quality Governance Committee (QGC)

QGC will report to the Board on the operation of the Trust's Complaints Policy. The Committee will receive appropriate information and monitor compliance with the NHS Complaints (England) Regulations 2009, and this policy, and make recommendations to the Board as appropriate.

2.4 Risk Management Group

The Risk Management Group is directly accountable to the Executive Leadership Board and is responsible for reviewing and monitoring trends in relation to complaints and concerns recorded on the Trust's risk management system as part of the risk management process. They must ensure that appropriate follow up action is taken, learning is disseminated and make recommendations for changes to policy or activity.

2.5 Clinical Quality and Safety Group (CQSG)

The CQSG is directly accountable to the Executive Leadership Board and has decision making powers devolved from the Board. Its purpose is to promote the delivery of safe, effective patient care outcomes and to ensure patient and carers views are actively sought, considered and acted upon and to ensure that appropriate mechanisms are in place to deliver high quality care. The CQSG will receive reports on complaints including trends, themes, issues to note and lessons learned where appropriate.

2.6 Patient Experience Lead

The Patient Experience Lead is responsible for the day to day management of the Patient Experience Department which handles all patient experiences to include: complaints, concerns, comments, compliments and requests for information. The Patient Experience Lead is also responsible for producing statistical information to the Board, Quality Governance Committee, the Senior Leadership Board, Executive Leadership Board, Lead Commissioners and other governance level groups to support and inform decision making.

2.7 Patient Experience Department (PED)

The PED is responsible for the day-to-day coordination of all feedback to the Trust. The team are required to work with the investigating managers to support the completion of a timely investigation and keep the complainant updated with the progress. The Patient Experience Department will ensure that:

- All complainants are treated with respect and dignity.
- No discrimination including age, gender, disability, ethnicity, religion, sexual orientation will occur as a result of making a complaint.
- The complainant will receive a letter of response from the Chief Executive or his deputy addressing their concerns, with demonstrable lessons learnt, actions taken and an apology if appropriate.

2.8 Regional Managers and Heads of Departments

Regional Managers and Heads of Departments have a responsibility to assist the complaints process to the satisfactory conclusion of the complainant by:

- Ensuring that all complaints are allocated to an appropriate investigating manager depending on the grading and seriousness of the complaint.
- Ensuring that the complaint is investigated in a timely manner as determined by the Policy.
- Ensuring that all aspects of the complaint have been fully investigated and any recommendations are followed up and actioned.
- Ensuring that all actions have been completed.
- Monitor complaint numbers and timeframes through the use of their dashboard on the Trust's complaints management system.

2.9 Investigation Manager

The Investigation manager is responsible for:

- Making contact with the complainant to establish a rapport and to gather any further facts.
- Ensure that the complaint is investigated within the timescale allocated and where this is not possible inform the Patient Experience Department of the reasons why.
- Submit their investigation to the Trust's complaints management system, ensuring all areas of the complaint have been addressed.
- Feedback investigation outcome and any lessons learned to the appropriate line manager and staff involved in the complaint.
- If appropriate, disseminate any identified learning across the Trust.

2.10 Managers and Staff

Managers are responsible to ensure that their staff are fully familiar with this policy and ensure they support the staff during the investigation process.

Individual members of staff have a responsibility to acknowledge and respond to patients' and carers' concerns and comments, ensuring that any necessary remedial action is taken. All staff involved in a complaint will be treated fairly, openly and with dignity throughout the investigation process. Staff who have been named in the complaint will receive feedback on how the complaint was handled and resolved, with associated learning where appropriate.

The Trust has empowered staff to resolve complaints and concerns at a local level whenever possible.

2.11 Peer Review Panel

A Peer Review Panel process has been developed to ensure that the Trust is receiving on-going objective feedback about the feedback process from members of the Community Engagement Group. The Panel's role will be to analyse a number of files per year and comment on the current process and make recommendations to improve this process.

The procedure is contained in Appendix 5.

3.0 Definitions

3.1 Complaint

A complaint can be defined as an expression of dissatisfaction from a patient or a member of the public and can be raised orally or in writing. Most complainants will be very clear that they wish their complaint to be treated formally and that they require a written response which explains what happened, why it happened, what we have learnt and what action is being taken to ensure it does not happen again. Complaints will be reported and managed in line with the NHS Complaints Regulations 2009 and can range from the clinical treatment provided, the driving skills of the member of staff or corporate matters, such as a breach of the Data Protection Act 1998.

3.2 Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) is an informal mechanism for patients, their relatives or carers to comment on services provided by the Trust. The Trust's PALS function is managed by the Patient Experience Department. It also forms part of the data gathering by the Patient Advice & Liaison Service to identify trends, gaps in service and share good practice.

- A number of NHS locations will display information regarding the 'free' telephone service.
- All staff will be aware of the service, what it offers and how to access it.
- The Trust will aim to deal with all comments received via PALS with similar standards of responsiveness and thoroughness as employed for complaints.
- The Patient Experience team will be the first point of contact for all PALS contacts in office hours. Out-of-hours the Trust has a voicemail service and calls to this are reviewed as soon as the office re-opens.

PALS files include concerns and comments, which are defined below:

- **Concern**
A concern can be described as negative feedback but which has not been or is not required to be dealt with as a formal complaint. It does not necessarily require a written response and can be resolved orally if appropriate. Where a complaint or concern is raised externally from another Health Service Provider, this will be dealt with as an incident and where appropriate a written response will be sent from either the investigating officer or the Patient Safety team.
- **Comment**
At times the Trust will receive comments, ask a question or seek advice or signposting within the wider NHS or social care network. These comments will be logged and responded to as appropriate or sent onto the relevant department if it is information only.

3.3 Access to PALS

PALS is about promoting a culture of good customer care and all Trust staff should undertake a PALS role, giving advice or information to patients, carers or relatives or signposting them to other relevant help.

PALS is accessed by the public by a free phone number, e-mail address, in writing and also via the Trust Website

The telephone line is staffed during office hours with a voicemail service when the office is closed.

3.4 Lost Property

Requests to trace lost property can be made via the PALS team either by telephone/letter/e-mail or via a dedicated Lost Property Request Form on the Trust's website.

All requests to trace lost property are passed to the local administrators for each service line to make the appropriate enquiries to trace the item(s) and feedback to the PALS team to respond to the request.

3.5 Compliments

A compliment can be defined as an expression of appreciation or thanks for a service received. It is important that these compliments are treated with the same importance as a concern or complaint. All letters/emails/telephone calls of appreciation are logged and sent directly to the



appropriate member of staff with acknowledgement to their line manager who will ensure that the staff involved receives appropriate recognition and that a record is made on their personnel file.

All compliments are promoted on the Trust's Need-to-Know forum monthly.

3.6 Adverse or Serious Complaint

All negative feedback is treated seriously; however, some complaints or concerns may trigger the criteria for a Serious Incident requiring investigation due to the serious nature or circumstances. Where this has been recognised through the triage process the complaint or concern will be highlighted to the Patient Safety Team for further review. Where negative feedback relates to a serious allegation against members of staff, additional consideration is given at the point of triage to notify the Safeguarding Team for potential investigation.

4.0 Complaints Management Process

The Trust has developed a system on their web page so that people who want to provide feedback can do so via a number of methods such as e-mail, Twitter, Facebook, letter or via telephone. This information is then picked up by a centralised team who will then process the feedback. Where feedback arrives at other departments within the organisation these should be directed to the Patient Experience Department. Feedback can also come via Patient Opinion and NHS Choices and these are managed by the Patient Experience Lead. The process for handling feedback is detailed in the flow chart in Appendix 3.

Any person who wishes to communicate by e-mail regarding their feedback will be alerted to the insecure nature of that method of communication and will be asked to confirm that that is the method in which they choose to correspond.

4.1 Who can Complain

A complaint can be raised by:

- A patient or their representative
- Any person affected or likely to be affected by the action, omission or decision of the Trust during care by a member of Trust staff.

A complaint may also be raised by a person acting on behalf of another person where that person:

- Has died
- Is a child or minor
- Is unable by reason of physical or mental capacity to make the complaint themselves
- Has requested the representative to act on their behalf
-

4.2 Issues that cannot be dealt with as a Complaint

There are some instances where the Trust is unable to investigate a complaint or is not required to investigate a complaint:

- Oral complaint resolved within 24 hours (not dealt with as a complaint but through this policy as a concern/PALS).
- A comment or concern
- Those arising from a Freedom of Information request
- From an employee in relation to their employment, past or present

- Previously investigated by the Trust or the Parliamentary and Health Service Ombudsman
- From an NHS or Local Authority Social Services Body
- During any Police investigation of a criminal matter
- Exceeding the time limit of 12 months for raising a complaint.

Whilst the above list is not reportable this does not mean that the issues raised should not be considered as a concern or dealt with through other policies.

4.3 What can the complainant expect?

The complainant should expect an acknowledgement of their complaint within 3 working days by telephone to establish the nature of their complaint, the timescale for investigation, to confirm a single point of contact and how they can get support from the local advocacy services. The Trust aims to investigate and respond to all complaints within 25 working days, however, there may be circumstances in which this doesn't allow enough time to thoroughly investigate the complaint, but the complainant will be kept up-to-date where necessary.

Where a complaints results in a Serious Incident, the Trust aims to respond within 60 working days to allow time for the Patient Safety Team to conduct a full and thorough investigation, and ensure that both learning and actions following investigation are implemented.

The complainant should receive a response in writing which addresses the areas of concern raised and an apology where an apology is required. They will also be kept informed throughout the complaints process and updated where a delay in the investigation has occurred. The letter will also explain their rights to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if all lines of enquiry are exhausted

4.4 What happens if a complaint cannot be resolved

Every effort will be made by the Trust to resolve the complaint; however, there may be occasions when we cannot reconcile the differences. The complainant will be informed via our responding letter that if they still remain dissatisfied and all attempts have failed to resolve their complaint then they should contact the Parliamentary and Health Service Ombudsman.

4.5 Complaints from other Health and Social Care Professionals

These will be dealt with as an incident, when the patient is not aware that a concern has been raised.

4.6 Complaints from External Agencies and Organisations

These will be dealt with as an incident when the patient is not aware that a concern has been raised.

5.0 Raising a Concern

Where the feedback does not meet the NHS Complaint Regulations or the complainant does not want the complaint to be formal then this will be logged as a concern. The process for handling the concern is detailed in the flow chart in Appendix 3.

5.1 Who can raise a Concern

All negative feedback is triaged to determine if it should be registered as a complaint and if not to be managed as a concern. Examples of a concern would be NHS organisations or Healthcare Professionals raising an issue about the service provided by the Trust. Some concerns raised by MP's which are not directly related to a specific incident or patient will be sent to the Head of Communications. Concerns are also raised by the Clinical Commissioning Groups (CCG's) via the Quality Incident Reporting (QIR) system; these are processed as incidents in line with concerns raised by external healthcare professionals.

6.0 Triaging and Grading Complaints or Concerns

All reported negative comments are triaged by a Patient Experience Co-ordinator in the Patient Experience Department to determine whether the feedback should be a complaint or a concern. The complaint or concern is then graded as defined in the Risk Management Procedure and documented on the complaint or concern record. Further information on the risk assessment and matrix can be found in the Risk Management Procedure held in the Document Library.

During this triage process, the file will also be:

- Flagged as a potential Serious Incident and forwarded to the Patient Safety Team,
- Flagged as a data or confidentiality breach and forwarded to the Information Governance Team,
- Flagged as a potential Claim and forwarded to the Claims Team,
- Flagged as a Safeguarding concern and forwarded to the Safeguarding Team with a Single Point of Contact (SPOC) Safeguarding referral made where appropriate.

7.0 Time limit to raise a Complaint

The time limit to make a complaint is normally:

- 12 months from the date that the event happened, or
- 12 months from the date the complainant first became aware of it.

The decision to investigate complaints that fall outside of the time frame is at the discretion of the Patient Experience Lead.

8.0 Duty of Candour, Transparency and Being Open

Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.

Being open and honest about what happened and discussing complaints promptly, fully and compassionately with patients and/or their carers can:

- Help patients and/or relatives cope better with the after-effects;

- Provide reassurance that everything will be done to ensure a similar type of complaint does not recur;
- Provide an environment where patients and/or their carers, healthcare professionals and managers feel supported when things go wrong;
- Help prevent such events becoming a litigation claim.

9.0 Consent

The principle adopted by this policy is to work in accordance within the current data protection regulations and the Caldicott Principles. Consent is required from the patient or person involved for the outcome of any investigation to be released to a third person. If it is not possible to gain formal consent, for instance the patient's condition is such it would be inappropriate to seek it, then the Patient Experience Lead has the discretion to waive the consent.

If the consent is a reasonable request but not received, the Trust has the right to stop the investigation or can provide limited information without breaching any confidentiality. This decision is again at the discretion of the Patient Experience Lead.

Should a complaint be made via a Member of Parliament (MP) on behalf of a constituent and a letter from the constituent is enclosed then consent is implied. Where there is no letter from the constituent or the complaint is raised by a third person then consent should be obtained.

Where a representative makes a complaint on behalf of a child (under 16 years), the Trust must not consider the complaint unless it is satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child. If the Trust is not satisfied, the Trust must notify the representative in writing, stating the reason for its decision.

Consent may be a sensitive issue and the Trust wishes to avoid giving complainants the impression that it is trying to avoid investigating their legitimate concerns. The issue of consent is often resolved when the investigating officer makes a home visit when both complainant and patient are present.

10.0 Confidentiality

All recorded information will be treated as confidential and in accordance with the current data protection regulations, the Caldicott Guardian principles and the Access to Health Records Act 1990.

11.0 Legal Action or Criminal Proceedings

The Patient Experience Department together with the relevant manager(s) will assess the likelihood of the complaint being the subject of legal action or criminal proceedings and, where appropriate, refer to the Patient Experience Lead in order to seek guidance; and the Patient Experience Lead will refer the matter to the Trust's Information Governance managers to seek legal advice in advance of preparing the response.

All letters which state that legal action is being taken, or that include a claim for compensation, must be forwarded immediately to the Information Governance Manager. This must not delay the

statutory obligation to acknowledge the complaint within 3 working days. The Patient Experience Lead will where necessary work with the Information Governance Manager and the Trust's solicitors regarding any further action required. The complaint should still be investigated and resolved as usual, however, all correspondence and actions must be passed to the Patient Experience Lead for advice and action. Where criminal proceedings are likely and the police are conducting an investigation into the complaint, then the Patient Experience Lead will seek guidance from the Trust solicitors in conjunction with the Information Governance Manager in order to determine whether progressing with the complaint might prejudice any criminal proceedings.

12.0 Financial Redress

The Trust works in accordance with the Principles of the Parliamentary and Health Service Ombudsman (PHSO) and its established Principles for Remedy.

The PHSO has made clear the expectation that there is an obligation to put the complainant back in the position they were in before they experienced the problems they encountered. The Trust recognises that there is consequently an obligation to consider financial redress in each appropriate case and where compensation is requested, regardless of whether the consideration relates to any financial loss a person has suffered as a result of service failings, or whether the payment is in recognition of the non-financial impact of failings, financial redress can be made without recourse to legal action.

Where financial redress is made, this will not be considered as an admission of liability in relation to any legal action that may ensue. Where a complaint gives rise to legal action, a response to the complaint will still be made. This decision will be made by the Director of Nursing and Clinical Quality in conjunction with the Patient Experience Lead.

13.0 Staff Complaints

Staff who have concerns about the care or treatment given to an individual or a particular group or by another member of staff should not use the NHS complaints process, but are encouraged to raise concerns with their line manager where appropriate or through the Trust risk reporting system. Staff should also be made aware of the Trust's Whistle Blowing Policy.

14.0 Learning from Feedback

The Trust recognises the value of learning from feedback so that there is continuous learning to improve the quality of service provided to patients and the public. Where appropriate, action plans are to be developed and lessons learned disseminated based on recommendations as part of the investigation outcomes. These recommendations should highlight the need for any training requirements and address arrangements for shared learning appropriate to the complaint or feedback (what is to be shared and with whom) and give consideration to the review of relevant policies and procedures where appropriate.

Action plans will detail who is responsible for implementing each action and the timescale in which they are to be implemented.

15.0 Equality, Diversity and Human Rights

In handling and responding to complaints, complainants will be treated fairly with equal opportunities to make their view known. Fairness requires all those who complain to be treated with dignity, respect and compassion. Where reasonable adjustments are appropriate to enable equitable access, these will be facilitated. Regardless of people's differences, everyone who complains has the right not to be discriminated against.

The Trust is committed to pro-diversity and anti-discriminatory practice. Information is available in accessible formats, including different languages on request that inform the public about our complaints process. The Patient Experience Lead will liaise on a regular basis with the Equality and Diversity Lead to ensure that the accessibility of the process is maintained and reasonable adjustments are made to facilitate the needs of those who might otherwise not be able to make a representation to the Trust. Examples of reasonable adjustments include translation services (for example, language line) or other formats if required.

Every complainant receives an Equal Opportunities Monitoring Form with their acknowledgement letter and they are asked to complete the form and return it to us. This information is then analysed on an annual basis and contributed to the Trust's Equality and Diversity Annual Report.

16.0 Process for Joint Handling of Complaints Between Organisations

Health and social care organisations are required to work together to ensure co-ordinated complaint handling and to provide the complainant with a single response that represents each organisations final response. Where a service user wishes to make a complaint about a healthcare related matter they have the choice of doing this either to the organisation providing the service or the Clinical Commissioning Group (CCG) that commissions the service(s). The CCG may decide that it is best placed to handle the complaint itself, and in such cases, or where other providers are involved, the Trust will afford every cooperation, negotiating the time frame for a response accordingly. On some occasions, the Trust will be unable to comply with the other provider's timeframe due to investigation constraints. In this case the lead provider should discuss this with the complainant to establish if a split response is appropriate.

In instances where the Trust receives a complaint involving more than one service provider, the Patient Experience Lead will discuss this with the complainant and share the complaint with the relevant Organisation, co-ordinating, where possible, a single, joint response to the complainant within an agreed timeframe. Every effort should be made to adhere to these time scales. We do have joint policies in place and these can be sourced from the Patient Experience Lead.

16.1 External Independent Investigations

The Trust recognises the need to have arrangements in place for a complaint to be investigated independently or for some level of independent scrutiny in order for a satisfactory resolution to be achieved.

This is not likely to be utilised frequently and would only ordinarily be exercised where a complainant's relationship with the Trust has deteriorated to the extent where the usual internal considerations are unlikely to be accepted by the complainant.

All complaints will be considered on a case by case basis and local arrangements will be made for the independent investigation or scrutiny of any case in which the Director of Nursing and Quality agrees this is appropriate.

17.0 Advocacy

The NHS Advocacy Service help individuals make a complaint and/or give advice to complainants during the process itself. The Trust has a duty to make complainants aware of this service and notifies them through the acknowledgement letter.

18.0 Habitual or Vexatious Complaints

Very occasionally complainants will persist with a complaint that staff consider has reached a conclusion through the complaints procedure. Guidance for handling such situations to protect both staff and complainants can be found in Appendix 1, and discretion sits with the Patient Experience Lead to decide how these are taken forward.

19.0 Staff Support

All staff who are the subject of a complaint or concern should be offered support throughout the process in conjunction with Staffside and Unison where appropriate. Staff will be required to contribute to any investigation by explaining their version of events either verbally or in writing. The purpose of the investigation is to understand what may have gone wrong, to clarify to the complainant what happened against what should have happened and apologise if an apology is appropriate. Staff should be notified by their line manager of any outcome from the complaint or concern and feedback the learning that has been realised as a result of the investigation. This is monitored by the Patient Experience Department through the Trust's complaint management system.

An overview of this policy is incorporated into staff induction programmes. All staff should have an understanding of the complaints process which can be accessed via the Trust's internet. Further advice and support will also be available from the Patient Services Manager to help staff deal with complaints.

20.0 Complaints Received During Out of Hours

Any complaint received or likely to be received outside of normal office hours should be reported to the line manager. Some complaints may be received in the Emergency Operations Centre (EOC). The line manager or EOC Duty Manager will assess the complaint and respond where appropriate to resolve the complaint. Where this is not possible or the complainant is still unhappy, the details should be passed to the Patient Experience Department via eoasnt.feedback@nhs.net or 0800 028 3382 at the start of the next working day.

POL031 - Complaints Policy (Complaints, Comments, Concerns and Compliments)

What	Who	How	Frequency	Evidence	Reporting arrangement	Acting on recommendation	Change in practice and lessons to be shared
Duties	Senior Locality Manager (SLM) or nominated Duty Locality Officer (DLO)	Review of processes and responsibilities. The Patient Safety Software System	Annually	Review report outputs	Issues with process will be raised to the relevant manager for resolution.	The Senior Locality Manager or Duty Locality Officer is responsible for taking any action	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Listening and responding to concerns / complaints of patients, their relatives and carers	Senior Locality Manager or Duty Locality Officer involved	The Patient Safety Software System Patient Services department will monitor quality of investigations and communication	On-going for each individual complaint	Emails, file notes, meeting notes and letters demonstrate compliance with the correct process	Issues with process will be raised to the relevant manager for resolution. The lead is expected to read and interrogate any report to identify deficiencies in the system and act upon them	The Senior Locality Manager or Duty Locality Officer is responsible for taking any action. Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
	Senior Locality Manager or Duty Locality Officer involved	The Patient Safety Software System Patient Services department will monitor quality of investigations and communication	On-going for each individual complaint	Emails, file notes, meeting notes and letters demonstrate compliance with the correct process	Issues with process will be raised to the relevant manager for resolution. The lead is expected to read and interrogate any report to identify deficiencies in the system and act upon them	The Senior Locality Manager or Duty Locality Officer is responsible for taking any action. Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all



POL031 - Complaints Policy (Complaints, Comments, Concerns and Compliments)

What	Who	How	Frequency	Evidence	Reporting arrangement	Acting on recommendation	Change in practice and lessons to be shared
							the relevant stakeholders.
Handling of joint complaints between organisations	Patient Experience Lead	Interrogation of the patient safety software system and audit of final response letters	Annually	Published report approved by the Clinical Audit and Patient Safety Group	The group are expected to read and interrogate any report to identify deficiencies in the system and act upon them	Required actions will be identified and completed in a specified timeframe by the Patient Services Manager.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Ensuring that patients, their relatives and carers are not treated differently as a result of raising a concern / complaint	Patient Experience Lead	Survey of complainants regarding satisfaction with the complaint process	Annually	Published report approved by the Clinical Audit and Patient Safety Group	The group are expected to read and interrogate any report to identify deficiencies in the system and act upon them	Required actions will be identified and completed in a specified timeframe by the Patient Services Manager.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Process of improving as a result of concerns / complaints raised.	Patient Experience Department	Production of monthly and quarterly reports for review by the Risk Management Group, Clinical Audit and Patient Safety Group, Clinical Quality and Safety Group,	Monthly, Bi-monthly, quarterly and annually.	Reports produced and archived. All data taken from the Patient Safety Software System	The committees and groups are expected to read and interrogate any report to identify deficiencies in the system and act upon them	Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons



POL031 - Complaints Policy (Complaints, Comments, Concerns and Compliments)

What	Who	How	Frequency	Evidence	Reporting arrangement	Acting on recommendation	Change in practice and lessons to be shared
		and the Quality Governance Committee					will be shared with all the relevant stakeholders.



References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- All employment, information and anti-discrimination legislation (as applicable).
- Making Experiences Count
- Care Quality Commission Complaints Matter
- Parliamentary and Health Service Ombudsman's Principles
- Department of Health "A guide to better customer care"
- East of England Ambulance Service NHS Trust relevant policies and procedures
- Standards for Better Health (DH July 2004)
- Francis Report Recommendations February 2013.
- NHS Complaints Review Report (Clwyd/Hart Review) – November 2013
- Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report (Keogh Report) – July 2013
- Improving the safety of patients in England (Berwick Report) – August 2013
- Investigative Skills course
- Patient Services Information Guide
- Investigation Handbook

Appendices

Appendix 1	Procedure for Handling Habitual or Vexatious Complainants
Appendix 2	Summary Timescales
Appendix 3	Complaint Investigation Flowchart
Appendix 4	4 C's Management flowchart
Appendix 5	Peer Review Panels Terms of Reference
Appendix 6	Equality Analysis form

Appendix 1 - Procedure for Handling Habitual or Vexatious¹ Complainants

1.0 Introduction

- 1.1 Habitual and/or vexatious complainants are becoming an increasing problem for NHS staff although this Trust does not experience this to any great extent. The difficulty in handling such complainants places a strain on time and resources and causes undue stress to staff that may need support in difficult situations. NHS staff are trained to respond with patience and empathy to the complainant's needs and feelings, but there are times when there is nothing further, which can reasonably be done to assist them or to rectify a real or perceived problem.
- 1.2 In determining arrangements for handling such complaints, the need to ensure an equitable approach is crucial. Staff are presented with two key considerations:
 - To ensure that the complaints procedure has been correctly implemented as far as possible and that no genuine element of a complaint is overlooked or inadequately addressed. In doing so, it should be appreciated that habitual or vexatious complainants can have issues, which contain some genuine substance.
 - To be able to identify the stage at which a complainant has become habitual or vexatious.
- 1.3 One approach is an approved procedure, which is incorporated into the complaints policy. Implementation of such a procedure would only happen in exceptional circumstances.
- 1.4 Information on the handling of habitual and vexatious complainants should also be made available to the public as part of the material on the complaints process as a whole.

2.0 Purpose of this Procedure

- 2.1 Complaints about services provided by the Trust are processed in accordance with the NHS complaints procedure. During this process staff inevitably have contact with a small number of complainants who absorb a disproportionate amount of NHS resources in dealing with their complaints. The aim of this procedure is to determine situations where the complainant might be considered to be habitual or vexatious and to suggest ways of responding to these situations.
- 2.2 It is emphasised that this procedure should only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints following the NHS complaints procedure, for example, through local resolution, conciliation, or involvement of the Independent Complaints Advocacy Service (ICAS).
- 2.3 Judgement and discretion must be used in applying the criteria to identify potential habitual or vexatious complainants and in deciding action to be taken in specific cases.
- 2.4 The procedure should only be implemented following careful consideration by, and with the authorisation of, the Director of Clinical Quality.

¹ Definition : not having sufficient grounds for action and seeking only to annoy
POL031 – Complaints Policy V7.0

3.0 Definition of a Habitual or Vexatious Complainant

3.1 Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or vexatious complainants where previous or current contact with them shows that they follow **two** or more (or are in serious breach of one) of the following criteria:

- 3.1.1 Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.
- 3.1.2 Change the substance of a complaint, continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint has been addressed. Care must be taken not to discard new issues, which are significantly different from the original complaint. These may need to be addressed as separate complaints.
- 3.1.3 Unwilling to accept documented evidence of treatment given as being factual, e.g. patient report forms, treatment/travel disclaimer or Computer Aided Dispatch (CAD) print outs; or deny receipt of an adequate response in spite of correspondence specifically answering their concerns; or do not accept that facts can sometimes be difficult to verify if a long period of time has elapsed.
- 3.1.4 Do not clearly identify the precise issues which they wish to be investigated, despite the reasonable efforts of Trust and, where appropriate ICAS to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.
- 3.1.5 Focus on a trivial matter to an extent, which is out of proportion to its significance, and continue to focus on this point. (It is recognised that determining what a 'trivial' matter is can be subjective and careful judgement must be used in applying this criteria).
- 3.1.6 Have threatened or used actual physical violence towards any member of staff. This will in itself cause personal contact with the complainant and/or their representative to be discontinued and the complaint will thereafter only be pursued through written communication.
- 3.1.7 Have in the course of addressing a formal complaint had an excessive number of contacts (or unreasonably made multiple complaints) with the Trust, placing unreasonable demands on staff. A contact may be in person or by telephone, letter, fax or e-mail. Discretion must be used in determining the precise number of 'excessive contacts' applicable under this section, using judgement based on the specific circumstances of each individual case.
- 3.1.8 Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint, or their families/associates. (It is recognised that complainants may sometimes act out of character at times of stress, anxiety or distress and, where appropriate, allowances should be made for this, provided it is not detrimental to the staff concerned.) All incidents of harassment or aggression should be documented, reported and investigated in accordance with the Trust's accident and incident reporting procedure.

3.1.9 Are known to have tape recorded meetings, or any conversations held either face to face or over the telephone without the prior knowledge and consent of the other parties involved. It may be necessary to explain to a complainant at the outset of any investigations into their complaint(s) that such behaviour is unacceptable and can, in some circumstances, be illegal.

3.1.10 Display unreasonable demands or expectations and fail to accept that these may be unreasonable once a clear explanation is provided to them as to what constitutes an unreasonable demand (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or recognised practice).

4.0 Options for Dealing With Habitual or Vexatious Complainants

4.1 Where complainants have been identified as habitual or vexatious in accordance with the above criteria, the Patient Experience Lead will determine what action to take. The Patient Experience Lead will implement such action and will notify complainants promptly in writing of the reasons why they have been classified as habitual or vexatious complainants and the actions to be taken.

4.2 This notification must be copied promptly for the information of others already involved in the complaint, such as operational managers, Independent Complaints Advocacy Service, MPs, etc. A record must be kept for future reference of the reasons why a complainant has been classified as habitual or vexatious and the action taken.

4.3 The Patient Experience Lead may decide to deal with habitual or vexatious complainants in **one or more** of the following ways:

4.3.1 Try to resolve matters, before invoking this procedure, by drawing up a signed 'agreement' with the complainant (and if appropriate involving the relevant staff member in a two way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action as indicated in this section.

4.3.2 Once it is clear that complainants meet any one of the criteria in (3), it may be appropriate to inform them in writing that they may be classified as habitual or vexatious complainants copy this procedure to them and advise them to take account of the criteria in any other dealings with the Trust. In some cases it may be appropriate, at this point, to copy this notification to others involved in the complaint and to suggest that the complainant seeks independent advice in taking their complaint further.

4.3.3 Decline further contact with the complainant apart from written correspondence or through a third party, for example ICAS. A suggested statement has been prepared for use if staff are to withdraw from a telephone conversation with a complainant. This is shown in 6.2 overleaf.

4.3.4 Notify the complainant in writing that the Trust has responded to the points raised and has tried to resolve the complaint, that there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant



should also be notified that further communications on the current complaint will not be responded to.

4.3.5 Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from the Lead Commissioning CCG or Trust Development Authority.

4.3.6 Inform the complainant that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors and/or, if appropriate, the police.

4.3.7 In cases where the complaint is made against the Chair or Chief Executive of the Trust, then the decision about whether the complainant is deemed to be habitual or vexatious will be taken by a Non-Executive Director of this Trust, together with a Non-Executive Director from another area.

5.0 Withdrawing Habitual or Vexatious Status

5.1 Once complainants have been determined as habitual or vexatious there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedure would appear appropriate.

5.2 Staff should previously have used discretion and careful judgement in recommending habitual or vexatious status at the outset and similar discretion and judgement should be used in recommending that this status be withdrawn.

5.3 Where this appears to be the case, a discussion will be held with the Patient Experience Lead and, subject to his/her approval, normal contact with the complainant and application of the NHS complaints procedures will be resumed.

6.0 Guidance for Staff Handling Habitual or Vexatious Complainants

6.1 The following form of words – or a very close approximation – should be used by any member of staff who intends to terminate a telephone conversation with a complainant. Grounds for doing so could be that the complainant has become unreasonably aggressive, abusive, insulting or threatening to the individual dealing with the call or in respect of other NHS personnel. It should not be used to avoid dealing with a complainant's legitimate questions/concerns, which can sometimes be expressed extremely strongly. Careful judgement and discretion must be used in determining whether or not a complainant's approach has become unreasonable.

6.2 Form of words

'I am afraid that we have reached the point where I believe your approach is unreasonable and I have no alternative but to end this conversation. Your complaint(s) will still be recorded and dealt with by the Trust as appropriate, but I am now going to end this telephone conversation.'

6.3 Follow up action

The incident should be reported through the completion of an accident/ incident report form. In respect of future means of communication with the complainant and any further action deemed necessary, advice should be sought from the Patient Experience Lead.

6.4 **Continuing with Clinical Care**

Where the complainant requires clinical treatment this should continue, unless the case falls within the Procedure for Withholding of Treatment. Where the complaint is against staff who are providing care to the complainant their care where possible should be transferred to a different clinician, following discussion with the relevant manager



Appendix 2 – Summary of Timescales

Event	Time Allowed
Original complaint	12 months from event, or 12 months of becoming aware of a cause for complaint – subject to discretion to extend. (Regulation standard)
Local Resolution	
Non-reportable Complaint	Dealt with on-the-spot or resolved by the next working day to the satisfaction of the complainant. Where the complainant does not wish to proceed under the complaints procedure (PALS)
Reportable Complaint	Not resolved on-the-spot or next working day. Where the complainant wishes the complaint to be investigated further under the complaints procedure.
Acknowledgement letter	3 working days of receipt (Regulation Standard)
Patient Experience Co-ordinator contact investigating manager to enquire about progress (automatic email from action chain)	10 working days of receipt (EEAST standard)
Investigation by operational manager due. Patient Experience Co-ordinator to raise issue to investigating manager and update enquirer (automatic reminder from action chain)	15 working days of receipt (EEAST standard)
Patient Experience Facilitator to raise issue with investigating manager asking for update and when investigation will be completed. (automatic reminder from action chain)	20 working days of receipt (EEAST standard)
Patient Experience Manager to escalate issue to Senior Locality Manager and Locality Director (automatic reminder from action chain)	25 working days of receipt. (EEAST standard)
Full response from Trust to be sent	25 working days of receipt. (EEAST standard)
Time limit for complaint to receive a response	6 months from the date of receipt of complaint or longer if agreed (Regulation standard)
Complainant referring their case for Review to the Parliamentary and Health Service Ombudsman	Within a year of becoming aware of the problem (Regulation standard)

Appendix 3 - Management of Identified Stages:

*- Responsible manager / ** - Patient Experience Department



Phone the complainant

If you speak to the enquirer you are more likely to get a fuller understanding of the issues they are raising and it may help to resolve some of their queries or defuse the situation. You may even be able to close their concerns down by telephone.

This is a good opportunity to arrange a meeting if required.

Request & Review Documentation

Review the CAD, Patient Care Record, Cleric, Call Recordings and Safeguarding Referrals.

If you require any documents, please contact the Patient Experience Department. (eoasnt.feedback@nhs.net)

Interview the staff

Take written statements as soon as possible from the staff involved so they have an opportunity to put forward their recollection of events. Follow this up with specific questions to ensure all the enquirer's concerns have been addressed. Give the staff members' time frames to respond by if requesting statements.

Upload any statements or conversation notes to Datix.

Update Patient Experience team

Keep your Experience Co-ordinator regularly updated of your progress or hold ups by phone, email or progress notes on the Datix.

They won't chase if they are kept informed.

Update DATIX with your investigation

Fill out method of investigation fields.

Answers to complaint (the Experience Co-ordinator will format this into a letter)

Complete the outcome code e.g. justified or not justified, reason for delay, date investigation completed fields.

Complete the risk assessment for the Patient Experience.

Make sure that all relevant documentation and evidence has been uploaded.

Email the Patient Experience Department to advise that your investigation is completed.

Investigation
This section contains key investigation information.

Additional Investigator/s
Please use this field to record details of any additional investigator/s involved in the complaint investigation.
This field will automatically send an email notification to the selected person/s once the record is saved.

Date started (dd/mm/yyyy)

Method of Investigation
Explain what process you followed and what you did in order to respond to this complaint. Include whether notes/documents/call recordings were reviewed or attached, whether staff were spoken to or statements were gathered, and what policies and guidelines (local and national) you considered.

Method of investigation

Question raised by complainant

Answer to complainant

Do you wish to add another question?

Other issue highlighted in investigation

Reasons for response taking longer than 25 working days

Has the investigator made contact with the complainant?

Outcome of investigation

Patient Experience Risk Grade

Likelihood of recurrence	Consequence			
	None	Minor	Moderate	Major
Will undoubtedly recur, possibly frequently	●	●	●	●
Will probably recur, but is not a persistent issue	●	●	●	●
May recur occasionally	●	●	●	●
Do not expect it to happen again but it is possible	●	●	●	●
Cannot believe that this will ever happen again	●	●	●	●

Grade: _____

Is this a positive or negative trauma pathway patient?

Lessons learned
What have the staff involved in the complaint learnt as a result of the investigation? Is there any wider learning for the Trust as a whole?

Are actions required or been completed?

Outcome code

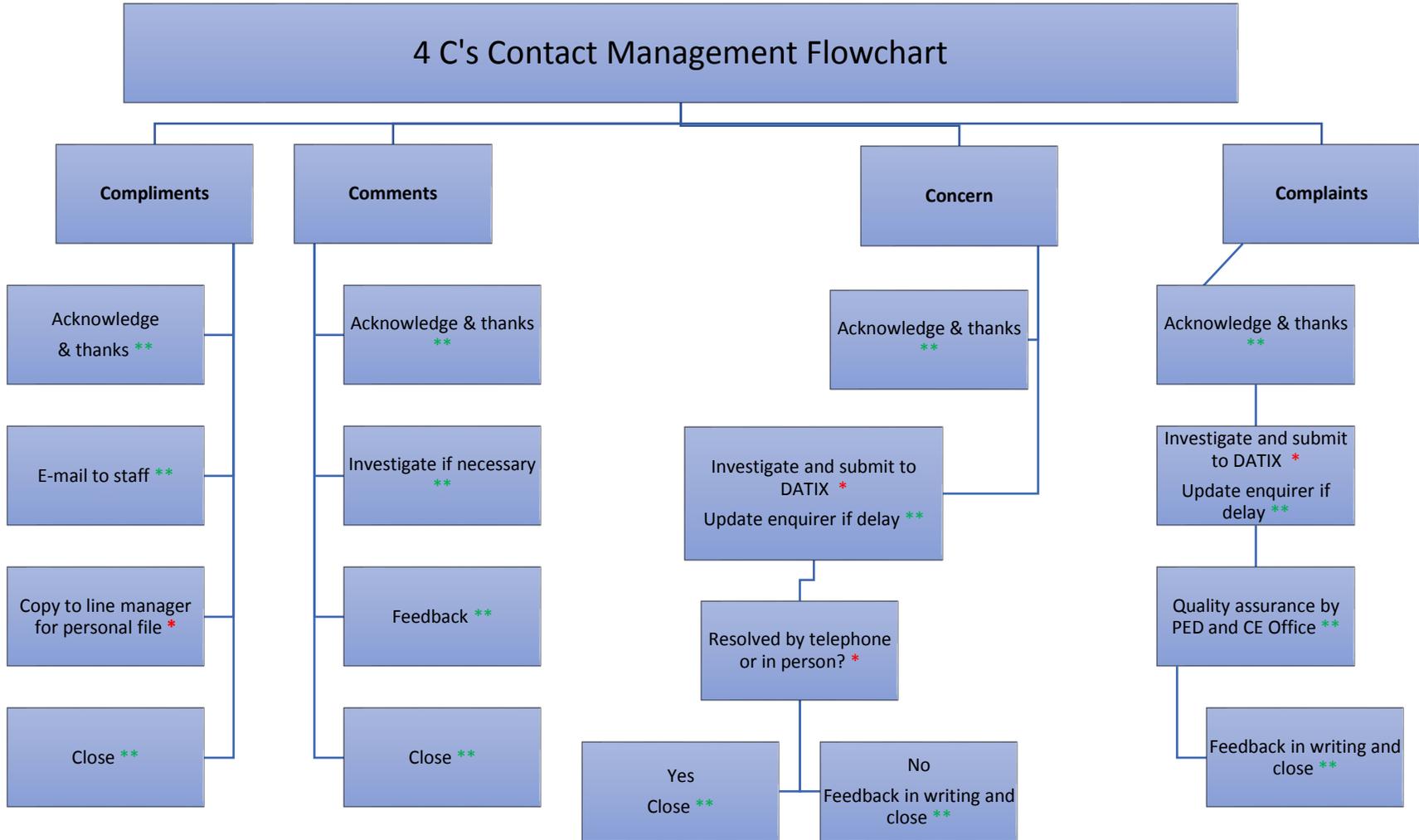
Date Completed (dd/mm/yyyy)

Date Finalised (dd/mm/yyyy)

Lessons Learnt

Complete the lessons learnt field in Datix and actions required. Set actions to remind yourself to complete the actions. Please provide evidence of the actions that have been carried out.

Appendix 4



Appendix 5 - Peer Review Panel Terms of Reference

Peer Review Panel: Terms of Reference

1. Constitution

The aim of the Peer Review Panel is to objectively evaluate the Trust's handling of complaints to ensure they are dealt with in accordance with our statutory obligations under the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 and in line with other best practice guidance (see section 4). They will provide assurance to the Director of Nursing and Clinical Quality and the Risk Management Group that complaints are being processed and managed fairly and in a timely manner.

1.1 These Terms of Reference will be reviewed and updated on an annual basis.

2. Membership

Below is a list of the members of the group:

Patient Experience Lead (Chair)
Patient Experience Manager
Member of Patient Experience Team
Community Engagement Group member
Community Engagement Group member
Community Engagement Group member

2.1 A quorum will consist of the Patient Experience Lead, or Patient Experience Manager, a member of the Patient Experience Team and at least two members of the Community Engagement Group.

3. Frequency of panels

As a minimum, five peer review panels will take place each calendar year. This will include one in each emergency care sector, one in primary care and one in patient transport services.

4. Authorisation

The complaint files will be redacted of all personal and sensitive date in order to protect patient confidentiality.

5. Duties

5.1 The members of the panel will review 3 complaint files per sector or service line each year.

5.2 The review will include the following key questions:

- Acknowledged within 3 working days?
- Correct consent requested and received?

- Did the Trust meet our internal timeframe (25 working days)?
- If not, was the complainant kept updated about the delay?
- Was the complainant advised of their right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if they were still dissatisfied with their response?

5.3 The review will also include additional questions outlined in Appendix A.

5.4 The panel will complete a Patient Experience Quality Assurance form for each complaint.

5.5 The panel will suggest any further learning or actions that should be taken that have not already been identified in the complaint file.

5.6 The panel will highlight any serious areas of concern that have not been addressed through the complaints process.

6. Reporting procedures

The Patient Experience Quality Assurance form will be passed back to the Patient Experience Lead and the feedback provided to the relevant senior Manager. A summary of the forms will also be reported to the Clinical Quality Safety Group.

7. Monitoring, self-assessment and review

The Terms of Reference will be reviewed each year by the Clinical Quality Safety Group to ensure that the panel is fulfilling the primary aim of the Terms of Reference.

Review date: January 2018



1 The complainant was given contact details for a named person with whom they could liaise throughout the process.

Yes No/Not recorded

2 The complainant's preferred method of communication was established at the earliest opportunity.

Yes No/Not recorded

3 An explanation of how the complaints process at the organisation works was provided.

Yes Partly No/Not recorded

4 The complainant was met with or spoken to in order to discuss the issues raised early on in the process.

Yes Partly No/Not recorded

5 The complainant was informed of the availability of third party support to help them during the complaint process.

Yes No/ Not recorded

6 The complaint was recorded and initially risk assessed and graded.

Yes No/Not recorded

7 In your opinion, this categorisation was appropriate.

Yes Partly No

8 The file was flagged as a Serious Incident if appropriate.

Yes No/Not recorded Not applicable

9 The complaint was communicated to internal specialists e.g. information governance team, safeguarding team.

Yes Partly No/Not recorded Not applicable

10 There is sufficient evidence to show, where necessary, patient records (e.g. clinical notes, booking system records, lab results) were reviewed.

Yes Partly Not applicable No/not recorded

11 There is sufficient evidence to show that statements were obtained from relevant members of staff involved with (or witnessing) the complaint.

Yes Partly No/not recorded Not applicable

12 There is sufficient evidence to show that statements were obtained from other individuals involved with (or witnessing) the incident that led to the complaint (e.g. friends, relatives, the complainant).

Yes Partly No/not recorded Not applicable

13 The interview notes gave a clear and concise account of the interview, including the date and time.

Yes Partly No Not applicable

14 Relevant copies of any organisation policies/protocols were obtained along with other documentary evidence, if appropriate e.g. NICE guidelines to support judgements on clinical practice.

Yes Partly No/Not recorded Not applicable

15 The investigator identifies any dispute of facts (e.g. different accounts of events).

Yes Partly Not applicable No/not recorded

16 The investigator indicates the preliminary conclusion(s) they have reached on each key complaint aspect, if appropriate

Yes Partly No/not recorded Not applicable

17 In your opinion any decisions reached were correct on the balance of probabilities.

Yes Partly No Not applicable

18 The complaint is classified as justified, partially justified or not justified.

Yes No/Not recorded

19 The file included all the documentation it should have?

- The initial complaint correspondence
- The initial assessment of the complaint severity and the details of the person making the assessment
- Dates, identities, position of all parties involved in the investigation
- Copies of all correspondence (patients, staff, opinions sought)

- Interview notes, emails in relation to the investigation
- Extracts from the patient record where appropriate
- Records of oral communications – face to face and telephone conversations
- Links to any previous complaints about the same persons or situation or process
- Links to any previous complaints from the complainant
- Other supporting information obtained to help formulate a judgement
- The final investigation report should be included, detailing the author, the decision making process, conclusions and recommendations i.e. a summary of the key facts relied upon in reaching the final decision
- The response letter to the complainant
- Evidence of support offered to staff involved in the complaint.

Yes Partly No

20 Final response sent from the Chief Executive

Yes No

21 Final response personalised and the tone of the letter courteous?

Yes Partly No

22 Final response expressed in a style and language that was appropriate

Yes Partly No

23 Technical or specialist terminology was explained in the final response

Yes Partly No

24 There was a summary or statement of the complaint that mirrored the complainant's original complaint in the letter.

Yes

Partly No

25 In your opinion, the response letter could reasonably be considered by the organisation to constitute a full and honest account of events.

Yes Partly No

26 The letter contained a response to each of the specific issues raised by the complainant.

Yes Partly No



27 An acknowledgment of responsibility and an apology was given where appropriate

Yes Partly No Not applicable

28 A sufficient explanation of next steps, including any remedial action, changes in policy or clinical practice was given

Yes Partly No Not applicable

29 Staff members involved in the complaint were informed of the outcome

Yes Partly No/Not recorded

30 In your opinion, the complaint process was managed fairly for the complainant.

Yes Partly No

31 In your opinion, the organisation would be able to successfully defend the quality and fairness of its investigative process for the complaint.

Yes Partly No



Appendix 6 - Equality analysis

Title: Complaints Policy

What are the intended outcomes of this work? *Include outline of objectives and function aims*

- To satisfy the Trust's legal obligations under the Local Authority, Social Services and NHS Complaints Regulations (England) 2009.
- To allow all patients, members of the public and other external organisations to provide feedback about the service the Trust provides.
- Where the feedback is negative, to ensure that a proportionate and objective investigation is completed and the outcome is fed back to the patient, member of the public or external organisation.
- To learn from the feedback received and implement actions to reduce the risk of a recurrence and ultimately improve the patient experience.
- To provide a structure to the management of feedback received and ensure the Trust is acting in line with best practice or guidance (e.g. Francis Report).
- To facilitate the Duty of Candour and the principles of being open.

Who will be affected? *e.g. staff, patients, service users, general population etc*

The Complaints policy affects staff, patients, their relatives, other healthcare professionals, advocacy services, MPs and other NHS organisations. The policy also affects the Patient Experience Team who co-ordinate all feedback.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results.* ²

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

- Previous complaints survey data
- Equality and Diversity Annual Report (patient satisfaction surveys)
- Information received from the Equal Opportunity forms sent out to enquirers

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers this may include safeguarding adults* ³

The Equality and Diversity Report completed shows that the Trust does not receive a high level of feedback from patients with disabilities. This may be because the patient may lack confidence or ability to raise concerns about the Trust alone so they may be more likely to require the use of an advocacy service. Physical access to the policy may be restricted if the patient has sight or hearing difficulties.

Every person who provides feedback to the Trust receives an acknowledgement letter or e-mail which includes details about the advocacy services available in their area. The Trust has also produced an Easy Read leaflet about the complaints process.

² [EEAST Being Open Policy](#)

³ [EEAST Safeguarding Vulnerable Adults Policy](#)

The Patient Experience Department is able to produce correspondence in larger font size to aid those patients with sight difficulties, this includes the leaflet, policy and any letters that are sent. The Trust's website's text size can be easily increased and the website also allows patients to highlight the text required so this can be read out (using the BrowseAloud software).

The Patient Experience Department does not usually require patients to visit Trust sites however consideration would be given to the appropriateness of a meeting location if the patient had physical disabilities.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups (e.g. Mencap, MIND).

All feedback received is triaged by a responsible person and any potential safeguarding or vulnerable patient issues are highlighted to the Safeguarding Team, with appropriate Safeguarding referrals made to the Local Authority via the Trust's Single Point of Contact (SPOC).

Gender Consider and detail (including the source of any evidence) on men and women

The Trust does receive a slightly higher number of complaints from women compared to men; however, there is no evidence to suggest why.

Race Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, including travellers and language barriers.

The Equality and Diversity Report shows that feedback is predominantly received from White British patients.

The Trust's website can be translated into different languages and the policy and leaflet are also available in different languages. The Patient Services Department has access to Language Line, which is a telephone interpreting service.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups. This poster can be made available in different languages if required.

Age Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding⁴, consent and child welfare.

The Trust receives a higher proportion of feedback from patients over 61 years old compared to younger patients and this is evidenced in the Equality and Diversity Report.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups (e.g. Age Concern).

Recently we have changed our processes to accept feedback through a number of different methods, including social networking sites (such as Twitter and Facebook) along with patient forums (NHS Choices and Patient Opinion). This is to encourage the younger population to provide feedback to the Trust about the care they received via a forum accessible and relevant to them.

The Trust has a rigorous consent process to ensure we are complying with the General Data Protection Regulations 2018, however, this does not adversely impact on any particular age group. If a third party is complaining on behalf of a patient, we always require a consent form to be completed unless the patient does not have capacity, has passed away or is a child.

All feedback received is triaged by a responsible person and any potential safeguarding or vulnerable patient issues are highlighted to the Safeguarding Team, with appropriate Safeguarding referrals made to the Local Authority via the Trust's Single Point of Contact (SPOC).

Gender reassignment (including transgender) Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.

⁴ [Safeguarding Children & Young People Policy.pdf](#)

There is no indication that patients who are considering or who have undergone gender reassignment are treated differently through the complaints process, although feedback from this patient group is low.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

There is no indication that patients are treated differently through the complaints process based on their sexual orientation, although feedback from lesbian, gay and bisexual patients is low.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups. This poster can be made available in different languages if required, including LGBT groups.

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

The Equality and Diversity Report shows that the Trust receives low levels of feedback from Hindu and Muslim patients.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups. This poster can be made available in different languages if required. The religious centres will include both Christian and non-Christian religious centres and the poster can be available in a different language if required.

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.⁵*

Feedback from patients who are pregnant or breastfeeding is low, however, it is unclear why at this point.

EEAST has previously disseminated a poster across the region to community centres, libraries, GP surgeries, A&E Departments, religious centres and specific patient groups. This poster can be made available in different languages if required. Many parent-toddler groups take place at community centres and village halls so we are trying to increase the accessibility of the service to parents.

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

There is no indication that patients who are considering or who have undergone gender reassignment are treated differently through the complaints process, although feedback from this patient group is low.

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

Feedback is received from patients and members of the public from all different socio-economic groups and residential statuses. However the Trust has not surveyed this area so further work may be required around this.

Engagement and involvement

Was this work subject to the requirements for public engagement/consultation?

Yes.

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Stakeholders were engaged through the request for completion of the Equal Opportunity Forms that are disseminated on receipt of any negative feedback. Further work is being carried out with the Trust User Group about the appropriate use of this Form.

⁵ [Pregnancy & Maternity Policy](#)



How have you engaged stakeholders in testing the policy/strategy or programme proposals?

The Trust is reviewing whether annual complaints survey should be reintroduced according to national policy, which requests feedback about the way their complaint/concern was handled. This would allow complainants to provide feedback on the process and if we have acted in-line with our policy.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

The annual complaints survey would be sent to all complainants whose files were closed in Quarter 3 of the relevant financial year. The survey results are then analysed and a report is produced (including recommendations), which is passed to the Clinical Quality Safety Group for further progress.

Summary of Analysis *Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.*

Has been covered above.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

From steps already taken, the Trust aims to eliminate discrimination, harassment and victimisation from the feedback processes. The Complaints Policy will be applied fairly to all patients and members of the public and additional support will be offered to the patient and / or complainant where required to ensure they are able to provide feedback to the Trust. The Patient Experience Department have all been trained in Equality, Diversity and Inclusion and all complete the mandatory workbook on an annual basis in relation to the equality and diversity principles.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

As stated above, the Patient Experience Department will not treat everyone the same but tailor the complaints handling process to ensure the patient and the Trust get the most out of the feedback. However, in terms of the investigation, this will be completed objectively, regardless of the patient group involved.

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

Not applicable.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The limited evidence the Trust has available does show that certain patient groups are less likely to provide feedback, although action is being taken to address this. The current Equal Opportunities Monitoring Form will also be reviewed by the Trust User Group to ensure it is suitable and that the Patient Experience Department send out the form at an appropriate point in the process.



Addressing the impact on equalities Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.
 The Trust is committed to addressing any inequalities within the feedback process and this is also enshrined within the Patient Experience Department's Francis Report Action Plan.

Action planning for improvement Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.
 No gaps or negative impacts identified, all elements of the Complaints policy are non-discriminatory and support the aims of the Equality Act 2010.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

- Plans already under way or in development to address the **challenges** and **priorities** identified.
- Arrangements for continued engagement of stakeholders.
- Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)
- Arrangements for embedding findings of the assessment within the wider system
- Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results
- Arrangements for making information accessible to staff, patients, service users and the public
- Arrangements to make sure the assessment contributes to reviews of EEAST strategic equality objectives.

No gaps or negative impacts identified, all elements of the Complaints policy are non-discriminatory and support the aims of the Equality Act 2010.

For the record

Name of person who carried out this assessment:

Patient Experience Lead

Date assessment completed:

January 2018

Name of responsible Director:

Director of Clinical Quality and Improvement

Date assessment was signed:



