Policy and Procedure on Handling and Resolving Complaints and Concerns

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Version History

Version	Date	Reason for Change
11.1	June 2019	Clarification of risk ratings section 22.5 Addition of section 18 in line with best practice and local learning from complaints.

CONTENTS:

1. POLICY STATEMENT

1.1 The Trust is committed to providing an accessible, fair and effective means for service users, carers and/or their representatives to express their views about Trust services.

1.2 Concerns and complaints matter to us because they tell us about the quality of care that we deliver. We aim to manage concerns and complaints through a procedure of local resolution, which is in line with the Trust's values and consistent with the NHS Constitution 2015[1].

1.3 The commitment of the Trust is that people who raise a concern or complaint will not face prejudice or discrimination as a consequence. Service users should always be reassured that in making a complaint it will in no way affect their eligibility for, or the nature of, current or future treatment.

1.4 The main aim of this policy is to ensure a robust process for investigating and enabling resolution of concerns or complaints, as quickly, sensitively and supportively as possible. The Trust's approach is to investigate and feedback matters locally, wherever possible, with the aim of providing reassurance to people that their issues have been heard and resolved.

1.5 We aim to involve people in our approach to resolving their concerns and complaints, wherever possible.

2. INTRODUCTION

2.1 We strive to deliver the best possible service for those in our care. Every person in contact with our service should receive a flexible, compassionate, empathetic, respectful, inclusive and timely response from ²gether staff and volunteers. The Trust is committed to make every reasonable effort to resolve things that go wrong as soon as possible and to give service users / carers an outcome that is fair.

2.2 Listening and responding to feedback and being proactive about the development of inclusive, quality services is of great importance to ²gether. When things do go wrong, the Trust response will not be one of blame or retribution, but of learning and a constant drive to improve services.

2.3 In accordance with Trust values and national complaint guidance and legislation, we will actively seek feedback about our services. Where feedback includes a complaint about services, the Trust is required to respond to a satisfactory standard and to comply with requirements as outlined within the NHS Constitution for England 2015 and contained within the National Health Service (England) Regulations 2009.

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

2.6 We aim to actively seek, listen to, respond to, and improve through a continuous cycle of learning from experience in order to provide the best quality care that we can.

2.7 The Trust is committed to having effective procedures in place to manage all issues brought to its attention. The organisation will learn from feedback and ensure that people's experiences are used to continually improve services. The Parliamentary and Health Service Ombudsman, Review of Complaint Handling for 2011/12 notes:

"...each complaint that is not fully addressed or investigated is a missed opportunity for the NHS to continue to improve, to pick up on possible systematic problems, and to reinforce the trust that we all place in the NHS to get our care and treatment right."

3. PURPOSE

3.1 The purpose of this policy is to ensure that any person who uses [2]gether's services (or their relatives, carers, representatives) has the opportunity to raise any concerns or to make a formal complaint should they wish to. The policy outlines the expected practice we will follow in relation to seeking to resolve matters of concern or formal complaint in a timely way.

3.2 To achieve this, the policy and procedure is designed to:

- Promote a culture within the Trust which welcomes expression of concern and complaint as an opportunity to engage with service users and to put matters right as quickly as possible.
- Provide a complaints handling system which is fair for complainants and staff alike.
- Facilitate coordinated handling of cross-boundary complaints.
- Ensure that the lessons learned from complaints and feedback is used to improve the service.
- Ensure that the complaints procedure is open, accessible and well publicised.

4. SCOPE

4.1 This policy and procedure applies to all concerns and formal complaints received by [2]gether. There are no limitations to its circulation within the Trust and the wider NHS community, and it is available to service users, their families and/or carers, and members of the public either via the Trust website or upon request.

4.2 The following are <u>excluded</u> from the scope of this policy:

- Complaints made regarding the management of Freedom of Information requests and data protection issues. These concerns should be managed via the Information Governance Team.
- Complaints made by organisations about a Trust service where the issue

is contractual or relates to a service level agreement. Disputes or queries of this nature should be addressed as part of contract monitoring.

- A complaint made by a Trust employee about any matter relating to his/her contract of employment, including complaints about others employed by the Trust. (Please refer to the Trust Grievance Policy).
- A complaint which is already under investigation (or has been previously investigated) by the Parliamentary Health Service Ombudsman (PHSO).
- A complaint where the complainant is solely wanting to take legal action for a claim or compensation and does not wish to raise a complaint (please refer to the Claims Policy).
- A complaint made more than 12 months after the event took place (please see section 17 for more detail).
- A complaint where events have previously been investigated within the Trust's complaints procedure. If a complainant remains dissatisfied with the response to their concerns an additional process can be offered (please see section 24 for more detail).
- Complaints not relating to any Trust service. Where possible these will be forwarded to the responsible organisation by the Service Experience Department, with the agreement of the complainant (please see section 26.2 for more detail).

5 CONTEXT

5.1 The Trust acknowledges its requirement to comply with current NHS national guidance and best practice to resolve complaints wherever possible.

5.2 A 'Review of NHS Hospitals Complaints System: Putting Patients Back in the Picture[2] identified key themes of complaint resolution which included the need for readily available and accessible information, for the process to be free from fear of jeopardising future care; that complaints are handled sensitively and promptly and followed a clear process. Best practice dictates that people should be supported through the complaints process. Cross-organisational complaints should be seamless; the outcome should be independent. Learning from complaints must be effectively cascaded in order to be embedded in practice and support service improvement.

5.3 The Trust has an obligation under the Duty of Candour Policy[3]. This requires all staff to demonstrate:

- **Openness** – enabling concerns and complaints to be raised freely without fear and for questions asked to be answered.
- **Transparency** – allowing information about the facts and experience of our service to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of our service must be informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it[4].

[2] Ann Clwyd MP and Professor Tricia Hart Oct 2013
[3] (CQC 2014 Regulation 20)
[4] (See Being Open/Duty of Candour Policy)

5.4 This document complies with:

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- NHS Constitution for England 2015
- Data Protection Act 1998
- Access to Health Records Act 1990
- Mental Health Act 1983 amended 2007
- Mental Capacity Act 2005
- Accessible Information Standard (DCB1605 Accessible Information 2017)

6. DUTIES

6.1 The **Trust Board** is the responsible body under the complaints regulations. The Board provides delegated responsibility to the Trust's Governance Committee to approve this document.

6.2 The **Chief Executive Officer (CEO)** is responsible for ensuring compliance with NHS Complaints Regulations and will ratify the release of investigation findings in a letter of response to the complainant.

6.3 **Service Directors / Clinical Directors (for medical staff)** are responsible for ensuring the timely allocation of complaint investigators, prompt and thorough review of investigation reports and that actions arising from complaint investigations are implemented.

6.4 **Complaint Investigators** will undertake and report accurately a robust, objective, preliminary complaint investigation. Mediation and or conciliation work may also be required.

6.5 **The Service Experience Clinical Manager (SECM)** has delegated authority to manage the complaints procedure on behalf of the Chief Executive. The SECM will ensure that the Complaint management team are readily available to service users, carers, the public and members of staff.

6.6 **All Trust staff** should be aware of the Policy on Complaints as they have a responsibility to enable resolution wherever possible and report all concerns and complaints. All staff have a duty to be open and transparent with service users and/or carers, otherwise known as the *Duty of Candour (See section 5.3)*

7. DEFINITIONS

7.1 [2]gether will seek to distinguish between requests for assistance in resolving a concern and requests to make a formal complaint. The Trust will address all issues in a proportionate, flexible and fair manner, and in close liaison with the complainant. Whenever a person identifies that they wish the issues that they

have raised to be dealt with as a formal complaint, they will be immediately treated as such. If it is unclear whether the issue is a complaint or a concern then advice must be sought from the Service Experience Department to establish this with the individual concerned.

7.2 **Complaint**
A complaint is an expression of dissatisfaction that requires a formal response from the Chief Executive. Complaints may be received verbally or in writing. All complaints require an investigation to be undertaken on behalf of the complainant, followed by a written response from the CEO outlining the findings, the learning from the complaint (regardless of whether or not the complaint is upheld) and sharing any actions which will be taken as a result.

7.3 **Concern**
A concern is an issue that can usually be resolved quickly and is managed outside of the formal complaints process.

7.4 **Complainant**
A complainant is a person raising a concern or complaint regarding their own experience of contact with Trust services, or on behalf of someone else and with their consent.

7.5 Healthwatch
An organisation gathering views of local people about their experiences of local health and social care services. Healthwatch also provide advice and help to make choices about services and help people to access advocacy services:
Info@healthwatchgloucestershire.co.uk
info@healthwatchherefordshire.co.uk

7.6 POhWER
Independent Complaints Advocacy Service Gloucestershire.
pohwer@pohwer.net

7.7 Onside Advocacy
Independent Complaints Advocacy Service Herefordshire
www.**onside-advocacy**.org.uk

7.8 **Patient Advice & Liaison Service** (**PALS)**
Advocacy service established by the NHS to provide people with help, advice and liaison regarding the NHS services, including complaints.

7.9 Care Quality Commission (**CQC)**
A government body that oversees quality within the NHS. www.cqc.org.uk
The CQC will be the source of independent advice and guidance for complainants whose complaint relates to the use of the MHA.

7.10 Mental Health Act 1983 (MHA)
The Mental Health Act (1983) is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

7.11 The Parliamentary and Health Service Ombudsman (PHSO)
(or Health Service Ombudsman) provides an independent referral service to the public when they feel that an NHS body has not investigated a complaint properly or fairly or have provided a poor service. www.ombudsman.org.uk

7.12 Datix
This is the name of the electronic information management system used by the Trust to record and manage complaints and incidents.

7.13 RiO
This is the electronic information system used within the majority of the Trust to record and maintain clinical information about service users.

7.14 IAPTUS
This is the electronic information system used by the Let's Talk Service/Mental Health Intermediate Care Team to record and maintain clinical information about service users.

7.15 Service Experience Department (SED)
[2]gether's department who review and coordinate feedback received about the Trust's services. The department is managed by the Service Experience Clinical Manager.

7.16 Non-Executive Director (NED)
These are members of the Trust board and have the same legal duties, responsibilities and potential liabilities as their executive counterparts.

8. OWNERSHIP AND CONSULTATION

8.1 The Director of Engagement and Integration has Board-level responsibility for the development, monitoring and review of this document and may delegate the authority to a deputy.

8.2 Executive Directors, Trust Locality Managers, Heads of Profession, members of the Service Experience Team and the Governance Team will be consulted alongside representatives of people who use services to guide the development of this policy and procedure.

9. RATIFICATION

9.1 This policy will be ratified by the Director of Engagement and Integration and endorsed at the Trust Governance Committee on behalf of the Board.

10. RELEASE DETAILS

10.1 This policy will be available to all staff via the Trust's policy section of the intranet and through wider communication channels internally.

10.2 This policy will be available to members of the public via the Trust internet site and also by request from the Service Experience Department. An accessible

version will be available.

11. REVIEW

11.1 This document will be reviewed every two years as a minimum, or sooner in response to any changes to:

- Legislation
- National Guidance
- Local Trust needs

12. PROCESS FOR MONITORING COMPLIANCE

12.1 Service Experience reports

Quarterly Service Experience reports are produced and submitted to the Governance Committee for scrutiny and assurance of continuous improvement.

12.1.2 The quarterly reports are presented to the Trust Board held in public and are published on the Trust's website as part of Board papers.

12.1.3 Scrutiny of complaint resolution processes is also undertaken with the Trust's commissioners as part of monitoring service quality.

12.2 Annual Complaints report

An annual complaints report is submitted for assurance to the Governance Committee for scrutiny on behalf of the Board of Directors.

12.3 Audit of complaints

12.3.1 Quarterly audits of complaints are undertaken by the Trust's Non-Executive Directors

12.3.2 The outcomes of the NED audits are reported to the Trust Board for assurance and contribute to the Trust's Continuous Improvement System.

13. EQUALITY AND DIVERSITY

13.1 The Trust is committed to promoting equality and diversity in all areas and will actively support services to make reasonable adjustments to help ensure that everyone who wants to is able to raise concerns or complaints regarding Trust services.

13.2 This policy has undergone an Equality Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust undertakes to continuously improve the experience of people who raise a concern or complaint about Trust services and to ensure that everyone is treated in a fair and consistent manner.

14. TRAINING

14.1 The Trust recognises that every member of staff, whatever their role, may receive a concern or complaint. The Trust therefore provides training regarding service experience as part of the induction programme for every new member of staff.

14.2 The Trust offers investigation training to staff undertaking internal investigations. This training is based upon the principles of Root Cause Analysis, with additional information provided by the Trust Complaints Manager on the investigation of formal complaints.

14.3 Additional tailored training for teams, professional groups, and/or individuals is delivered through the Service Experience Department and is available, as required.

15. SOURCES OF CONCERNS OR COMPLAINTS

15.1 Who can raise a concern/complaint?

15.1.1 A concern/complaint may be made by:

- a person who receives or who has received services from the Trust or
- a person who is affected by, or likely to be affected by, the action, omission or decision of the Trust.

15.2 Concerns/complaints on behalf of a service user

15.2.1 Someone acting on behalf of a service user may raise issues when the service user is unable to do so themselves or has asked the person to do so on their behalf or support them in making a complaint.

15.2.2 Where an issue is being raised on behalf of someone else, the representative will need to have had sufficient interest in the person's welfare and be an appropriate person to act on their behalf. Complaints/concerns can be raised by health and social care professionals on behalf of service users, their carers and relatives (please see section 27).

15.3 Concerns/complaints from children and young people

15.3.1 Children who access Trust services have the right to make a complaint. In the case of a child under 16, a parent or guardian may make the complaint on their behalf.

15.3.2 It may be appropriate to obtain consent from a child if they are considered to be capable of understanding the situation and can provide informed consent (please see section 26).

15.4 Members of Parliament and County Councillors

15.4.1 Enquiries from Members of Parliament (MPs) are normally directed to the Chief Executive Officer (CEO). Responses to MP enquiries are normally coordinated by the CEO's office with support from the Service Experience Department, as required. Such enquiries are not usually subject to a formal complaint investigation when they are received via this route.

15.5 Care Quality Commission

15.5.1 The Trust may receive enquiries from the Care Quality Commission (CQC) on behalf of complainants who have contacted them directly. Responses will be coordinated by the Service Experience Department in line with Trust Policy. The response will be made to the complainant and CQC will be informed of the outcome.

15.6 Anonymous complaints/concerns

15.6.1 Issues raised anonymously fall outside the scope of this process as it is not possible for the Trust to provide the complainant with a response. However, these complaints/concerns will be recorded, reviewed and investigated, as appropriate.

16. SUPPORT FOR THOSE INVOLVED IN A CONCERN OR COMPLAINT

16.1 Support available to people who raise a concern or complaint

16.1.1 The Trust acknowledges that raising a concern or complaint may feel daunting and the thought of navigating the formal complaints process may discourage some people from voicing their concerns. The Trust is therefore committed to supporting people to highlight their issues in the most accessible way for the individual. The SED and PALS Officers can offer support and guidance on the range of methods available to raise a concern or complaint, including the reasonable adjustments that can be made.

16.1.2 The Service Experience Department will offer details of the independent local NHS Complaints Advocacy Service to all people who raise a formal complaint. Information, including contact details, will be sent to the complainant when their complaint is acknowledged.

16.2 Support for complainants with language or other access difficulties

16.2.1 If a complainant has difficulty in expressing their concerns, for example, due to language differences or disability, their needs will be identified and the appropriate support will be offered in order to help them to raise their concern or complaint.

16.3 Support for colleagues identified within a concern/complaint

16.3.1 Any member of staff named within a concern or complaint will be entitled to receive a copy of the letter and final Trust response. If more than one member

of staff is named within a complaint then the staff will only receive the response to the complaint issues relating to them.

16.3.2 It is recognised that being identified in a concern/complaint can be stressful and colleagues must be able to draw upon support and guidance from the Trust. Initial support will be provided by the individual's line manager. Staff should also be advised that a counselling service is available to them via Working Well (occupation health). Colleagues may also wish to obtain support from their professional organisation or Trade Union and / or to speak with the Freedom to Speak Up Guardian.

16.3.3 Details of how staff should be supported are outlined in the Trust document: Guidance in Supporting Staff involved in an Incident, Complaint or Claim[5].

17. WHEN TO RAISE A FORMAL COMPLAINT

17.1 A formal complaint should usually be made within twelve months of the date on which the matter which is the subject of the complaint occurred or came to the notice of the complainant.

17.2 The Service Experience Clinical Manager has the discretion to extend this time limit where the complainant had sound reasons for not making the complaint within the 12 month period and where it is still possible to investigate the concern/complaint effectively and efficiently. This discretion will be used flexibly and with sensitivity**.**

17.3 In the event that it is decided not to investigate a complaint on the grounds that it has not been made within the time limit, it may still be possible to provide the complainant with some limited information about the matter complained about (such as a copy of the relevant part of the health record) on an informal basis.

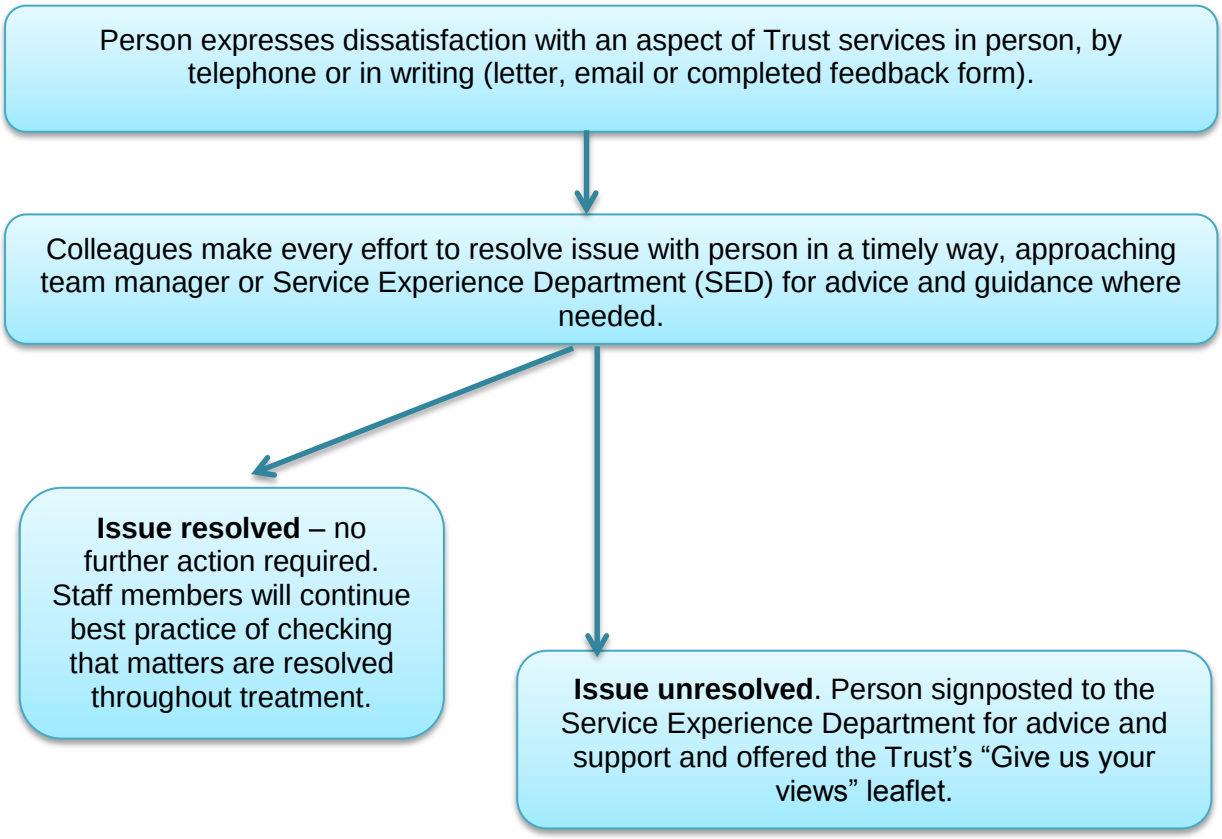
17.4 When the Chief Executive advises that a decision has been taken not to investigate due to timescales, the complainant will be advised of their right to contact the Parliamentary and Health Service Ombudsman (PHSO) to consider further. If the complaint issues concern any aspect of the use of the Mental Health Act 1983, complainants will be advised that they should instead contact the CQC for further guidance.

18. HOW TO RAISE A CONCERN OR COMPLAINT

18.1 A person may contact a member of staff involved in their care, the team manager, or the Service Experience Department to express dissatisfaction with an element of the Trust's services (see Figure 1).

[5] Link to guidance: Intranet - Guidance for staff involved in Incidents

Fig 1 Management of initial contacts of concern or complaint



18.2 **Concerns or complaints expressed verbally**

18.2.1 Staff should always endeavour to recognise and resolve verbal, informally presented concerns or complaints at the time they are made by service users and / or carers. If it is not possible to do this to the satisfaction of the complainant, the Service Experience Department must be advised immediately and provided with full details of the concern/complaint in order to support a resolution.

18.3 **Written concerns or complaints**

18.3.1 Upon receipt of a written concern/complaint the manager of the service should contact the complainant promptly and make a plan for resolution of the issues, either by meeting the person or providing the agreed response verbally or in writing. In addition, they can signpost the person to the Service Experience Department for further assistance, if required. If the issue is identified as a formal complaint then the Service Experience Department should be informed immediately. The manager can also contact the Service Experience Department at any time for advice and support in relation to the receipt of any concerns or complaints.

18.4 **Reviewing concerns with complaints**

18.4.1 A meeting between operational colleagues and the person raising concerns may often be the most appropriate way to acknowledge and respond to

concerns and may be an opportunity to be able to resolve issues with those involved.

18.4.2 When a meeting is arranged to discuss concerns raised by a complainant, notes (not necessarily verbatim) of such a meeting, particularly where contentious issues may be discussed, should be taken.

19. PROCESS FOR RESPONDING TO CONCERNS

19.1 The SED will triage the content of each concern that they receive in order to assess the seriousness of the issue(s) raised and to establish the potential impact on the people involved, the potential risks to individuals, the organisation, and the level of response required. Should issues of concern or risk arise during the triage process the SECM or Complaints Manager will escalate to the appropriate senior manager related to the type of risk identified or the CEO office should this be indicated.

19.2 Once the content of the concern has been reviewed, the SED will make contact with the complainant in order clarify the nature of the issues, establish what outcome they wish to achieve, and to explain the SED processes. The SED will attempt to achieve informal resolution at this stage.

19.3 Informal resolution of concerns

19.3.1 We want front-line staff to feel empowered to work in partnership with service users and carers to resolve problems and queries immediately and informally whenever this is possible. Wherever possible, a process will be agreed in consultation with the complainant and the staff and service involved, whereby the identified issues can be successfully addressed.

19.3.2 The Trust's Patient Advice and Liaison Service (PALS) is based within the SED to facilitate close working to resolve concerns. The PALS Officers provide information, guidance and signposting regarding Trust services. PALS officers also offer a liaison service between people who use our services and staff in our teams in order to seek a resolution to concerns they have. The PALS officers provide an outreach service and visit Trust hospital sites to promote feedback and resolution for people who are currently within Trust inpatient services.

19.3.3 Examples of ways in which concerns can be managed and resolved include**:**

- An apology from someone at a suitably senior level in order to assure the complainant that their concern has been heard and taken seriously.
- A timely meeting to listen to concerns and/or offer an explanation where a misunderstanding or communication breakdown has occurred.
- A commitment to change an aspect of a service when it becomes apparent through a concern that an improvement could be made.

19.3.4 Concerns will be recorded but will not usually require a full investigation

because resolution can be provided either by offering clarification to the person or by taking immediate action (for example offering alternative appointments, correcting erroneous information).

19.3.5 Any person who is dissatisfied with the preliminary response to a matter which has been dealt with as a concern will be advised of their right to pursue the matter through the complaints procedure and they will also be signposted to support from independent advocacy (See Section 7.6 and 7.7). A complainant can request that their concern is escalated to a formal complaint at any point.

19.3.6 In the following circumstances, staff **must report to** the Service Experience Department (SED) **within 1 working day** in order that issues are managed as a formal complaint:

- If the person who has raised the issue requests that it is treated as a formal complaint.
- Concerns that are regarded as moderate or high risk.

20. PROCESS FOR RESPONDING TO FORMAL COMPLAINTS

The SED will triage the content of each formal complaint that they receive in order to assess the seriousness of the issue(s) raised and to establish the potential impact on the people involved, the potential risks to individuals, the organisation, and the level of response required. Should issues of concern or risk arise during the triage process the SECM or Complaints Manager will escalate to the appropriate senior manager related to the type of risk identified or the CEO office should this be indicated.

20.1 Every effort will be made in the first instance by the SED to resolve issues locally through engagement and in a timely way. However, if an individual indicates that they would like to raise an issue as a formal complaint, the SED must send a written acknowledgement to the complainant within 3 working days. Best practice suggests that an individual is contacted by telephone as soon as possible from receipt of their matters of concern/complaint to gain a full understanding of the concerns, to reassure that the Trust wants to resolve issues with people and to provide information and advice as required.

20.2 The acknowledgement letter will advise of the complainant's right of assistance from advocacy services and contact details will be enclosed with the letter of acknowledgement.

20.3 The complaint issues will be sent to the complainant for their review and confirmation or amendments, with a request for a response within 5 working days to support initiation of investigation in a timely way.

20.4 Once issues of complaint are agreed with the complainant then a timescale for CEO response is proposed to the complainant by the SED.

20.5 When the content of the complaint and timescale for investigation have been agreed with the complainant, the complaint will be sent to the appropriate Locality Director / Clinical Director (for medical staff complaints) for allocation

of an investigator. The timeline for completion of the complaint investigation and response from CEO starts at this point.

21. TIMELINESS OF THE TRUST RESPONSE TO COMPLAINANTS

21.1 The NHS Constitution for England 2015 requires the Trust to discuss the manner in which the complaint is to be handled, and to inform the complainant of the period within which the investigation is likely to be completed and the response sent.

21.2 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 regulations require that the complainant is offered the opportunity to discuss their complaint. If the complainant does not accept the offer of a discussion, the Trust will (a) determine the response period for the answering the complaint in a timely way and (b) notify the complainant in writing of that period via the Service Experience Department.

21.3 As soon as reasonably practicable after completing the investigation, the Trust will send the complainant a response which is in effect the final report of the Trust's investigation findings. This will be signed by the CEO as responsible person. Timescales for the response will take into account the scope and complexity of the issues raised.

22. FORMAL COMPLAINT INVESTIGATION PROCEDURE

22.1 Upon receipt of the complaint information, the Locality Director / Clinical Director will allocate an **impartial** internal investigator and inform the SED of this (See Figure 2) so as to avoid any conflict of interest.

22.2 The SED will make contact with the investigator to ensure that they are familiar with and equipped to undertake the investigation process and feel confident to interview those involved, including the complainant.

22.3 The investigator will review relevant clinical records, policy, interview relevant staff members, and listen to the person who has complained. The investigator will develop a report using the investigation template provided by the SED and send the completed preliminary report to the Locality Director / Clinical Director and the SED.

22.4 The Locality Director / Clinical Director will review the investigation and, if satisfied with the rigor of the investigation, complete a sign-off checklist. This ensures ownership of the investigation findings as well as the action and learning recommended. The Locality Director / Clinical Director will review the learning/recommendations contained within the investigation report and ensure actions are taken forward in order to improve practice and service provision based upon the learning from feedback.

22.5 The SED will review the investigation for completeness and commence drafting the letter of response to send to the complainant.

The SECM or Complaints Manager will review and record the risk and impact of each complaint using the risk matrix on the SE module of Datix following the completion of each investigation, in order to rate the risk based upon the findings and outcome of the investigation.

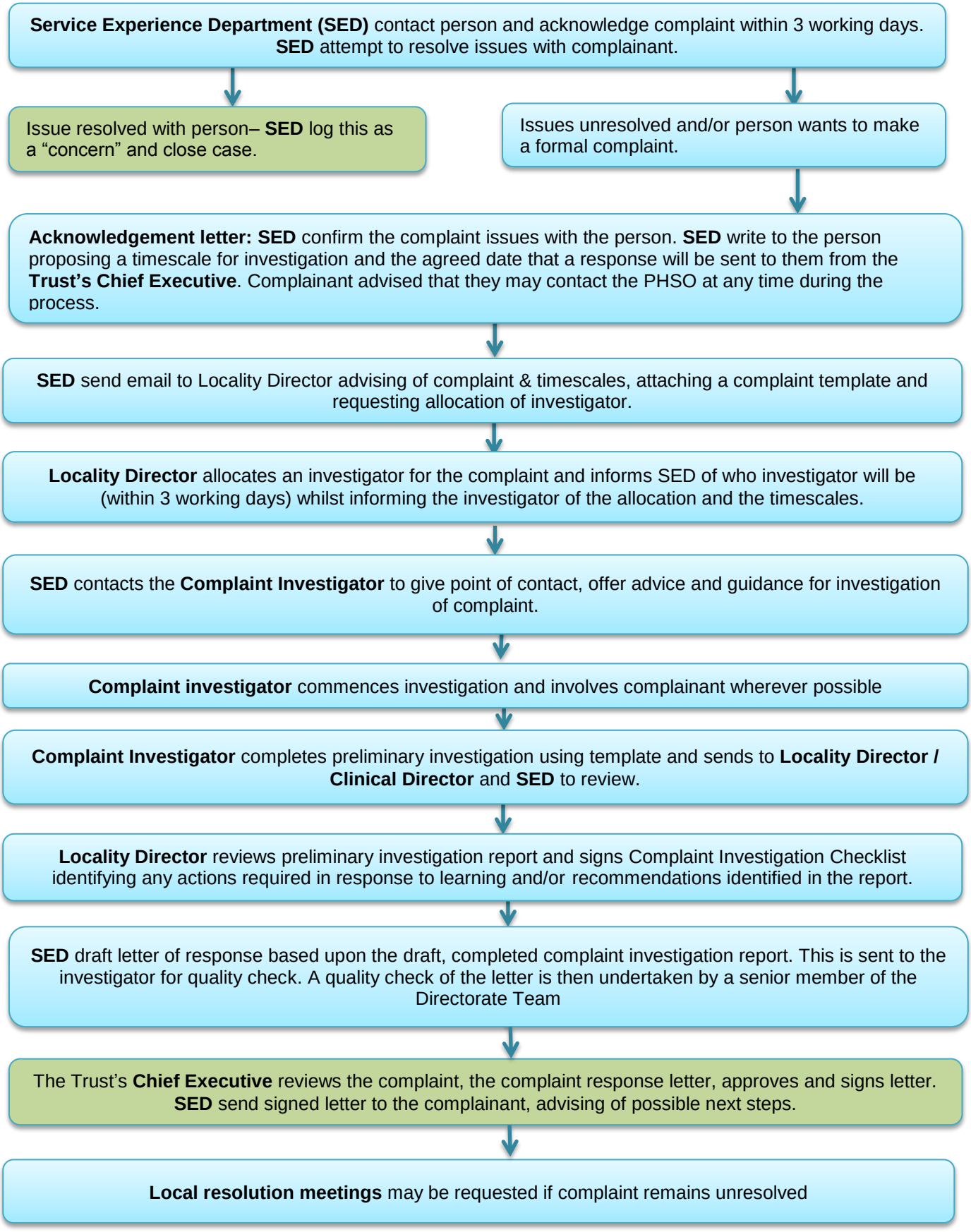
22.6 The Service Experience Clinical Manager will review the draft response letter prior to sending it to the complaint investigator for agreement that the response letter is an accurate reflection of the investigation findings**.**

22.7 The draft response letter summaries and confirms the concluding complaint investigation findings. This is reviewed and signed by the Trust Chief Executive Officer (or nominated deputy) and sent to the complainant by the SED.

22.8 If it becomes impossible to complete the process in the timescale initially agreed, the complainant will be advised, an apology and explanation offered and a new expected date set. The matter will be escalated to the Director of Engagement and Integration.

22.9 Overview of the process and timescales to respond to a formal complaint

Fig 2 Overview of the Formal Complaint process.



23. ACTIONS FOLLOWING A CEO RESPONSE LETTER TO A COMPLAINANT

23.1 The SED will provide a copy of the final response letter to the relevant Locality Director / Clinical Director and Team Manager (as appropriate) in order for them to ensure that the learning is cascaded to all relevant parties. This will include staff named within a complaint; this is usually done via their line manager. Where appropriate, the Medical Director/Director of Nursing/Director of Engagement and Integration (or nominated deputy) will receive a copy of the response and cascade information and learning to relevant clinical staff.

23.2 The SED will advise the complainant of their options if they are dissatisfied with the outcome presented in the CEO's letter.

24. RESOLVING FURTHER QUERIES AND CONCERNS

24.1 If a complainant expresses dissatisfaction about the complaint investigation or letter of response, the Service Experience Department will make contact with them, with the aim of resolving their concerns.

24.2 Should issues remain, the SED will offer the complainant a meeting with appropriate members of Trust staff to review their outstanding queries. This is called a Local Resolution Meeting.

24.3 An agenda of matters for discussion will be agreed prior to the meeting and will be limited to those issues identified within the original complaint.

24.4 Appropriate Trust colleagues such as the complaint investigator and the team/service manager for clinical areas involved may attend the meeting. Individual colleagues identified within the issues of the complaint will not usually attend the meeting. Additional attendees can be invited dependant on relevance to queries raised.

24.5 The meeting will be generally be chaired by a senior member of the SED and a record will be made of the meeting. Complainants are able to attend with an advocate to support them if they wish.

24.6 Parliamentary and Health Service Ombudsman / Care Quality Commission

24.6.1 People who complain will be advised that they can contact the PHSO for further advice and guidance at any stage during the complaint process should they have concerns regarding the investigation and/or management of their complaint. If the complaint issues concern any aspect of the use of the Mental Health Act 1983, complainants will be advised that they should instead contact the CQC for further guidance.

24.6.2 We will always endeavour to provide satisfaction and aim to achieve resolution with all people who raise concerns or formal complaints. However, on occasion, resolution may not be possible to achieve. In such instances, the complainant will be advised that they may refer their concerns to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO are required to practice within the scope of the Health Service Commissioners Act 2015. This Act sets out that the PHSO require that a complaint must be raised with them **within a year of when the person first became aware of the problem** they are raising as a formal complaint. The PHSO have discretion to waive the time limit in certain cases. Each case is dealt with by the PHSO on an individual basis and all mitigating factors will be considered.

24.6.3 To assist with complaint resolution, it may be appropriate in some instances for the Trust to refer a matter of complaint to the PHSO under section 10 of the Health and Social Care Act 2012.

24.6.4 The Service Experience Department will ensure that all complainants are provided with details about what the PHSO or CQC do and how they can be contacted, at the earliest opportunity.

24.6.5 The Service Experience Clinical Manager will ensure that the Director of Engagement and Integration is informed of any referrals to the PHSO and these will also be reported in an anonymised way in the quarterly service Experience Report

25. BEING OPEN

25.1 The Trust's policy is to provide people who raise issues with a full and frank explanation of the events giving rise to their concern or complaint. Care will be taken to ensure that sufficient information is given to explain what happened and any subsequent action that might be necessary. A sincere apology will be given whenever this is appropriate. This is in line with Trust values and the duty to be open and transparent with service users and/or carers, otherwise known as the "Duty of Candour" as cited in the Health and Social Care Act 2008 (Regulation 20).

25.2 The Trust is committed to ensuring that people are not treated negatively as a result of making a complaint. As such, the format for investigations is standardised across the Trust and comply with expected national standards. Documentation regarding a complaint will be held separately from the clinical record and only those staff participating in the investigation will be party to the complaint details. If there is evidence that someone has been treated negatively by staff as a result of making a complaint, this will be discussed with Human Resources and action will be taken, as appropriate.

26. SPECIFIC TYPES OF CONCERNS AND COMPLAINT

26.1 Complaints about an incident which may have involved harm

26.1.1 Wherever possible a discussion will take place as soon as possible between

the SED and the complainant in order to take a detailed history of their experience, to accurately record the issues that they wish to raise, and to ascertain how the complainant wishes the complaint to be resolved.

26.1.2 The SED will inform the complainant that the SED must discuss their concerns with the Director of Engagement and Integration, who will then liaise with Executive Colleagues regarding onward management of the complaint. The SED will contact the complainant to discuss the next steps to be taken.

26.1.3 If an incident is identified within a complaint it must be reported via the incident reporting module on Datix.

26.1.4 Where a complaint has previously been investigated through the Trust's Serious Incident[6] process; the SED, the Director of Quality and the Director of Engagement and Integration (or nominated deputies) will jointly review the issues that were previously investigated to understand what further investigation needs to take place. Information about these types of incidents can be found within the Incident Reporting and Management Policy.

26.2 Complaints involving the service of other organisations

26.2.1 Where complaints involve or require referral to and collaboration with external agencies such as the Police or other NHS organisations, advice should be sought from the SECM.

26.2.2 The SED will offer to contact and forward the complaint to the appropriate organisation.

26.2.3 Where a concern or complaint contains issues that relate to both the Trust and another organisation(s), the SED is responsible for liaising with the other organisation(s) in order to establish the lead agency for responding to the complaint and to ensure effective coordination and a joined up response to the complaint, whenever possible.

26.3 Complaints about safeguarding

26.3.1 If there is an urgent concern about a child or vulnerable adult at risk of harm then this should be acted upon immediately in order to protect the person at risk. This can be done by discussing the concern with the Trust Safeguarding Lead during the hours of 9am-5pm, Monday to Friday. Outside of these times the Clinical On-Call Manager must be notified.

26.5 Complaints from Service Users who have been detained under a Section of the Mental Health Act 1983

26.5.1 If a complaint is about something which happened while a person was detained under the Act, the CQC would not normally become involved until

[6] An incident is any event that has, or may have, impacted upon the safety of patients, staff, and the delivery of a service or health improvement. Incidents can include hazards, accidents, dangerous occurrences, significant events, and near misses (please see the Incident Policy for more details).

after the Trust complaints process has been completed. A complaint about the way in which powers or duties have been exercised under the Act can be made directly to the CQC. However, the CQC has discretion to refer this kind of complaint to the Trust to deal with under its own complaints procedure.

26.5.2 If a person wishes to complain that they are being detained against their will, the CQC has no power to discharge them. They should ask for their case to be considered by the Mental Health Act Managers and/or the Mental Health Review Tribunal.

26.5.3 Service Users who are detained and have made a complaint should be made aware of their entitlement at any stage to contact the Care Quality Commission (CQC) and be helped to do so if necessary. The CQC has the authority to investigate complaint issues relating to the use of theMHA and can also support and advise detained patients through the NHS complaints process, advising them of their rights and corresponding on their behalf with the Trust.

26.6 Concerns and complaints raised out of standard office hours

26.6.1 If an issue is raised out of standard office hours which is felt to be of a serious nature, and cannot be managed by the staff present, the On Call Manager should be contacted. The complainant will be advised that this has been done and when they can expect a response. All staff working shifts outside standard office hours should be made aware of how to contact the On Call Manager.

26.7 Concern and complaint information and clinical records

26.7.1 All staff should note that documentation relating to concerns and complaints, including; letters, correspondence, consent forms and investigation documents, **should not be placed on a person's clinical record**. Additionally, information about a complaint that has been made should not be included in any documentation which is then placed on a person's clinical record.

26.7.2 If there is an occasion where the clinical team believe that it may be necessary and clinically appropriate to include reference to a concern or complaint in a service user's clinical record, this must be discussed with the Service Experience Clinical Manager and the Trust's Health Records Department.

26.8 Concerns or complaints about the Service Experience Department (SED)

26.8.1 If a complainant wishes to raise issues regarding the SED then these should be sent directly to the Director of Engagement and Integration, Chief Executive Officer (CEO) or the Trust Chair.

26.8.2 A robust and independent investigation of the issue will be undertaken in line with usual policy but managed through an alternative route to maintain

objectivity.

26.9 Concerns or complaints about the Chief Executive Officer, Executive Directors or Non-Executive Directors

26.9.1 If a complainant wishes to raise issues regarding the CEO, an Executive Director or a Non-Executive Director then these should be sent to the Trust Chair.

26.9.2 The Trust Chair will ensure that a robust and independent investigation of the issue raised will be undertaken.

26.10 Concerns or complaints about the Trust Chair

26.10.1 Complaints or concerns about the Trust Chair should be sent to the CEO or the Senior Independent Director.

27. CONSENT AND CONFIDENTIALITY

27.1 Where a concern or complaint is made on behalf of someone else, care must be taken not to disclose personal or health information to the complainant unless the person has expressly consented to this disclosure. When appropriate, the complainant will be informed by the SED of the requirement to approach the person to seek their consent to share information in a full response to the complainant.

27.2 The SED will approach the person about whom the concern/complaint relates in order to explain the content of the complaint and to seek consent for the investigation to commence. Ideally, the initial contact will be made verbally so that the SED can explain the process thoroughly. This will be followed up in writing and with a request for a consent form to be signed and returned to the SED.

27.3 The duty of confidentiality applies equally to third parties who have given information contained within the clinical record or who are referred to in the person's clinical records.

27.4 If the person about whom the concern/complaint relates does not consent to share information with the complainant, a limited response will be given to the complainant. Personal information and/or information included in the clinical record will not be included.

27.5 If the complainant does not have sufficient interest in the person's welfare, or is not suitable to act as their representative, the SED will seek advice and guidance from the Trust's Safeguarding Lead. If it is decided that it is not in person's best interest to proceed with the complaint then the complainant will be notified of this decision in writing. An example of such a scenario may be where the case relates to the safeguarding of an Adult at Risk.

27.6 Children who receive/have received Trust services are able to make a

complaint in their own right. In the case of a child (under 16), a parent or guardian may be approached to make the complaint on their child's behalf and to support their child. In some cases it may be appropriate to obtain consent from a child to proceed with the concern/complaint if that child is considered to be capable of fully understanding the situation and can give informed consent. The decision as to whether they are capable will need to be assessed on an individual basis, alongside the child's Responsible Clinician.

28. CAPACITY ISSUES

28.1 If there are concerns about whether the person about whom the concern/complaint relates has the capacity to give consent, then this matter should be discussed with the clinical team. A capacity assessment should be undertaken in relation to the information that is contained within the formal complaint and the requirements/scope of a complaint investigation (please refer to the Mental Capacity Act Policy).

29. REPORTING AND LEARNING ARRANGEMENTS

29.1 In order that lessons can be learnt from concerns and complaints, agreed actions and learning from investigations will be logged on the Service Experience Datix module and analysed by the Service Experience Department. Reports will be made to Locality Governance meetings, the Trust's Quality and Clinical Risk sub-committee, the Trust's Governance Committee. Action plans will be drawn up to inform aggregated learning plans and address the issues raised to drive and maintain ongoing quality improvements.

29.2 The results of actions taken as a consequence of receiving concerns and complaints will be monitored to provide assurance regarding the effectiveness of the learning process. The SED will facilitate and coordinate this process and the relevant Locality or service within the Trust will take ownership of its implementation. Localities and services will provide the SED with confirmation that the agreed actions have been completed. The SED will share learning for wider dissemination across the Trust through the development of practice notice alerts.

29.3 The SED will provide information to and attend the Locality Governance meetings in order to support the local processes for dissemination of learning, recommendations and actions. SED attendance at Locality Governance meetings also ensures that learning from complaints and quality improvements can be systematically tracked through regular liaison with the localities/services.

29.4 Action plans for complaint responses where limited assurance of process has been identified, such as those developed in response to Parliamentary Health Service Ombudsman (PHSO) reports, are monitored and scrutinised by the Trust's Governance Committee on behalf of the Board.

30. MANAGING UNREASONABLE COMPLAINTS

30.1 One of the Trust's core values is engaging with and listening to service users, carers and staff and this is particularly important when managing complaints. The Trust will take all reasonable steps in order to reach a resolution with the complainant.

30.2 On rare occasions, someone may make very regular contact with the Trust regarding an issue to which the Trust has already attempted to provide a reasonable resolution, and possibly also following a referral to the PHSO for independent review. Similarly, a complaint may be raised with the primary purpose and/or effect to disturb, disrupt and/or pressurise the Trust or its staff.

30.3 Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this.

30.4 The Trust will ensure that staff receive an appropriate level of support in such circumstances through line management, supervision and other sources of support, as indicated. Any incidents of harassment should be reported and documented on Datix.

30.5 Where all avenues have been explored to reasonably assist the complainant and to resolve concerns further action may be considered. Guidance on defining and managing unreasonable complainants is contained in Appendix A. This procedure will only be used in exceptional circumstances and as a last resort when all other measures to resolve issues for a complainant have been exhausted. There will be an initial conversation between the Service Experience Clinical Manager and the Director of Engagement and Integration, for onward report for Executive Team review and agreement, if appropriate.

31 ENQUIRIES

Enquiries about this policy, or its operation, should be addressed to:

The Service Experience Clinical Manager,
Rikenel, Park Road, Gloucester, GL1 1LY

32 REFERENCES

- NHS Constitution for England 2015
- Health Service Commissioners Act 2015
- Parliamentary and Health Service Ombudsman Service Charter 2016
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Listening, Responding, Improving: Guidance to support implementation of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- NHS complaint procedures in England; SN/SP/5401; Social Policy Section; April 2014

- NHS Constitution; October 2015 https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
- The Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust; January 2005-March 2009; Robert Francis QC
- A Review of the NHS Hospitals Complaint System, Putting Patients back in the Picture. Final Report October 2013. Ann Clwyd MP and Professor Tricia Hart.
- PHSO Principles of Good Complaint Handling, February 2009
- PHSO, The NHS hospital complaints system – A case for urgent treatment? April 2013
- PHSO, Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12, November 2012
- PHSO Working together to investigate health and social care complaints; December 2016
- CQC Complaints Matter; December 2014
- Regulation 20: Duty of Candour. Guidance for NHS Bodies. (CQC 2014)
- Health Services Commissioners for England (Complaint Handling) Act 2015

Appendix A

PROCEDURE FOR MANAGING UNREASONABLE OR UNREASONABLY PERSISTENT COMPLAINANTS

1 INTRODUCTION

1.1 On rare occasions, people who complain may present as unreasonable or unreasonably persistent. This is not because they raise uncomfortable or searching issues but because complaints are perused in a way which can either impede the investigation or can have significant resource issues for the organisation. In addition, some people may display inappropriate behaviour towards staff when making a complaint.

2.2 CRITERIA FOR UNREASONABLE OR UNREASONABLY PERSISTENT BEHAVIOUR

2.2.1 Complainants (and/or anyone acting on their behalf) may be deemed to be unreasonably persistent where current or previous contact with them shows that they have met at least two of the criteria below. However, once it is clear that a complainant meets any one of the criteria, it would be appropriate to inform them verbally and/or in writing that they are at risk of being classified as unreasonably persistent and what the outcome of this would be. A copy of this procedure should be provided to the person.

- Making the same complaint repeatedly (with minor differences) but never accepting the outcomes.
- Making contact with the organisation which is unreasonably lengthy, complicated, aggressive, threatening or abusive towards staff.
- Making unnecessarily excessive demands on staff time and resources while a complaint is being investigated, for example excessive telephoning or numerous emails or writing lengthy complex letters every few days and expecting immediate responses.
- Continuing to complain about an historic or irreversible decision or event.
- Significantly changing aspects of the complaint partway through the investigation or denying statements made at an earlier stage.
- Persistently approaching the Trust through different routes about the same issue in the hope of getting different responses (a ‘scattergun’ approach).
- Unwillingness to accept documented evidence as factual or denying receipt of an adequate response despite correspondence specifically answering their questions/concerns. This could also extend to complainants who do not accept that facts can sometimes be difficult to verify after a long time period has elapsed.

- Refusal to identify the precise issues they wish to be investigated, despite reasonable efforts to do so by staff and, where appropriate, their advocates.
- Focusing on a small detail to an extent that it is out of proportion to its significance and continuing to focus on this point.
- Abusive or verbal aggression towards staff dealing with their complaint or their families or associates.
- Making defamatory comments about staff to the media.
- Having insufficient, or no grounds for their complaint and making it for reasons that they do not admit or make obvious.
- Refusing to cooperate with the complaint investigation process, whilst still wishing their complaint to be resolved.
- Insisting on their complaint being dealt with in ways that are incompatible with NHS procedure or good practice or are disproportionate to the complaint.
- Has identified concerns outside the jurisdiction of the Trust and does not accept this when it is explained.
- A history of repeatedly making unreasonably persistent complaints.
- Displaying unreasonable demands or expectations and failing to accept that these may be unreasonable after a clear explanation has been provided about what constitutes an unreasonable demand. For example, insisting on responses to complaints or enquiries being provided more urgently than is reasonable or recognised practice.

2.2.2 It is important to differentiate between persistent complainants and unreasonably persistent complainants. Some people may be persistent because they feel that the Trust has not dealt with their complaint properly and are not prepared to leave the matter there. Unreasonably persistent complainants pursue their complaints in an inappropriate way which can cause great strain on both staff and resources.

3.0 PROCEDURE FOR IDENTIFYING AND ADVISING ABOUT UNREASONAL OR UNREASONABLE PERSISTENT BEHAVIOUR

3.1 If the Executive Team is satisfied that an individual is presenting as unreasonable or unreasonably persistent then a decision will be made about taking any further action that is necessary to take.

3.2 The complainant should be informed that if the behaviour persists that action may be taken and explanation as to why this is the case must also be offered.

3.3 If a complainant's unreasonable behaviour is abusive or threatening, it is reasonable to require them to communicate in a specific way, such as in writing or with one or more designated members of staff. If a complainant or their representative threatens or uses actual physical violence towards staff or their families or associates at any time, this will in itself cause personal contact to be discontinued and the complaint to be responded to through written communication only. Any such incidents should be documented and

reported via the incident reporting function on Datix and in association with the Trust's Security Policy.

4.0 ACTION THAT CAN BE TAKEN

4.1 It may be appropriate, in the first instance, for the Chief Executive to inform a complainant that they are at risk of being classified as unreasonable or unreasonably persistent. A copy of this procedure will be sent to the complainant, who will be advised to take account of the criteria in any dealings with the Trust. In some cases it might be appropriate to copy this notification to others involved in the complaint and suggest that the complainant seeks advice before taking their complaint further, e.g. from an independent advocate.

4.2 It may also be appropriate to try to resolve matters by drawing up a signed agreement with the complainant setting out a code of behaviour for the parties involved.

4.3 If these steps do not lead to a change in the complainant's behaviour, members of the Trust Board such as the Chief Executive, Medical Director/Director of Quality /Director of Engagement and Integration and a Non-Executive Director will determine whether to identify the complainant as 'unreasonable or unreasonably persistent' and, if so, what action to take. If the complainant is a service user, the advice of the appropriate clinician will be sought. The support of the Local Security Management Specialist may also be sought.

4.4 The Chief Executive will implement such action and will notify the complainant, in writing, of the reasons why they have been classified as unreasonable or unreasonably persistent and what action will be taken. This notification may be copied for the information of others already involved in the complaint. A record must be kept for future reference of the reasons why a complainant has been classified in this way. The Chief Executive may deal with the complainant in one or more of the following ways:

- Withdraw contact with the complainant in person or by telephone, letter, fax, email or any combination of these, provided that one form of contact is maintained. Alternatively, restrict contact to liaison through a third party. If staff are asked to withdraw from a telephone conversation with a complainant, there will be an agreed statement available for them to use at such times.

- Notify the complainant, in writing, that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant may be notified that correspondence in relation to their complaint or any further complaints relative to the same period of time or the same or similar issues as an earlier complaint, is at an end and that further letters received will be acknowledged but not answered.

- Inform the complainant that in extreme circumstances, the Trust reserves the right to pass unreasonable or unreasonably persistent complaints to the Trust's solicitors or Police, which may result in legal action against the complainant.

- Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from solicitors, the Security Management Service or other relevant agencies.

4.5 Any decision to classify a complainant as unreasonable or unreasonably persistent will be reported in an anonymised format to the Trust Board as part of the quarterly Service Experience report.

5.0 MANAGING UNREASONABLE AND UNREASONABLY PERSISTENT STATUS

5.1 Any steps taken to consider the behaviour of an individual as 'unreasonable or unreasonably persistent' should be viewed as temporary.

5.2 There will be a mechanism for withdrawing this status put in place. For example, if the complainant subsequently demonstrates a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate, a reversal of the decision may be made. Subject to the approval of the Executive Team, normal contact with the complainant and application of NHS complaints procedures will be resumed.

5.3 A complainant will also have an opportunity to apply to have their 'unreasonable or unreasonably persistent' status withdrawn. A Non-Executive Director should review the circumstances and establish the current position. If this remains unchanged, then the policy continues to be applied to the complainant.

5.4 If there is demonstrable evidence that the circumstances have changed, then the Non-Executive Director and the Executive Team will consider withdrawing the status of 'unreasonable or unreasonably persistent'. Subject to their approval, normal contact with the complainant and application of the NHS complaints procedure will be resumed.