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NHS

Internal Audit Report
For
Bradford Teaching Hospital NHS Foundation Trust

Concerns and Complaints Management
BH/14/2021

Contents

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Objective

The objective of the audit was to provide assurance that robust systems and processes are in place to manage patient complaints and concerns and the Foundation Trust seeks to identify learning and improvements to the quality and safety of services provided.

Overall Opinion

High	The review of the Foundation Trust's complaints arrangements found that effective support systems and processes are in place for the management of complaints. Monitoring and reporting systems are in place to inform management and the Quality Academy of compliance with policies and procedures and to evaluate performance against legislative requirements. The review found that clear lines of accountability are in place within the organisation for the management of complaints, with assurance being provided by the Patient Experience Sub Committee to the Quality Committee (the Quality Academy from November 2020). The Quality Committee has been reporting to the Board of Directors on a quarterly basis and through the annual report, the Quality Academy now reports to the Board of Directors via the Regulation and Assurance Committee. It should be noted that due to COVID-19, the committee meetings did not meet as anticipated but mechanisms are in place for weekly senior management virtual meetings providing oversight to assess the current position on all complaints. A record of complaints received and investigated is maintained on Datix, where evidence and progress in relation to the investigation for each complaint is recorded.

Assurance on Key Control Objectives

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
There are clearly defined policies and procedures in place for the receiving and managing of complaints and concerns.	✓ A 'Management of Patient Feedback including Complaints and Concerns Policy' is in place on the Intranet and is accessible to all staff. The policy was approved by the Patient Experience Sub-Committee, before ratification by the Executive Management Team (EMT) in May 2019. The policy is reflective of the standards of The Local Authority Social Services and National Health Service Complaints (England) Regulations	High	0	0	0

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	(2009) and reference is made to the Patients Association, Good Practice Standards for NHS Complaints Handling (2014). ✓ The Chief Executive is the designated "Responsible Person" who has overall responsibility for complaints, with delegated authority to the Chief Nurse. ✓ The Chief Nurse is the nominated lead for the Board of Directors for ensuring that the 'Management of Patient Feedback' Policy is implemented operationally and monitored. This includes a review of all complaints investigated and their sign off, alongside immediate oversight of complaints assigned a 'High' grading (A complaint where issues regarding standards, quality of care and safeguarding of or denial of rights is involved and possibly involve risk of adverse media or other external attention). ✓ Lead Investigator training is offered to staff involved in the investigation of complaints. The audit reviewed training records held by the Complaints team and established that staff were fully up to date with relevant training module. Mechanisms are embedded to identify and prevent any investigators from managing a complaint before they have successfully attended and completed the relevant training. ✓ Information regarding raising a concern or complaint is advertised on posters and leaflets which are displayed around the Foundation Trust sites. ✓ The review established that information is available on the Foundation Trust website to explain to patients and their families the options and the processes for raising a complaint. ✓ An information sheet titled 'The complaints procedure. What happens next' is issued to all complainants in the Foundation Trust's open and transparent approach. This outlines the two stages to each investigation and includes details on how complainants have the right to request the Parliamentary Health Service Ombudsman to review and investigate their complaint if they are not satisfied with the outcome received from the Foundation Trust.				

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
There are systems and processes in place to record, effectively manage and respond to patient complaints and concerns which enable the Foundation Trust to discharge its statutory duties.	✓ A record of complaints received and investigated is maintained on Datix (electronic incident reporting system) by the Patient Experience Team. Datix is utilised to record key dates, including the date the complaint was received, the date on which a complaint was acknowledged and when a final response investigation report was issued to the complainant. ✓ A Complaints tracker is used by the Patent Experience team for requesting updated responses from the Clinical Business Unit (CBU) Complaints co-ordinators. This is utilised to identify any delays being encountered which may have an adverse effect in meeting the response deadline. ✓ Effective mechanisms are embedded within the Complaints team procedures to ensure all verbal complaints received are formally recorded and promptly investigated. Through sample testing of complaints, the process was demonstrated as being appropriately followed. ✓ A sample of 10 closed complaints were selected for review. It was found that all complaints were logged on Datix, when the complaint correspondence was received. All 10 complaint files reviewed by Internal Audit had the original complaint correspondence available on Datix. ✓ Under NHS England requirements, the Foundation Trust will only investigate a complaint within 12 months of the incident occurring. A review of the 10 complaints identified that all related to an incident within the last 12 months. ✓ The 10 complaints sampled confirmed that all 10 acknowledgement letters were held on file and had been sent to the complainant within three days of receipt of the complaint in line with the Complaints procedure. - On 16 March 2020, the Foundation Trust issued a notification to current complainants, following advice from NHS England, that all complaint responses would be put on hold to concentrate on COVID-19 planning and response. Out of the 10 sampled complaints, this led to four being responded to within a	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	timeframe over the recommended 60 working days. No recommendation is being issued due to the circumstances affecting service delivery, which have been out of the Foundation Trust's control. ✓ A 'Complaint Response Letter Checklist' is required to be completed and presented to the Chief Executive before responding formally to the complainant. The Audit confirmed that the checklist was available on file for nine out of 10 complaints, with the remaining complaint being exempt from this requirement due to a verbal response being provided. ✓ A final formal response letter was issued to the nine complainants, which were appropriately signed off by the Chief Executive or by the Chief Nurse.				
Regular and effective monitoring is in place to inform management and the Board of performance against Foundation Trust policy and legislative requirements.	✓ The review established that the Complaints Steering group (CSG) reports to the Patients Experience Sub Committee, which will now be reporting up to the Quality Academy (previously reporting was undertaken to the Quality Committee). The Patient Experience Group provides assurance on examination of patient complaints data. ✓ A quarterly Patient Experience paper, which incorporates complaints information, was confirmed as being presented through the Quality Committee to the Board of Directors in January, March and July 2020 for information and assurance. ✓ The Board of Directors also receive assurance reporting on complaints arrangements through an annual report assessing compliance against the requirements of the Complaints Regulations 2009. ✓ The review established that an annual report was produced and reported in July 2020. This detailed the number of complaints received for 2019/20, grading assigned, top five key themes emerging. Complaints responded to beyond six months were reported for 2019/2020, with this averaging to two cases over the full year. There had also been a reduction in the annual number of complaints received on the previous year by 20%.	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	- The review identified that the Patient Experience Group updated their Terms of Reference (ToR), which were reviewed and were provisionally approved in February 2020, alongside the CSG updating their ToR in December 2019. Due to COVID-19 restrictions, recent scheduled Patient Experience and CSG meetings have not been conducted. However, assurance reporting continues to be undertaken directly to the Senior Nursing management team. ✓ The review established that a weekly catch-up for the Complaints management team is scheduled every Monday. This is attended by the Deputy Chief Nurse, Assistant Chief Nurse-Patient Experience, Quality Lead for Patient Experience and Senior Patient Experience Officer. The attendees are provided with a progress tracker of all complaints for discussion. ✓ Processes and controls are in place to deal with cases determined as high or extreme in categorisation. It was confirmed that at the time of the writing of this report there have been no high or extreme cases since April 2020.				
There are systems and processes in place to identify and disseminate learning from complaints and concerns and seek to improve the quality and safety of services provided across the Foundation Trust.	✓ The review established that there is a process of escalation of complaints through review via the risk huddle, Incident Performance Management Group (IPMG) and Quality of Care Panel Meeting (QOUC) to identify risks in safety of service provided. ✓ In respect to lessons learnt from moderate complaints, the initial concerns and findings are discussed at the daily risk huddle. A decision will be made at the huddle if the complaint needs to be discussed at IPMG, or if further details surrounding the circumstances are needed before escalation to IPMG. ✓ At IPMG complaints will be discussed and the group can decide to escalate to QOUC due to the concern/risk level. ✓ At the QOUC, a senior member of the Patient Experience Team will attend the meeting to provide a verbal update to the group on complaints to allow discussion. Any key learning and feedback taken from QOUC is shared via the representative	**High**	**0**	**0**	**0**

Control Objective	Review Highlights (✓ Positive Assurance, ! Action Required)	Assurance Level	Recommendations (Priority)		
			Major	Moderate	Minor
	from Patient Experience back to the clinical teams. ✓ Any Trust-wide learning will be undertaken through the Learning Hub, through the dissemination 'Learning Matters' awareness material to share lessons learned. ✓ A walkthrough test was undertaken on how CBU areas share complaints information. A review of Women's & Children's 'Quality and Safety' governance meetings established that Complaints and Compliments are a standing agenda item. ✓ Action plans are submitted via Datix and actions are tracked by the Complaints team, to ensure completion before a complaint can be closed down. The CBU's have monitored action trackers managed by the Complaints co-ordinators, this was confirmed from evidence of the Women's and Children areas complaints tracker, which includes an action plan for all complaints upheld. A summary of each complaint is recorded with actions and tasks required to ensure lessons are learnt. ✓ The Complaints team have recently started to develop a central tracker which will pick up any upheld complaints. This is still in the development phase. There are plans to centralise all learning via action plans and include progress in weekly reports as to any outstanding action plan. Once established this will also allow the Complaints team to share learning and have a base to perform regular audits.				
Overall		**High**	**0**	**0**	**0**

Background Information

The Foundation Trust is committed to ensuring that patients have a positive experience of the care they receive, with a dedication to listening to all patients and service users to ensure better and safer care is provided.

A concern is an issue raised by a patient, their carer or family member or a member of the public that is not serious or complex, which can be addressed promptly with minimal intervention and may require a written response.

A complaint is an expression of dissatisfaction with any aspect of the service provided to a patient, their carer or family member or a member of the public which requires the Trust to provide a formal response.

The Complaints and PALS teams have recently merged to become one Patient Experience Team. The team focuses on working with the complainant to understand and resolve their concerns in a timely and appropriate fashion.

Key Risks

Key risks associated with this area include:

- Staff are not aware of their requirements for receiving, managing and learning from complaints and concerns received.
- Complaints, concerns and outcomes may not be managed in in accordance with legislative requirements.
- There are inadequate reporting and oversight arrangements in place at the Foundation Trust.
- The Foundation Trust does not identify learning from concerns and complaints in order to improve the quality and safety of services and/or reduce the risk of incident occurrences.

Objectives & Scope

The objective of the audit was to provide assurance that robust systems and processes are in place to manage patient complaints and concerns and the Foundation Trust seeks to identify learning and improvements to the quality and safety of services provided.

In order to meet this objective, the audit focused on the following key control objectives:

- There are clearly defined policies and procedures in place for the receiving and managing of complaints and concerns.

- There are systems and processes in place to record, effectively manage and respond to patient complaints and concerns which enable the Foundation Trust to discharge its statutory duties.
- Regular and effective monitoring is in place to inform management and the Board of performance against Foundation Trust policy and legislative requirements.
- There are systems and processes in place to identify and disseminate learning from complaints and concerns and seek to improve the quality and safety of services provided across the Foundation Trust.

Methodology

The objectives of this review were achieved by:

- Discussions with key staff to gain an understanding of the system and ascertain the controls in place for managing concerns and complaints;
- Review of the policies and procedures in place.
- Fieldwork was undertaken to ensure controls are operating as expected.

Limitations

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by us should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Where information resulting from audit work is made public or is provided to a third party by the client or by Audit Yorkshire then this must be done on the understanding that any third party will rely on the information at its own risk. Audit Yorkshire will not owe a duty of care or assume any responsibility towards anyone other than the client in relation to the information supplied. Equally, no third party may assert any rights or bring any claims against Audit Yorkshire in connection with the information. Where information is provided to a named third party, the third party will keep the information confidential.

Public Sector Internal Audit Standards

Audit work undertaken by Audit Yorkshire conforms with the International Standards for the Professional Practice of Internal Auditing.

Report Circulation

Draft	Final		
✓	✓	Karen Dawber	Chief Nurse
✓	✓	Joanne Hilton	Assistant Chief Nurse: Quality & Workforce
✓	✓	Karen Bentley	Assistant Chief Nurse: Patient Experience
✓	✓	Laura Booth	Quality Lead – Patient Experience
	✓	Matthew Horner	Director of Finance
✓	✓	Jacqui Maurice	Head of Corporate Governance
	✓	Sheridan Osborne	Corporate Governance Officer
	✓	Laura Parsons	Associate Director of Corporate Governance/Board Secretary

Acknowledgement

The auditor is grateful for the assistance received from management and staff during the course of this review. The following members of the Audit Yorkshire team were involved in the production of this report:

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Audit Manager: Jonathan Hodgson
Senior Auditor: Kuljit Singh

Date: 9 March 2021

Section 3: Schedule of Findings and Recommendations

Finding	Risk	Recommendation	Priority	Management Response	Responsible Officer	Target Date
No significant findings have been identified as part of this audit. As a consequence, we have not raised any recommendations.						

Audit Opinion

The following opinions provide management assurance in line with the following definitions:

Opinion Level	Opinion Definition	Guidance on Consistency
High (Strong)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.	The system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. Controls are operating effectively and consistently across the whole system. There are likely to be core controls fundamental to the effective operation of the system. A High opinion can only be given when the controls are working well across all core areas of the system. For example with 'Debtors' the controls over identifying income, raising debt, recording debt, managing debt, receiving debt, etc. are all working effectively – there are no serious concerns. Note this does not mean 100% compliance. There could be some minor issues relating to either systems design or operation which need to be addressed (and hence the report may include some recommendations) – however these issues do not have an impact on the overall effectiveness of the control system and the delivery of the system's objectives.
Significant (Good)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas	The system is generally well designed - but there may be weaknesses in the design of the system that need to be addressed. In addition most core system controls are operating effectively – but some may not be. Whilst any weaknesses may be significant they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.

Opinion Level	Opinion Definition	Guidance on Consistency
Limited (Improvement Required)	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives	The system is operating in part but there are notable control weaknesses. There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved. In terms of what differentiates a borderline Significant Opinion to a borderline Limited opinion – the main factors are the scale and potential impact of weaknesses found. Multiple weaknesses across a range of core areas would suggest a Limited Opinion level is applicable. However it also true that ONE weakness can suggest a Limited Opinion if it is fundamental enough to mean that a number of core system objectives will not be achieved.
Low (Weak)	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives.	The audit has found that there are serious weaknesses in either design or operation that may mean that the overall system objectives will not be achieved and there are fundamental control weaknesses that need to be addressed. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses. The report will clearly state if 'No Assurance' is actually more applicable than low assurance.

Where limited or no assurance is given the management of the Foundation Trust must consider the impact of this upon their overall assurance framework and their Annual Governance Statement.

Priorities assigned to individual recommendations

Individual recommendations are graded in accordance with the severity of the risk involved to the Foundation Trust. Audit Yorkshire has a standard definition for each level of recommendation priority. This is represented in the table below:

Grading	Definition	Guidance on Consistency
Major (High)	Recommendations which seek to address those findings which could present a significant risk to the organisation with respect to organisation objectives, legal obligations, significant financial loss, reputation/publicity, regulatory/statutory requirements or service/business interruption.	These are recommendations which aim to address issues which if not addressed could cause significant damage or loss to the organisation. The expectation is that these recommendations would need to be taken as a matter of urgency. These recommendations should have a high corporate profile – with a clear implementation tracking process in place, overseen by the Board or a Board level committee.
Moderate (Medium)	Recommendations which seek to address those findings which could present a risk to the effectiveness, efficiency or proper functioning of the system but do not present a significant risk in terms of corporate risk.	These are recommendations which if not addressed could cause problems with the safe or effective operation of the system being reviewed. The recommendations should have appropriate profile within the division or business area in which the system being considered sits and some profile at Board /Audit Committee level also. These recommendations should be carefully tracked to ensure that action reduces the risks found
Minor (Low)	Recommendations which relate to issues which should be addressed for completeness or for improvement purposes rather than to mitigate significant risks to the organisation. (This includes routine/housekeeping issues)	All other recommendations fall into this category. This includes recommendations which further improve an already robust system and housekeeping type issues.