

COMPLAINTS PROCEDURAL GUIDELINES

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PROCEDURE SUMMARY

The purpose of this procedural document is to ensure that complaints about services provided by the Trust are dealt with in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame.

The Trust monitors the implementation of and compliance with this procedure in the following ways;

Executive Directors/Service Directors receive weekly open complaints situation report, and fortnightly complaints overview identifying any areas of concern.

Regular assurance and exception reports to the Clinical Commissioning Groups (CCG's) and Quality Meetings. Quarterly Thematic Report and quarterly lessons learned update.

Internal audits to monitor and check key areas of complaints process.
Non-Executive Directors (NEDs) review and monitor complaints monthly as an independent quality assurance check.

Services	Applicable	Comments
Trustwide	✓	
Essex MH & LD	✓	
CHS	✓	

**The Director responsible for monitoring and reviewing this policy is
Executive Director of Corporate Governance & Strategy**

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

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COMPLAINTS PROCEDURAL GUIDELINES

Assurance Statement

The purpose of this procedural document is to ensure that complaints about services provided by the Trust are dealt with in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame. This Policy ensures the Trust incorporates into our practice the Risk Management Standards (NHSLA), CQC Registration Requirements, Making Experiences Count (DH, June 2007), NHS Constitution (2009) and Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman 2009).

1.0 INTRODUCTION

1.1 A complaint is an oral or written expression of dissatisfaction about any matter reasonably connected with services supplied by this Trust. This includes NHS services and Local Authority services delegated to the Trust under its partnership agreements.

The Trust proactively seeks feedback from our patients/residents and their families/carers in the following ways;

- A complaint may be made orally or in writing (including email and through the Trust website). The Trust website provides contact details of the Complaints and Patient Experience Teams.
- Every public area within the Trust will display posters and information leaflets that inform patients/residents, carers and visitors about the Trust's complaints procedure.
- This procedure should be read in conjunction with the Complaints Policy .

1.2 The aim of the Trust's Complaints Policy and Procedural Guidelines is to encourage communication on all sides to resolve the complaint satisfactorily, and for the Trust to learn from complaints. The Trust will proactively consider and manage all complaints raised by patients/residents or their families/carers. The Complaints Procedure will attempt to involve the complainant from the outset and determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and what these options mean.

1.3 This procedure sets out how issues are to be handled in an appropriate and proportionate manner. The Trust recognises that there are times when the complainant is satisfied with the outcome but there is still a need for the Trust to further investigate a matter. Some complainants will ask for a very thorough investigation of their issues, the Trust will

determine what a proportionate response to the matter, including any investigation, actually is.

- 1.4 Council of Governors and members of the Foundation Trust do not have any role in the complaints procedure. Governors and members however should refer, or ask the Trust Secretary to refer, any complaints that they receive to the Complaints Department or the Patient Advice and Liaison Service (Appendix 5).
- 1.5 “Working days” will in this procedure mean Mondays to Fridays, excluding Bank Holidays.
- 1.6 Inadequate complaints handling can itself be grounds for complaint.
- 1.7 The rules about patient/resident confidentiality must be adhered to throughout this procedure and consent from complainants (and any patient/resident where the complainant is not the patient or resident) sought when required. Consent will be valid for a period of 6 months, when this has expired; the Trust will require further written consent. If the patient/resident does not have capacity other alternatives of consent will be sought.
- 1.8 Complaints records will be kept separately from health records. Subject to the need to record information which is strictly relevant to the patient’s/residents health, no references to the complaint shall be made in the health records.
- 1.9 Under the NHS Constitution (2013) all patients/residents and their families have the right to have any complaint they make about the NHS dealt with efficiently and for it to be properly investigated. They also have the right to be kept informed of progress and to know the outcome of any investigation undertaken. In the event of a member of staff being investigated through the Conduct and Capability policy as a result of a complaint, the Trust has a duty of confidentiality to the employee not to disclose this to the complainant.
- 1.10 Complaints will be handled in the strictest confidence in accordance with the NHS Confidentiality Policy. Care will be taken that information is only disclosed to those who have a demonstrable need to have access.
- 1.11 Anyone disclosing information to others who are not directly involved in the complaint will be dealt with under conduct procedures.
- 1.12 Any complaints against a person working with children must reflect the Safeguarding Children Procedures CLPG 37 and the appendix on Safer Working Practices with children and Managing Allegations. In such cases the Head of Safeguarding Team should be contacted to discuss the complaint and a decision made to report to the Local Authority Designated Officer (LADO) as per national guidance, Working Together to Safeguard Children 2015.

2.0 WHAT IS A COMPLAINT? WHO CAN COMPLAIN AND HOW TO COMPLAIN?

- 2.1 Complainants will generally be existing or former patients/residents of the Trust's services, or people who are affected by the action, omission or decision of the Trust. A patient/resident must give their written consent for someone to act on their behalf.
- 2.2 A complaint may be made by a person (in regulations referred to as a representative acting on behalf of a person, but not acting on behalf of themselves without the complainant's knowledge) who has:
- requested a representative to act on their behalf.
 - delegated authority to do so, for example in the form of Power of Attorney.
 - is an MP acting on behalf of and by instruction from a constituent.
 - has died;
 - is a child;
 - is unable to make the complaint themselves because of
 - (i) physical incapacity; or
 - (ii) lack of capacity within the meaning of the Mental Capacity Act 2005.
- 2.3 Where a representative makes a complaint on behalf of a child, the Trust will consider the complaint, if it is satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child; and if it is not satisfied, must notify the representative in writing, and state the reason for its decision. The Trust must be satisfied that the representative is conducting the complaint in the best interests of the child on whose behalf the complaint is made.
- 2.4 Where a representative makes a complaint on behalf of a person who lacks capacity within the meaning of the Mental Capacity Act 2005. The Trust must be satisfied that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made. If it is not satisfied the complaint must not be considered and the Trust must notify the representative in writing, and state the reason for its decision.
- 2.5 Carers have a right to complain about issues that affect them in their role as carers. Where it is necessary to share information which relates to a patient's care, the patient's consent will be sought in writing.
- 2.6 Persons wishing to make a complaint can contact the Complaints Team at epunft.complaints@nhs.net or by telephone on 01268 407817 or by writing to the Chief Executive. Leaflets are available at all Trust sites and details on the Trust website: www.eput.nhs.uk Details are attached as Appendix 2.

3.0 TIME LIMITS FOR MAKING A COMPLAINT

- 3.1 A complaint should be made as soon as possible after the action giving rise to it, to enable a full investigation whilst all the facts regarding the complaint are still readily available. The time limit for making a complaint is within 12 months of the event.
- 3.2 There is discretion to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier. Therefore, all complaints made outside of the above time limits will be referred to the Head of Complaints for guidance. The time limit in paragraph 3.1 (above) will not apply if the Trust is satisfied that the complainant had good reasons for not making the complaint within that time limit; and despite the delay, it is still possible to investigate the complaint effectively and fairly.
- 3.3 In any case where the Head of Complaints has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Parliamentary and Health Service Ombudsman (PHSO) to consider it.

4.0 ROLES AND RESPONSIBILITIES

- 4.1 All Trust staff are expected to:
- take any concerns raised by a patient/resident or their family/carer seriously, to act compassionately, listen and to view it as an opportunity to learn and improve the services provided for current and future patients
 - make every effort to resolve concerns and complaints when they are raised within their ward/work area and know who to escalate the issue to if they are unable to resolve the concerns personally.
 - follow the Trust's Complaints Policy and Procedure and know where and how to find the information about the Patient Experience and Complaints Teams for patients/residents and relatives should they request it.
 - forward any written complaints received immediately to the Complaints Team for action.
 - assure complainants that the Trust will not reprimand or discriminate against any person who makes a complaint.
- 4.2 **Chief Executive**
- Is the accountable and responsible person who will ensure that the Trust's complaints handling processes comply with the National Regulations.

- Will ensure that no patient/resident is discriminated against or their care adversely affected following a complaint.
- Will personally respond to all formal complaints, if, for any reason this is not possible, an Executive Director will have delegated responsibility.
- Will ensure that a customer service culture that always puts the patient /residents first is actively promoted.

4.3 Executive Director of Corporate Governance

- Has overarching responsibility for the complaints process.
- Is a designated signatory for the Chief Executive.

4.4 Executive Directors/Service Directors

- Appoints an investigator.
- Agrees if a complaint meets complex criteria.
- Approves extension timescales.
- Reviews and amends as appropriate draft complaint responses
- Approves complaints Investigation Report and identified lessons learned.
- Ensures the lessons learned are embedded in their relevant service area and arrange local events for their services to learn from complaints.

4.5 Non-Executive Directors

- The Non-Executive Directors (NEDs) of the Trust will review and monitor four complaints monthly; these will be selected randomly from the list of closed complaints during the relevant period and will consist of two Mental Health and two Community Health Service complaints.
- The NEDs will refer to the Investigation Report and the response letter and consider if the complaint was investigated robustly, the quality and openness of the response, reflect the Trust's customer service standards and the likely satisfaction of the complainant with the response.
- The NEDs will also satisfy themselves that deadlines were adhered to and any learning is identified. They can make further suggestions for learning for the Trust if appropriate.
- These reviews shall be sent to the Chair for sign off and a copy will be kept in the complainant's file.

- If the Non-Executive Director believes the case was deficient in identified ways, they will discuss their findings with the relevant Director.

4.6 Investigating Officers – Clinical and Non Clinical

Department of Health guidance on investigating complaints can be found on the Trust's intranet under the Executive Director of Corporate Governance/Complaints.

The Complainant can request that their complaint is investigated by someone from a different Service/Directorate if appropriate.

Investigating Officers;

- Will be appointed by the Executive Director/Service Director.
- Are responsible for contacting the complainant immediately to introduce themselves either by telephone or letter to:
 - Clarify their issues
 - Identify the outcome the complainant is seeking
 - Agree a Complaints Handling Plan
 - Extend the timescale if the complaint meets the identified complex complaint criteria, or other appropriate reasons, as approved by the Executive Director.
- Are responsible for keeping the complainant informed as reasonably practicable, as to the progress of the investigation and the reasons for any delay. Any required extension to the timescale should be approved by the Executive Director and should be discussed with the complainant. Such agreement can be indicated in a telephone call.
- Will conduct a thorough investigation in a timely manner into all concerns raised by the complainant through examination of relevant documentation, and by conducting staff interviews, whilst ensuring that the investigation is conducted in a manner that is supportive to those involved and takes place in a blame free atmosphere.
- Will base their decisions on available facts and evidence, acting fairly and objectively.
- Will complete the Complaints Investigation Report, including identified lessons learned.
- Will draft a written response, ensuring PHSO's principles are reflected and send to the relevant Director with the completed Investigation Report for approval. Once this is approved by the Director, the draft response and the Investigation Report, together with documented lessons learned and accompanying statements, records etc., should be sent to the Complaints Team Mailbox (epunft.complaints@nhs.net) All records relating to the investigation may be required by the Non-

Executive Directors when they review a complaint and by the Ombudsman at later stages of the complaints procedure.

4.7 **Complaints Team Roles**

- **Head of Complaints and Customer Service** will act as the Trust's Senior Manager and lead for the management and handling of complaints.
- This post will oversee the complaints team and:
- Ensure any learning from complaints is triangulated with all other forms of patient/resident feedback, through the Lessons Learned Group, to ensure it informs on-going work to improve the patient/resident experience.
- Provide complaint and compliment data for the monthly quality report and include information on lessons learned on a quarterly basis.
- Provide a quarterly Thematic Report, highlighting any trends and emerging themes, to the Integrated Governance and Quality Steering Committee.
- Will ensure the complaints annual report is published on the Trust website and a copy sent to the appropriate Clinical Commissioning Groups, which arrange for the provision of the services by the Trust.
- Is responsible for ensuring that regular assurance reports are developed which will include aggregated information about complaints, qualitative and quantitative analysis of information, action plans to deal with the management of risks identified and information about lessons learnt and compliments received by the Trust. These reports will be presented as required by;
 - Department of Health (annually)
 - Trust Board
 - Trust Executive Team
 - Clinical Commissioning Groups (CCG's)
 - Integrated Quality and Governance Steering Committee
 - Performance and Finance Scrutiny Committee

4.8 **Complaints Manager**

- Reports to Head of Complaints.
- Will have day to day responsibility for handling complaints.
- Will ensure that best practice is followed by staff in the handling and management of complaints and provide support and help with the complaints procedures.

- Will manage all Ombudsman's reviews and requests as well as concerns raised by Parliamentary MPs.
- Will be the first point of contact for any Clinical Commissioning Group (CCG) to liaise with on any issues about the Trust that complainants choose to take to the CCG.
- Will be responsible for liaising with other NHS and Social Care Organisations about who takes the lead when a complaint covers more than one organisation.
- Ensure all complaints are documented on the Datix system.
- With the agreement of the complainant, the Complaints Manager or the Investigating Officer will make arrangements for conciliation, mediation or other assistance for the purpose of resolving the complaint. The Trust will ensure that appropriate conciliation and mediation services are available.
- Will stop the formal complaints process if a complainant decides to withdraw their complaint. The complainant's request will be acknowledged by the Complaints Manager, who will consider with the relevant Director whether to continue with the investigation for the Trust's purposes of identifying if there are lessons to be learned.
- Will ensure that the complainant is kept informed in writing of any decision to discontinue or put on hold a complaint investigation stating the reason for the decision.

5.0 COMPLAINTS HANDLING PROCESS

5.1 Local Resolution

- A complaint can be made orally or in writing to any member of Trust staff (any complaints received in writing must be passed to the Complaints Team). The Trust expects all staff to attempt to resolve issues on the front line speedily and effectively and to the complainant's satisfaction. This is a fundamental requirement of the Trust's customer service standards.
- If a patient /resident, relative or visitor approaches a member of staff with a concern, the staff member is expected to resolve this immediately with the assistance of a more senior member of staff when necessary. They should ensure that they obtain appropriate consent from the patient/resident, where possible. The most satisfactory outcome to complaints often comes when complaints are dealt with fully and effectively within the service. The details of the concern and the outcome should be documented on the Complaint Monitoring Form located on the Trust intranet, under Forms on the home page and sent to the Patient Experience Team.

- Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect their or their relative's treatment.
- If front line staff cannot resolve a concern within 24 hours they should advise the complainant of the role of the PALS team who may be able to assist in the first instance, a copy of the Complaints, Comments, Compliments and Concerns leaflet should be provided to ensure they have the relevant contact numbers and options to take their concern forward.
- The first responsibility of the recipient of a complaint is to ensure that the patient's/residents immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.
- Where the issue raised is about a member of staff, another member of staff should be appointed by the local manager to seek to resolve the matter speedily. The complainant should be approached in a non-defensive manner to ascertain their concerns. Complainants will be listened to and treated courteously with dignity and respect.
- The complainant can have a friend, advocate or representative present in any meetings with staff (and staff should record if this is offered and/or declined). If appropriate, the staff member should respond with an apology, explanation of the circumstances that gave rise to the complaint, and provide a suitable explanation/remedy if possible.
- A summary of the Local Resolution meeting will be sent to the Patient Experience Team outlining any action that will be taken in response to the complaint: in order to prevent the same thing happening again.

5.2 Formal Complaints (Low/Medium risk)

- When a complaint is received by the Complaints Department a decision will be made as to whether it can be dealt with by the Patient Experience Team, locally (local resolution) or formally (complaint). If the complainant specifically asks for it to be formally investigated this will be respected and acted upon accordingly.
- Where a complaint is made orally, the Complaints Team must make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made with a copy of the record sent to the complainant with the acknowledgement letter, inviting the complainant to check for accuracy, then sign and return it.
- Oral complaints can also be received by the Patient Experience Team who will escalate to the Complaints Team as appropriate.
- All complaints received by the Complaints Team will be risk rated according to a system based on consequences. The purpose of this

risk rating is to decide what level of intervention is appropriate to the risk to patients/other patients, residents or other residents and the Trust (eg where there is media interest, and to decide if any immediate remedial action is needed).

- All formal complaints will be acknowledged within 3 working days of the date on which the complaint was received in the Complaints Department.
- The acknowledgement letter advises the complainant of independent Advocacy Services and encloses an ethnicity form and information of the complaints process. The appointed Investigating Officer will make contact with the complainant immediately either by telephone or letter to:
 - Clarify their issues
 - Identify the outcome the complainant is seeking
 - Agree a Complaints Handling Plan
 - Extend the timescale if the complaint meets the identified complex complaint criteria or more time is needed to complete the investigation.
- Complaints should be reviewed by the relevant Service Manager to consider if there is a safeguarding concern so as to comply with guidance. (Clinical Governance and Adult Safeguarding - An Integrated Process (DoH February 2010).
- Complainants can request or be offered a meeting at any point during the complaints process.
- Where staff, have been mentioned in a complaint, the acknowledgement letter will advise complainants that the details/summary of their complaint will be shared with the staff involved in order for internal investigation to take place. The complainant will be given the opportunity to “opt out” of their complaint if they do not want their information shared.
- Confidentiality will be maintained in such a way that only managers and staff who are leading the investigation know the content of the complaint.
Anyone disclosing information to others who are not directly involved in the complaint should be dealt with under disciplinary procedures.
- Putting things right is about the remedy offered. Remedies include:
 - apologies
 - explanations
 - changes to prevent a recurrence (and will consider if the complainant can be involved in some way)
 - financial remedies where they are justified and appropriate
 - all payments shall be in line with the procedure in Appendix 3.

- Financial remedies can involve:
 - financial recompense for direct or indirect financial loss, loss of opportunity, inconvenience, distress, or any combination of these.
 - time and trouble payments. (Please see the NHS Finance Manual and the Local Government Ombudsman’s good practice guide on remedies).
 - returning complainants who have suffered injustice or hardship as a result of maladministration or poor service, to the position they were in before this took place. If that is not possible, it means compensating complainants appropriately.
 - Appendix 2, Guidance for the payment of financial remedy, sets out the procedure to be followed when a financial payment is considered to be a remedy.

5.3 Formal Complaints (Major and Catastrophic Risk)

- “Major risk” and “Catastrophic Risk” means a more thorough investigation and response is needed and an independent investigation of the issues is required. Where the complaint is rated “major (or catastrophic) risk” a full investigation into the concerns raised will be instigated by the Director of the service concerned. It is imperative that a record of the investigation, including statements made by witnesses, is made. This is important as any independent review will consider how robust the process was. The Director will appoint the Investigator and will decide on issues of independence from the area complained about, and whether any other arrangements will be made, according to the circumstances of the case, so that issues are investigated thoroughly and independently.
- For major (and catastrophic) risk rated complaints, the Director of the service will delegate responsibility for carrying out an investigation to a member of their team or an external investigator (the Investigating Officer), but will be responsible for drafting a full and detailed response to the issues raised, based on the Investigation Report , and on behalf of the Chief Executive. Investigators will produce an Investigation Report and present this to the Director. The Investigator will seek clinical help if appropriate, and extend the response timescale, if required. They will also decide if the complaint is upheld or not.
- The Director will approve the investigation’s conclusions and also decide if the matter should be further reviewed by another independent person about the conclusions reached and whether they are in line with a reasonable interpretation of policy and good clinical practice. This should be recorded in the Complaints Investigation Report .
- The Investigation Report (and relevant statements, records, and notes etc) must accompany the response letter prepared by the Director to the Complaints Manager, who will maintain a record of complaints handling. Investigating officers should make a written record of all interviews to ensure that information is relayed correctly. These records may be required by the Ombudsman at later stages of the complaints procedure.

5.4 **Complaint Response Letter/Complaints Investigation Report**

Investigators will draft a response letter and send (together with the Complaints Investigation Report and supporting documentation) to their Director at least a week before the due date, for quality checking. The Director should complete the check within 48 hours so as not to delay the sign off process.

The response letter should;

- Summarise the nature and substance of the complaint
- Be comprehensive, fair and timely and not proportion blame.
- Contain language that is easy to understand and avoiding jargon and acronyms (as per the Trust's Customer Service standards).
- Reflect the Ombudsman's principles
- Answer all of the points raised as they appear, putting in numerical order if appropriate.
- Aim to satisfy the complainant that their complaint has been fully and fairly investigated.
- Acknowledge mistakes and offer apologies where appropriate.
- Advise of any lessons learned from the complaint and identify any recommendations/changes to current practice or policy

5.5 When the draft response has been approved by the relevant Director it should be sent (password protected), to the Complaints Manager who will carry out a check to ensure that all issues identified within the original complaint have been responded to, and that adequate records of the investigation are evident with lessons for the Trust identified. The letter will then be sent to the Chief Executive (or delegated person) for signing.

5.6 The final response letter must notify the complainant of their right to refer the complaint for Independent Review by the Ombudsman and also advise what they can do if they disagree with the response received or would like further explanation.

5.7 All correspondence relating to complaints shall be in 12 point, Arial type-size, shall be sent by first class post and marked "Private and Confidential" and/ or "Personal".

5.8 In line with Department of Health guidelines, the Complaints Team will send a questionnaire approximately six weeks after the response has been received, to ask whether the complainant was satisfied with the outcome of the investigation and the way the matter was handled.

6.0 ACTION PLANNING AND LEARNING LESSONS FROM COMPLAINTS

- The Trust is determined to learn from complaints as part of good customer service and as a means of helping to improve Trust services.

- Following the investigation of all concerns/complaints raised, identified lessons learned will be recorded in the Complaints Investigation Report
- Executive Directors/Service Directors will provide the Complaints Team with completed action plans of lessons learned from complaints, including supporting evidence as appropriate, and ensure lessons learned are embedded in their relevant service area.
- Executive Directors will also arrange local events for their services to share learning from complaints.
- The Complaints Team will use the service action plans provided in Trust reporting mechanisms.
- The Complaints Team will share lessons learned with all staff in the Trust via the Trust Intranet.
- Lessons learned will also be published in the Complaints Annual Report.

7.0 INDEPENDENT REVIEW (PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN)

Complainants may refer their case to the Parliamentary and Health Service Ombudsman for review where:

- The complainant is not satisfied with the result of the Trust's investigation
- The complaint has not been resolved within six months (or such longer period as may be agreed before the expiry of that period with the complainant)
- The Trust has decided not to investigate the complaint on the grounds that it was not made within the time limits.

- 7.1 A complainant can approach the Health Service Ombudsman with his/her complaint. It is unlikely that the Ombudsman will take up the complaint prior to the completion of the Trust's Health Service Complaints Procedure. However, the Ombudsman does have the power to consider complaints that have not been put to the Trust and/or where the stages of the complaints procedure have not been exhausted.
- 7.2 The Trust will make these arrangements for Ombudsman review known to all complainants at the end of the process and will include the Parliamentary Health Service Ombudsman's contact details in the final response letter.

- 7.3 Any reports from independent reviews conducted by the Ombudsman will be used as valuable sources of feedback for the Trust to learn from.

8.0 COMPLAINTS ABOUT SERVICES CONTRACTED TO OR BY THE TRUST

- 8.1 Where the Trust makes arrangements for the provision of services through an NHS contract or with an independent provider, it will ensure that the NHS Contract and/or independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of services which shall be in line with this policy and procedure and passed to the Trust.
- 8.2 When the Trust undertakes to provide a service through a commercial arrangement with another organisation, the contract shall also state how complaints under that arrangement will be managed (which will usually be by the Trust) and this procedure will be used, unless the contractual arrangements provide otherwise.

9.0 MIXED SECTOR COMPLAINTS

- 9.1 Where a complaint involves more than one NHS provider, or one or more other bodies such as a Local Authority or a purchaser, there should be full cooperation and coordination in seeking to resolve the complaint through each body's local complaints procedure. NHS bodies and Local Authorities will need to ensure that, between them, they address all matters of concern to the complainant. Whichever body the majority of the complaint relates to will take the lead in this matter and will write to the complainant explaining this and asking for their permission to pass the relevant parts of the complaint onto the pertinent bodies.
- 9.2 If a complaint is a joint NHS/Social care complaint (requiring a Trust and Local Authority Social Care response), such complaints will be rated at least as 'moderate risk' and the Complaints Manager will agree with the relevant Social Care provider who will lead on the matter and how to coordinate the response. The issues raised about the Trust will be investigated according to this procedure.
- 9.3 If the complaint comes from a Clinical Commissioning Group (CCG), on behalf of a complainant, the CCG will decide, with the Trust, how to handle the issue and will discuss this with the Complaints Manager. When a CCG decides, with the complainant's consent, that the Trust is the appropriate body to deal with the complaint, the complaint will be handled as if the complainant had complained directly to the Trust from that date.
- 9.4 If the Trust receives a complaint that is solely concerned with services provided by another organisation, the Complaints Manager will seek the complainant's permission to pass the complaint to the other

organisation's Complaints Manager. The Complaints Manager will be responsible for liaising with the person making the complaint and if the complainant agrees, will forward it to the correct body. Any doubts over which body is responsible for handling the complaint should be resolved before the complaint is dispatched. This should then be recorded in writing.

10.0 COMPLAINTS MADE FOLLOWING SERIOUS INCIDENTS (SIs)

- 10.1 All complaints will be checked to see if it is part of a Serious Incident (SI).
- 10.2 Any complaint received by the Complaints Department that could be connected to an Adverse Incident or Serious Incident will be identified and sent to the Risk Management Team and Head of Serious Incidents and Quality for cross referencing.
- 10.3 These issues will be included in the Terms of Reference of the SI Investigation (Full Internal Investigation Report).
- 10.4 If a complaint arises as part of the Serious Incident process, the appointed Complaint Investigator will liaise with the investigator of the Serious Incident as the /serious Incident Report must be used as the basis of the response to the complainant. All complaint responses must be checked to ensure that there is no contradiction. The complainant will be kept informed of progress by the appointed Complaint Investigator.
- 10.5 Where the Trust accepts that there has been negligence, a speedy resolution should be sought.

11.0 SUPPORTING STAFF

- 11.1 The purpose of the complaints procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants whilst being fair to staff
- 11.2 It will be the decision of the relevant Operational Manager, with advice from Human Resources, whether or not to investigate under the Conduct and Capability Policy.
- 11.3 When a disciplinary warning or other action is imposed on an individual member of staff as a result of a complaint, the Line Manager is responsible for investigating and informing the individual concerned if any information will be provided to the complainant about the action to be taken by the Trust.
- 11.4 Any information collected in the complaints procedure can be used in the Conduct and Capability procedures, but the two procedures must remain separate, and confidentiality maintained at all times.
- 11.5 The Trust has a policy and procedure in place for Workforce Wellbeing and Stress Management (Procedural Guideline HRPG 36).

- 11.6 The Workforce Well-being and Stress Management Policy provides a personal support line service to staff. Should it be identified that a staff member involved needs additional support, the manager must make the staff member aware of the service and how to access it. It is essential that line managers provide immediate and ongoing support. Support offered must be recorded in the staff member's personal file.
- 11.7 Contact Freephone number is: 0800 282 193 or further assistance for staff is available via www.livewell.optum.com using the username 'SEPT' and the password wellbeing.
- 11.8 If there is any staff member at serious risk of personal criminal proceedings or action by any regulatory body, they will be advised to contact their trade union or professional representative for support.
- 11.9 The Complaints Team will advise the member of staff's Line Manager, in writing, that the Trust has received a complaint about a member of staff that they manage. The Line Manager is advised a copy of the complaint has been sent to the Director of the Service to arrange for the complaint to be investigated. The appointed Investigating Officer will be able to provide the Line Manager with details of the complaint. The Line Manager is asked to arrange to meet with the staff member to discuss the complaint and offer any support he/she may need. The Line Manager is asked to advise the staff member about expert counselling and support services available to them if required (email and telephone details provided).
- 11.10 Any staff members who are asked to act as witnesses in any complaints interventions or investigations will be given support by their Line Manager. The Line Manager will discuss any issues with the staff member and make suggestions of further support where this is necessary. The Complaints Team will provide advice to any staff member involved in a complaint.

12.0 MATTERS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

- 12.1 The following are outside of the Trust Complaints procedure.
- 12.2 Complaints made by an NHS body which relates to the services provided by another NHS body, except where a joint response is required under this procedure.
- 12.3 Complaints made by an independent provider about any matter relating to arrangements made by an NHS body with that independent provider unless otherwise stated in the contractual arrangements.
- 12.4 A complaint made by an employee about any matter relating to their contract of employment. Separate mechanisms exist under the Trust's 'Grievance Policy Procedure'.

- 12.5 A complaint which has already been investigated by the Trust or is being or has been investigated by the Ombudsman except where they have referred an issue back to the Trust for further investigation.
- 12.6 A complaint arising out of the Trust's alleged failure to comply with a data request under the General Data Protection Act 2016 or a request for information under the Freedom of Information Act 2000. The Trust Information Governance Manager should be consulted with regard to complaints arising out of data subject requests under the General Data Protection Act 2016
- 12.7 A complaint by non-patient/non-resident third parties who are not complaining, who have not been affected by an action, omission or decision of the Trust.

13.0 LEGAL CASES AND POTENTIAL LITIGATION

- 13.1 It should not be assumed that a complainant who has used a solicitor to lodge a complaint has decided to take formal action. However, the Complaints Manager should be notified of any such complaint.
- 13.2 Where there is a prima facie case of clinical error, the person dealing with the complaint should immediately inform the Complaints Manager. The Complaints Manager will seek advice from the Trust's Legal Advisor who will implement the Trust's Corporate Procedural Guidelines for Negligence and Insurance Claims.
- 13.3 In all prima facie cases of clinical error, there should be a full and fair investigation regardless of whether the complainant has indicated that they propose to start legal proceedings. The principles of good claims management and risk management should be applied.
- 13.4 A complaint can only be suspended if the Trust has legal advice that it would prejudice a legal process. (Department of Health Guidance).

14.0 PERSISTENT AND UNREASONABLE COMPLAINANTS

- 14.1 It is the Trust's intention to capture the spirit of the complaints regulations by creating and using an open, fair, flexible and conciliatory approach to all complaints, viewing them as opportunities to address concerns rather than as criticisms which need to be defended. However, it is recognised that in a minority of cases complainants become persistent and unreasonable in their pursuit of a complaint and that this in turn has a detrimental effect on staff and services.
- 14.2 A persistent and unreasonable complainant may include one or more of the following criteria:
- Has been personally abusive or aggressive towards staff dealing with the complaint.

- Is unreasonably unwilling to accept documented evidence of treatment given as being factual; e.g. medication charts, nursing records.
- Unreasonably insists that he/she has not had an adequate response, in spite of a large volume of correspondence specifically answering their questions.
- Focuses on a small matter which is out of all proportion to its significance, and keeps returning to this at meetings.
- Constantly and unreasonably raises new concerns, which did not appear in the original complaint in an apparent attempt to keep the correspondence going.
- Unreasonably changes the complaint/story as time goes on, telling 'horror stories' about their experiences.
- Is a relative, carer or friend, complaining on behalf of a patient/resident who has confirmed that they do not have a personal complaint against the Trust.

14.3 When faced with a persistent and unreasonable complainant the following action will be taken:

- The complaint will be reviewed, as even a persistent and unreasonable complainant may have a complaint which contains some substance.
- Inform and pass details of the complaint and the complainant to the Head of Complaints and request the persistent and unreasonable procedure is implemented.
- The Head of Complaints will refer all alleged persistent and unreasonable complaint and details of the complainant to the Executive Team who will review, make recommendations to manage persistent and unreasonable clients or residents and agree on a course of action.

14.4 If the Executive Team decides a complainant is persistent and unreasonable, the Chief Executive will write to the complainant informing them of any restriction put in place; what it means for their future contact with the Trust; how long those restrictions will remain in place; and what they can do to have their position reviewed and provide the client or resident with a copy of the policy. It can also include that:

“The Chief Executive has responded fully to all the points raised, and has tried to resolve the complaint; however there is nothing more that can be added. Therefore, from this point the Trust will acknowledge any letters but not respond to them unless new issues are raised.”

- 14.5 Following this action any further attempt by a persistent and unreasonable complainant to raise the issue directly with staff can be refused. Staff will be supported not to enter into dialogue with the complainant but to request them to address their complaint to the Complaints Manager in writing.
- 14.6 The Trust will make it clear that while it welcomes complaints and takes them seriously, unreasonable or persistent and unreasonable complainants may be referred to the Trust's Head of Legal Services/Solicitor.

15.0 ANONYMOUS COMPLAINTS

- 15.1 Where a service user/resident or carer or other concerned individual wishes to make an anonymous complaint the Trust will review it, but outside of the complaints process. If a complaint is received totally anonymously the Complaints Manager will pass it to the relevant Director for their consideration.
- 15.2 Whilst the Trust will act on anonymous information where it has concerns (in line with the intentions behind the Trust Whistle Blowing Policy, or the Child and Vulnerable Adult Policy, the Trust will not bring any complaints about an individual or team to the attention of anyone mentioned or to the Team Manager unless it is a general issue.
- 15.3 The Trust's policy about raising a concern about practice, (Human Resources Policy, Whistle Blowing) offers staff a process to raise issues/concerns. This process recognises that staff may wish to remain anonymous when raising concerns. This does not preclude staff from using the complaints policy where they are considered to have sufficient interest in the patient's/residents welfare.

16.0 TRAINING

- 16.1 All staff shall be responsible for knowing and understanding the Trust policy and procedure on complaints.
- 16.2 All new Trust staff will be made familiar with the Complaints Policy and Procedures at the staff induction (including e-learning).
- 16.3 Complaints Investigators will be provided with appropriate training to enable them to investigate and complete complaint documentation.
- 16.4 The Head of Complaints or the Complaints Manager will provide training as and when required for Investigators.

17.0 MONITORING OF IMPLEMENTATION AND REVIEW OF EFFECTIVENESS

- 17.1 The Complaints Team will provide the Executive Team with:

- Weekly complaints situation report to Executive Directors/Service Directors highlighting open complaints and completion dates.
- Fortnightly complaints overview identifying any areas of concern.
- Monthly complaints information for the Quality Report.
- Quarterly Thematic Reports providing trends analysis and highlighting any trends/themes.
- Quarterly lessons learned update.

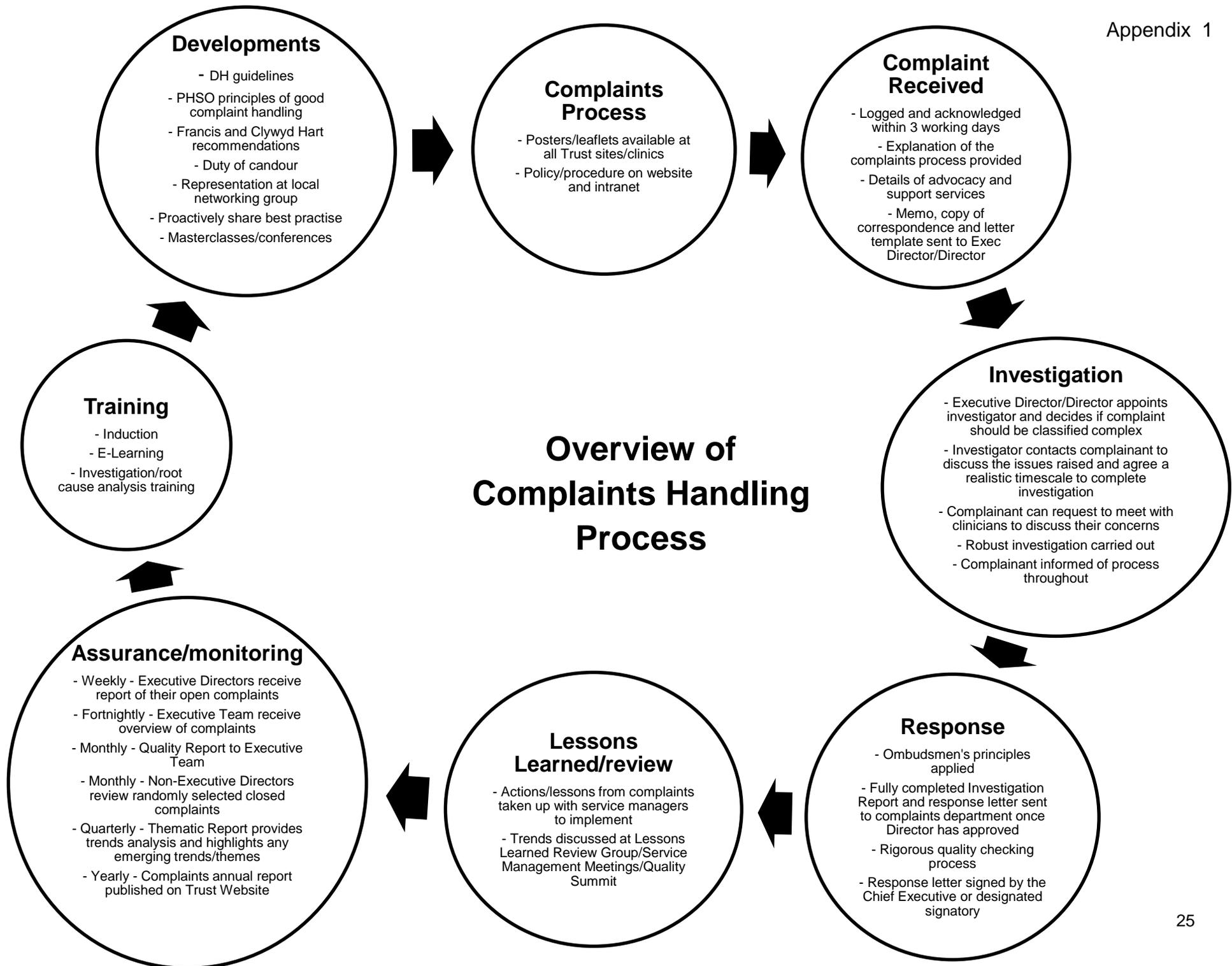
17.2 The Complaints Team will provide the Clinical Commissioning Groups (CCGs) regular assurance and exception reports.

17.3 The Complaints Team will carry out internal audits to monitor and check the following key areas:

- Process for listening and responding to concerns/complaints i.e. was the complaint handled in line with procedural guidelines?.
- Was the response open and honest?
- How front line resolution was carried out.
- How investigations were carried out including looking at appropriate severity and following up of action plans.
- Support given to staff members involved in complaints.
- Duties as outlined in the procedural guideline.
- How the complainant was treated following complaint.
- Lessons learnt/ and any improvements made to services.
- Completion of action plans.
- Process for handling joint complaints between organisations.

17.4 The Non-Executive Directors (NEDs) of the Trust will review and monitor complaints monthly as an independent quality assurance check. This process is highlighted in 4.5 of this document.

END



Complaints Process

Flow chart guide for persons wishing to make a complaint

