Harrogate and District NHS
NHS Foundation Trust

Making Experiences Count Policy

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1. INTRODUCTION

1.1 Purpose

The Trust's objective is to achieve effective, safe and patient centred care. In order to achieve this the Trust recently launched its values and behaviours framework which state that staff should be responsible, respectful and passionate. The Trust recognises that managing patient feedback well can both improve services and enhance the public perception of the Trust. The way an organisation views and handles feedback is an indicator of how it regards its service users and identifies lessons to be learnt for continued service improvement.

Handling feedback well and good customer care demonstrate the responsiveness of an organisation. By understanding why patients are dissatisfied and the type of feedback received we can work in partnership with them to improve the quality of care and patient experience. The policy follows the principles set out by the Health Service Ombudsman and the Department of Health Guidance and refers to all forms of feedback including compliments, comments, concerns and complaints (the 4 Cs).

The Trust promotes pro-active on the spot resolution of problems at a local level thus reducing the need for patients / carers to raise issues in a more formal way. It is recognised that lessons must be captured from this type of feedback locally to promote sharing of learning and good practice. Quality of Care teams are encouraged to facilitate the resolution of issues in their own areas and promote learning. This policy sets out the way in which the Trust will receive and respond to Patient Feedback at a Corporate and Directorate level.

The Trust is obliged to have a policy on how to handle complaints in accordance with the Complaints Regulations, however to ensure we listen to, investigate, respond, identify trends and learn from all types of feedback we have incorporated the process for handling compliments, comments and concerns into this policy. The main part of the policy remains however on the handling of complaints as defined by the National Health Service Complaints (England) (Amendment) Regulations 2009 (No. 1768).

1.2 Scope

The policy applies to all staff employed by the Trust and the users of its services.
This policy incorporates guidance from the Local Authority Social Services and National Health Service Complaints (England) (Amendment) Regulations 2009 (No. 1768), the NHS Bodies and Local Authorities Regulations 2012and the Health Service Ombudsman principles of good practice.

All feedback will be handled in accordance with the Department of Health and Health Service Ombudsman guidance and in keeping with a philosophy for continuous improvement. Feedback will be considered thoroughly and objectively with findings shared in an open, honest and timely manner in accordance with the Being Open Policy.

1.3 Definitions

Making Experiences Count encompasses 4 types of Feedback (the 4C's):
Compliments
Comments
Concerns
Complaints

The established definition of a complaint used within the NHS is *"any expression of dissatisfaction requiring investigation and response".* The regulations state that any issues raised which are resolved within 1 working day fall outside the remit of the regulations. Any contacts falling out with these definitions do not need to be handled in accordance with the National Health Service Complaints (England) (Amendment) Regulations 2009 (No. 1768). This information will be taken into account however, as part of our openness to all feedback and commitment to continually improving our services.

The Health Service Ombudsman has applied six principles to good complaint handling:
Getting it right
Being customer focused
Being open and accountable
Acting fairly and proportionately
Putting things right
Seeking continuous improvement

2. POLICY

2.1 Background

The Trust has legal and statutory obligations to record and report certain defined incidents as set out in the Identification, Reporting and Management of incidents including SIRIs Policy ("the Incident Policy")

If the issue is sufficiently serious, or front line staff are unable to resolve it, staff are encouraged to seek assistance within office hours from their manager in the first instance, members of the Quality of Care Team in their area, the Patient Experience Team (01423 555499) or to telephone the Head of Risk Management (01423 554436). Out of hours, staff should contact the Site Coordinator (hospital bleep 2005) or hospital chaplain. Staff should also consider if the matter requires escalation to the senior manager or director on call when responding to the needs of distressed relatives.

The contact must raise their issues with the Trust either verbally or in writing, with the emphasis on local resolution by the Trust. Issues can be raised via telephone, email, letter, social media, comment form, or in person.

There is a Patient Experience Team (PET) across the Trust and additional support is provided via Patient Experience Volunteers (PEV) at Harrogate District Hospital Reception. Front line staff, departmental managers and matrons also identify potential issues and address them before they escalate. Leaflets and posters are in

each department and there is information on the Trust website on how to give feedback and raise concerns.

The PET assess each case with input where necessary from the Patient Safety Manager and Head of Risk Management. To assist this assessment the issue is graded to identify the severity of the concern being raised and the level of investigation that is necessary as well as the internal and external reporting requirements. The grading matrix can be seen in Appendix V. Local resolution may, for example, be achieved by means of a written investigation, meeting with staff or a telephone call.

There is an obligation under the Duty of Candour statutory requirement to follow a set process where a 'Notifiable Safety Incident' has occurred. These processes reflect the legal statutory duty of candour.

The Duty of Candour Requirements involve:

Recognising when an incident occurs that impacts on a patient in terms of harm;
Acknowledging when things go wrong;
Notifying the patient in person (wherever possible), explaining that something unintentional or unexpected has occurred and providing a true account of what happened;
Apologising to the patient and / or representative
Conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring in accordance with the Incident Policy
Ensuring the patient, families and carers are kept informed during the investigative process;
Keeping proper records of all steps in the process and sending a written notification to the patient
Supporting those involved to cope with the physical and psychological consequences of what happened in accordance with the Investigations, Learning and Supporting Staff Policy.

Further detail on Duty of Candour and the process to follow can be found in the Being Open and Duty of Candour Policy.

Any case identified as a complaint follows the process in the next section.

2.2 Process for green & yellow complaints

Flow chart for green / yellow complaints

Day 0-3

- PET to collect letters at agreed time from Chief Executive's CE Office. Check PET emails, telephone messages, comment forms, social media. PET to grade with input from Patient Safety Manager / Head of Risk Management (PSM/HoRM)as appropriate.
- Copy letters / complaint details as necessary to HoRM/PSM/CE/Chief Nurse / Medical Director
- PET complaint file created. Log case on Datix and database . Update PET whiteboard with complaint name / reference and response date
- All complaints must be acknowledged within 3 working days by PET Officer on triage.
- Email to Directorate Governance Lead to ascertain name of Lead Investigator.

Day 3

Lead Investigator in Directorate to have already triaged **by** Day 3

Lead Investigator to undertake investigation using electronic toolkit. Investigation to include

File note of triage conversation plus a file note of any subsequent contact with complainant

Statements / interview notes

Supporting evidence from investigation such as policies, protocols, photographs, patient information leaflets, rosters etc

Completed action plan (for upheld complaints)

Investigation report / meeting notes

Day 15

Investigation and all supporting documentation to be submitted to the Governance Lead for the Quality Assurance (QA) process.

Operational Director with input from the Clinical Lead as appropriate to QA the investigation and complete the QA checklist

Day 20

- Full investigation and all supporting documentation, including
  - QA checklist
  - Completed action plan (for upheld complaints)
  - File note of triage conversation plus a file note of any subsequent contact with complainant
  - Statements / interview notes
  - Supporting evidence from investigation such as policies, protocols, photographs, patient information leaflets, rosters etc
  - Meeting notes

To be sent electronically to the PET inbox

Clarification of Response

Day 20-25

- Draft report and any covering letter to be reviewed by PET and then checked by Head of Risk Management or deputy (and Chief Nurse/Medical Director/CORM if appropriate

Day 25- USUAL RESPONSE DEADLINE *NB unless amber or red complaint – see separate flow chart below for details*

- Draft report or draft meeting notes with cover letter from PET to be sent to the complainant and any identified advocate seeking early contact from them to determine if issues resolved. Advise final response will be sent in 15 working days if no comments received

Day 40 RESPONSE CLARIFICATION CHECK

- Review if case can be closed and final letter confirming resolution complete sent from CE with report / meeting notes marked final.
- If complainant unhappy with report / meeting notes PET to agree next steps in conjunction with the Governance Lead
- Further investigation, clarification may be required in conjunction with a further report or meeting

Day 50

Amended report or draft meeting notes to be provided for QA via PET or Medical Director or Chief Nurse

Day 55

Draft report or draft meeting notes with cover letter from PET to be sent to complainant and any identified advocate seeking early contact to determine resolution

Day 70

Final closure letter from CE unless complainant wishes further action / resolution

Final actions for Governance Leads

Log actions on Datix

Share final draft with staff involved

Share key learning across Directorate & with Governance Leads in other Directorates

Final actions for PET

Perform QA of coding on Datix

Close case on Datix and Database

Close file and ensure all documents scanned to electronic folder on shared drive

2.3 Process for amber and red complaints

Flow chart for amber / red complaints

Day 0-5

- When a serious complaint is received it should be shared with the HORM /PSM immediately
- Circulate copy of complaint by email to CORM & to the Governance Lead / OD / CD in the Directorate
- If a the complaint is a potential SIRI a 72 hour real time manager report should be obtained from the Directorate via the Governance Lead to facilitate discussion at CORM
- Formal written acknowledgement of the complaint by the Chief Executive to be prepared by the PET **by Day 3**
- Governance Lead to request / gather statements from staff involved in complaint
- Complaint is discussed at CORM and grading confirmed and a Lead Investigator appointed – this may be outwith the Directorate involved. CORM will decide in any external expert input is required and make the necessary arrangements. If complaint is graded red CCG & Monitor should be informed

Day 5

Lead Investigator to triage complaint – statements forwarded by Governance Lead to assist

Lead Investigator to undertake investigation using electronic toolkit. Investigation to include

File note of triage conversation plus a file note of any subsequent contact with complainant

Statements / interview notes

Supporting evidence from investigation such as policies, protocols, photographs, patient information leaflets, rosters etc

Completed action plan (for upheld complaints)

Investigation report / meeting notes

Day 50-55 (amber) / Day 80-85 (red)

Full investigation and all supporting documentation, including

- Completed action plan (for upheld complaints)
- File note of triage conversation plus a file note of any subsequent contact with complainant
- Statements / interview notes
- Supporting evidence from investigation such as policies, protocols, photographs, patient information leaflets, rosters etc
- Meeting notes

To be sent electronically to the PET inbox. This will then be circulated to CORM for the Quality Assurance (QA) process.

- Lead investigator to attend CORM to discuss investigation findings.Draft report and any covering letter to be reviewed by PET and then checked by Head of Risk Management or deputy (and Chief Nurse/Medical Director/CORM if appropriate

Clarification of Response

Day 60 (amber) / Day 90 (red) USUAL RESPONSE DEADLINE

- Draft report or draft meeting notes with cover letter from PET to be sent to the complainant and any identified advocate seeking early contact to determine if issues resolved. Offer of a meeting with Medical Director / Chief Nurse in addition to Lead Investigator is usually provided

Day 75 (amber) / Day 105 (red) RESPONSE CLARIFICATION CHECK

- Review if case can be closed and final letter confirming resolution complete sent from CE with report / meeting notes marked final.
- If complainant unhappy with report / meeting notes PET to agree next steps in conjunction with CORM
- Further investigation, clarification may be required in conjunction with a further report or meeting

Day 85 (amber) / Day 115 (red)

Amended report or draft meeting notes to be provided for QA via CORM or Medical Director or Chief Nurse

Day 90 (amber) / Day 120 (red)

Draft report or draft meeting notes with cover letter from PET to be sent to complainant and any identified advocate seeking early contact to determine resolution

Day 105 (amber) / Day 135 (red)

Final closure letter from CE unless complainant wishes further action / resolution

Final actions for Governance Leads

Log actions on Datix
Share final draft with staff involved
Share key learning across Directorate & with Governance Leads in other Directorates

Final actions for PET

Perform QA of coding on Datix
Close case on Datix and Database

A suggested list of options for resolution is shown below:-

Verbal apology from service (on telephone or face to face)
Telephone call with management (Matron / Head of Department) to discuss concerns and obtain verbal feedback
Written apology from service
Forum for giving feedback to relevant staff
User group meeting
Use of concern in case study in professional forum
Meeting with staff involved (e.g. consultant)
Directorate investigation report

Financial recompense for out of pocket expenses
Meeting with management (Matron / Head of Department / OD / General Manager) facilitated by Patient Experience Officer
Formal root cause analysis (RCA) by the team involved
Formal RCA out with the Directorate involved
External expert opinion / review
Investigation by Commissioner
Telephone call / meeting with the Chief Executive / Chairman/Other Director e.g. Chief Nurse, Medical Director
Pass to relevant professional group e.g. HR

2.4 Process for complaints that involve a Public Health function

Currently the Trust provides a number of public health services on behalf of the Local Authority (LA). These include the 0-19 services (health visiting and school nursing), Child Health Information Service (CHIS), 4 Speech and Language Therapy staff involved in the No Wrong Door Project (https://www.northyorks.gov.uk/no-wrong-door) and the Oral Health Promotion Service.

When a complaint is made to the Trust regarding any of the above services the relevant LA must be notified by a member of the patient experience team. The patient experience team will share a copy of the complaint with the LA via file protected email when it is first received, and then when the final report is agreed with the complainant a copy will be forwarded to the LA by the patient experience team. As part of the final response the PET will ensure that the appropriate next stage of the complaints process is referenced (see section 2.14).

2.5 Who can use the MEC procedures

Feedback may be received from existing or former patients who have used the Trust's services and facilities, as well as relatives, carers and visitors. Members of hospital staff and other health professionals including the General Practitioner may also make representations about aspects of patients care. Suggestions for improvement are followed through and actioned.

Often patients may approach the Trust Governors to give feedback about their experiences. It is important for the Governors to advise patients they will be passing on the issues to the Patient Experience Team to make contact with the patient direct.

If the person is not a patient, but is raising issues on behalf of a patient, it is important to check that the patient knows about this and has given consent. The person must be told that, in order not to be in breach of patient confidentiality, any matters relating to the patient's care and treatment can only be answered with the patient's consent. In exceptional cases, where the complaint is graded yellow, amber or red, CORM will determine what investigation can proceed without consent and what, if anything is disclosed.

Relatives or others making representations on behalf of patients will need to have consent from the patient in writing unless the issue is dealt with as a concern and is raised verbally. In these instances verbal consent will be obtained from the patient

and documented on Datix. For cases handled as a complaint, the patient will sign to confirm their agreement to a reply being sent to the person who raised the issue. If the patient is unable to act for him or herself, the Trust will take reasonable steps to ensure that the contact is an appropriate person to receive information. In any event, if there is no signed consent from the patient as to what personal information can be passed on, there is a greater limitation on the content of the Trust's response.

Where a representation is made on behalf of a patient who has died, the Trust will check that the person raising the issue is the deceased patient's Personal Representative (i.e an executor if there is a will or administrator under the relevant statutory provisions on intestacy if there is no Will). Where this is not the case, the consent of the Personal Representative will be sought in writing.

2.5.1 Management of complaints also involving civil litigation

The Department of Health have clarified the situation with regard to the coexisting investigations of a complaint via the Complaints Regulations 2009 and civil litigation by means of a circular released in February 2010.

On receipt of a complaint in which legal action has already been started or is being contemplated, it is good practice for discussions to take place with the relevant authorities (for example, local legal advisors or the NHS Litigation Authority) to determine whether progressing the complaint might prejudice subsequent legal action. The complaint should be put on hold only if this is so, with the complainant being advised of this and given an explanation.

The default position in cases where the complainant has expressed an intention to take legal proceedings is to resolve the complaint unless there are clear legal reasons not to do so. In such a situation advice must be sought from the Head of Risk Management / Deputy.

2.6 Time limits

There is no time limit for giving feedback to the Trust for those issues which fall outside the Complaints Regulations. All feedback will be received and acted upon wherever possible to ensure learning and improvement for the organisation. Where the issue is coded as a complaint the regulations set a time limit of 12 months from the event or awareness of the event for making the complaint. The Trust however adopts a flexible attitude to complaints about incidents occurring outside this timescale.

2.7 Confidentiality

Patient confidentiality will be respected throughout the MEC process. All records pertaining to contacts will be kept confidential and completely separate from patient records.

A contact made by a third party requires valid consent by the patient as detailed in section 2.2. Any clinical information about the patient is confined to that which is relevant to the investigation of the complaint and is only disclosed to those who have a need to know. Should the contact request any copies of the patient's Medical Record, these should be requested in writing and provided by the Medical Records Access Officer at no cost to the contact.

The MEC records must not be filed in the medical notes.

Under no circumstances must a patient, their relative or carer be discriminated against during or after raising a concern. The patient's dignity and respect must be maintained at all times throughout any investigation and the individual involved must be treated with dignity and respect throughout the process.

Staff reports and statements will be kept confidential within the MEC process except when necessary to implement improvements to procedures. Staff should be aware, however, that their reports and any covering letters, will not be legally privileged, and may be disclosed to the patient or their representative and his/her solicitor if the complaint is pursued as a legal claim against the Trust. Reports should therefore be clear, accurate and factual without opinion.

2.8 Patient Experience Team

2.8.1 Compliments

Compliments received by the Chief Executive or Chairman, via email to the Patient Experience inbox or on Patient Experience comments forms will be shared with the appropriate staff. An acknowledgement will be sent and the numbers collated and included in the quarterly Patient Experience Report to the Learning from Patient Experience Group (LPEG). The detail of the compliments should be used by the Directorates to share good practice between wards and departments.

2.8.2 Comments

With the assistance of Patient Experience Volunteers, comments will be passed on to the relevant staff for consideration. Feedback will be provided to the contact based on their wishes e.g. written response, verbal feedback from department involved. The number of comments will be collated and presented in the quarterly report to LPEG. Directorates are expected to act on the themes from comments to ensure learning. The Patient Experience Team will also highlight in real time to the Directorates if a common issue or theme is identified from the comments to enable timely action to be taken where appropriate.

2.8.3 Publicity

The Trust will ensure that the right to give feedback, advice on how to use the MEC procedure and help available from Local Advocacy Services is well publicised to all users of our services, visitors and staff. Information will include the right to request a review from the Health Service Ombudsman or the Local Government Ombudsman where the complaint is about a Public Health Service. The Trust has developed a strategy for ensuring that information regarding Making Experiences Count is widely available to Patients and the Public. This includes the following:

Posters and leaflet
Media / press release
Website information
Trust news and members newsletter

Hospital radio
Social Media

The MEC policy is accessible on the intranet and will be cascaded to all staff via the Operational Directors and Heads of Departments.

2.9 Involvement of external organisations

Where a complaint involves the Trust and a CCG, or other Trusts, Yorkshire Ambulance Service, Harrogate Borough Council, North Yorkshire County Council or Social Services, a joint response will be provided. The Trust will liaise with the appropriate lead at the organisation and decide who will coordinate the response and seek consent from the contact with regard to providing a joint response and sharing information between organisations. The individuals will ensure that between them they address all matter of concerns. A joint protocol is detailed in Appendix III.

2.10 Serious Complaints

Where a complaint is graded as yellow, amber or red or where there are serious risk management implications, the Patient Experience Officer will refer to the Head of Risk Management / Deputy to ensure appropriate action is taken in relation to any ongoing patient care or incident investigation. Please refer to the Grading Matrix at Appendix V.

The following criteria will be used as a guide to identify those issues which should be escalated to the Head of Risk Management:

- Allegations of clinical negligence
- Allegations of staff assault or incidents of similar seriousness
- Serious nursing and medical complaints where the patient is still currently an inpatient
- Situations where a patient known to the Trust (identifiable via Datix) is already being dealt with by the Department of Risk Management e.g. Coroner's Inquest, Clinical Negligence, SI

The issue will be taken to the next Complaints and Risk Management Group (CORM) in accordance with the Incidents Policy However there will be no delay in escalating the issues as appropriate to a member of the CORM group in the meantime. For such complaints, a root cause analysis of the case will be carried out by the investigating officer. The organisation has clear guidance on investigation and root cause analysis. Further information is also available in the Investigations, Learning and Supporting Policy.

2.11 Action plans

Action plans are considered by the Directorates for each complaint which is raised. Action plans are required for all issues that have been upheld following investigation and quality assurance by the directorate. These are logged on Datix by the Governance Lead in the Directorates and updates on progress against the actions identified are the responsibility of the Governance Leads. Complaint trends and action plans, including those developed in response to Health Service Ombudsman or Local Government Ombudsman reviews will be reported to LPEG on a quarterly

basis. At the Directorate Governance Meetings regular trend reports are shared including feedback of actions taken in response to identified themes.

For each complaint that is upheld the Directorate consider what the top key messages for learning are. These key messages are uploaded by the Governance Leads to the shared Governance drive to enable sharing of learning across the Directorates.

2.12 Habitual and vexatious complainants

The Trust has a procedure for dealing with complainants who are habitual or vexatious (Appendix III)

2.13 Advocacy Services

Advocacy Services continue to have an important role in assisting patients to put forward feedback. The Trust recognises that for some patients the involvement and support provided by Advocacy Services can often be a helpful part of facilitating a resolution. As such the role of Advocacy will be explained to contacts when they contact the Patient Experience Team. At present Independent Health Complaints Advocacy Service is the Advocacy Service for complainants living in North Yorkshire. A list of all the Advocacy service providers in the country is available from the PET.

Where complaints are received via a representative of the patient such as an Advocacy Service, Member of Parliament or General Practitioner, a response will be sent to them directly with a copy to the patient unless requested otherwise.

2.14 Parliamentary & Health Service Ombudsman and Local Government Ombudsman

If the complainant remains dissatisfied following receipt of the Chief Executive's letter the complainant has the right to request the Parliamentary & Health Service Ombudsman (PHSO) to review their case where it concerns health care. For those complaints either wholly or in part related to Public Health (see section 2.4) the complainant has the right to request the Local Government Ombudsman (LGO) review their case. This request must be made within 12 months of the initial concern unless there are extenuating circumstances. The PHSO / LGO will only consider investigating if the complaint has already undergone local resolution by the Trust. Each final response has a summary of information in relation to contacting the relevant Ombudsman. Complainants are encouraged to advise the Trust if they are still unhappy to enable further discussion regarding options for local resolution.

The Head of Risk Management / Deputy will be informed of all cases that have been referred to the Ombudsman for review. The Head of Risk Management / Deputy will appoint a member of the Risk & Patient Experience Team to make copies of relevant correspondence for the Ombudsman and assist in their enquiries. Datix will be updated to reflect that the Ombudsman is involved in the case.

2.15 Recording of feedback and computer held records

All concerns and complaints will be logged on Datix by the Patient Experience Officer / Patient Experience Administrative Officer. The Patient Experience Officer is also responsible for keeping the record updated and entering subject codes in line with the MEC logging guide. Letters and correspondence will be scanned into Datix when the case is closed for all contacts that have not undergone a Directorate Investigation.

A complaint file will be opened for each issue coded as a complaint. This will be held in the Department of Risk Management. An electronic folder will available to the Investigating Officer who will populate the relevant information at the end of the investigation. The complaints file will include:

- The original complaint
- A copy of the acknowledgement letter from the Chief Executive stating timescale for response
- Individual resolution plan / investigation plan
- File notes of telephone calls or discussion regarding the complaint
- Complaint report and covering letter
- Supporting evidence (statements, interview summaries, meeting notes, policies, protocols etc) NB this will also include any audio recording of the meeting.
- A quality assurance of the complaint investigation signed by the directorate
- A completed action plan (for upheld complaints)

All files will be kept for 10 years.

NB: Although the Department of Health reduced the statutory timescale to 8 years, any complaint which is involved in a claim must be retained for 10 years, therefore for ease all files will be retained for 10 years.

All emailed responses or accounts will be password protected and draft versions deleted by the receiver and sender (staff members only).

3. ROLES AND RESPONSIBILITIES

3.1 Responsibility of the Chief Executive

The Chief Executive is ultimately responsible for ensuring that all complaints are dealt with effectively. The Chief Executive signs all final responses to complaints and compliments.

3.2 Responsibility of the Board of Directors

The Executive Director (Medical Director or Chief Nurse) ensures that arrangements are in place for the management and monitoring of complaints and that areas of concern are reported to the Board of Directors as well as actions taken.

3.3 Responsibility of the Medical Director and Chief Nurse

The Medical Director and Chief Nurse are the designated Board of Directors members responsible for compliance with the MEC procedure.

3.4 Responsibility of the Learning from Experience Group

Reporting to the Senior Management Team (SMT) and in turn the Board, the group provides assurance that the MEC functions and other Trust systems for monitoring patient experience are working satisfactorily. LPEG review trends from MEC and report to SMT.

3.5 Responsibility of the Complaints and Risk Management Group (CORM)

The Group meets weekly to review incidents and near misses within the Trust and reports to outside agencies and also reviews serious complaints.

3.6 Responsibility of the Department of Risk Management & Patient Experience

The Department of Risk Management & Patient Experience includes the Head of Risk Management who is the Trust's designated Complaints Manager and is accountable to the Medical Director. This post, alongside the Chief Nurse, oversees the implementation of the MEC procedure and ensures effective investigation and handling of feedback. This includes collating information and responding to requests and recommendations for action from the Health Service or Local Government Ombudsman. The post holder also ensures that relevant data and statistics are recorded and reported.

The Patient Experience Team receive patient feedback and handle in accordance with this policy. They will ensure sufficient documentation is provided to the LA to support their corporate complaints process for complaints involving public health.

3.7 Responsibility of Clinical and Operational Directors

The Operational Director is responsible for the process within their Directorate and ensuring that appropriate Quality Assurance of each response is provided when a Directorate Investigation is undertaken. They will identify Investigating Officers for the investigation of complaints and designated complaint leads for the implementation of the MEC procedure through close liaison with the Department of Risk Management and ensure that all staff are aware of their responsibility in the investigation and resolution of concerns and complaints. Guidance on how to undertake an investigation is provided in the Investigations, Learning and Supporting Policy.

The Clinical Director is accountable for ensuring that there is a robust system within their Directorate for receiving and responding to feedback including how learning is shared both within and across the Directorates.

The Operational Director will ensure that trends and themes from feedback are shared and discussed at the Quality of Care Team meetings.

Investigating Officers will be responsible for

- Liaising with the Patient Experience Team during the investigation of a concern / complaint.
- Gathering all relevant information & obtaining statements.
- Communicating with complainants within 3 working days.
- Liaising with other staff members as part of the investigation

- Conducting root cause analyses as part of the investigation.
- Maintaining accurate records of all information including file notes, records of meetings etc.
- Co-ordinating information across Corporate and Clinical Directorates and departments as necessary.
- Providing an investigative report (overview), accompanying statements, protocols or other evidence.
- Developing action plans to take forward any identified improvements arising from the complaint.

Governance Leads will be responsible for

- Monitoring compliance with action plans.
- Ensuring that staff are given the necessary support, training and information to resolve patient concerns. See the Investigations, Learning and Supporting Policy for further details
- Ensuring quality assurance of investigative reports is obtained and completed by the appropriate directorate management lead.
- Ensure complaint correspondence is not held on the clinic record and is destroyed in accordance with this policy.
- Escalating any delay in response or difficulty in meeting the pre-agreed deadline to the Head of Risk Management. In some cases extensions may be sought but only with the agreement of the Head of Risk Management or Deputy.

3.8 Responsibility of the Governors

It is recognised that the Governors are a key focal point for members of the public. The Governors will advise the public to contact the Patient Experience Team if they have any issues that they wish to raise about either the care they have experienced or that of a friend or a relative. The Governors are responsible for ensuring that the public are aware of this route in to give feedback and advising the public that it is not appropriate for the Governors to pass on specific patient concerns / complaints as these should wherever possible be made direct to the Patient Experience Team or other front line members of Trust staff.

Prompt referral to, and intervention by the Patient Experience Team will resolve as many issues as possible in a timely manner.

3.9 All Staff

All staff must be able to access this policy on the intranet and comply with the principles within it. All Staff are encouraged to adopt a positive attitude to all feedback including complaints as it is recognised that this information is vital in improving the services that we offer.

4. POLICY DEVELOPMENT

This policy was developed following wide consultation. It has undergone Stage 1 Equality Impact Assessment screening. It does not require a full Stage 2 Equality Impact Assessment

5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

All operational directors, clinical directors, executive directors and others as detailed in Appendix II have been consulted during the revision of this policy.

The Learning from Patient Experience Group will approve and ratify this policy.
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6. DOCUMENT CONTROL

This will be an open policy and accessible via the intranet.

The author will in conjunction with the intranet administrator be responsible for ensuring archiving of replaced electronic versions within the electronic document library, as evidence of previous policy.

Copies of policy documents should not be printed unless it is absolutely necessary, to reduce the risk that out of date copies may be in circulation. Requests for this policy in an alternative language or format (such as Braille, audiotape, large print etc) will be considered and obtained whenever possible

7. DISSEMINATION AND IMPLEMENTATION

7.1 Dissemination and Communication

A “publish and point” method of communication will be used, where relevant staff are informed about the publication of a new or revised document on the intranet and pointed to the location of that document.

The directorates will also be responsible for informing staff of the policy.

7.2 Implementation

This policy is a reference document. Relevant staff will be made aware of its existence and pointed to it for reference via staff induction, induction handbook, risk management training programme, case conferences and other risk management briefings.

7.2.1 Training & Support

To ensure the successful implementation and maintenance of the Trust’s approach to Making Experience Count, all staff will be appropriately trained in receiving and handling patient feedback. The Training Programme detailed clearly sets this out.

Each directorate have appointed a number of lead investigators to take responsibility for investigating complaints. These staff have received bespoke Complaint Investigation Training and are supported by the PET. The Operational Directors will be responsible for ensuring appropriate staff, as described in the training needs analysis, undergo this training.

As well as support from their own line manager, support is always available to staff via any member of the Department of Risk and Patient Experience. Further information on supporting staff can be found in the Investigations, Learning and Supporting Policy.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

The Head of Risk Management, Medical Director and Chief Nurse have responsibility for ensuring appropriate monitoring / audit and reporting of results

8.1 Standards / Key Performance Indicators

Care Quality Commission (outcome 17)
People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

This is because providers who comply with the regulations will:

- Have systems in place to deal with comments and complaints, including providing people who use services with information about that system.
- Support people who use services or others acting on their behalf to make comments and complaints.
- Consider fully, respond appropriately and resolve, where possible, any comments and complaints.

Complaints Metrics

Metric	Detail
Response Times for complaints	95% of cases should meet the initial deadline set at the outset of the complaint
Number of complaints	Number of complaints compared with the average of complaints received the previous year. The IBR metric will be used (*Blue if number complaints in latest month is below LCL, Green if below HDFT average for 2016/17, Amber if above HDFT average for 2016/17, Red if above UCL. In addition, Red if a new red rated complaint received in latest quarter)*
Number of reopened complaints	The number of cases that that are re-opened as a % of the total. *NB we will now only be closing a complaint once dialogue between the complainant and the PET indicate that local resolution is complete and we have addressed their concerns. We will amend the process box to show those cases which have received a response but that we are currently in dialogue with regards their satisfaction with the response*
Number of concerns	Number of concerns resolved within 2 working days.

	An increase in this metric compared with a decreased in the number of complaints is our aim
Number of cases investigated by the PHSO / LGO	We will report this as a % of all complaints received
Number of cases upheld by the PHSO or LGO following investigation	Out of those cases accepted for investigation in current financial year by the PHSO / LGO the number that are found to be upheld will be reported. This again will be as a % of all complaints investigated by the PHSO / LGO
Number of Actions developed as a result of complaints and how many completed within target date	Visual representation of the number of actions completed within target date as a percentage. 100% of actions should be completed within deadline set
Measurement of the satisfaction of complainants	This will include the handling of the complaint as well as the response to the issues raised. It is likely that this will be measured as part of a survey and then this data will be represented graphically.

8.2 Process for Monitoring Compliance

8.2.1 Monitoring

The numbers & types of patient feedback will be recorded on the Datix Database and this information will be used to report back to LPEG on a quarterly basis regarding what feedback the Trust has received.

The 2009 Complaints Regulations state:

"18.—(1) Each responsible body must prepare an annual report for each year which must—
(a) specify the number of complaints which the responsible body received;
(b) specify the number of complaints which the responsible body decided were well-founded;
(c) specify the number of complaints which the responsible body has been informed have been referred to—
(i) the Health Service Commissioner to consider under the 1993 Act; or
(ii) the Local Commissioner to consider under the Local Government Act 1974; and
(d) summarise—
(i) the subject matter of complaints that the responsible body received;
(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints"

The annual report which is presented to LPEG in the summer must therefore cover all aspects above.

The Patient Experience Team will link with the Clinical Effectiveness and Audit Department to develop methods for measuring the satisfaction of complainants. This will be in the form of focus groups and verbal surveys

8.2.2 Feedback

Quarterly reports are shared with LPEG & SMT as well as directorates. A monthly complaints dashboard is presented to the SMT.
An annual monitoring report is submitted to LPEG.

The monitoring, audit and feedback process is summarised in section 11.2.

9. REFERENCE DOCUMENTS

Complaints Regulations 2009
NHS Bodies and Local Authorities Regulations 2012
Ombudsman Principles
DoH guidance – listening , responding improving

10. ASSOCIATED DOCUMENTATION

Being Open
Incidents Policy
Investigations, Learning and Supporting Policy

11. APPENDICES

Appendix 1: Consultation Summary
Appendix 2: Monitoring, Audit and Feedback Summary
Appendix 3 – Joint working protocol
Appendix 4 – Habitual & Vexatious Complaints Policy
Appendix 5 – Grading Matrix

Appendix 1: Consultation Summary

	List Groups and or Individuals Consulted
Those listed opposite have been consulted and comments/actions incorporated as required. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Learning from Patient Experience Group
	All Clinical Directors & Operational Directors
	Chief Nurse
	Senior Management Team
	Medical Director
	Governance Leads
	Clinical Effectiveness and NICE Manager

Appendix 2: Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Concerns with results escalated to
CQC Outcome 17	How many complaints have been received and how were they handled? How many complaints were well founded? What themes & actions have been identified?How many cases were referred to the Ombudsman	Dept of Governance	Quarterly	LPEG	LPEG
CQC Outcome 17	Do contacts feel discriminated against as a result of raising a concern/ complaint? Do contacts feel their concerns were listened to and did they receive an appropriate response?	PET / CEAD	Annually	LPEG	LPEG

Appendix 3 – Joint working protocol

Protocol for the Handling of Inter-Organisational Complaints

Introduction

It is intended that this protocol will be agreed and formally approved by local health and social care organisations across North Yorkshire. The protocol should ensure that complainants receive a seamless, effective service regardless of the organisations involved.

A number of appendices have also been attached. These include:

- A form confirming the names of the signatory organisations
- A consent form
- A form of authority (when the person making the complaint has been authorised to do so by the service user)
- A flowchart which aims to provide clarity about how inter-organisational complaints might be handled.

When seeking consent from the complainant the requirements of the Data Protection Act, Caldicott principles and the confidentiality policies of each signatory organisation must also be taken into account.

York and North Yorkshire

PROTOCOL FOR THE HANDLING OF LOCAL INTER-ORGANISATIONAL COMPLAINTS

Relevant Legislation

The Local Authority Social Services Complaints (England) Regulations 2006
Learning from Complaints (Department of Health 2006)
National Health Service (Complaints) Regulations 2004
National Health Service (Complaints) Amendment Regulations 2006
Supporting Staff, Improving Services (Department of Health 2006)
Data Protection Act 1998
Freedom of Information Act 2000
Human Rights Act 1998

1 Purpose

To ensure a commitment to high standards in the management of complaints so that that customers and patients who complain either to social services or to NHS bodies are provided with a prompt, systematic and consistent response.

- To avoid confusion for people about how complaints will be dealt with, and by whom;
- To provide clarity about the respective roles and responsibilities of organisations;
- To ensure enhancement co-operation in complaints handling between health and adult social care services;
- To clarify the responsibilities of health and adult social care services in complaints handling;

  To ensure regular and effective communication between Complaints Managers;

  To ensure that learning points arising from complaints, covering more than one body, are identified and addressed by each organisation.

2 The Role of the Complaints Manager

2.1 For each signatory organisation, the designated Complaints Manager is responsible for co-ordinating whatever actions are required or implied by this protocol.

2.2 To co-operate with other Complaints Managers and to agree who will take the lead role in inter-organisational complaints.

2.3 To clarify whom any requests should be addressed to when s/he is absent (through leave, illness etc).

2.4 In the unlikely event that Complaints Managers are unable to reach agreement about any matter covered by this protocol, they should each refer the matter promptly to the relevant Directors/Senior Managers in their respective organisations for resolution.

3 Factors to Determine the Lead Organisation

3.1 The following factors should be taken into account when determining which organisation will take the lead role with any inter-organisational complaint:

The organisation that manages integrated services;
The organisation that has the most serious complaints relating to it;
If a disproportionate number of the issues in the complaint relate to one organisation compared to the other organisation(s);
The organisation that originally receives the complaint (should the seriousness and number of complaints prove roughly equivalent);
If the complainant has a clear preference for which organisation takes the lead;
The organisations can agree separately from the above should other factors be pertinent. For example, if the impact on the individual organisation's governance arrangements.

4 Process

4.1 A flowchart which outlines the process to be used when dealing with inter-organisational complaints can be found in Appendix 7.

4.2 It is desirable, where possible, for all responses to be provided to the complainant as one joint response covering all areas of the complaint, or at least to be delivered within a single cover. The Complaints Managers will need to co-operate closely for this purpose, in agreement with the complainant.

5 Complaints about one organisation which are addressed to another organisation

5.1 On occasions a complaint which is concerned in its entirety with Social Services is sent to an NHS body, or vice versa. This may be due to lack of understanding about which body is responsible for which service, or because the complainant chooses to entrust the information to a professional person with whom s/he has a good relationship.

The Complaints Manager of the organisation receiving such a complaint should contact the complainant within three working days. They should advise them that the complaint has been addressed to the wrong organisation and ask if s/he wants it to be forwarded to the other organisation on their behalf. Providing the complainant consents, the complaint should be sent to the other organisation at once and a written acknowledgement should be sent to the complainant detailing where the letter has been sent and including the contact details.

6 Complainant's consent to the sharing of information between agencies

6.1 Nothing in this protocol removes the obligation to ensure that information relating to individual customers and patients is protected in line with the requirements of the Data Protection Act, Caldicott principles and the confidentiality policies of each signatory organisation. It is for this reason that the complainant's consent must always be sought before information relating to the complaint is passed between organisations. Moreover, the complainant is entitled to a full explanation of why his/her consent is being sought.

6.2 Consent to the passing on or sharing of information under this protocol should be obtained, in writing, wherever possible. Where this is not possible, the complainant's verbal consent should be recorded and logged.

6.3 If the complainant withholds consent to the complaint being passed to the other organisation, the Complaints Manager of the organisation receiving the complaint will seek to engage with him/her to resolve any issues or concerns about remit and responsibility and offer any liaison which could contribute to the resolution of the matter of concern. The complainant should be reminded of his/her entitlement to contact the other organisation direct.

6.4 The only circumstances in which a complainant's lack of consent could be overridden would arise if the complaint included information which needed to be passed on in accordance with Safeguarding Children or Protection of Vulnerable Adults procedures or other safety issues. In such cases, the complainant would be entitled to a full written explanation as to the agency's Duty of Care and its obligation to pass on the information.

6.5 A form is attached to this protocol as Appendix 2, which records the consent of complainants for their case records to be disclosed for the purpose of complaints investigations.

6.6 Close co-operation between Complaints Managers will be crucial in ensuring that confidential case-file information is shared appropriately, and that the necessary safeguards are put in place. Information

exchanged under this protocol must be used solely for the purpose for which it was obtained.

Complaint Grading Procedure

It will be the responsibility of the lead organisation to ensure that a comprehensive assessment is undertaken in order to assess the complaint and decide how this should be dealt with. This assessment will require communication with personnel in all affected organisations. Contact with staff from another organisation is to be made via the relevant complaints service.

When direct contact is made with the complainant then it is the responsibility of the individual undertaking the investigation to be satisfied with the information pertaining to the grading and make any necessary arrangements in response to any factors identified.

Serious Untoward Incidents

Complaints which include something which would otherwise be considered a serious untoward incident (SUI) due to risk or potential risk to service users or the organisation, should be dealt with through the organisations usual SUI procedures and the complainant informed how this will be progressed.

Learning from complaints

Each organisation will be responsible for ensuring lessons are learnt and service improvements are made in their own areas.

Where lessons need to be learnt jointly across organisations complaints managers should work together to ensure these lessons are learnt within both organisations.

All complaints services will use the process of at least quarterly and annual reporting to support effective communication between organisations

and share learning. These will include any findings and recommendations that have an inter-organisational impact.

Complaints activity will be reported separately by the complaints services in accordance with their own agreed procedures.

The lead partner, at the end of the process, should where possible send a questionnaire to the complainant to gain feedback on the process.

Appendix 1

Statement of consent for the disclosure of personal records

Complainant's Name: _____

Complainant's Address: _____

_____

_____

_____

Telephone Number: _____

I give my consent for _____ (Lead Organisation) to share any relevant information with the organisations listed below, in order to complete the investigation into my complaint. I also give permission for all organisations listed to look into and share relevant information from the customer/patients records.

_____ (Organisation)

_____ (Organisation)

This will assist the investigation of my joint-organisation complaint.

Name _____

Signature _____

Date: _____

Once completed, please return this consent form in the freepost envelope provided.

Appendix 2

Form of Authority

To be completed by the complainant

Complainant's Name: _____

Complainant's Address: _____

_____

_____

_____

Complainant's Tel. No.: _____

I, the above-named, give consent for

Name: _____

Address: _____

_____

_____

_____

Telephone: _____

to contact

_____ (Name of Complaints Manager) of

_____ (Organisation)

on my behalf, and for the complaints manager named above to discuss my complaint with him/her.

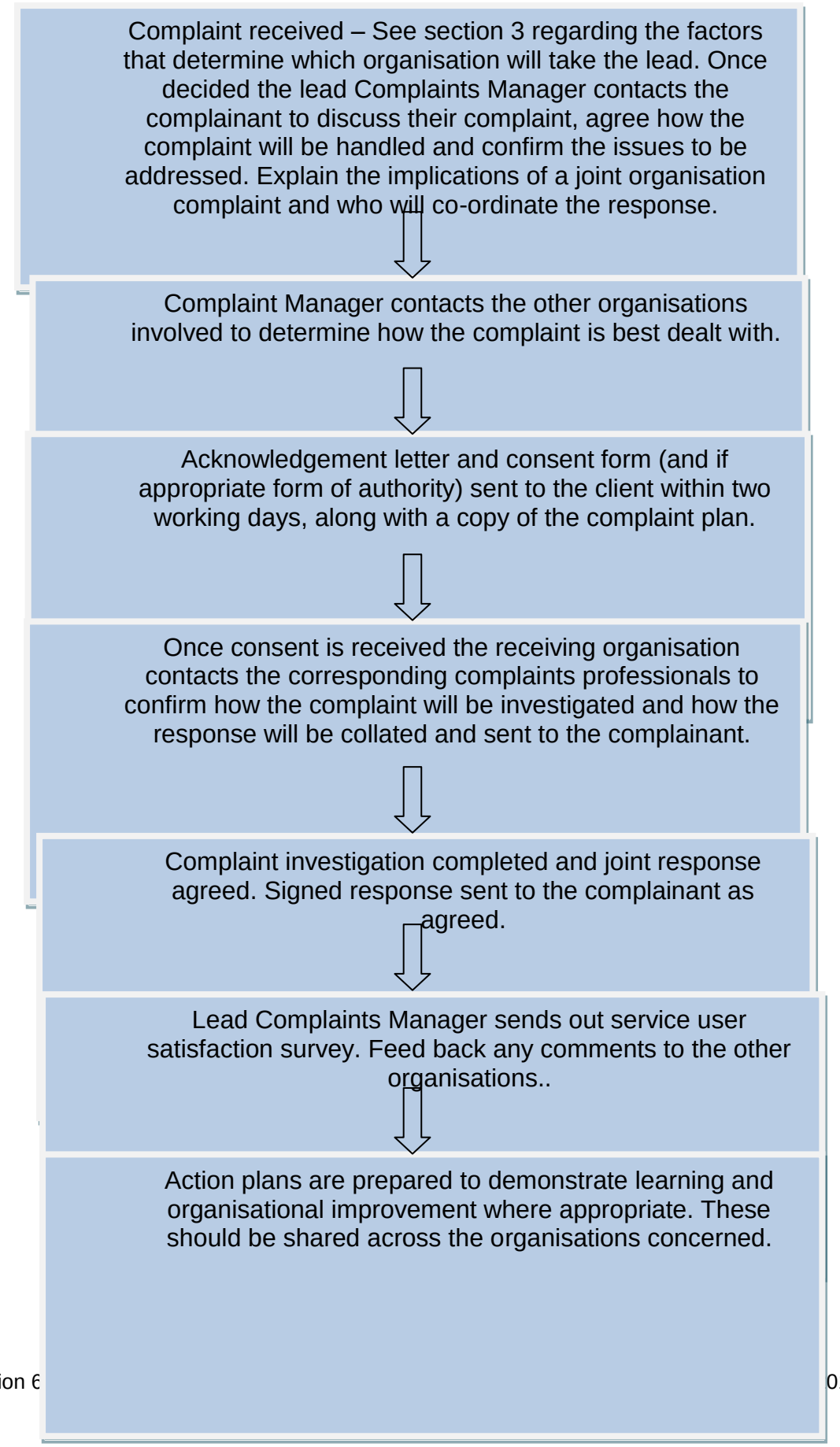
Signed: _____

Date: _____

Once completed, please return this consent form in the freepost envelope provided.

Appendix 3

Flowchart for the Handling of Joint Organisation Complaints



Appendix 4 Habitual & Vexatious Complaints Policy

INTRODUCTION

Complaints are processed in accordance with the Trust's complaints procedure and the Trust will make every effort to achieve a satisfactory outcome for each complainant. However a small number of complainants absorb a disproportionate amount of NHS resources in dealing with their complaints.

The Trust expects staff to respond with patience and sympathy to all complainants but recognises that handling habitual or vexatious complainants places a strain on time and resources and causes undue stress for staff. There are times when nothing further can reasonably be done to rectify a real or perceived problem.

There are two key considerations for handling such complaints:

- To ensure that the Trust's complaints procedure has been correctly and equitably implemented, as far as possible, and that no material element of a complaint has been overlooked or inadequately addressed.

- To identify the stage at which a complainant has become habitual or vexatious.

PURPOSE OF THIS PROCEDURE

The aims of this procedure are:

To identify situations where a complainant might be considered to be habitual or vexatious and to implement a procedure whereby they can be treated equitably and fairly.

To protect staff from the nuisance, abuse and threatened or actual harm which may be caused by such complainants.

The procedure outlined in this document will only be used as a last resort and after all reasonable measures have been taken to try and resolve complaints through the NHS complaints procedure.

Judgement and discretion must be used in applying the criteria to identify habitual or vexatious complainants and in deciding on the action to be taken in specific cases. If appropriate, clinical advice will be sought prior to implementing the procedure. The procedure will only be implemented following careful consideration by, and with the authorisation of, the Chairman and Chief Executive of the Trust or, their deputies in their absence. Where deputies are used, the reason for the non-availability of the Chairman or Chief Executive should be recorded on the file.

DEFINITION OF A HABITUAL OR VEXATIOUS COMPLAINANT

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 meet **TWO OR MORE** of the following criteria:

3.1

Where a complainant:

Persists in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (including where investigation has been denied as "out of time".

Seeks to prolong contact **by raising further concerns or questions** upon receipt of a response. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).

Is unwilling to accept documented evidence of treatment given as being factual, **or denies receipt** of an adequate response in spite of correspondence specifically answering their questions or **does not accept that facts can sometimes be difficult to verify** when a long period of time has elapsed.

Does not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Trust staff 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.

Focuses 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 is a 'trivial' matter can be subjective and careful judgement must be used in applying this criteria).

Has had, in the course of addressing the complaint, **an excessive number of contacts** with the Trust, placing unreasonable demands on staff time or resources. (A contact may be in person or by telephone, letter or fax). Judgement must be used in determining what is an "excessive number" of contacts and this will be based on the specific circumstances of each individual case.

Has **harassed** or been personally **abusive or verbally aggressive** on more than one occasion towards staff dealing with their complaint, their families or associates. However staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or illness.

Has **recorded** meetings or face-to-face/telephone **conversations without** the prior knowledge and **consent** of other parties involved.

Displays unreasonable demands or expectations and fails to accept that these may be unreasonable (e.g. insist on responses to complaints or

enquires being provided more urgently than is reasonable or normally recognised practice).

3.2

Complainants (and/or anyone on their behalf) may be deemed to be **vexatious** where current contact with them shows that they meet the following criteria:-

Has threatened or used actual physical violence towards staff, their families or associates. This will, of itself, cause personal contact with the complainant and /or their representatives to be discontinued and the complaint will, thereafter only be pursued through written communication. All such incidents will be documented on notification to the Medical Directorate Team.

OPTIONS FOR DEALING WITH HABITUAL OR VEXATIOUS COMPLAINTS

Where complainants have been identified as "habitual or vexatious" in accordance with the above criteria, the Chief Executive and Chairman (or appropriate deputies in their absence) will determine what action to take. The Chief Executive (or deputy) will implement such action and will notify complainants in writing of the action that has been taken and the reasons for it.

If appropriate under this procedure, notification may be copied for the information of others already involved in the complaint, e.g. General Practitioners, Patient Advocate, ICAS, Member of Parliament. A record will be kept of the reasons why a complainant has been classified as "habitual or vexatious". This will not be placed in the medical case notes but in the Medical Directorate Team Office.

Once classified as "habitual or vexatious", complaints will be dealt with as follows:

Stage 1

Once it is clear that complainants meet any of the criteria above, it may be appropriate to inform them, in writing that their conduct is unacceptable and that, if it continues, they may be classified as "habitual or vexatious" complainants. The letter should state clearly which elements of their behaviour are causing problems and be accompanied by a copy of this procedure. Complainants should also be advised to seek advice e.g. from their local ICAS, in presenting their complaint.

Stage 2

It may be appropriate to try and resolve matters by drawing up a signed agreement with the complainant and their advocate where appropriate, 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 will be given to implementing Stage 3 of the procedure.

Stage 3

Where the Trust has responded fully to the points raised in the complaint and has tried to resolve the issue, but there is nothing more to add and continuing contact on the matter would serve no useful purpose, the complainant will be notified that the correspondences is at an end and that further letters will be acknowledged but not answered.

In extreme cases, or where the safety of staff is at risk, complainants will be informed that the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors. All contact with the complainants and/or investigation of the complaint will be suspended whilst seeking legal advice or guidance from other relevant agencies.
The Chairman, Chief Executive or their Deputies, at their discretion, chooses to omit one or more of the above stages.

WITHDRAWING "HABITUAL OR VEXATIOUS" STATUS

Complainants can only be classified as "habitual or vexatious" with regard to pre-existing issues. New issues will be dealt with under the Trust's complaints procedure unless the unacceptable behaviour is repeated.

Where complainants have been determined as habitual or vexatious and their conduct improves; the status of "habitual or vexatious" can be withdrawn. However, staff should previously have used discretion in recommending "habitual or vexatious" status at the outset and discretion should similarly be used in recommending that this status should be withdrawn.

Where it appears to be appropriate to withdraw "habitual or vexatious" complainant status, the approval of the Chief Executive, Chairman or Deputies will be required. Subject to this approval, normal contact with the complainant and application of the NHS complaints procedure will be resumed.

Appendix 5-Grading Matrix

Rating	Type	Description	Level of investigation	Internal Reporting	External Reporting	Response*
1 White	**Concern**	Unsatisfactory service or issue easily resolved with simple action	**Line manager Matron**	LPEG		Within 2 days
2 Green *Low*	**Complaint** (*resolution plan in acknowledge letter & final response sign off by CE*)	Unsatisfactory service user experience related to care clinical or non clinical, minimal impact. No risk of litigation.	**Directorate**	LPEG & Q of C Teams Dashboard	Annual Korner return (Health and Social Care Information Centre (HSCIC))	Within 25 working days
3 Yellow *Moderate*		Unsatisfactory service user experience in several areas but not causing lasting problems. Some potential for litigation (if so refer to CORM).	**Directorate**	LPEG & Q of C Teams CORM Dashboard	Annual Korner return (HSCIC)	Up to 25 working days
4 Amber *High*	**Complaint** (*resolution plan / terms of reference sent to complainant to agree & final response sign off by CE*)	Significant issues of standards, quality of care, safeguarding, with quality assurance or serious risk management issues that may cause lasting problems or death. Possibility of litigation and adverse local publicity (refer to CORM)	**Consider Outwith Directorate involved** *(if SI concise or comprehensive RCA with external input)*	LPEG CORM Dashboard If SI= Board	Annual Korner return (HSCIC) Consider SI & CCG	Up to 60 working days
5 Red *Extreme*		Serious adverse incidents also raised as a complaint causing long-term damage or death such as criminal offence, gross substandard care or gross professional misconduct, multiple allegations of neglect resulting in serious harm or death.	**Outwith Directorate** Comprehensive RCA	LPEG CORM Dashboard **<u>Board</u>**	Annual Korner return (HSCIC) **<u>SI & CCG</u>** **<u>Monitor</u>**	Within 90 working days

***NB If a complaint is multi-agency or if the staff involved are absent the timescale may be negotiated with PET and the complainant. This should be agreed within 7 working days of the complaint**