Complaints Policy

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Complaints Policy

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences

Document History			
Version	**Date**	**Review date**	**Reason for change**
5.3	**April 2019**	**April 2021**	Updates to job titles/committee names; Updates to complaints process.
5.2	**March 2014**	**April 2017**	New internal complaints process introduced in 2013, updated job titles/committee names. Publication of report following review of NHS complaints process by Rt. Hon Ann Clywd MP and Professor Tricia Hart.
5.1	**March 2011**	**March 2014**	Review against requirements for NHSLA Risk Management Standards.
5	**September 2009**	**September 2012**	Review due to the Local Authority Social Services and National Health Service Complaints Regulations (2009)
6	**July 2020**	**July 2023**	Updated roles and teams; Produced Policy document removing all procedural aspects to associated procedure

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Executive Summary

It is the objective of St George's Healthcare NHS Trust to ensure that users of the services provided by the trust have easy access to information about how to make a complaint and the issues they raise are handled promptly, fairly and justly.

This policy sets out the process for the handling of complaints in accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints are one way of identifying users' perspectives of the service provided. They can act as an early indicator that a service is not functioning effectively and appropriate trend analysis of the factors which prompted the complaint, can provide valuable insight into where improvements may be required. Complaints are intrinsically linked with incidents and possibly claims. It is therefore essential that due consideration is given to the relationship between individual complaints and the incident and claims policies and procedures. Organisationally, it is essential that the data from complaints is considered alongside that of incidents and claims. To this end, methods to achieve this and to ensure learning and improvement are described further in this policy, as those for incidents and claims. The Trust is committed to learning from complaints using a range of approaches to support effective learning. The expectation is that sharing of learning takes place across clinical areas to support proactive management of issues prior to complaints arising.

St George's University Hospitals NHS Foundation Trust recognises complaints as being a valuable tool for improving the quality of health services. Careful handling of complaints is an essential requirement for the trust. It is recognised that being involved in a complaint can be stressful for those who are making a complaint and challenging for those who receive complaints about the care that their service provides. The process should run as smoothly as possible and should not be undertaken in an adversarial manner. The emphasis should always be on resolution in as open and transparent manner as is possible. Learning organisations are those who are able to accept criticism, investigate thoroughly, provide clear answers with an honest apology and improve.

This policy should be read in conjunction with the associated Complaints and Concerns Procedure which sets out the detail of how complaints and concerns are managed by the PALS and Complaints Service.

1. Introduction

Complaints and concerns received by the trust are valuable feedback on our services from patients and the public. We have processes in place to listen, investigate and respond in a timely and transparent way. We want to hear from our patients and learn how our services can be improved.

This policy describes our process for achieving the resolution of complaints and complying with the NHS Complaints Regulations 2009.

2. Purpose

The aim of the policy is to ensure that all complaints are handled in the Trust in a systematic and empathetic manner, that they are understood and investigated thoroughly, fairly and quickly. In liaison with the complainant a method of resolution is agreed that is proportionate to the issue being raised and in line with the complainant's desired outcome

The purpose of the complaints process is to establish the source of the complainant's dissatisfaction and through investigation address any service or care delivery problems which are found to improve the service quality.

A further purpose is to ensure trends are identified which enable lessons to be learned and for the quality of services to be improved locally and trust wide.

The NHS Constitution gives patients and the public the following rights:

- To have a complaint they make about NHS services dealt with efficiently and properly investigated
- To know the outcome of an investigation into their complaint
- To refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO), if they are not satisfied with the local resolution of their complaint

In addition, there are three closely related pledges for NHS trusts:

- to ensure patients and the public are treated with courtesy and receive appropriate support throughout the handling of a complaint
- to acknowledge and apologise for errors, and put things right quickly and effectively
- ensure the trust learns lessons from incidents, complaints and claims and uses these to improve NHS services.

These pledges are consistent with the Parliamentary and Health Service Ombudsman Principles of Good Complaint Handling:

1. getting it right
2. being customer focused
3. being open and accountable
4. acting fairly and proportionately
5. putting things right

seeking continuous improvement

3. Definitions

A complaint or concern can be defined as: “an expression of dissatisfaction about an act, omission or decision, either verbal or written, and whether justified or not, which requires a response and /or redress”.

Concern: A concern is an expression of dissatisfaction by a patient or their representative which can be resolved within 48 hours of the concern being raised. Concerns are not part of the Local Authority Social Services and National Health Service Complaints Regulations (2009).

NHS Complaints Advocacy: NHS Complaints Advocacy is a free and independent service that can help patients and their representatives make a complaint about the National Health Service.

Parliamentary and Health Service Ombudsman: If the complainant remains dissatisfied after all efforts have been made to resolve their concerns at local resolution, they have the right to ask the Ombudsman to carry out an independent review of their complaint and the way it has been handled by the Trust. They must contact the Ombudsman within a year of first becoming aware of the problem although if more than a year the Ombudsman may be able to help if there were good reasons for the delay.

4. Scope

This policy applies to all staff (temporary or permanent) working in all the locations registered by St George’s University Hospitals NHS Foundation Trust with the Care Quality Commission, to provide its regulated activities. This includes volunteers, contractors, students and/or trainees.

This procedure does not apply to staff who may wish to make a complaint about practices within the Trust; they should follow the trust’s relevant HR procedures unless the complaint is about care they have received as a patient of the trust.

5. Who can make a complaint?

A complaint may be made **by the person who affected by the action**, or it may be made by a person acting on behalf of a patient I any case where that person:

- is a child: (an individual who has not attained the age of 18) In the case of a child, we must be satisfied that there are reasonable grounds for the complaint being made by a representative of the child, and furthermore that the representative is making the complaint in the best interest of the child.

- has died; In the case of a person who has died, the complainant must be the personal representative of the deceased. The Trust needs to be satisfied that the complainant is the personal representative. Where appropriate we may request evidence to substantiate the complainant’s claim to have a right to the information.

However, the Trust recognises that a partner or close family member of a person who has died, may not fit any of the above legal criteria. We would look to have evidence of the relationship/involvement in the deceased patient's care before providing information. We would look to give out the minimum personal information to answer the complaint. We would also maintain out legal duty of confidentiality to the deceased patient. This option is only to be used in exceptional circumstances as there is no legal basis to support this.

- has **physical or mental incapacity**; In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, the Trust needs to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made.

- Has given **consent to a third party acting on their behalf**; In the case of a third party pursuing a complaint on behalf of the person affected we will request the following information; - Name and address of person making the complaint; - Name and either date of birth or address of the affected person; and – Contact details of the affected person so that we can contact them for confirmation that they consent to the third party acting on their behalf. This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected.

- Has **delegated authority to act on their behalf**, for example in the form of a registered **Power of Attorney which must cover health affairs.**

- Is an **MP**, acting on behalf of and by instruction from a constituent.

5.1 Consent

Appropriate consent for all of the above types of complainant must be obtained before communicating any personal information. Gaining consent should not delay the investigation of concerns which are raised as it is important that potential learning is harnessed to enable service improvement. Details of this can be found in the **associated procedure**.

There is an expectation that when obtaining consent for the use and sharing of information, that the patient has made an informed decision and clearly understands the processing and potential sharing of their information.

Staff must also understand the expectations of confidentiality that the information is provided under.

Information may be disclosed to or requested from third parties but the complainant will have been informed of this in the acknowledgement of their complaint. At that point, the

complainant will have been given the option to dissent (opt out) from this. If the complaint is identified as multi agency, the patient will be informed of this.

If by the 40th working day consent has not been received the complaint should be closed and categorised as a concern. This will be communicated to the complainant.

5.2 Multi agency complaints

In cases where a complaint is received which also concerns services provided by another organisation, agency or provider, the Patient Services Team will seek consent to forward any correspondence/information received to the other relevant organisation(s). The Patient Services Team will be responsible for facilitating an appropriate response to this type of complaint. The Directorate team responsible for handling the complaint will work to:

- Agree a lead organisation.
- Agree who will answer which parts of the complaint
- Agree who will be the central contact point for the complainant

Data must be shared via secure means with every effort made to resolve the complaint in a cooperative manner, and a coordinated response sent to the complainant unless specifically requested otherwise. Time limits for responding to multi-agency complaints will be in line with the timescale requirements of this policy. Where other organisations leading on a multi-agency complaint stipulate an alternative timeframe to the one set out in this policy, every effort will be made to support that organisation to ensure a timely response for the complainant. Trust staff have a duty to cooperate in this situation.

5.3 Safeguarding Information

If there is Safeguarding information in the Trust medical record of the patient and it is crucial to the complaint, then the Safeguarding team would be contacted for their advice as to whether it can be released. The release of such information would also very much depend on who the information would be released to - especially if the complaint is being made on behalf of a patient who lacks capacity and the concerns are about the patient's representative.

Where the Trust has received sensitive information in relation to a patient complaint from another Trust/Organisation, additional consideration should be given as to whether this should be mentioned to the patient. It may be appropriate to contact the originator of the information about the release.

5.4 Safeguarding Issues

If during the investigation of the complaint it becomes apparent that a safeguarding referral should have been made during the original period of care with the Trust, this referral should be now be made by the individual who identified it, to the Safeguarding Team.

Additionally if during the investigation of the complaint new issues come to light which may require a safeguarding referral, this should now be made by the individual who identified it, to the Safeguarding Team. This may involve care at home, in a care home or care delivered by a third party provider.

6. Roles and Responsibilities

Chief Executive

Executive responsibility for all complaints lies with the Chief Executive, which is delegated to the Chief Nurse and Director of Infection Prevention and Control. A complaint response which has addressed all areas of the complaint, is appropriately apologetic and has stated what will be done to prevent recurrence is approved accordingly.

Divisional Directors of Nursing and Governance

Divisional Directors of Nursing and Governance are responsible for overseeing the complaints process in their areas and providing direct oversight of the investigation and response when the complaints concern nursing issues. They are also expected to monitor the response rate in each care group and set improvement trajectories where performance falls short of expected standards. They are responsible for ensuring that strong local processes are in place to ensure review and learning from complaints within clinical areas/ teams and that these actions are clearly recorded and monitored for their Governance Boards.

Divisional Directors of Operations

Divisional Directors of Operations must ensure that they have oversight of complaints for their areas and will provide direct oversight of the investigation and response in the absence of the Divisional Director of Nursing and Governance.

Care Group Leads/Clinical Directors/Divisional Chairs/Medical Director

Senior medical colleagues are responsible for overseeing investigations and responses when the complaints contain medical/surgical issues. The designation depends upon who is complained about; for example if a Care Group Lead is a subject of a complaint then the investigation will be overseen by the Clinical Director.

General Managers

General Managers are responsible, under the direction of the Divisional Directors of Nursing and Governance, for the investigation of complaints within their areas. Whilst parts of the investigation may be delegated to an appropriate person, accountability for the timeliness and quality of the investigation and complaints response cannot be delegated. They should seek statements from all staff involved in the complaint and ensure that these are all received within the agreed timescale for the complaint response.

Complaints Team

The Head of Patient Experience and Partnership is responsible for management of the complaints process. The Complaints Investigation and Casework Manager together with the central team of PALS and Complaints Officers deliver the centrally held elements of the complaints service which are discussed and tracked daily. The team provides training

to staff on investigating and responding to complaints as part of the corporate training programme in the Training and Development Department and as and when required by services/individuals. Weekly Meetings between the PALS and Complaints Team and the divisions maintain a detailed understanding of the complaints in each division.

All staff
All staff have a responsibility to listen and respond to concerns and complaints raised by patients, their relatives, carers or service users. They should respond at the time the concerns are raised in an understanding, empathetic way and know when to refer complaints to senior staff for investigation. They should seek to understand and learn from complaints in a positive, constructive way and identify and implement actions to improve service delivery.

The Trust expects all complaints to be dealt with in a timely and efficient manner. Divisional Governance Boards will receive regular reports about complaints being managed by the division, it will include numbers of complaints received; compliance with KPIs; analysis of themes and tracking of actions to improve.

Patient Safety and Quality Group
The Patient Safety and Quality Group reports to the Quality and Safety Committee and has responsibility for monitoring lessons learned from patient feedback including concerns and complaints and the effectiveness of service improvements through the quarterly reports from the Divisions.

7. Local resolution of complaints

Complaints and concerns may be raised orally or in writing. The NHS Complaints Regulations 2009 make provision for complaints to be managed flexibly and appropriately.

1. The Regulations say that a complaint raised orally, and resolved to the complainant's satisfaction by the next working day, is not governed by the Regulations.

This allows for a flexible and responsive approach to a complaint. All staff have a responsibility to communicate directly with a complainant and staff are empowered to resolve issues without the need for them to go through the process required by the Regulations. If a complaint cannot be resolved in this way the complainant must be given clear and comprehensive information about how to make a complaint under the 2009 Regulations.

The Patient Advice and Liaison Service (PALS) provides a point of access for patients and their families to raise such concerns, or for them to access support with expressing their concerns and talking to staff in the services. This is part of the wider information service provided by PALS.

- Where it becomes clear that a patients concern cannot be resolved within two working days, or where the complainant makes such a request, the complaint is within the Complaints Regulations 2009.

8. Complexity/Severity rating of complaints

The PALS and Complaints Officers will make an initial assessment of each complaint and grade them in accordance with the matrix below. It is the responsibility of the Divisional team investigating the complaint to adjust the grading if necessary.

This is vital to ensure that urgent/critical matters are dealt with by relevant senior staff and in a timely way. If there is a concern about a possible Serious Incident (SI) or Safeguarding issue these are discussed with the clinical governance department and the relevant Safeguarding lead(s) for children or adults.

This system is an internal flag to ensure critical issues or incidents are escalated and investigated appropriately. It also provides the framework for determining the time frame for investigation.

The working days allocated for providing a response recognise the time needed to complete the investigation for complaints about complex issues. The working days for each category is a maximum time and there will be situations where it is reasonable and appropriate to provide a response in less time. For example a complaint may be made that concerns a serious incident that has already been investigated.

Below are examples of how types of complaint may be categorised:

25 days Green	40 days Amber	60 days Red
Customer service/single issue/straightforward	Clinical care/more than one service	Clinical care/clinical harm caused to patient/other providers involved.
- Appointment postponed or changed - Repeated cancellation of appointments - Car parking - No apparent clinical harm - Attitude of staff/poor	- Perceived neglect or failings of care/treatment - Possible clinical harm. - More than one service involved. - A mixture of customer service and clinical	- Serious clinical harm identified. - Involves other providers external to SGH. - Neglect or abuse by SGH staff identified.

9. Discrimination against Patients who raise a Complaint, Comment or Concern

To ensure that patients who raise a complaint, comment or concern are not treated differently as a result of making a complaint:

- Complaint information/related statements/letters will not be kept in the patient's health records

- Information regarding complaints will be shared on a demonstrable ‘need to know’ basis only
- Complaint files will be stored securely
- Complaint files will be inaccessible to members of the public or unauthorised members of staff, to ensure patient confidentiality is not breached
- Induction and customer care training will remind staff of this duty

The trust will address any instances where it is evident staff have discriminated against a patient, relative or carer following the raising of a complaint or concern. All such matters will be dealt with through the disciplinary route, ensuring the appropriate level of involvement from line management and Human Resources.

10. External Agencies/non-NHS facilities

It may sometimes be necessary to involve external agencies during a complaint investigation (e.g. the police, Social Services). Any queries should be directed to the Chief Nurse or the Divisional Director of Nursing and Governance in their absence.

Patients, their relatives and carers can use the NHS complaint process where their care, treatment and support was funded by the NHS, whether or not that care, treatment and support was provided in an NHS facility.

11. Parliamentary and Health Service Ombudsman (PHSO)

The trust follows the national two stage process in dealing with complaints:

Stage One: Local Resolution
Stage Two: Referral to the Ombudsman (PHSO)

The Ombudsman is able to investigate both clinical and non-clinical complaints and is the final stage of the NHS complaints process. Before the Ombudsman can consider a complaint for review, they will wish to be satisfied that all reasonable attempts have been made to resolve the complaint at local level. All final response letters will include relevant details for complainants to refer to the PHSO where they remain dissatisfied with the response.

12. Learning from complaints

An inherent part of complaints management is ensuring that lessons are learned and action is taken to improve services.

Lessons can be learnt during the investigation of individual complaints and from trends and themes identified during reporting and analysis. Any trends identified must be analysed across complaints, PALS contacts, adverse incidents and claims.

Actions identified from individual complaints will be recorded and monitored by the Divisional Governance Boards. Divisional Directors of Nursing and Governance are responsible for ensuring that strong local processes are in place to ensure review and learning from complaints within clinical areas/ teams and that these actions are clearly recorded and monitored.

- Key issues identified via data analysis or from Health Service Ombudsman recommendations will be reported to the Patient Safety and Quality Group in the quarterly Complaints and PALS report.

- An annual report will be prepared for circulation within the Trust and to local Commissioners. The report must specify:

a) the number of complaints received by the trust in the period
b) the number of complaints which the trust considered were well-founded
c) the number referred to the Health Service Ombudsman

and must summarise

i) the subject matter of the complaints received
ii) any matters of general importance arising out of those complaints or the way in which they were handled
iii) action taken to improve services as a consequence of those complaints

13. Time Limit

The time limit for initiating a complaint is within 12 months of the event or 12 months from the date on which the complainant became aware of the cause for complaint.

An acknowledgement of the complaint must be sent to the complainant within three working days outlining the process to be taken, timescale and who they may contact in the meantime for further information.

A complaint not considered to fall within this timescale may still be investigated but the complainant will be made aware that due to the time that has passed it may not be possible to compile a comprehensive response. These complaints do not come within the Complaints Regulations 2009. The decision on whether an out of time complaint can be investigated will be made jointly between the relevant Divisional Director of Nursing and Governance and the Head of Patient Experience and Partnership.

14. Unreasonable behaviour

Complainants who display unreasonable behaviour can put strain on time and resources, and cause stress to staff. All staff are trained to respond to complainants with patience and sympathy, but there are times when unreasonable behaviour is extreme or persistent and there is nothing further which can reasonably be done to assist the complainant or to rectify a real or perceived problem.

The Procedure for Dealing with Intractable Complaints (Appendix B) is to help to identify situations where a complainant may legitimately be regarded as behaving unreasonably and to outline ways of responding in such situations.

15. Advocacy

Complainants should be encouraged to seek support if they do not speak English as their first language, have a learning or sensory difficulty, or require assistance to make their complaint. Assistance and advice may be sought from NHS Complaints Advocacy Service. PALS and Complaints will also be able to assist in drafting letters. All attempts should be made to support those who for whatever reason find it difficult to make their complaint. This support should be in line with the Trusts Equality policies.

16. Dissemination and implementation

a. Dissemination:
This policy will be available to all staff to access on the trust's internal intranet.
Patients, relatives and service users can view details of the procedure via the Trust's website at www.stgeorges.nhs.uk

b. Implementation
To facilitate continual improvement in the handling of complaints, workshops are run throughout the year, for frontline staff, managers and those who investigate and draft responses for signature by the Chief Executive. The Divisional Directors of Nursing and Governance, Divisional Directors of Operations and Divisional Chairs should ensure that staff within their areas who require such support attend these sessions.

In addition, members of the PALS and Complaints Department are available to give advice to staff over the telephone and work with individual departments to address their specific training and learning needs. Managers should contact PALS and Complaints Department direct when this is necessary

17. Monitoring compliance

External:
Complaints handling is subject to external monitoring and reporting as one of the NHS indicators of trust performance. The number of complaints received, action taken and service improvements made as a result of complaints and the number of complaints that have been fully or partly upheld are some of the data available in the public domain.

Internal to the Trust:

Key Performance Indicator	Lead Responsible for Audit	Evidence	Reviewed by / Frequency	Lead Responsible for any Required Actions
Complaints are acknowledged within 3 working days	Complaints Manager	Weekly overview of outstanding complaints report send to divisions and Chief Nurse.	Reviewed by Chief Nurse weekly and included in annual report.	Complaints Manager.
Complaints are responded to within the agreed timescales	Complaints Manager	Divisional reports to Patient Safety and Quality Group. Quality and Safety Committee IQPR. Trust Board, IQPR and annual complaints report	Patient Safety and Quality Group – quarterly. Quality and Risk Committee, Trust Board - annual	Divisional Directors of Nursing and Governance/General Managers/Heads of Nursing/Divisional Directors of Operations.
Number of complaints received by the trust & those referred to the Ombudsman	Complaints Manager	Reports to Patient Safety and Quality Group. Quality and Risk Committee and Trust Board.	Quality and Safety Committee Board Monthly through IQPR	General Managers/Divisional Directors of Operations
Actions/improvement identified & monitored	Divisional Directors of Nursing and Governance	Reports to Patient Safety and Quality Group. Quality and Risk Committee and Trust Board.	Patient Safety and Quality Group – quarterly divisional reports. Quality and Safety Committee – quarterly complaints and PALS report	Directors of Nursing and Governance Complaints Manager

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18. Associated documents

Disciplinary Procedure

Complaints procedures should be kept separate from disciplinary procedures. Inevitably, some complaints will identify information about serious matters, which may indicate a need for disciplinary investigation. A case for considering disciplinary investigation can be suggested at any point during the complaints procedure but consideration of whether disciplinary action is warranted is a separate matter for management, outside the complaints procedure, and must be subject to a separate process of investigation. This would be actioned under trust disciplinary procedure.

Serious Incident Procedure (SI)

The procedure for the investigation of serious incidents is separate from the complaints procedure. PALS and Complaints Department should acknowledge the complaint as usual. The complainant should be kept informed according to the normal time scales of the complaints procedure even though a detailed response might not be sent until the SI investigation is completed. If during the course of investigating an incident, a complaint is also received, the SI procedure should take precedence in terms of an investigation.

Where the investigation of a complaint reveals the need to take action under the adverse incident procedure, the General Manager should inform the Complaints Manager and again the incident procedure should take precedence in terms of investigation. In these circumstances the appropriate response to the complaint would be to tell the complainant about the review and keep them and the General Manager informed of the progress and the outcome.

In some circumstances a complaint may highlight an aspect of the patient's care/treatment that requires investigating as a serious incident. In these cases the SI panel and Complaints and Improvements department should agree and confirm the aspects to be investigated by the SI panel and the aspects to be investigated through the complaints procedure.

Being Open and Duty of Candour Policy

Being open means being honest and transparent, apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident. Trust staff are encouraged to say sorry at the earliest opportunity.

Each of the policies related to investigations of complaints, claims and incidents describes the process for monitoring recommendations and action plans.

19. Organisational Learning

The value of an investigation is limited unless there is organisational learning and feedback on the lessons learned and any required changes in practice implemented. The Trust has introduced a number of processes to enable learning and feedback, which include:

- An actions table within complaint responses
- Discussion of complaints within Divisional Governance Boards
- Assurance through PSQG

20. Risk

The process for implementing risk reduction measures is described in the Risk Management Policy, including the management and monitoring of those risks through the risk register and Assurance Framework. Any risks identified as a result of an incident, complaint or claim are considered by the Divisional Management Team for potential inclusion on the divisional risk register. The Divisional Governance Manager will escalate any high level (15+) risks to the Quality and Risk Committee, for discussion and potential transfer to the Board Assurance Framework.

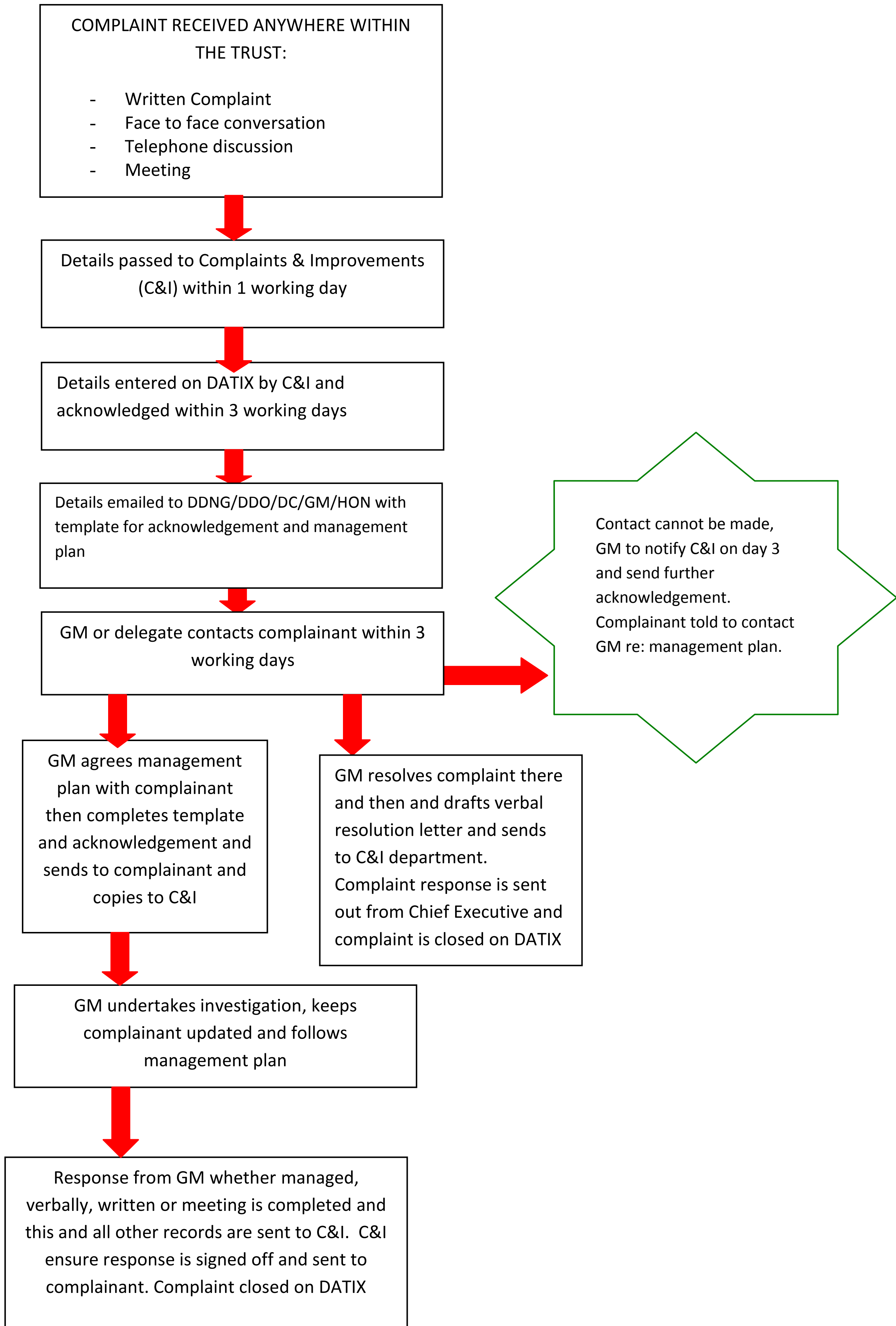
The divisional risk registers are monitored by the Divisional Governance Boards and the Organisational Risk Committee and the Trust risk register is monitored by the Quality and Risk Committee, to ensure appropriate actions are taken and lessons learned to address any identified risks.

21. References

- *The Data Protection Act 1998* London: Office of Public Sector Information. Available at: www.opsi.gov.uk
- *The National Health Service (Complaints) Regulations 2009* London: Office of Public Sector Information. Available at: www.opsi.gov.uk
- The Parliamentary and Health Service Ombudsman. *Principles for Remedy (2007).* Available at: www.ombudsman.org.uk
- The Parliamentary and Health Service Ombudsman. *Principles of Good Administration (2007).* Available at: www.ombudsman.org.uk
- The Parliamentary and Health Service Ombudsman. *Principles of Good Complaint Handling.* Available at: www.ombudsman.org.uk

APPENDIX A

Complaints management process



APPENDIX B

PROCEDURE FOR DEALING WITH INTRACTABLE COMPLAINTS

1. Introduction

Complaints about the services provided by the trust are processed in accordance with NHS complaint procedures. These complaints consume varying amounts of resource depending on the context and seriousness of the allegations disclosed. There are also, however, a small number that consume resources out of proportion to the significance of the allegations made.

In determining arrangements for handling such complaints, staff are presented with two key considerations. The first is to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that even habitual or vexatious complainants may have aspects which contain some genuine substance. The need to ensure an equitable approach is crucial.

The second is to be able to identify the stage at which a complaint has become habitual or vexatious.

This procedure aims to assist in identifying some of the more common situations of this type, and suggest ways of responding to such situations. It should be read as an addendum to the Trust's Complaints Policy, and should also be interpreted in the light of other relevant policies, particularly the 'Prevention and Management of Intimidation and Violence' Policy.

NHS staff are at all times expected to deal with complaints about NHS services, patiently, courteously, thoroughly, professionally, and within the Regulations governing complaints. The Trust will provide its staff with regular complaint training sessions. There are, however, times when, after a thorough investigation, there is nothing further that can reasonably be done to answer all a complainants concerns to their satisfaction.

The difficulty in handling such complainants places a strain on the time and resources available and can cause unacceptable stress for staff, who may need extra support in these difficult situations.

The challenge for the NHS is to support staff in their attempts to bring such situations to a conclusion in a manner which, where possible, can be accepted by the complainant and, if not, clearly and courteously states the facts and explains the reasons why the NHS cannot help further. High quality training, and continuing professional and personal support, for NHS complaints staff is essential if these objectives are to be achieved consistently.

2. Identifying the 'Intractable' Complainant

Complainants (whether acting on their own or another persons behalf) are all, in some way, expressing dissatisfaction with a service provided, which requires a response from the NHS. Very often complainants are themselves under considerable stress of one kind or another at the time and this can show itself in a variety of ways. They may act out of character at times of stress, anxiety or distress, and it is necessary to be sensitive and make allowance for this.

Sometimes, however, a point is reached where the conduct of the complainant makes it impossible to continue with the complaint or to actually identify the issue and action they require. This may arise where a complainant:

i) Persists in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.
ii) Seeks to prolong a complaint by changing the substance of the complaint or continually raise new issues or seeks to prolong contact by continually raising further concerns or questions. (However, care must be taken not to mistakenly discard new issues, which are significantly different from the original complaint. These might need to be addressed as separate complaints).
iii) Refuses to accept validated documentary evidence of treatment given as being factual e.g. drug sheets, health records, nursing notes, etc.
iv) Denies receipt of a substantive response to a complaint despite evidence of it having being sent.
v) Refuses to accept that different perceptions of incidents can occur, and verification of the facts can be impossible, especially when a long period of time has elapsed.
vi) Does not clearly identify the precise issues that they wish to be investigated. Despite reasonable efforts of the staff, and where appropriate any friend/relative, or other recognised advocate to help them specify their concerns, register their complaint in writing and/or determine what outcome they would hope to achieve.
vii) Refuses to accept that the concerns identified are not within the remit of the organisation to investigate.
viii) Maintains a disproportionate focus on a 'minor' aspect of a complaint after the complaints has been investigated, to the extent that it becomes out of proportion to its significance within the complaint as a whole. (Defining 'minor' can be a subjective judgement, and must be used with caution in applying these criteria).
ix) Having in the course of addressing a registered complaint had an excessive number of contacts with the Trust (through personal visits, phone calls, fax, email or letter) placing unreasonable demands on staff.
x) Have threatened or used physical or verbal abuse or violence towards staff or their families or associates.

3. Process for dealing with the complainant who becomes 'intractable'.

Staff will first need to check that the complainant meets one or more of the criteria identified above.

They should also make sure that:

i) The complaints procedure is being correctly applied and that all the material elements of the complaint that have been identified during the process are being, or have been, addressed. In doing so it should be appreciated that all complaints, even those that seem most trivial, may contain issues of some substance. It is critical that staff maintain an impartial and equitable approach.
ii) There is nothing more within the terms of the complaints procedure that the staff could reasonably be expected to do to help the complainant eg arrange a meeting/second opinion/continue contact but only in writing, etc.
Having done this and discussed the position with the complainant, hopefully achieving some level of mutual understanding and agreement, a letter clarifying the position that the complaint has reached should be sent. This will be agreed by and signed by the Chief Executive or delegated Executive Director.

It may include:

- Declining contact with the complainant either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained,

(If staff are to withdraw from a telephone conversation with a complainant, it may be helpful for them to have an agreed statement available to be used at such times).

- Restricting contact to liaison through a third party by negotiation.
- Notifying the complainant in writing that the Chief Executive or delegated Executive Director 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 should also be notified that the correspondence is at an end and that further letters received about the same issue will be acknowledged, but not answered.

NB: wording on receipt of further communication should 'acknowledge' and not thank the complainant for it.

The letter should also repeat the information already given in previous correspondence that if the complainant remains dissatisfied with the Trust’s response he/she has the right to contact the Health Service Ombudsman or consider legal redress. The Health Service Ombudsman’s details, including full address and telephone number, should be included (again) with the letter.

4. Withdrawal of intractable complaint status

All new complaints from the same complainant should be dealt with in accordance with the appropriate complaint regulations in the normal way.

APPENDIX C

1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Complaints and concerns policy and procedures	Complaints and Improvements – Corporate Nursing	Director of Quality Governance	Existing	May 2019
1.1 Who is responsible for this service / function / policy? Chief Nurse – Director of Quality Governance – Head of Patient Experience and Partnership – Complaints Manager				
1.2 Describe the purpose of the service / function / policy? Who is it intended to benefit? What are the intended outcomes? The aim of the policy is to ensure that all complaints are handled in a systematic and sympathetic manner, and that they are investigated thoroughly, fairly and quickly, in liaison with the complainant, using a method of resolution agreed with the complainant that is proportionate to the issue(s) being raised and is also in line with the complainant's desired outcome.				
1.3 Are there any associated objectives? E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives That access to all parties who wish to contact the PALS & complaints and improvements services is supported. The outcomes are that all complaints are dealt with within the timeframe agreed with the complainant.				
1.4 What factors contribute or detract from achieving intended outcomes? See 1.5.				
1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights? Details: [see Screening Assessment Guidance] While the policy itself actively seeks to ensure non-discrimination , we must ensure that in practice our processes and practice take account of our patients and user base and acknowledge that there is direct relevance to some of the equality categories set out in legislation and in line with general evidence * Age – we should endeavour that people at all ages, especially the elderly and lone people are given the support required to raise any concerns they have * Men are less likely to complain then women * Disability – there is a high relevance to disability. The policy and practice must be that all support is given to patients and relatives to raise their concerns and that any resources such as interpreters or advocates are used at all times. * Race – People from some BAME communities report lower levels of satisfaction with NHS services and are less likely to complain. The Trust has a high number of BAME patient groups				

and it is essential that we collect demographic data on all equality strands to provide assurance * Language – We must ensure that all staff are aware they can request interpreting services for any patient who requests this. This is a service that must be promoted pro-actively through the organisation and through the general process of the policy * Religion/Belief – there is no strong evidence that people from different religious background can be discriminated against. Care must be taken that there are cultural norms associated with religion and belief and that these are respected through the process. * Sexuality – published evidence still shows that for some lesbian, gay, bi-sexual and transgendered people, their experience of NHS services is not as positive as the larger population. There is no evidence that this policy will discriminate on access to the complaints procedure * Human Rights – all efforts will be made through the practice and process of this policy that the fundamentals of human rights to the patients are protected. In particular the dignity, privacy and autonomy of the patient and/or complainant must be protected.
1.6 If yes, please describe current or planned activities to address the impact. As the patient literature is revised through PInG, all efforts will be made to comply with best practice standards for accessibility.
1.7 Is there any scope for new measures which would promote equality? We will continue to promote/inform the PALS and complaints and improvements service through the trust website, public meetings and through published literature.
1.8 What are your monitoring arrangements for this policy/ service As in 1.6.
1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above Medium
2.0. Please give you reasons for this rating As in 1.5

APPENDIX D

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document submitted to the Policy Approval Group for ratification.

Title of document being reviewed		Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?		Patient Experience Committee
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have human resources/staff side committees (or equivalent) approved the document?	N/A	

7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Yes**	
	Does the plan include the necessary training/support to ensure compliance?	**Yes**	
8.	**Document Control**		
	Does the document identify where it will be held?		
	Have archiving arrangements for superseded documents been addressed?		
9.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**Yes**	
	Is there a plan to review or audit compliance with the document?	**Yes**	
10.	**Review Date**		
	Is the review date identified?	**Yes**	
	Is the frequency of review identified? If so, is it acceptable?		
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Yes**	