Moorfields Eye Hospital NHS
NHS Foundation Trust

Complaints Policy

Policy Summary
This policy and procedures exist to ensure that there are effective arrangements in place to be compliant with statutory obligations and ensure the process is open and easily understood by all Trust staff and by anyone who may wish to make a complaint about any aspect of care and treatment provided by Moorfields Eye Hospital.

Version 4.3

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Version History

Version	Date Issued	Brief Summary of Change	Author
2.0	September 2008	Updated to clarify internal roles and responsibilities	Helen Tate/ Tracy Luckett
3.0	October 2009	Amended to reflect the changes to the NHS complaints procedure as made by The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	Helen Tate/ Tracy Luckett
4.0	November 2010	Amended to reflect the establishment of the new Learning from Experience Group Amendment to accurately reflect current monitoring processes	Helen Tate/ Tracy Luckett
4.1	November 2012	Amended to reflect the changes in title of certain Trust departments and staff	Helen Tate/ Tracy Luckett Kaajal Chotai
4.2	December 2014	Redrafted. Updated to include recommendations of Parliamentary report: 'A Review of the NHS Hospitals Complaints System: Putting patients back in the picture'	Tim Withers Marion Keys
4.3	November 2017	Amendment to divisional handling of complaints	Tim Withers Marion Keys

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Executive Summary

Moorfields Eye Hospital NHS Foundation Trust acknowledges the importance of managing complaints well in order to provide a caring and informative response to our patients and carers , and also to utilise the opportunity to learn how to improve our services.

This Complaints Policy sets out the trust's arrangements for the handling of patient concerns and complaints and ensures that we comply with the relevant legislation, namely the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 as well as to meet the recommendations set out in the parliamentary report: 'A Review of the NHS Hospitals Complaints System: Putting patients back in the picture' (2013).

The policy sets out the responsibilities of Moorfields staff for dealing with complaints and patient advice and liaison service (PALS) concerns, in order that they are dealt with efficiently, properly investigated, and where necessary, a timely and appropriate response is sent. Ultimately the aim is to resolve patient's issues to their satisfaction and improve quality and safety of care we provide.

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1.0 INTRODUCTION

For the majority of patients attending Moorfields Eye Hospital NHS Foundation Trust, the experience of care they receive is positive and greatly appreciated. However, on occasion the patient's expectations are not met and how the trust responds determines not only whether the individual ultimately sees an outcome they are satisfied with, but also whether the trust is able to learn and respond to what might have gone wrong.

In 2013 Robert Francis QC published his report into the failings of Mid Staffordshire NHS Foundation trust, noting that a complaints system that does not respond with promptness, flexibility and effectiveness to the justifiable concerns of patients not only allows poor practice to continue but undermines the trust the public have in the service provided.

As a result of the Francis report, a parliamentary review was commissioned to examine the NHS complaints system. 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' (2013) set out several recommendations which this policy has incorporated to support both patients and staff in achieving an honest and satisfactory resolution to our patients' or carers' concerns.

A complaint is an expression of dissatisfaction when expectations, even sometimes unreasonable ones, are not met. All users of our services have the right to complain. Complaints should be looked upon as a constructive method of gaining feedback on how users view our services. How we handle complaints, queries and concerns will affect our reputation with our users and the communities that we serve.

2.0 SCOPE

This policy applies to all Moorfields Eye Hospital NHS Foundation Trust employees and includes:

- Permanent staff
- Temporary staff
- Agency staff
- Interims
- Contract staff
- Sub-contracted staff
- Locums
- External contractors
- Volunteers
- Honorary staff
- Bank staff

3.0 PURPOSE

The purpose of the policy is as outlined below:

3.1 To outline the process whereby patients and their carers who have concerns about the care or treatment they are receiving or have received, can make a complaint and feel supported throughout the process when doing so.

3.2 To ensure that the process is transparent and honest with a focus on resolving the complainants' issue to their satisfaction.

3.3 To clarify for staff their role and expectation in addressing patient's concerns and complaints.

3.4 To identify ways in which local and organisational learning can take place as a result of the issues raised by patient complaints and concerns.

3.5 To outline a procedure that complies fully with the NHS Complaints Procedure.

3.6 To ensure that the complaints process at Moorfields takes into account recommendations outlined in 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' (2013).

3.7 To clarify the difference between the Patient Advice and Liaison Service (PALS) and the complaints function of the trust and to ensure that a degree of independence is evident for those who choose to follow the formal complaint route.

4.0 Policy

Standards to be achieved within this policy are defined by the Local Authority Social Services and National Health Complaints Regulations 2009.Consideration is also given to the recommendations relating to complaints handling as detailed in parliamentary report, 'A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture' (2013) and 'Designing good together: transforming hospital complaint handling: Parliamentary and Health Service Ombudsman' (2013).

This policy primarily refers only to NHS patients or NHS funded patients cared for whilst under the care of Moorfields Private or those private patients who have who have concerns about the aspects of their care that relate to Moorfields NHS service e.g. issues with NHS staff in theatre or Cumberlege Wing. However, Moorfields Private would be expected to manage their complaints within the broad outline of this policy appropriate to them.

4.1 Complaints Procedure: Immediate resolution

4.1.1 Potentially, any member of trust staff might receive a suggestion, criticism or a complaint from a patient or carer. In many cases the initial response can determine whether the situation is resolved immediately or goes on to become a more significant issue. Courtesy and an apology will make the patient or carer feel they are being taken seriously, even if the issues cannot be resolved immediately. When staff encounter someone who wants to make a complaint they should take responsibility for it and must be prepared to listen and try to resolve any issues at the time it arises. Every effort must be made to do so but, if unable to resolve it, they should escalate the issue to their line manager and divisional management team.

4.1.2 All issues that are handled and resolved at this immediate level must be reported to the line manager so that root causes might be addressed, and where necessary an incident form completed.

4.1.3 Where the complaint cannot be resolved, requires in depth investigation, a detailed written response, or the complainant wishes to speak to someone not involved with their treatment, a member of staff from the Patient Advice and Liaison Service should be contacted.

4.1.4 If a patient is referred to the PALS team, they (The PALS team) should be contacted beforehand and the patient escorted to the PALS office so that a better understanding of both sides of the issue might be obtained. Patients should not be sent to the PALS office by staff unaccompanied. If the patient is on the telephone, the patient's telephone number should be taken and the PALS team informed with a brief outline of the issue and why it could not be resolved immediately. The PALS team will then contact the patient. They should not transfer a call straight through to the PALS team without any prior introduction (See Moorfield's' Telephone Best Practice Policy including mobile phones' 2017).

4.2 Complaints Procedure: Resolution by the Patient Advice and Liaison Service (PALS)

4.2.1 The PALS team are based at the City Road site, though the service is promoted across the all trust network sites. The Moorefield's PALS team are readily accessible to the public to provide support and information for patients and their carers with questions or issues about the trust services and act as a liaison between them and trust staff.
They also provide a point of contact for patients with concerns should immediate resolution not be successful or appropriate. Patient concerns are received by letter, email, telephone and face to face. In all instances the PALS staff will attempt to contact the patient or carer to discuss their concerns the outcome they would like to see. Where possible they will resolve the issue by liaising with the necessary trust staff and management teams. Issues which are dealt with by the PALS team are recorded on the PALS section of Ulysses (the Trust's safeguard risk management system that incorporates risk, complaints, PALS and claims) and monitored to ensure that they are answered in line with the timescale that has been agreed with the patient or person asking for advice and support.

4.2.2 If the patient wishes to make a formal complaint or if the PALS team feel the patient would benefit from it being handled in a formal manner, they will be encouraged write down their own interpretation of events or questions, but if they are not able or willing to do this the PALS staff will transcribe the patient's concerns for them and pass them on to the complaints manager to be logged as a formal complaint.

4.2.3 A complaint to the trust should be made within 12 months of the event, or within 12 months of the complainant being aware that there was cause for making a complaint. However the trust will agree to investigate all complaints of a clinical nature and other complaints which fall outside of these time constraints would normally be investigated unless there is a strong reason not to. If a complaint is not investigated, the Complaints Manager will write to the complainant explaining the

reasons why.

4.3 Complaints Procedure: Permission

4.3.1 In circumstances where the complaint is not being made by the patient, permission must be obtained from the patient. The third party making the complaint will be asked to supply:

- The name and address of the person making the complaint
- The name, date of birth and address of the patient
  And
- Contact details of the patient so that they might be contacted for confirmation that they consent to the third party acting on their behalf
- The relationship of the complainant to the patient.

If the Complaint Manager is of the opinion that the third party does or did not have sufficient interest in the person's welfare, is not acting in their best interests or is unsuitable to act on the patients behalf, they will notify that person in writing stating the reasons and seek to support the patient in other ways, possibly through external advocacy.

4.3.2 In order to investigate a complaint, written permission should be sought in the first instance. Where this is not practical, verbal consent may be taken and this confirmation must be recorded by a member of the PALS and complaints team on Ulysses safeguarding system. The complaint response should be sent directly to the patient unless the patient has agreed that the response should be sent directly to the complainant.

4.3.3 In the case of a patient who has died or who lacks capacity, the complainant must be a family member or other person who has sufficient interest in the welfare of the patient.

4.3.4 Where a Member of Parliament (MP) has written to the trust, on behalf of their constituent, the Trust will respond directly to the MP who will forward it to their constituent. Even though the complainant has contacted their MP for redress, the consent of the complainant is required for the complaint to be investigated.

4.4 Complaints Procedure: Complaints by or on behalf of Children and young people

4.4.1 In the case of a complaint made on behalf of a child, the complainant must be a parent or carer with parental responsibility or a legally appointed guardian. Where the child is under the care of children's social services, the complainant must be an authorized by the local authority or the voluntary organisation and, in the opinion of the Complaints Manager, is making the complaint in the best interests of the child. The Complaint Manager will ask the advice of the Named Nurse for Child Protection where necessary.

4.4.2 Where the complaint or issue or concern has been made on behalf of a child, the trust must be satisfied that there are reasonable grounds for the complaint being made by the parent, etc. on behalf of the child. If they are dissatisfied, they must

write to the parent explaining the decision not to pursue the complaint, and the reasons for it.

4.4.3 Children and young people are entitled to complain on their own behalf and will be replied to directly if it is felt they have the capacity to understand the response and its implications. In the first instance, the child or young person will be asked for their permission to include their parent or carer in the correspondence. If this is refused and it is felt that the child lacks the capacity to fully understand the response (even if written in age appropriate language), legal advice will be sought from the trust solicitor and the Named Nurse for Child Protection.

4.4.4. Where the complainant is a child or young person, the trust's Named Nurse for Child Protection will be informed within 24 hours or next working day of receipt of the complaint and the most appropriate investigation agreed. Where it is known that the complaint involves a vulnerable child or the complainant makes specific reference to a safeguarding child concern and/or reference to safeguarding agencies, the trust's Named Nurse for Child Protection will be informed and appropriate trust child safeguarding procedures followed.

4.4.5 Where the Complaints Manager has concerns relating to the content of the complaint, for example threats to a child, they will take action in line with the trust Child Safeguarding policy (2017).

4.5 Complaints Procedure: Stage 1. Formal Complaints (known as Local Resolution)

For the purposes of this policy, a formal complaint is defined in 5.0.1 and the process outlined in appendix 2:

4.5.1 Complaints are received by the complaints manager via the PALS team, by telephone or face to face, by letter or email directly from the complainant or via the directorate management teams, the Executive Offices, NHS Choices, the trust website, clinical commissioning groups or local Healthwatch. If a complaint is received by trust staff and immediate resolution is not possible, it should be passed to the Complaints Manager who will attempt to contact all complainant in the first instance.

4.5.2 Written complaints where immediate resolution is not possible should only be responded to formally by the Complaints Manager. If a complaint is received personally by the Chief Executive, the trust Chairman, Consultants or other member of staff, an acknowledgment should be sent by the Complaints Manager. Complaints should not be investigated and responded to outside of the formal complaints process.

4.5.3 Where possible, the complainant will be contacted by telephone in order to clarify their concerns and establish what they would like the final outcome to be. It is also a means of establishing a relationship with the complainant so that they have a named person that they can contact for advice and to feel supported through the process. If at this stage the issue can be resolved to the patient's satisfaction, it will be. This notwithstanding, they will be asked if they also wish to pursue the formal complaint route.

All complaints relating to clinical issues or those deemed to be a risk or potential risk to the patient or others, will be treated as a formal complaint.

Where an issue poses a reputational threat to the trust, a discussion will be held with the complainant, if they have not already decided, to see if they are happy to have their issue raised as a formal complaint.

4.5.4 Details of the complainant and the complaint will be entered onto the complaints (Ulysses) safeguarding database. This will include a record of every time the patient is contacted by, or contacts, the trust and record the name of those mentioned adversely in the complaint.

4.5.5 Copies of all correspondence, emails and record of conversations between the complaints manager and staff will be recorded on the Ulysses safeguarding system, with a hard copy kept in the patients complaint file. Copies of the initial scanned complaint letter will be saved onto the safeguarding system, sand any letters to the complainant are automatically generated and save on the same system.

4.5.6 The handling and acknowledgment of a complaint should commence immediately, but certainly no later than three (3) working days following its receipt by the Complaints Manager, who will acknowledge receipt of the complaint in writing and include a leaflet ‘How will my complaint be investigated’.

The complaints manager will scan the complaint letter or transcription into the Ulysses safeguarding system and forward a copy of it to the appropriate divisional management team i.e. The Divisional Manager, the Head of Nursing, the Divisional Administrator (copying in the Risk and Safety and Safeguarding teams and others where appropriate). They will also send a Complaint Alert Form (appendix 1), which should be returned with the final investigation. The Complaints Manager will write to the patient acknowledging receipt of the letter and explaining that they should receive a response from the Chief Executive within 25 working days.

4.5.7 When a complaint is received that is about care in more than one trust, organisation or other provider, discussions should take place between the relevant Complaints Managers as to whether the issues should be handled separately or as part of a joint response. When it is decided to provide the complainant with a joint response, one manager should be nominated to co-ordinate the investigations and to be the main point of contact for the complainant. The complainant should be provided with details of how the investigation will take place and the timescales. If a written complaint is received where it is recognised that it is solely concerned with areas properly dealt with by another trust or organisation, the complaint will be referred to their Complaints Manager at the responsible organisation with a copy of the complaint if the complainant confirms permission to share the complaint.

4.6 Complaints Procedure: Required response times

4.6.1 Care must be taken not to introduce delays into the system by exceeding the agreed stated time limits. The aim should be to process the complaint speedily and thoroughly at all stages. A full response should be sent from the Chief Executive within 25 working days. The divisional manager is responsible for the management

of complaint investigations within their division.

4.6.2 Once the Complaint Manager forwards the complaint letter and complaint alert form to the divisional management team they should return their response within ten (10) working days. The date will appear on the complainant alert form. If it appears that this time limit will be exceeded by more than five (5) working days the directorate management team must contact the complaints manager with an explanation for the delay.

4.6.3 The complainant must be kept informed of progress or reasons for any delay and, if necessary, a holding letter will be sent if it appears that the final response will not be sent 25 working days of receipt of the complaint. The Complaints Manager will also contact the patient by telephone to explain the delay and keep them updated going forward.

4.6.4 In instances where the complainant demands that a complaint response is prepared to their timeframe, rather than that of the trust, the Complaints Manager will advise the complainant whether this is possible and inform the divisional management team. In circumstances where it is not possible to meet the requests of the complainant the response will be prepared within the usual timeframe.

4.6.3 Each week an Open Complaints report will be circulated to the divisional management teams clearly indicating the status of each complaint and be RAG rated as such. This report will also include PALS concerns for the week and comments on social media such as NHS Choices.

Once the response has been received from the directorate management team by the complaints manager, the name will be removed from the Open Complaints List, though retained on the Complaints Managers Open Complaints List.
Where a complaint appears under threat of breaching the 25 day response period, it may be escalated to the Director of Nursing and Allied Health Profession or Clinical Director for investigation in to the delay.

4.6.4 Key performance indicators for response times in relation to complaints are:

- That 95% complaints will be formally acknowledged within three working days following receipt of the complaint by the Complaints Manager

- That 90% of complaints will be sent a final response within 25 working days of receipt of the complaint by the Complaints Manager.

4.7 Complaints Procedure: Investigation and response

4.7.1 The responsibility of investigating complaints and ensuring they are managed within the correct timeframe sits with the Divisional Manager and Head of Nursing (or head of department e.g. research, estates etc.).

They will decide who will lead the investigation, ensure that that person is appropriate to investigate the complaint, and oversee the coordination and management of how the process is handled.

Upon receipt of the complaint and complaint memo alert, the nominated investigator will commence an investigation. The investigation should ensure that each complaint is treated individually, that the investigation is pertinent to that complaint and that it addresses all specific points raised in the complaint. Guidance notes are attached as appendix 4.

The investigation might include:

- Obtaining statements from relevant staff
- Examining relevant documents
- Identifying any related issues
- Identifying any constraints operating at this time
- Asking the Complaint Manager to contact the patient to clarify certain issues.
- Reaching a conclusion as to the validity of a complaint and ensuring there is a response to each element.
- Clearly identifying areas of improvement or corrective action if applicable, as a result of the complaint and how these will be carried out
- Offering to meet with the complainant if appropriate.
- Consider whether some form of financial redress (such as travel expenses) is appropriate

4.7.2 Staff involved in a complaint are at liberty to seek help or advice from their professional association/trade union. However this should not delay the response to a complaint. Being implicated in a complaint can be disquieting for the member of staff concerned. Line managers should be cognisant of this and support staff in those circumstances. Staff can also contact the Complaint Manager for advice on the process and additional support, especially if they are required to provide a written statement to aid the investigation of the complaint. Also, staff who are the subject of a complaint must have the opportunity to see the complaint, other relevant information and the final response letter.

4.7.3 If the response to a complaint consists of an individual response from a member of staff, the response should be written as though they are addressing the complainant (introductory and closing remarks are not necessary). However the response is formatted, the following should be borne in mind by those writing the statements:

- Try to see the issues from the complainant's perspective.
- Address all the points the complainant has raised.
- The response should be factual but avoiding the use of jargon and technical terms where possible.
- Any medical terms used should be clarified.
- The use of emotional terms should be avoided.
- Clearly state what has been done as a result of the complaint.

Where staff are interviewed or are asked to make a statement, they should write this themselves and not have their comments reported by the investigator or another person, but be supported by them in providing their statement.

Where staff are named or identified by job title or circumstance, they must be informed that a complaint has been made about them and a statement obtained.

The Complaints Manager, on receiving the information or statements from the staff involved, will assess the information and ask for further clarification or a more comprehensive response from the divisional management team, should this be necessary.

Only once the investigation is completed, should the statements etc. be forwarded to the complaints manager. The Complaints Manager should not be included in email trails during the investigations as this can cause confusion as to when the complaint investigation has concluded.

4.8 Complaints Procedure: Conclusion of investigation

Once the investigation has concluded, it should be reviewed by the Divisional Manager and Head of Nursing to ensure that all the points in the complaint and any actions taken in response are clearly indicated as is the risk score for that complaint.

Where a complaint has been upheld or partially upheld, an action for change must be included.

4.8.1 When an investigation is completed, a comprehensive written response will be compiled by the complaints team detailing the results of the investigation. The letter will address the points of concern, be informative both as to reasons for any failure in service and steps taken to avoid a recurrence, and include an apology where appropriate. The letter should be written in language appropriate to the complainant's understanding and where necessary will be translated or produced in braille, easy read etc.

4.8.2 If the complaint concerns a clinical issue, it will be reviewed by the Medical Director, prior to being signed by the Chief Executive.

4.8.3 The Chief Executive or designated deputy will sign all response letters.

4.8.4 Any letter concluding the local resolution stage of a complaint should advise complainants what they can do should they disagree with the response and refer to the complainant's right to take the complaint to the Parliamentary and Health Service Ombudsman (PHSO). Information about how to do this will be included with the final response letter.

4.8.5 A copy of the final response will be sent to:
The complainant and any third party the complainant wishes to be included e.g. their representative or advocate. The Divisional Manager and Head of Nursing of the relevant Division who will ensure that those staff involved in the complaint see a copy of the final response.

4.9 Complaints Procedure: Conclusion of local resolution

4.9.1 Local resolution ends with the final response from the Chief Executive.

4.9.2 However, where a complainant replies to the final response with supplementary

questions or raises new issues then it may be appropriate to instigate a further investigation or to offer a meeting with the relevant manager or clinician.
This will be recorded on the Ulysses safeguarding system as a 'Re-Opened Case' and subject to the 25 day response time.

4.9.3 At any stage of the process the complainant may decide to take legal action against the trust. Should this occur all complaints correspondence will be made available for the trust's legal team through the Chief Executive Office.

4.9.4 There are occasions when financial recompense may be offered as result of the complaint investigation. This would normally be to compensate for out of pocket expenses including travel expenses, telephone calls, inconvenience or as a good will gesture. The sum will be determined by the appropriate divisional management team in discussion with the Complaints Manager and will be funded from the division's budget. The Chief Executive will approve any payment by signing the final response.

4.9.5 A meeting may be arranged between key members of staff and the complainant in order to provide a more personal explanation of events and to help resolve the complaint. Notes may be taken at the meeting and on occasion, with the permission of both parties, the meeting may be recorded and the recording made available to the complainant. A member of the PALS and Complaints team should be present and a written summary sent to the patient as appropriate.

4.10.6 Complaint documentation will be retained by the trust for eight years following the closure of the complaint.

4.10 Complaints Procedure: Risk Assessment

4.10.1 The divisional management team will make the grading of the risk attached to a patient complaint using the matrix set out in the trust's Risk Management Strategy Policy (2016) (appendix 3).
The final risk score will be decided by the divisional management or clinical team investigating the complaint and will inform the complaint manager on the Complaint Alert Form when returned with the results of the investigation.

4.10.2 The Risk and Safety team will be copied into all complaints at the time they are sent for investigation to establish those complaints which should also be recorded as an incident or serious incident. If an issue has is identified but has not been recorded as such and should have been, the Risk Management team will contact the appropriate staff and request that it be done. The level of harm or suspected harm will also be discussed.

4.10.3 The Risk Management team review all complaints and PALS concerns to assess if any need to be recorded as an incident or referred to the Serious Incident (SI) Panel.

4.10.4 Where the Complaints Manager suspects there is an issue relating to the safeguarding of an adult or child, they will take action in line with the trust Safeguarding Adults at Risk Policy and Safeguarding Children and Child Protection

policies (0-18) policies.

4.10.5 The Complaints Manager will bring the matter to the immediate attention of the Director or Nursing and Allied Health Profession and / or the Medical Director where:

- There is a complaint involving the exercise of clinical judgment which cannot be resolved by discussion with the clinician (s) concerned.
- Where the Complaints Manager suspects the complaint constitutes a Serious Incident or 'never event' involving harm to patient or visitor
- The conduct of any member of staff which may potentially be the subject of disciplinary proceedings
- The alleged physical abuse of patients
- A possible criminal offence (In cases where it is considered that there is a prima facie case, it is usual practice to refer the matter for police investigation)
- Where a referral to one of the professional regulatory bodies would be appropriate

4.10.6 Where it is decided to take action under any of the above, before or after the formal complaint process has been completed, a report of any further investigation should be made available to the complainant, e.g. a copy of the SI report, outlining the outcome and any actions to be taken, being mindful of patient and staff confidentiality.

4.11 Stage 2. The Parliamentary and Health Service Ombudsman (PHSO)

4.11.1 The role of the PHSO is to consider complaints made by or on behalf of people who have suffered an injustice or hardship because of what they consider to be unsatisfactory treatment or service by the NHS or by private providers who have provided NHS funded treatment to the individual.

4.11.2 The PHSO is not obliged to investigate every complaint and will not usually accept a case until local procedures have been exhausted, i.e. the completion of the local resolution stage of the complaints process.

A complaint to the PHSO should be made within 12 months of the event, or within 12 months of the complainant being aware that there was cause for making a complaint. However the PHSO may agree to investigate a complaint which falls outside of these time constraints at their discretion. This would include circumstances where the complainant has suffered particular distress or trauma that has prevented them from making their complaint before.

4.11.3 The PHSO is also able to investigate complaints from staff if they feel that they have suffered hardship or injustice as a result of the complaints procedure, provided established grievance procedures have been exhausted.

4.11.4 The Complaints Manager will act as liaison officer and provide all the information required for the PHSO's investigation e.g. the complainants heath care record, the complainants complaint file, and any relevant trust policies or procedures etc. If the PHSO instigate an investigation, a record of this will be included in the complainants file on Ulysses safeguarding system..

4.11.5 The PHSO will contact the trust to advise whether the case will go to full investigation or not. At the end of full the investigation they might suggest service changes, recompense to the complainant or other action with which the trust must comply.

4.12 Reporting / Learning from complaints

4.12.1 The feedback that the trust receives when complaints are made is invaluable in assisting us to continuously improve our services for all patients. To avoid mistakes being repeated it is important that the trust learns from any mistakes that have been made. Complaints and the resultant service changes should be discussed at clinical governance half days and at service meetings.

4.12.2 As part of the formal complaints response, Divisional Management teams will be asked to detail what service changes have been made to ensure that any negative issues around the complaint will not be not repeated. These changes will be recorded on the Complaint Alert Form (appendix 1), to be returned to the Complaints Manager with the directorate response. They will be collated on a central database within the complaints department and used for reporting with a summary on the trust website. The Divisional Management Team will be responsible for ensuring that any actions are implemented.

4.12.3 An anonymised report of complaints activity and the response taken by the trust will be put on the PALS and Complaints Moorfields website page. .

4.12.4 As part of the six monthly quality and safety reports, a report will be forwarded to the Trust Board detailing the complaints and PALS issues that have been received and a detailed annual complaints report will be submitted to for board consideration each June. This will include:
The number of complaints received
The number of complaints by category and service
The number of complaints to have been upheld
An overview of the themes of complaints and learning and action that has taken place as a result.
The number of complaints and outcomes investigated by the PHSO
A report will also be submitted to the Clinical Quality Review Group on a quarterly basis.

4.12.5 A report of complaint activity will be discussed with the nominated trust board member to provide assurance.

4.12.6 A six monthly summary of complaints actions will be shared with across the divisional management teams to encourage shared learning and a quarterly summary of PALS concerns by theme and site will be provided in the same way.

4.12.7 Where available, complaints logged by Moorfields Private will be included in all reporting to ensure consistency across all Moorfields services.

4.13 Record Keeping

4.13.1 On no account should a service user feel discriminated against because they have raised a concern or complaint.

It is important to note that complaints correspondence or reference to a patient's complaint must not be filed or recorded in the patient's healthcare record.

4.13.2 All complaints correspondence will be kept in a patient complaint file held within the Moorfields complaint office. All correspondence (scanned), emails and records of telephone contact) will also be held on the Ulysses safeguarding system where possible. Hard copy patient complaint files will be held securely on site by the complaints team for two years. Complaint files older than this will be stored in a secure place for a total of eight years and will then be destroyed in line with the trust's policy on the destruction of confidential information.

4.14 Removing barriers to making a complaint.

4.14.1 The Trust is committed to ensuring that the complaints procedure is easily accessible, equitable, sensitive and open. To ensure patients are aware of the process of how to make a complaint and are supported in doing so, the complaints team will ensure that PALS leaflets detailing how to make a complaint are available in appropriate languages and circulated throughout the City Road and satellite sites and on the trust website. Braille copies of the leaflet will be held in the PALS office. Similar information will be included in the Moortfields Patient booklet. The complaint training delivered by the PALS and Complaints team will focus on the handling of complaints in a positive and constructive manner and how they can be a source of service improvement.

4.14.2 The complaints team will assist and support complainants whose first language is not English through the provision of interpretation services and where appropriate, advice regarding external patient advocate services.

4.14.3 The complaints team will also be aware of, and mitigate for the help and support complainants with a learning disability, dementia or other cognitive problems might require with regard to navigating the complaints process and in the nature of any written correspondence in regard to their complaint. Easy read complaints leaflets will be available. Leaflets in other formats will be provided in line with the accessible information standard.

4.15 Unreasonably Persistent Complainants

4.15.1 Trust staff are encouraged to respond in a professional and supportive manner to the needs of all complainants and try to meet all their needs in relation to any complaints raised. Occasionally, following completion of the local resolution nothing further can reasonably be done and no additional clarification given to assist the complainant or to solve their problem.

4.15.2 Where a complainant persists in pursuing a complaint, even though the trust's complaints procedure has been fully followed and exhausted and where they have not sought redress from the PHSO, or where the PHSO have declined to

investigate their concern, the trust might be obliged to write to the complainant explaining that no further investigation will be undertaken. The decision to do this, once the Complaint Manager has reviewed the issues and response with the complainant one final time, will be taken by the Director of Nursing and Allied Health Professions, the Medical Director and the Chief Executive Officer. The Chief Executive will write to the complainant, informing them that the trust has responded as fully as possible to their complaint and that any further communication from the complainant on the same subject will be acknowledged but not responded to.

4.15.3 It must be noted that such recourse is issue specific and that any new issues raised by the complainant will be dealt with in the normal way as either a re-opened complaint or as a new complaint.

4.16 Complaints relating to Moorfields Private

4.16.1 The Moorfields Private complaints handling process should follow the broad principles set out above.

4.16.2 Complaints received by Moorfields Private should be responded to, by them, in same time frame as NHS complaints as outlined in 4.5, i.e. the complaint will be acknowledged with in three working days and a final response sent within 25 working days.

4.16.3 Complaints for Moorfields Private received by the NHS Complaints team will have forwarded to Moorfields Private. Where a complaint is received directly, Moorfields Private Managing Director and Head of Nursing or designee will complete the MEH Private complaint database including the details of the complaint and complainant details.

4.16.4 Where there are elements within a Moorfields Private complaint that involve Moorfields NHS staff or facilities, a discussion between them and the NHS complaints manager will take place to determine who is best to manage it. If Moorfields Private, they will be supported and advised as to how to approach these elements of the complaint and will liaise with the NHS Divisional management teams and collate the investigation results from them, but the lead and responsibility for the complaint handling will remain with Moorfields Private.

4.16.5 Where a complaint is about the clinical care provided by a Moorfields Private, the Consultant Ophthalmologist, Managing Director or Head of Nursing will liaise directly with them in addressing the complaint to ensure that the complainants issues are addressed.

4.16.6 Support and advice will be available from the NHS Complaints manager at all times in handling complaints received by Moorfields Private.

4.16.6 The Moorfields Private management team will be responsible for the investigation of any complaint, and updating of the complainant if there will likely be a delay in sending the final response.

4.16.7 The Moorfields Private Managing Director will be responsible for overseeing the complaint investigation and compiling the final response. This will be signed by

them and a copy of the final response will be saved on the shared database. They will also complete the 'complaint outcome' section of the shared database.

4.16.8 Moorfields Private complainants do not normally have recourse to the PHSO, unless the complaint is about NHS-funded healthcare services which privately-funded patients get in an NHS hospital or NHS funded care delivered in a private setting. If dissatisfied with the final response will need to refer to the General Medical Council or seek legal redress as appropriate.

5.0 Explanation of Terms Used

5.1 Complaint: In the context of this policy a formal complaint is one that goes through the formal complaints process e.g.:

- An issue where the complainant wishes the it to be treated as a formal complaint
- A complaint that requires a detailed investigation and comprehensive response
- Complaints regarding clinical care
- An oral complaint that is subsequently put in writing and signed or agreed by the complainant which requires an investigation and comprehensive response
- A PALS concern which cannot be resolved to the patient's satisfaction in a few days or in which the complainant remains dissatisfied with the investigation and response that has taken place.
- A concern dealt with informally at local level where the complainant remains dissatisfied and their complaint cannot be resolved

5.2 PALS Concern:
A complaint dealt with and resolved by the PALS and local management teams i.e. not a formal complaint.

5.2 Divisional management team:
In terms of liaison between the Complaints Manager and the trust, the divisional management team will constitute: the Divisional Manager, the divisional Head of Nursing and the Divisional Administrative Assistant. Where appropriate this would also include the heads of other departments e.g. Estates, Finance and Research. Where a complaint involves Moorfields Research the Medical Director will be included.

5.3 Immediate Resolution:
Is a concern that is resolved by staff within the directorate team or the PALS team and does not require a formal investigation, a detailed written response and should be able to be resolved within five working days.

5.4 Local Resolution (Stage one):
A formal complaint that requires investigation and a written response from the trust Chief Executive Officer. This may include meetings with the complainant and follow up investigations.

5.5 Stage Two Resolution:
Where the complainant is not satisfied with the stage one response and has referred their complaint to the Parliamentary and Health Service Ombudsman

(PHSO).

6.0 Duties

6.1 Responsibility of the Trust Board

The Trust Board receives a quarterly and an annual report outlining the number of complaints received, performance against response targets and themes arising from complaints.

6.2 Responsibility of the Chief Executive

The Chief Executive Officer is responsible for the conduct of the Complaints Procedure, which is delegated through the Director of Nursing and Allied Health Professionals to the Head of Patient Experience and the Complaints Manager.
The Chief Executive Officer receives copies of all formal letters of complaint and signs all response letters. In the absence of the Chief Executive, to avoid delay, an Executive Director will sign the response letters.
The Chief Executive will, in cases where financial redress has been suggested, have the final responsibility for approving this.

6.3 Responsibilities of the Director of Nursing and Allied Health Professions

The Director of Nursing and Allied Health Professions, through the Head of Patient Experience, monitors the overall performance of the Complaints service.
They ensure that any complaints, that are graded as 12 or above and where it is suspected that it may constitute a Serious Incident (SI), are forwarded to the director of quality and safety and the head of risk & safety for inclusion on the corporate risk register and discussed at the SI panel. Further detail regarding this classification is available in the Incident and Serious Incident Reporting Policy and Procedure.

6.4 Responsibilities of the Complaints Manager

The Complaints Manager will monitor the performance of the complaints/PALS service on a day to day basis and be the first point of contact for complainants and liaise between them and the Directorate Management Teams.

6.5 Divisional Managers, Heads of Nursing

Divisional Managers and Head of Nursing, will receive details of all complaints that relate to their area of responsibility, oversee any investigation required and monitor the responses to complaints to ensure that they are complete and comply with the deadlines set. They will be prepared to meet with complainants, where this has been requested, in order to assist in the Local Resolution stage of their complaints and ensure that any service improvements highlighted by the complaint are addressed to prevent a recurrence.

6.6 Responsibility of Trust Employees (including those mentioned in section 2)

All staff:

Should be aware of the Complaints Policy, how to access it and are expected to co-operate with complaints investigations and respond openly and honestly with any investigation. They must ensure that they do not treat patients, relatives or their carers any differently as a result of them raising a concern or making a complaint.

7.0 Training

All new staff are advised of the trust's Complaints and PALS policy during their initial induction. This includes understanding their role and duties as outlined in the policy.

Training sessions in complaint handling will be provided on a monthly basis by the complaint and PALS team for members of staff within the trust who handle complaints investigations in order to ensure that they are fully aware of their role and responsibility in line with the trust's complaints procedure.

General sessions around complaints issues, handling and outcomes are available across the trust at the request of local managers or individuals.

8.0 Stakeholder Engagement and Communication

This policy was put before the Management Executive (ME) and the Board for consultation and comment. It was submitted to the Clinical Quality Review Group and Patient Representatives of the Patient Experience Committee for consultation and comment.

9.0 Approval and Ratification

The policy was approved by the Clinical Governance Committee (CGC), and ratified by the Management Executive team (ManEx).

10.0 Dissemination and Implementation

Once ratified, this policy will be uploaded onto the intranet, and to the Marketing and Communications team to publicise in the Trust's Weekly Staff Bulletin.

11.0 Review and Revision Arrangements

This policy will be reviewed every three years. A review will also occur if there are legislative changes to be incorporated.

12.0 Document Control and Archiving

12.1 The current and approved version of this document can be found on the Trust's intranet site. Should this not be the case, please contact the Compliance and Quality team.

12.2 Previously approved versions of this document will be removed from the intranet by the Compliance and Quality team and archived in the policy repository. Any

requests for retrieval of archived documents must be directed to the Compliance and Quality team.

13.0 Monitoring compliance with this Policy

The Trust will use a variety of methods to monitor compliance with the processes in this document, including some or all of the following methods:

Measurable Policy Objective	Monitoring/ Audit method	Frequency Of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
Process for responding to complaints: 3 day response (90% of all complaints) 25 Day final response (80% of all complaints)	Annual Report Quarterly Report Integrated performance report	Annual Quarterly Monthly	Director of Quality and safety Director of Quality and safety Director of Quality and safety	Patient Participation Experience Committee / Quality and Safety Committee Quality and Safety Committee / CQRG Quality and Safety Committee / CQRG
Number of complaints received against six month rolling average	Quality and Safety report	Monthly	Director of Quality and safety	Clinical Governance / Quality and Safety Committee
Patient Satisfaction with PALS / Complaints handling	Patient questionnaire (Independently administered)	Annual	Complaints Manager	Patient Experience Committee Quality and Safety Committee
Process for the handling of joint complaints between organisations (as per section 4.3)	Documentation review to assess effectiveness of process in line with policy.	Annual	Complaints Manager	Patient Experience Committee

In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this policy as a response to the identification of any gaps, or as a result of the identification of risks arising from the policy prompted by incident review, external reviews or other sources of information and advice. This monitoring may include commissioned audits and reviews, detailed data analysis or another focussed study, for example. Results of this monitoring will be reported to the committee and/or individual responsible for the review of the process and/or the risks identified.

Monitoring at any point may trigger a policy review if there is evidence that the policy is unable to meet its stated objectives.

14.0 Supporting References / Evidence Base

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

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

NHS Constitution (For England) 2013

Principles of Good Complaint Handling (PHSO) for England 2009

A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture. (DoH) 2013

Designing good together: transforming hospital complaint handling (PHSO) 2013

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

15.0 Supporting Documents

Moorfields Incident and SI reporting Policy 2016

Moorfields Being open Policy 2015

Moorfields Claims Policy 2016

Safeguarding Adults at Risk Policy and Procedures 2015

Safeguarding Children and Child Protection (0-18 years) Policy and Procedures (2017)

Please also see Appendices 1-4.

Appendix 1: Complaint alert form

Moorfields Eye Hospital NHS
NHS Foundation Trust

Complaint alert form - To be returned to complaints manager with final statements / investigations

Date:	
To:	
Report due by:	
Complainant:	
Patient number:	

Specific actions to be taken in response to complaint	
1	
2	
3	
4	
5	

Please submit to complaint manager only once all investigation / Statements have been received. Please explain any technical / clinical terms used in layman's language.

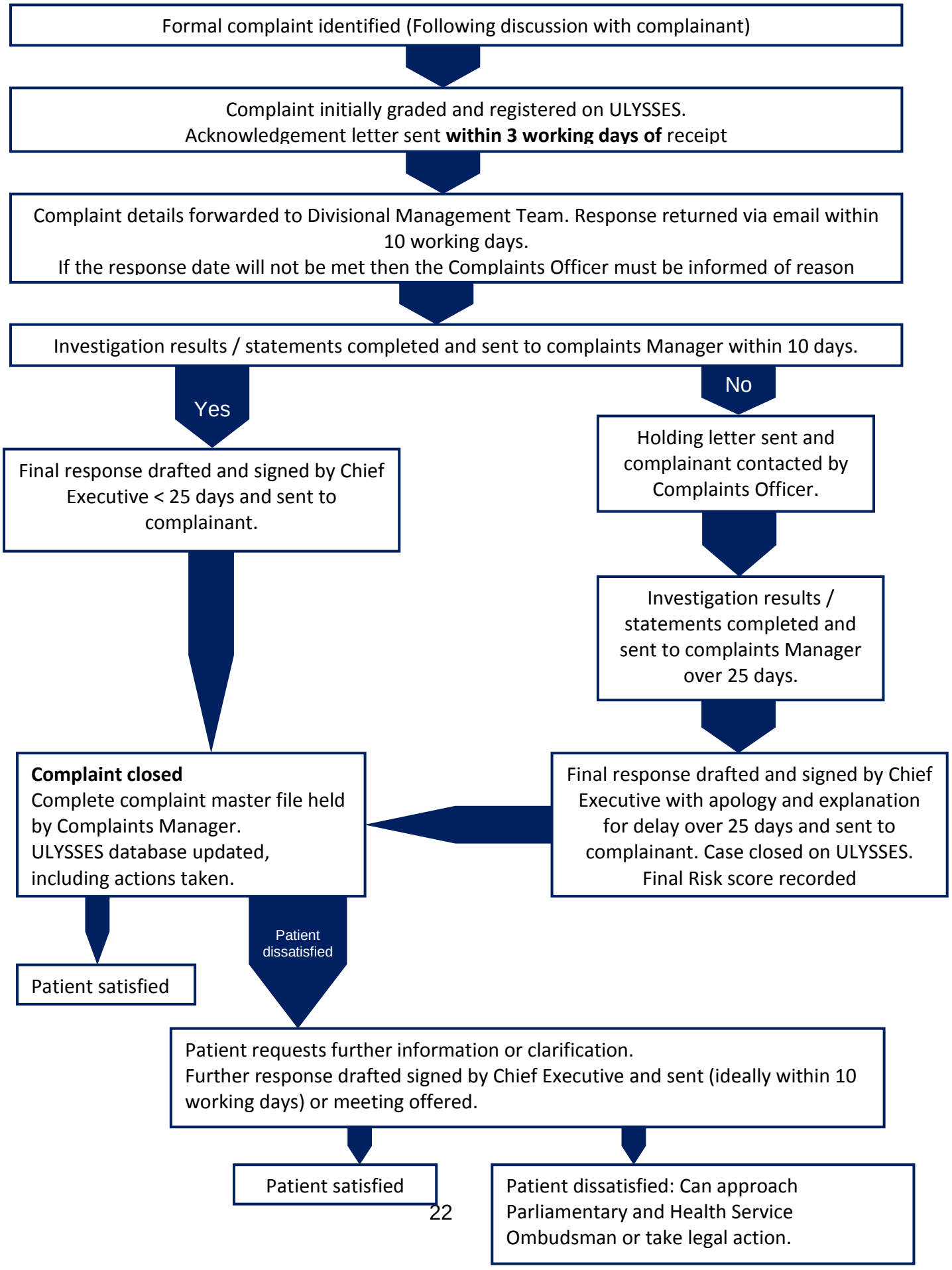
1) Final rating: consequence x likelihood
(Please place a cross reflecting the appropriate risk category)

	Rare 1		Unlikely 2		Possible 3		Likely 4		Almost certain 5	
Catastrophic 5	5		10		15		20		25	
Major 4	4		8		12		16		20	
Moderate 3	3		6		9		12		15	
Minor 2	2		4		6		8		10	
Negligible 1	1		2		3		4		5	

TPW/CRF/2/14

Appendix 2: Complaints Management Pathway

Complaints Management Pathway



Appendix 3: Risk Scoring Matrix (Moorfields Risk Strategy and Policy (appendix 1) (2016)

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency of occurrence.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 3 Risk rating = consequence x likelihood (C x L)

Consequence scores (C)	Likelihood scores (L)				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	LOW risk
4 - 6	MODERATE risk
8 - 12	HIGH risk
15 - 25	EXTREME risk

Instructions for use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
3. Calculate the risk rating by multiplying the consequence score by the likelihood score:
C (consequence) x L (likelihood) = R (risk score)
27
4. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix 4

Guidance for responding to patient concerns or complaints

1. Introduction

A complaint is an expression of dissatisfaction when expectations- even unreasonable ones, are not met. All users of our services have the right to complain. Complaints should be looked upon as a constructive method of gaining feedback on how users view our services. How we handle complaints, queries and concerns will affect our reputation with our users and the communities that we serve.

When you encounter someone who wants to make a complaint, **take responsibility for it** and deal with it then and there if possible so that the patient gets a swift resolution to their problem.

If the complainant is satisfied:

Write up a note of the incident for future reference or in case the complainant comes back again, so that what happened is documented. Discuss it with your line manager so that if this is a re-current problem it can be addressed.

If the complainant is not satisfied:

Speak to your line manager. Most issues can be resolved at the time, so do not be afraid to escalate if you need a decision to be made that is out of your control.

Consider whether PALS (x2324 / 2325) may be able to assist, but only after you have discussed it with your line manager first.

If you do need to involve the PALS team, contact them first and then escort the patient to the PALS office. If the patient is on the telephone, take the patient's telephone number and the PALS team will call them back.

The PALS team will need an explanation of why the issue cannot be resolved at the time.

If the complainant is not satisfied:

Should the patient wish to make a complaint and not go through PALS, give them a copy of the PALS and Complaints leaflet which explains how they can get their issue resolved.

If the patient has a learning disability or dementia user the easy read version of the leaflet, though it is better to pass them onto PALS if you can as they might need extra support.

2. Investigating Complaints

If the PALS and Complaint team receives a formal complaint the Complaints Manager will send a copy of the complaint, by email, to the divisional manager and head of nursing of the relevant division.

If you are asked to investigate a complaint you will receive the letter of complaint and the Complaint Alert Memo (forwarded initially to the divisional manager and head of nursing) outlining the main points to be addressed.

Read the letter of complaint and any other relevant material at least twice and where appropriate look at the medical records before deciding what the main issues are and who else you will need to speak to. If there is any doubt about what issues are to be addressed, speak to the Complaints Manager who will be able to clarify with the patient.

Staff who are being asked for information about the complaint should see the complaint letter so that they get a better understanding of the issues.

During your investigation, or if asked to make a statement, try to see things from the patient's perspective. What would you wish to know in their position?
It might be useful to ask:

- What actually happened?
- What should have happened?
- Why was there a difference between the two?

Establish the facts as far as possible and see if there are any witnesses who could help clarify the situation.

Ask all those involved for a written statement as this will help build a fuller picture of the events. Advise them not to be defensive but to state the facts as they see them. Openness and honesty will help to ensure a clearer picture of the events. They should be signed and dated and clearly state the name, designation and place of work.

Once all the evidence has been collected, you can review the complaint to identify any inconsistency or to ask for further information you think the patient might need. When you return your investigation to the complaints manager, include a summary of your opinions of what happened and any suggestions for how service change might prevent a re-occurrence. The final response from the Chief Executive will reflect the point made in your investigation and it is important that **all** the questions raised are answered.
Even where complaints are felt to be unfair, unjustified or the result of a misunderstanding, we should recognise how circumstances can be perceived differently and express regret that the patient felt they needed to complain.

This process must be completed within 10 working days of the Trust's receipt of the complaints.

3. Responding to Complaints

It should be noted that it is the responsibility of the Complaints Manager to draft the actual letter of response for the Chief Executive Officer to sign. The Divisional team is responsible for providing a factual report on which the letter will be based.

- That each issue raised is addressed
- That a full explanation is provided for what has happened
- An apology is provided where appropriate
- Details of any action proposed or already taken to ensure the event does not occur again
- Details of the Parliamentary and Health Service Ombudsman.

4. Guidance notes for complaints meetings

Meetings can be a particularly effective way of diffusing a potential complaint, resolving an ongoing complaint or clearing up outstanding issues following a final response to a complaint. It is often far easier to discuss issues and avoid misinterpretation through verbal communication rather than correspondence.

The Complaints Officer will co-ordinate these meetings

Checklist

- Check with the complainant what the issues are and who will be attending with them.
- Determine where and when the meeting will be and which staff should attend.
- Ensure staff who attend the meeting are fully briefed and offered support.
- Ensure the venue is appropriate. Have water, tissues etc. available.
- Begin with introductions and your understanding of the reasons for the meeting.
- Have a note-taker at the meeting so that you can concentrate on the issues at hand. Also, they can summarise and agree any follow-up action at the end of the meeting and the notes can be used to write the response following the meeting.
- Listen – ask the complainant to outline **their** key issues.
- Accept blame and apologise if necessary.
- At the end of the meeting: summarise the key points and any actions agreed Tell the complainant what will happen next and when.
- Stick to the time scales you have agreed
- Provide complaints manager with copy of notes from meeting

Appendix 5

Equality Impact Assessment

The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer.

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Comments / Evidence
1	Which groups is the policy/guidance intended for? Who will benefit from the policy/guidance? (refer to appropriate data)	
	• Race	All: Extra provision for those for whom English is not a first language
	• Gender (or sex)	All
	• Gender Reassignment	All
	• Pregnancy and maternity	All
	• Marriage and civil partnership	All
	• Religion or belief	All
	• Sexual orientation including lesbian, gay and bisexual people	All
	• Age	All
	• Disability (e.g., physical, sensory or learning)	All: Extra provision for those with a learning disability or other cognitive impairment
2	What issues need to be considered to ensure these groups are not disadvantaged by your proposal/guidance?	Extra provision as outlined above. Assurance that confidence will be maintained throughout process
3	What evidence exists already that suggests that some groups are affected differently? (identify the evidence you refer to)	Those with learning or sensory deprivation do not access hospital services to the full and are at risk of diagnostic overshadowing, a form of which might apply in regards to making a complaint.
4	How will you avoid or mitigate against the difference or disadvantage.	Extra provision offered with easy read guidance and if identified extra support and/or referral to support agencies will be offered to guide complainants through the process
5	What is your justification for the difference or disadvantage if you cannot avoid or mitigate against it, and you cannot stop the proposal or guidance?	N/A

If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of quality and safety, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the director of quality and safety (ext. 6564).

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.

Appendix 6

Checklist for the Review and Approval of Documents

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Complaints Policy
Policy (document) Author: Helen Tate, Senior PASS manager
Policy (document) Owner: Tracy Luckett, Director of Nursing and AHPs

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	Yes	
	Is the purpose of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	Yes	
	Who was engaged in a review of the document (list committees/ individuals)?	Yes	Directorate management teams, Risk and Safety Team, Patient representatives Quality and Safty Executive and non-executive director
	Has the policy template been followed (i.e. is the format correct)?	Yes	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	Yes	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	N/A	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how	Yes	

		Yes/No/ Unsure/ NA	Comments
	this will be done?		
	Does the plan include the necessary training/support to ensure compliance?	Yes	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	Yes	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (Clinical Governance Committee)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	Declan Flanagan, Medical Director	Date	30.01.18
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: 14 December 2010			

Appendix 7

Policy Applicability to Trust sites

This document applies to all premises occupied by Trust staff/activities, unless explicitly stated otherwise.

For any sites that are excluded from the policy, the policy must list those sites together with a brief explanation as to why the site is excluded, and name the local/host policy and any other documents that are used in its place.

Excluded sites	Reason for exclusion	Host policy and any other documents used in its place

Where the list indicates that the policy does not apply, this implies that the Trust will adhere to the policy of the host. Where a query exists then this must be referred, in the first instance, to either the:

- SDU general/Directorate/nurse manager
- Policy owner
- Accountable director
- Service director

Moorfields Dubai will adhere to their own local policies and procedures and Trust-wide documents will not apply, unless explicitly stated otherwise.