Policy No. 014
Template Version: Mar 2025

COMPLAINTS POLICY

Originated by:	Director of Patient Care
Date Ratified:	Sept 2021
Ratified by:	Governance & Oversight Committee
Revised by:	Name: Sue Tunaley
Revision No. 009	Date: 13.2.25
Ratified by:	Clinical Policies & Procedures Group
Date ratified:	24.04.25
Date of next review:	01/01/2028
Document Owner:	Director of Care
Document Classification:	Internal

Revision Summary	Feb 2025: Policy and procedure revised as part of transition to complaints being added to Vantage.
Revision History	Revision 4: Sept 21 biannual review Revision 5: Dec 22 Amendment in line with NHS Complaints guidelines Revision 6: Mar 23 Title changes Revision 7: Sep 23 Extended 6 months due to PSIRF being introduced Revision 8: Mar 24 Extended 6 months due to PSIRF being introduced

Policy Statement

What is this policy intended to achieve?	To ensure that St Elizabeth has an effective and accessible system for identifying, receiving, handling and responding to all complaints, both clinical and non-clinical. To ensure that the complaints process is flexible and responsive to the needs of individual complainants and all complaints are investigated thoroughly. This will ensure that any necessary actions are taken to respond to failings and that this is done in a way that is open, transparent, fair and satisfactory to all parties involved. This will enable St Elizabeth to learn and improve the quality of care for patients, families and carers. This policy and procedure also describes a complainant's options should they remain unsatisfied at the conclusion of their complaint.

	All St Elizabeth staff should read and be aware of this policy so that they are able to log any complaints or concerns that they become aware of, using the Vantage system. This document will be made available to the public via the hospice website and updated as required.
To whom does this policy apply?	All staff should read and understand this policy and their responsibility for receiving and logging complaints.
Which locations does this policy apply to?	East Suffolk and GYW services. For ECCH see: managing-concerns-and-complaint-policy-v2-march-2024-final.pdf
Who should read this policy?	All Paid staff

DEFINITIONS The following definitions are intended to provide a brief explanation of the various terms used within this policy. **Term**	**Definition**
Complaint	Means an expression of dissatisfaction from a patient or carer about the care or service they (or the person for whom they care) have received. It will require investigation and usually a written response.
Complainant	For the sake of clarity, in this policy and procedure, a Complainant is anyone making a complaint or registering a concern. If the complaint made by a person is on behalf of somebody else, that latter person is the Person Affected.
Concern	Is a notification that an aspect of our service is, or might be, unsatisfactory; but not so much that the Complainant feels they, or a person they care for, has personally suffered as a result. A concern generally will not be serious or complex and can be addressed promptly with minimal intervention. It is unlikely to require a written response

Compliment	Is **an** unsolicited expression of praise or thanks received by a department or service in relation to the service, care or treatment provided.
Openness	Is enabling concerns and complaints to be raised freely without fear of recriminations and with a commitment to answer questions.
Transparency	Accurate information about performance and outcomes to be shared with staff, patients, the public and regulators.
Candour	Any patient harmed by a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made.
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission

General Principles

1. Anyone should be able to make a complaint or raise a concern with any member of staff, either verbally or in writing or via the hospice website. This includes third parties with no other involvement with St Elizabeth.
2. Concerns or complaints received anonymously should be dealt with as fully as practicable. When anonymity means the complaints or concern process cannot be applied fully, any exceptions or limitations should be documented and explained. Anonymity should never prejudice the credibility of a complaint or concern.
3. Consent to share details of the complaint with other providers, where necessary, will be sought from the complainant at the time we receive the complaint and confirmed in writing in the acknowledgement letter/email.
4. If the complainant is not the patient, then they must have authorisation, in writing, from the patient, or next of kin if the patient is deceased, to act on their behalf.
5. All complaints should be managed as quickly as possible and in accordance with national frameworks and this policy, which is 30 working days from receipt of the complaint. However, in exceptional circumstances this can be extended with the explicit agreement from the Director of Care and the complainant informed and updated with progress.
6. Staff are empowered to deal with complaints as they arise in an open and non-defensive manner.
7. The recording of complaints will be done via the Vantage complaints module.
8. The learning from complaints and concerns is identified and used for staff training and service improvement.
9. Staff and volunteers will be given support, if involved.
10. Confidentiality and data protection (GDPR) applies as normal.
11. St Elizabeth should ensure that guidance on how to raise a concern is made readily available to the public, patients, and carers. This should be done using the public website and in printed material displayed in St Elizabeth facilities and supplied to patients on referral or admission. Complainants should be fully supported to raise concerns or make complaints and this support may entail, for instance, advocates or interpreter services.
12. Any complaint we are made aware of will be recorded and investigated, regardless of whether the person making the complaint wants it to be official or taken further. Our explanation to the complainant is that we wish to learn from things that don't go well and make changes to improve where we can, and not because we wish to put blame on staff.

13. If a 'complaint' is quickly resolved, eg an apology is accepted or a change made, then it will be recorded as a concern and any learning or improvements still made.
14. Patients and families will be reassured that any future care will not be prejudiced

Responsibilities

Chief Executive Officer – has overall responsibility for concerns/complaints and fulfils the role of the responsible person under the CQC Regulations. In addition they will review any complaint where the complainant remains dissatisfied with the response or disputes the outcome of the investigation.

Director of Care – has responsibility within the hospice for clinical concerns/complaints.

Director of Income Generation and Marketing – has responsibility within the hospice for non-clinical concerns/complaints i.e. retail, fundraising and lottery.

Investigators – will be appointed by the Director of Care or the Director of Income Generation and Marketing. It is the responsibility of the nominated investigator to liaise with the staff concerned and gather the relevant information in relation to all elements of the complaint. The investigator will ensure that all documentation relevant to concerns and complaints is recorded on Vantage.

The investigator is responsible for drafting written responses to complaints and the relevant Director should approve any final responses.

A proactive approach to resolving the complaint is encouraged and should be taken wherever possible. This may involve telephoning the complainant or inviting them in for a meeting with the relevant staff. Home visits may be arranged where needed.

The investigator will ensure any member of staff about whom a complaint is made is advised of the final outcome. The staff member must be offered support by the investigator and any necessary support arranged.

The Incident Risk and Complaints Group (IRC) – oversees the timely and effective management of complaints related to care services.

Ensures that complaints are thoroughly investigated, learning and themes are identified and any resulting recommendations are actioned and evidenced.

Reviews complaints in detail, assuring quality of reports, investigations, mandating and monitoring actions, assessing trends and sharing learning.

Identifies a group of complaint investigators and ensures that they are appropriately trained and equipped to carry out the role.

Raising any risks identified as a result of its work to the Care and Clinical Governance risk register.

Ensures that follow up actions identified on the Action Log have a specific timeframe and responsible owner and they are carried out by their due date.

Ensures any extension to a response is discussed and agreed with the complainant.

Procedure

1. Initial responsibility for handling complaints and concerns resides with the individual staff member receiving them until such time as they are reported via Vantage. The Vantage system will automatically notify the relevant teams of the complaint or concern.
2. Staff should use common sense to respond to urgent concerns promptly and report them to their line manager. Urgent concerns must still be logged on Vantage with a full recording of any immediate actions taken.
3. Staff should establish at the outset the outcome that the complainant (s) is looking to achieve; be this an immediate remedy, an explanation or apology, a full investigation, a legal claim or a change to the organisation's policies. So far as this is proper and practicable we should strive to provide the outcome complainants desire.
4. Once the concern has been reported, the Incident, Risk and Complaints Group (IRC) has operational responsibility for managing care related concerns and complaints re patient services. This includes ensuring staff are sufficiently trained to receive, report and investigate concerns and complaints.
5. If the concern or complaint is related to retail, lottery or income generation it should be logged on Vantage as a non-clinical complaint and have the relevant notifications set up on Vantage.
6. Where possible the Investigator will make an initial call to the complainant and offer to meet with the complainant as well as explaining the process and time scales. The complainant should have an initial response within 72 hours from the responsible Director or their deputy, acknowledging the complaint and informing them of the process and when to expect a formal response. St Elizabeth Hospice will apply Duty of Candour principles whenever something goes wrong irrespective of the seriousness of the incident (refer to PSIRF policy).
7. If there is a possible issue regarding a staff member which could lead to a disciplinary action, the HR Team will be consulted, along with the manager of the member of staff.
8. The Investigator will gather and examine the evidence and make recommendations. The relevant Senior Leadership Team member (s) will agree the final response. This could be delivered through a meeting or by a written reply as agreed with the complainant.
9. If the complainant is not happy with the response they receive, the CEO or the Chair of Care and Clinical Governance committee will review the complaint in the first instance. If the complainant remains dissatisfied they should be given advice and assistance to refer their complaint to the NHS Suffolk and North East Essex Integrated Care Board (ICB) for their review. There are times where patients and/or their loved ones may remain dissatisfied and wish to have an independent review of their concern/s. In these circumstances you can then refer the complaint to the Parliamentary and Health Service Ombudsman (PHSO) to consider an independent investigation. You can contact the Ombudsman using these details:
   //www.ombudsman.org.uk/making-complaint *0345 015 4033*
10. If the complaint is referred to the ICB or PHSO St Elizabeth will cooperate fully with any ensuing investigation and will comply with any requirements that may result.
11. The IRC will ensure that an adequate record is made of all concerns and complaints, including all correspondence, investigation findings, outcomes and actions. Without exception, where no action is taken, the reasons for this should be recorded. All staff are expected to maintain the Vantage system.
12. The IRC will ensure compliance with all actions mandated in response to concerns and complaints.
13. At its discretion, the IRC may raise the status of any concern to a complaint, regardless of whether the person reporting the concern has requested this. In this event, the investigation process should place no additional undue burden on the complainant.

Complaints involving other organisations

When a complaint involves more than one health and social care organisation St Elizabeth has a duty to co-operate with those organisations to ensure full co-ordination of the handling and response to the complaint. Consideration must be given to patient confidentiality and consent before contacting another organisation and consent sought where appropriate. Where the concern is to be handled by another organisation, the IRC will request follow up to ensure the matter is resolved.

Consent must be obtained from the complainant to liaise directly with the other organisation, and it should be agreed if the complainant would like responses sent individually by the organisations or if they require a joint response. If a joint response is required discussion will take place with the other organisations involved to establish who will lead and co-ordinate the response.

The complaint investigation will follow the same process of investigations, as if the complaint had only involved St Elizabeth services.

Seeking continuous improvement

St Elizabeth should welcome concerns and complaints as an important source of feedback and an 'early warning of failures in service delivery'. Every concern or complaint is an opportunity to improve the quality of care for other people.

Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Actions taken should be documented on Vantage to demonstrate that the organisation has learnt from it. Where actions are taken, these should be evidenced rather than merely asserted.

The IRC shall have principal responsibility for monitoring care related complaints, looking for trends and identifying areas of risk. It will bring these to the attention of other clinical governance sub-groups as required. The IRC will produce quarterly reports for the Care and Clinical Governance Committee.

The IRC will also enforce compliance with complaints handling standards, having principal operational responsibility for ensuring investigations are timely and adequate, and actions mandated in response to concerns and complaints are monitored and completed, related to care only.

Persistent and unreasonable contact and unusual complaints

There are complainants who raise a number of concerns in a short space of time, repeat complaints with the same elements, or constantly bring new elements to the same complaint. This may be deemed persistent or unreasonable contact. On such occasions the Director of Care will decide whether the complainant's behavior would be considered unreasonable, and they will be written to and advised of the action to be taken.

A complainant's behaviour may be considered unreasonable if:

1. The complainant has threatened, has harassed or been abusive towards staff
2. The complainant continually makes unreasonable demands on staff
3. The complainant insists on speaking to a particular member of staff

4. The complainant frequently changes the substance of a complaint and prolongs contact by raising new issues during a complaint investigation
5. The complainant refuses to believe documented evidence given as factual and continues to contact staff following a complaint investigation
6. The complainant makes frequent phone calls or sends repeated communication re-iterating existing concerns.

Associated Policies and Procedures

- ECCH policy for complaints: managing-concerns-and-complaint-policy-v2-march-2024-final.pdf

Compliance with Statutory Requirements

The hospice will align with the NHS Constitution 2023. This complies with guidance from the Care Quality Commission, and Parliamentary and Health Service Ombudsman (PHSO)

Staff Training Requirements

All staff should receive training as part of their induction.

Monitoring (Including Audit) and Frequency of Review

Complaints and feedback will be monitored and audited by the Incident, Risk and Complaints Governance Group. Policy will be reviewed 3 yearly.

Data Protection

Does this Policy require sign off from the Data Protection Officer?	Yes	
DPO approved: Joshua Arden		Date: 07/03/25
DPO comments	Handling of data covered by GDPR. Explicit consent required for handling and sharing information.	

Equality Impact Assessment Initial Screening Tool

Document Reviewer(s):	Director of Care	Date Assessment Completed:	13.02.25

Assessment of possible adverse impact against any minority group			
Could the document have a significant negative impact on equality in relation to each area below?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Age		x	
2. Sex		x	
3. Disability		x	
4. Race or Ethnicity?	x		Complainant may be unable to read the document if English not their first language but can be translated.
5. Religion and Belief?		x	
6. Sexual Orientation?		x	
7. Pregnancy and Maternity?		x	
8. Gender Reassignment?		x	
9. Marriage and Civil Partnership?		x	

- You need to ask yourself:
- Will the document create any problems or barriers to any community or group?
- Will any group be excluded because of this document?
- If the answer to either of these questions is yes, you must complete a full Equality Impact Assessment.

Assessment of positive impact			
Could the document have a significant positive impact by reducing inequalities that already exist?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Promote equal opportunities		x	
2. Eliminate discrimination		x	
3. Eliminate harassment		x	

4. Promote positive attitudes towards disabled people		x	
5. Encourage participation by disabled people		x	
6. Consider more favourable treatment of disabled people		x	
7. Promote and protect human rights		x	

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality?

Positive	Please rate (delete as applicable) the level of impact					Negative
			NIL			

Is a full equality impact assessment required? No