TRUST POLICY FOR THE HANDLING OF COMPLAINTS AND CONCERNS

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Version / Amendment History	Version	Date	Author	Reason
	1	August 2024	A Cuthbert, K Than	Re-written policy to reflect NHS Complaints Standards, published 2023, along with existing regulations and legislation.

Intended Recipients: All Trust staff

Training and Dissemination: Awareness for all staff at Trust Induction. Specific training for the Complaints Team and Divisional Leads. Specific update to Lead Investigators at a briefing session. Dissemination via the Trust Intranet. Updates to the Complaint Handling Masterclass training for new Lead and Support Investigators or those attending to refresh skills and knowledge.

To be read in conjunction with:

a) *The NHS Complaint Standards 2023*

b) *Model Complaint Handling Procedure for NHS Services in England*

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

d) *Department of Health, The NHS Constitution for England (26 March 2013) The Constitution was first published in January 2009 following recommendations in Lord Darzi's report High Quality Care for All (2008). Under the Health Act 2009 all providers and commissioners of NHS care have a statutory duty to have regard to the NHS Constitution in all their decisions and actions.*

e) *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Care Quality Commission Regulation 16: Receiving and acting on complaints*

f) *Trust Policy for the Management of Risk (V1.1, 2023)*

g) *Trust Policy for Incident Reporting, Management and Learning (V2.9, 2021)*

h) *Trust Policy for Information Governance (V3.0, 2022)*

i) *Trust Policy and Procedure for Data Protection and Dealing with Confidential Information (V4, 2021)*

j) *Trust Policy for Safeguarding Children (V2.13, 2023)*

k) *Trust Policy and Procedures for Safeguarding Adults (V4.6, 2022)*

l) *Trust Policy for Health and Safety (V1.1, 2022)*

m) *Trust Policy for Freedom to Speak Up (V7.2, 2023)*

n) *Trust Policy and Procedure for Legal Services Claims Handling (V6, 2022)*

o) *Trust Policy for Violence, Aggression, Reduction and Prevention (V1, 2023)*

In consultation with and date:

- Patient Experience, Engagement and Insight Group (PEEIG), 14 March 2024:

  Directors of Nursing, Divisional Nurse Directors, Director of Midwifery, Director of Allied Health Professionals, Deputy Divisional Nurse Directors

- Policy distributed for comments, 21 March 2024:

  Executive Chief Nurse, Directors of Nursing, Divisional Nurse Directors, Director of Midwifery, Director of Allied Health Professionals, Deputy Divisional Nurse Directors

- Consultation session, 2 May 2024:

  Divisional stakeholders (Lead Investigators, Support Investigators, Senior Sisters, Divisional Complaints/Governance Coordinators, Divisional Leads (Quality Assurance) etc.)

- Further policy distribution, 20 May 2024
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stage Two Completed No - N/A

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Contact for Review	Anna Cuthbert, Complaints Service Manager
Executive Lead Signature	Donna Bird, Interim Executive Chief Nurse

Contents

Section	Description	Page
1	**Introduction**	5
2	**Purpose and Objectives (Policy Statement)**	6
3	**Definitions**	7
4	**Identifying a complaint**	7
5	**Who can make a complaint**	9
6	**Consent**	10
7	**Timescale for making a complaint**	10
8	**Complaints and other processes**	11
9	**Confidentiality of complaints**	12
10	**How we handle complaints**	13
11	**Roles and Responsibilities**	19
12	**Complaints involving multiple organisations**	21
13	**Monitoring, demonstrating learning and data recording**	22
14	**Guidance relating to habitual or vexatious complainants**	23
15	**Patient Safety Incident Response Framework**	25
16	**Duty of Candour**	26
17	**Parliamentary and Health Service Ombudsman / Local Government Ombudsman**	27
18	**Staff training and learning resources**	27
19	**Media**	28
20	**Complaints about a private provider**	28
21	**Complaining to the commissioner of our service**	28

	Appendices	
	Appendix 1: Roles and responsibilities	30
	Appendix 2: Complaints flow chart	37
	Appendix 3: Consent	38
	Appendix 4: Early resolution flow chart	45
	Appendix 5: Complaints triage	46
	Appendix 6: Complaint investigation guide	48
	Appendix 7: STOP moments	54
	Appendix 8: Meetings guidance	55
	Appendix 9: Habitual and vexatious guidance	57

TRUST POLICY FOR THE HANDLING OF COMPLAINTS AND CONCERNS

1. Introduction

1.1 This policy outlines our commitment at University Hospitals of Derby and Burton NHS Foundation Trust (referred to as the Trust) to providing an open and transparent process for people to make a complaint. We recognise that there are occasions when people are dissatisfied with the service received and we value the insight from complaints made to the organisation. It is important that we provide a thorough and fair approach to investigations and responses, whilst seeing complaints as opportunities to learn and improve services.

1.2 The NHS Complaint Standards provide a single vision of good practice for complaint handling for a consistent approach across the NHS in England. This complaints and concern handling policy describes how we will put into practice the core expectations outlined in the Standards. The Standards are split into four key sections:

- Promoting a Just and Learning Culture
- Welcoming Complaints in a Positive Way
- Being Thorough and Fair
- Giving Fair and Accountable Responses

1.3 This policy sets out how we handle complaints and the standards we will follow. This procedure follows the relevant requirements in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations) including the Care Quality Commission (CQC) Regulation 16: Receiving and acting on complaints.

1.4 This policy should be read in conjunction with the NHS Constitution which outlines the rights that the patients and public have in relation to complaints and redress.

1.5 Staff should read this policy in conjunction with the more detailed modules available on Net-i and information is also available on the Parliamentary and Health Service Ombudsman's (PHSO) website at www.ombudsman.org.uk.

1.6 The Complaint Standards and this policy contribute to supporting the delivery of our Trust values of Compassion, Excellence and Openness. It will also support the Trusts strong commitment to the duty of candour so there is a culture of being open and honest when something goes wrong. This policy also supports our Commitment to Feedback and our Always Pledges, as described in our Patient Experience, Engagement and Insight Strategy 2024-29.

2. Purpose and Objectives (Policy Statement)

This policy describes the Trust's approach to ensuring it handles complaints effectively, providing a framework to enable the Trust to comply with the NHS Constitution, complaint regulations and the national standards.

We recognise the value and importance of complaints as an insight into how we can improve services that the Trust offers. We will ensure that the processes we have in place make it as easy as possible for services users to make a complaint and our staff will be supported, empowered and trained to resolve issues that are raised quickly with compassion, empathy, dignity and respect.

We will provide an open, honest answer to complaints that are raised, as quickly as possible, whilst considering the complexities of the issues raised.

We will ensure that the responses we provide will demonstrate that the issues raised have been investigated in a fair and objective way, based on the facts which will be explained to the complainant in a manner that meets their needs. Complainants will have the opportunity to discuss the outcome of the investigation at a complaint resolution meeting should they wish to do so.

Our response to the issues raised will set out what happened and, where appropriate, where the organisation is accountable and the actions taken to remedy the issues raised and also action taken to ensure any learning identified is used to improve the services and experiences of our patients.

We will foster a just and learning culture by welcoming complaints as an opportunity to develop and learn. This will involve providing all staff with support and training to embed an open and non-defensive approach to learning from feedback. This will demonstrate regular examples for staff and services users to see how learning from complaints is used to improve services for everyone.

The policy sets out how the Trust offers an open, honest and equitable system that enables patients and the public to come forward when dissatisfied with the service received. This includes both clinical and non-clinical issues and applies to experience with members of Trust staff as well as those not directly employed by the Trust including bank staff, agency staff, contractors, students and volunteers. The policy supports the delivery of an accessible complaints and concerns system and helps patients, relatives and carers understand how the Trust handles complaints and concerns.

The objective of this policy is to provide an effective way for people who are dissatisfied to raise their concerns. The policy will help:

- To ensure complainants feel they are heard and that we can demonstrate action has been taken where appropriate.
- To provide assurance that we learn from mistakes.
- To ensure that the complaints process is timely, efficient, and effective.

The Complaints Service and the Patient Advice and Liaison Service (PALS) administer the complaints and concerns processes. These teams form the Advice & Support Services and come under the umbrella of Patient Experience.

3. Definitions

Concern	An expression of dissatisfaction raised informally at local level and usually resolved outside of the formal process. Raised with front line staff / and or the Patient Advice and Liaison Service (PALS), to resolve the concerns or send forward to be managed in line with this policy.
Complaint	A formal expression of dissatisfaction made to the Trust, either verbally or in writing, whether justified or not, which requires a response in line with this policy.
DATIX / DCIQ	The system used for the recording and reporting of complaints, concerns, enquiries, compliments, ex-gratia claims and incidents.
Compliment	Positive feedback.
Comment	Comments on services / experience.
Enquiry	Enquiry for information about any services provided within the hospital or by external organisations.
S42 Enquiry	A safeguarding issues arising from a safeguarding referral to Social Services identified by Adult Social Care Safeguarding Services as indication of a potential act or omission by Trust staff / services.

4 Identifying a complaint

Everyday conversations (all Trust staff)

4.1 All Trust staff speak to people who use our service every day. This can often raise issues, requests for a service, questions or worries regarding care, or worries around admission to or discharge from hospital. These are concerns that our staff can help with immediately and would not necessitate signposting to the Advice & Support Services. We encourage patients, relatives, friends and carers to discuss any issues they have with our staff, as it may be possible to resolve the issue to their satisfaction quickly and without the need for them to make a complaint.

4.1 We recognise that we cannot always resolve issues as they arise and that sometimes people will want to make a complaint.

The NHS Complaint Standards define a complaint as an expression of dissatisfaction, either spoken or written, that requires a response. It can be about:

- an act, omission or decision we have made
- the standard of service we have provided

4.2 People may want to provide feedback instead of making a complaint. In line with the NHS Constitution people can provide feedback, make a complaint, or do both. Feedback can be an expression of dissatisfaction (as well as positive feedback) but is normally given without wanting to receive a response or make a complaint.

Feedback can be given to any member of Trust staff and volunteers.

The Trust website holds information on how to provide feedback including online feedback forms, email addresses, telephone numbers and the address of the PALS and Complaints offices. We also have leaflets available along with posters which can be found on all sites. For those who would like to complain in person, information on how to do this is also available online.

4.3 People do not have to use the term 'complaint'. We will use the language chosen by the patient, service user, or their representative, when they describe the issues they raise (for example, 'issue', 'concern', 'complaint', 'tell you about'). We will always speak to people to understand the issues they raise and how they would like us to consider them.

4.4 For more information about the types of complaints that are and are not covered under the 2009 Regulations please see The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

4.5 If we consider that a complaint (or any part of it) does not fall under this policy we will explain the reasons for this. We will do this in writing to the person raising the complaint and provide any relevant explanation and signposting information.

4.6 Complaints and concerns can be raised with us:

- In person at PALS/Complaints Offices:
  - Royal Derby Hospital, Uttoxeter Road, Derby, DE22 3NE
  - Queen's Hospital, Belvedere Road, Burton-on-Trent, DE13 0RB
- By telephone

    - PALS 01332 785156
    - Complaints 01332 787257 / 786352 / 786945
- By text
    - PALS 07799 337500
    - Complaints 07384 871053
- In writing
    - Patient Advice and Liaison Service, Royal Derby Hospital, Uttoxeter Road, Derby, DE22 3NE
    - Patient Advice and Liaison Service, Queen's Hospital, Belvedere Road, Burton-on-Trent, DE13 0RB
    - Complaints Department, Royal Derby Hospital, Uttoxeter Road, Derby, DE22 3NE
- By email
    - PALS uhdb.contactpals@nhs.net
    - Complaints uhdb.complaintsteam@nhs.net
- Online form
    - Can be found on the UHDB website

We will consider all accessibility and reasonable adjustment requirements of people who wish to make a complaint in an alternative way. We will record any reasonable adjustments we make.

4.7 We will acknowledge a complaint within three working days of receiving it. This can be done in writing, electronically or verbally. We will also discuss with the person making the complaint how we plan to respond to the complaint.

4.8 We may receive an anonymous or general complaint that would not meet the criteria for who can complain (see below). In this case we would normally take a closer look into the matter to identify if there is any learning for our organisation unless there is a reason not to.

5 Who can make a complaint

5.1 As set out in the 2009 Regulations, any person may make a complaint to us if they have received or are receiving care and services from our organisation. A person may also complain to us if they are not in direct receipt of our care or services but are affected, or likely to be affected by, any action, inaction or decision by our organisation.

5.2 If the person affected does not wish to deal with the complaint themselves, they can appoint a representative to raise the complaint on their behalf. There is no restriction on who may represent the person affected. However, they will need to provide us with their consent for their representative to raise and discuss the complaint with us and to see their personal information (including any relevant medical records). The complaints team will provide the appropriate consent form

dependent on who is complaining and whether we need to approach other organisations.

5.3 If the person affected has died, is a child or is otherwise unable to complain because of physical or mental incapacity, a representative may make the complaint on their behalf.

There is no restriction on who may act as representative but there may be restrictions on the type of information we may be able to share with them. We will explain this when we first look at the complaint.

5.4 If at any time we see that a representative is not acting in the best interests of the person affected, we will assess whether we should stop our consideration of the complaint.

If we do this, we will share our reasons with the representative in writing. In such circumstances we will advise the representative that they may complain to the Parliamentary and Health Service Ombudsman if they are unhappy with our decision.

6 Consent (Appendix 3)

6.1 Information will not be disclosed to third parties unless the complainant, or appropriate authorised party, who has provided the information has given consent to the disclosure of that information.

6.2 The requirement for consent will stop the clock and will only restart when consent is received, at which point it will be recalculated.

6.3 The Trust will request signed consent or valid documentation for the purpose of sharing the Trusts response. Verbal consent can be accepted unless we require consent in writing to approach other organisations.

6.4 The Trust will start a full investigation into all complaints within 3 working days from receipt. The response, however, will not be shared with the complainant until the required documentation has been received.

7 Timescale for making a complaint

7.1 Complaints must be made to us within 12 months of the date the incident being complained about happened or the date the person raising the complaint found out about it, whichever is the later date.

7.2 If a complaint is made to us after that 12-month deadline, we will consider it if:

- we believe there were good reasons for not making the complaint before the deadline, and
- it is still possible to properly consider the complaint.

7.3 If we do not see a good reason for the delay or we think it is not possible to properly consider the complaint (or any part of it) we will write to the person making the complaint to explain this. We will also explain that, if they are dissatisfied with that decision, they can complain to the Parliamentary and Health Service Ombudsman.

8 Complaints and other processes

8.1 We make sure staff who deal with complaints are properly supported and trained to identify when it may not be possible to achieve a relevant outcome through the complaint process on its own. When this happens, the staff member dealing with the complaint will inform the person making the complaint and give them information about any other process that may help address the issues and has the potential to provide the outcomes sought.

8.2 This can happen at any stage in the complaint handling process and may include identifying issues that could or should:

- Trigger a patient safety investigation.
- Trigger our safeguarding procedure.
- Involve a coroner investigation or inquest.
- Trigger a relevant regulatory process, such as fitness to practice investigations or referrals.
- Involve a relevant legal issue that requires specialist advice or guidance.

8.3 When another process may be better suited to cover other potential outcomes, our staff will seek advice and provide clear information to the individual raising the complaint. We will make sure the individual understands why this is relevant and the options available. We will also signpost the individual to sources of specialist independent advice.

8.4 This would not necessarily prevent us from continuing to investigate the complaint. We will make sure that the person raising the complaint gets a complete and holistic response to all the issues raised. This includes any relevant outcomes where appropriate. The staff member dealing with the complaint will engage with other staff or organisations who can provide advice and support on the best way to do this.

8.5 If an individual is already taking part or chooses to take part in another process but wishes to continue with their complaint as well, this will not affect the investigation and response to the complaint. The only exceptions to this are if:

8.5.1 the complainant requests or agrees to a delay
8.5.2 there is a formal request for a pause in the complaint process from the police, a coroner or a judge.

In such cases the complaint investigation will be put on hold until those processes conclude.

8.6 If we consider that a staff member should be subject to remedial or disciplinary procedures, or referral to a health professional regulator, we will advise the person raising the complaint. We will share as much information with them as we can while complying with data protection legislation. The outcome of this will not be shared as part of the complaints process.

8.7 If the person raising the complaint chooses to refer the matter to a health professional regulator themselves, or if they subsequently choose to, it will not affect the way that their complaint is investigated and responded to. We will signpost to sources of independent advice on raising health professional fitness to practise concerns.

8.8 If the person dealing with the complaint identifies at any time that anyone involved in the complaint may have experienced or be at risk of experiencing harm or abuse, then they will discuss the matter with relevant colleagues and contact Safeguarding.

9 Confidentiality of complaints

9.1 We will maintain confidentiality and protect privacy throughout the complaints process in accordance with UK General Protection Data Regulation and Data Protection Act 2018. We will only collect and disclose information to those staff who are involved in the consideration of the complaint. Documents relating to a complaint investigation are securely stored in DATIX/DATIX IQ (risk management system) and kept separately from medical records or other patient records. They are only accessible to staff involved in the consideration of the complaint and the complaints/PALS staff.

9.2 Complaint outcomes may be anonymised and shared within our organisation and may be published on our website to promote service improvement.

9.3 If a complainant requests access to health records the Complaints Team will redirect this to the Subject Access Team who will manage this request.

9.4 Consent processes will be followed for all complaints received (Appendix 3).

10 How we handle complaints

Making sure people know how to complain and where to get support

10.1 We publish clear information about our complaints process on our website, including how people can get advice and support with their complaint through their local independent NHS Complaints Advocacy services. Information can be found on the Trust website.

10.2 We will make sure that everybody who uses (or is impacted by) our services (and those that support them) know how they can make a complaint by having our complaints procedure and/or materials that promote our procedure visible in public areas and on our website. We will provide a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to our complaints process online and providing information in an easy read format.

10.3 We will make sure that our patients ongoing or future care and treatment will not be affected because of a complaint that has been made by them or on their behalf.

What we do when we receive a complaint

10.4 We want all people, patients, their family members and carers to have a good experience while they use our services. If somebody feels that the service received has not met our standards, we encourage people to talk to staff who are dealing with them and/or to contact the Patient Advice and Liaison Service, to see if we can resolve the issue promptly.

10.5 We want to make sure we can resolve complaints quickly as often as possible. To do that, we encourage staff to proactively respond to service users, and their representatives, and support them to deal with any complaints raised at first point of contact. All new members of staff are advised of the important part they can play in managing concerns as soon as they arise during the Trust induction.

10.6 All of our staff who have contact with patients, service users (or those that support them) will handle complaints in a sensitive and empathetic way. Staff will make sure people are listened to, get an answer to the issues quickly wherever possible, and any learning is captured and acted on.

Our staff will:

- Listen to the service user and their representatives to make sure they understand the issue(s)
- Ask how they have been affected
- Ask what they would like to happen to put things right

- Carry out these actions themselves if they can (or with the support of others)
- Explain why, if they cannot do this, and explain what is possible
- Capture any learning to share with colleagues and improve services for others

Tier 1: Complaints that can be resolved quickly (all Trust Staff)

10.7 Our frontline staff often handle complaints that can be resolved quickly at the time they are raised, or very soon after. We encourage our staff to do this as much as possible so that people get a quick and effective answer to their issues.

10.8 In keeping with the 2009 Regulations, if a complaint is made verbally (in person or over the telephone) and resolved by the end of the next working day, it does not need go through the remainder of the process described in this policy. For this to happen, we will confirm with the person making the complaint that they are satisfied we have resolved the issues for them. If we cannot resolve the complaint within that timescale we will handle it in line with the rest of this procedure.

Focus on early resolution as part of the complaints process (Appendix 4)

10.9 When we receive a complaint, we are committed to making sure it is addressed and resolved at the earliest opportunity. Our staff are trained to identify any concerns that may be resolved at the time they are raised or very soon after. If staff consider that the issues cannot be resolved quickly, we will take a closer look into the matter.

10.10 When our Team believe that an early resolution may be possible, they are authorised to take action to address and resolve the issues raised and put things right for the person raising them. This may mean giving a quick explanation, or apology themselves, if they have the information at hand or making sure a colleague from who is more informed of the issues does so. Trust staff will resolve complaints in person or by telephone wherever possible, otherwise this will be provided in writing either via email or letter.

10.11 If we think a complaint can be resolved quickly, we aim to do this in a matter of days. We will always discuss, with those involved, what we will do to resolve the complaint and how long that will take.

Tier 2: Resolving concerns quickly (PALS)

10.12 If we can answer or address the complaint quickly and the person making the complaint is satisfied that this resolves the issues, our staff have the authority to provide a response on our behalf. This will often be done in person, over the telephone, or in writing (by email or letter) in line with the individual circumstances.

10.13 We will capture a summary of the concern in our DATIX/DATIX IQ systems with information on how we have resolved it. We will share that with the person raising the issue. This will make sure we build up a detailed picture of how each of the services we provide is doing and what people experience when they use these services. We will use this data to help us improve our services for others.

If we are not able to resolve a complaint

10.14 If we are unable to find an appropriate way to resolve the concern to the satisfaction of the person making it, we will look at whether we need to take a closer look into the issues.

Tier 3: A closer look into the issues (Complaints)

10.15 Not every complaint can be resolved quickly and sometimes we will require a longer period of time to carry out a closer look into the issues and carry out an investigation. In these cases, the Complaints Team will make sure the complaint is allocated to an appropriate member of staff (Lead Investigator), who will take a closer look into the issues raised. This will always involve taking a detailed and fair review of the issues to determine what happened and what should have happened.

10.16 We will make sure staff involved in carrying out a closer look (Lead and Support Investigators) are properly trained to do so. We will also make sure they have:

- The appropriate level of authority and autonomy to carry out a fair investigation
- The right resources, support and time in place to carry out the investigation, according to the work involved in each case

10.17 Where possible, complaints will be looked at by someone who was not directly involved in the matters complained about. If this is not possible, we will explain to the person making the complaint the reasons why it was assigned to that person. This should address any perceived conflict of interest.

Clarifying the complaint and explaining the process

10.18 The complaints team member dealing with the complaint will:

Engage with the person raising the complaint (either face-to-face or by telephone) to make sure they fully understand and agree (Appendix 5):

- The key issues to be looked at
- How the person has been affected
- The outcomes they seek

Signpost the person to support and advice services, including independent advocacy services, at an early stage. Information is held on the Trust website.

Share a realistic timescale for how long the investigation is likely to take with the person raising the complaint, depending on:

- The content and complexity of the complaint
- The work that is likely to be involved
- Determine if the complainant would like a call from the LI

The LI dealing with the complaint will:

- Agree how they will keep the person (and any staff specifically complained about) regularly informed and engaged throughout the complaint investigation. If the complainant has not opted for a call with the LI then information must be provided to the Complaints Team to be passed on to the complainant
- Make sure that any staff members specifically complained about are made aware at the earliest opportunity

Explain how they will carry out the closer look into the complaint, including:

- What evidence they will seek out and consider
- Who they will speak to
- How they will decide if something has gone wrong or not
- Who will be responsible for the final response
- How the response will be communicated

Carrying out the investigation (Appendix 6)

10.19 There is a five stage process managed through key performance indicators. These five stages are split within a 40 working day timescale.

10.20 Staff who carry out investigations will give a clear and balanced explanation of what happened against what should have happened. They will reference relevant legislation, standards, policies, procedures and guidance to clearly identify if something has gone wrong.

10.21 They will make sure the investigation clearly addresses all the issues raised. This includes obtaining evidence from the person raising the complaint and from any staff involved or specifically complained about.

10.22 If the complaint raises clinical issues, they will obtain a clinical view from someone who is suitably qualified. Ideally, this person will not have been directly involved in providing the care or service that has been complained about.

The LI may seek an explanation of the care/treatment provided by the person providing it but have this reviewed by someone suitably qualified, such as:

- Senior Sister/Charge Nurse
- Clinical Director/Assistant Clinical Director
- Director of Nursing/Director of Midwifery/Director of Allied Health Professionals

10.23 We will aim to complete our investigation within the timescale shared with the complainant at the start of the investigation. Should circumstances change the LI will:

- Apply a stop moment in line with appendix 7
- Notify the person raising the complaint (and any staff involved) via the telephone or email immediately
- Explain the reasons for the delay
- Agree a new target timescale for expected completion

10.24 Unless we have agreed a longer timescale with the person raising the complaint within the first six months, we will inform them if we cannot conclude the investigation and issue a final response within six months. Our Chief Executive or their nominated Executive Director will write to the complainant to explain the reasons for the delay and the likely timescale for completion. The reason for the delay will be provided by the LI.

The executive will maintain oversight of the case until it is completed and a final written response issued.

10.25 Before sending a final written response to the complainant, where possible, the LI will share and discuss (by telephone, in a meeting or in writing) the outcome of the investigation and the actions we intend to take, with all of the key parties including the complainant. We will consider any comments received before issuing a final response. Where this is not possible it will be clear in the response letter what the next steps are for the complainant should they have further questions.

10.26 STOP moments can be applied to pause the timescale, as outlined in Appendix 7. When stop moments are applied these will be done in line with the policy and liaison with the complainant. When a stop moment is applied, the due date for providing a final response will be amended.

Exceptional stop moments as described in appendix 7 and those that fall outside of the remit of the policy will only be initiated in liaison with the Head of Patient Experience and Insight, Deputy General Manager for Patient Experience and Insight or the Complaints Service Manager.

The reason for the request will be recorded in DATIX/DATIX IQ and shared with the complainant.

Providing a remedy

10.27 Following the investigation, if the LI identifies that something has gone wrong, they will seek to establish what impact the failing has had on the individual concerned. Where possible they will put that right for the individual, and any other people who have been similarly affected. If it is not possible to put the matter right, they will decide, in discussion with the individual concerned and relevant staff, what action can be taken to remedy the impact.

10.28 In order to put things right, the following remedies may be appropriate:

- An acknowledgement, explanation and a meaningful apology for the error
- Reconsideration of a previous decision
- Expediting an action
- Issuing a payment if we feel there have been significant issues relating to emotional, material, physiological or bereavement related matters. To consider the Severity of Injustice scale as set out by the PHSO when assessing this
- Changing policies and procedures to prevent the same mistake(s) happening again and to improve our service for others

Local resolution meetings (Appendix 8)

When it is agreed that a local resolution meeting is beneficial, rather than a written response, a suitable date will be co-ordinated and agreed with the complainant and relevant members of staff. The meeting will be held within 40 working days, unless there are extenuating circumstances that require a stop moment.

Local resolution meetings can be held face to face or virtually via Microsoft Teams.

An audio recording of the meeting will be taken as a full, unedited record of the meeting. This will be provided to the complainant as an audio file and sent securely via email with password protection.

The option of a meeting may be removed if the complainant displays behaviours that would fall under the vexatious and habitual section of this policy (Section 12).

As soon as practicable, following the investigation/meeting, the LI will coordinate a post meeting letter which will summarise the meeting and act as supplementary to the recording.

Support for staff

10.29 We will make sure all staff who look at complaints have the appropriate training, resources, support and time to investigate and respond to complaints effectively. This includes how to manage challenging conversations and behaviour.

10.30 Divisions/Business Units will make sure staff specifically complained about are made aware of the complaint, and we will give them advice on how they can get support from within our organisation, and externally if required.

10.31 We will make sure staff who are complained about have the opportunity to give their views on the events and respond to emerging information. Our staff will act openly and transparently and with empathy when discussing these issues.

10.32 The Lead Investigator will keep any staff complained about updated. These staff will also have an opportunity to see how their comments are used before the final response is issued.

Referral to the Parliamentary and Health Service Ombudsman

10.33 In our response we will clearly inform the person raising the complaint that if they are not happy with the outcome of our investigation, they can take their complaint to the Parliamentary and Health Service Ombudsman.

10.34 If the complaint is about detention under the Mental Health Act, or a Community Treatment Order or Guardianship, we will inform the person making the complaint that, if they are not happy with the outcome, they can take their complaint to the Care Quality Commission.

11 Roles and Responsibilities

11.1 Overall responsibility and accountability for the management of complaints lies with the responsible person (as defined by the 2009 Regulations). In our organisation this is the Chief Executive Officer. The function of the responsible person can be performed by another Executive authorised by the Trust to act on behalf of the responsible person. The Executive Chief Nurse has Board level responsibility for complaints and concerns management.

11.2 We have processes in place to make sure that the responsible person, relevant senior managers and partners, regularly review insight from the complaints and concerns we receive, alongside other forms of feedback on our care and service. They will make sure action is taken on learning arising from complaints so that improvements are made to services.

11.3 They demonstrate this by:

- Leading by example to improve the way we deal with compliments, feedback, concerns and complaints
- Understanding the obstacles people face when raising a concern or making a complaint to us and taking action to improve the experience
- Knowing and complying with all relevant legal requirements regarding complaints
- Making information available in a format that people find easy to understand
- Promoting information about independent complaints advocacy and advice services
- Making sure everyone knows when a complaint is a patient safety incident, or a safeguarding or legal issue and what must happen
- Making sure that there is a strong commitment to the duty of candour so there is a culture of being open and honest when something goes wrong
- Making sure we listen and learn from complaints and improve services when something goes wrong

11.4 The 2009 Regulations allow us to delegate the relevant functions of the Responsible Person and Complaints Manager to our staff where appropriate. We do this to ensure we can provide an efficient and responsive service.

Complaints management, roles and responsibilities

11.5 The Complaints Service Manager (as defined by the 2009 Regulation) is responsible for managing this policy and for overseeing the handling and consideration of any complaints we receive.

The PALS Service Manager is responsible for overseeing the handling of compliments, enquiries and concerns received.

The Complaints and PALS Service Managers have operational responsibility for the management of their respective areas.

11.6 Divisional Directors / Medical Directors / Divisional Nurse Directors / Director of Midwifery / Director of Allied Health Professionals (AHPs), or their deputies, are responsible for ensuring the division appropriately investigate and respond to complaints within the Trust's agreed timescales and, according to policy, standards and regulations. These roles also have overall divisional oversight of complaints and concerns. In addition, they have responsibility for monitoring the quality and effectiveness of the investigation and response letter through the Quality Assurance (QA) process, assessing which aspects of the complaint are upheld and which are not.

11.7 The Trust's Safeguarding Lead is responsible for determining appropriate and timely investigations of all Section 42 enquiries.

11.8 Appropriate Lead and Support Investigators will be identified by Business Unit (BU) leads.

Lead Investigators (LI) and Support Investigators (SI) will be of appropriate seniority to carry out an investigation. They will be an experienced manager who have undertaken appropriate training and have considerable experience in the investigation of complaints and writing response letters. LI's may delegate the investigation to SI's as they see appropriate but will retain overall responsibility and accountability for the timeliness, quality and content of the investigation and response.

LI's have responsibility for thoroughly investigating complaints received, liaising with all relevant individuals, to provide a comprehensive response to the complainant. This will be either in the form of a meeting or a letter. The method of response will be agreed with the complainant. It will also be the responsibility of the LI to outline any actions and learning identified during the investigation process.

11.9 The PALS Team are the first point of contact for all concerns that require immediate response. These can include queries relating to current care, issues with appointments, admission queries or a wait to be seen in hospital.

They offer support, advice and information to patients, relatives and carers. Comments, enquiries, compliments, concerns and complaints can be raised via the PALS Team.

The Team are responsible for assisting with issues raised by complainants that can be managed in a shorter timeframe. They will act as liaison between the complainant and the department/BU/Division to ensure concerns are answered in full.

11.10 The Complaints Team are designated as the service that will listen, coordinate and administer the complaints process. They are responsible for providing expert knowledge of the complaints process to both the complainant and the organisation.

They are responsible for the monitoring of each Key Performance Indicator (KPI) and liaising with the Division/BU to ensure efficient handling of each complaint. The KPI breakdown can be found in Appendix 2.

12 Complaints involving multiple organisations

12.1 If we receive a complaint that involves other organisation(s) (including cases that cover health and social care issues) we will make sure that we investigate in

collaboration with those organisations. The people handling the complaint for each organisation will agree who will be the 'lead organisation' responsible for overseeing, and coordinating, consideration of the complaint.

12.2 The person investigating the complaint for the lead organisation will be responsible for making sure the complainant is kept involved and updated throughout. They will also make sure that the individual receives a single, joint response.

12.3 Before we approach other organisations, we will require a signed consent form from the complainant to allow us to approach them for a response.

12.4 Once consent has been received, we will forward the complaint and consent form to the other organisation(s) and ask them to provide a response in line with our timescales. If we are made aware that the other organisation(s) have a longer timescale e.g. 60 days, we will amend our timescales accordingly, adding 10 working days to this to allow time for their element to be incorporated into our response.

12.5 In circumstances where the other organisation have not provided their response within the prescribed timeframe the Trust will contact the other organisation to remind them that the complaint is due. If we do not receive a response the Trust will provide its response to the complainant. The complainant will be advised that as the only matter remaining outstanding relates to the other organisation the matter has now been transferred to them for completion. Complainant details will be provided to the organisation, if not already shared, and named contact details will be provided to the complainant for the other organisation. The responsibility for responding will now be with them.

12.6 In circumstances where the Trust has taken lead on a shared complaint and the complainant remains dissatisfied with the response, but this relates wholly to the other organisation the further management of this complaint will be handed to the other organisation. The complainant will be advised of this. They will be provided with a named contact for the other organisation. Equally if we are feeding into a complaint for another organisation and the complainant remains dissatisfied with our response, we will take lead on further responses.

12.7 If a complaint is received that relates wholly to another organisation, the complainant will be referred to the appropriate organisation by a member of the complaints or PALS team and will be advised on contact details.

13 Monitoring, demonstrating learning and data recording

13.1 We expect all staff to identify what learning can be taken from complaints, regardless of whether mistakes are found or not.

13.2 Our Senior Managers take an active interest and involvement in all sources

of feedback and complaints, identifying what insight and learning will help improve our services for other users.

13.3 We maintain a record of:

- Each complaint we receive
- The subject matter
- The outcome
- Whether we sent our final written response to the person who raised the complaint within the timescale agreed at the beginning of our investigation

13.4 To measure our overall timescales for completing consideration of all complaints and our delivery of the NHS Complaint Standards, we seek feedback on our service from:

- People who have made a complaint and any representatives they may have. A link to a survey is sent to complainants following completion of investigation and receipt of their final response
- Staff who have been specifically complained about
- Staff who carried out the investigation

13.5 We monitor all feedback and complaints over time, looking for trends and risks that may need to be addressed.

13.6 In keeping with the 2009 Regulations section 18, as soon as practicable after the end of each financial year, we will produce and publish a report on our complaint handling. This will include how complaints have led to a change and improvement in our services, policies or procedures.

13.7 Divisional Governance standards have been set to ensure that complaints monitoring within divisions examine the narrative, ensuring that learning takes place and action plans are monitored, as well as numbers and performance.

13.8 The Complaints Review Group (CRG) meet eight-weekly to review a structured sample of recently closed complaints. Assurance will be provided to the Operational Patient Experience Group (OPEG) who will then upwardly report into the Patient Experience, Engagement and Insight Group (PEEIG). The group will ensure compliance with the NHS Complaints Standards. This group identifies issues with the management of the complaints process, the quality of the investigation and response. It provides learning for staff involved in the complaints process and influences future training requirements.

13.9 The Patient Experience, Engagement and Insight Group (PEEIG) provides overarching coordination of all Patient and Public Feedback activity. This group oversees the compliance with this policy, the Patient Experience, Engagement &

Insight Strategy, CQC Regulation 16: Receiving and acting on complaints, the NHS Complaints Standards, and the NHS Complaint Regulations 2009. The Operational Patient Experience Group (OPEG) provides operational coordination of patient experience and feedback activity, identifies emerging themes and hotspots to coordinate key focus areas for escalation and action.

13.10 Quality Governance Steering Group (QGSG) undertakes a review of divisional complaints performance, including response times, actions and learning. This includes trends/themes and actions taken. Divisions report via Performance Review Meetings.

13.11 The Trust Board receives assurance through an annual report of complaints and concerns in accordance with the Complaint Regulations 2009.

14 Guidance relating to habitual or vexatious complainants (Appendix 9)

The Trust is committed to effectively dealing with all complaints, concerns, enquiries and feedback fairly and in line with agreed timescales. It is acknowledged that there may be occasions when complainants feel dissatisfied if investigations take longer than expected, feel they have not been initially heard, understood or that their concerns have not been taken seriously. In the light of this, a small minority of complainants exhibit behaviours which may be identified as vexatious or habitual. A legal definition of vexatious behaviour is “unreasonable behaviour of anyone making a request or complaint in an abusive, threatening or offensive manner or unreasonably persistent manner by the frequency of requests and complaints.”

It is recognised that habitual and/or vexatious behaviours as well as any inappropriate conduct or harassment can be linked to the mounting frustration of awaiting a response or outcome from the Trust whilst internal investigations or reviews are completed.

On such occasions, some people will increase the frequency of their contact with the Trust to the point that dealing with their concerns through the NHS complaints procedure becomes unmanageable and poses a risk to the safety, welfare and well-being of our staff. The nature of a person’s behaviour or conduct can also affect the Trust’s ability to respond to them effectively as well as others who require advice and support.

It is important to distinguish between people who make a number of contacts and those whose persistent or demanding contact goes far beyond what is reasonable. We acknowledge that people may often be significantly frustrated, aggrieved, or bereaved and it is, therefore, imperative to consider the nature and context of their contact.

We are also committed to ensuring the safety, welfare and wellbeing of our staff, service users and members of the wider public, is maintained on our premises.

All staff are actively encouraged to assist individuals in resolving concerns, complaints, enquiries and feedback, as well as requests for information in accordance with the Trust's values. However, there are times when there is nothing further that can reasonably be done to help an individual reach resolution.

We recognise that there are a number of statutory duties and obligations in relation to the management of contacts, complaints, concerns and requests for information. This process does not interfere with those rights and duties.

In these circumstances, the Standard Operating Procedure (SOP) (Appendix 9) sets out the process that will be instigated where habitual or vexatious behaviour is confirmed. This SOP will operate only with Executive authorisation. It establishes a procedure and process whereby habitual or vexatious complainants can continue to be treated fairly within local complaints handling processes.

15 Patient Safety Incident Response Framework

When a complaint requires a higher level of investigation due to a patient being exposed to harm, the Lead Investigator will determine whether there is an opportunity for learning and the type of investigation required, according to guidance available within the Trust's Patient Safety Incident Response Framework (PSIRF), e.g. Patient Safety Incident Investigation (PSII) or external review.

The decision to investigate will be made within 3 days. Investigations should ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of the investigation. In this case, any extended timeframe should be agreed between the healthcare organisations with the patient/family/carer. No local investigation under PSIRF should take longer than six months. A balance must be drawn between conducting a thorough investigation, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

If PSIRF is deemed to address all concerns raised in the complaint, the complaint will be closed. When there are outstanding concerns that warrant further investigation, which will not be addressed through the PSIRF, the complaint will remain open, and the appropriate complaints timeline will remain.

The Lead Investigator has responsibility for keeping the complainant informed and agreeing with the complainant how the findings and actions will be fed back.

Once the PSIRF report is finalised, the investigation findings will be shared with the complainant. PSIRF encourages the sharing of draft reports with patients / relatives so that they have an opportunity to provide comments.

When a complaint involves concerns regarding maternal and perinatal death (intra-partum still birth, early neonatal death, severe brain injury or maternal death), an additional external investigation is carried out by the Healthcare Safety Investigation Branch (HSIB) to support the organisation's internal investigation.

The Lead Investigator will inform the family of the HSIB investigation and will update them on progress, as the investigation can take up to six months. The complaint will continue to be assessed and investigated as described above.

16 Duty of Candour

The regulations for Duty of Candour require all providers registered with the CQC, both healthcare and adult social care providers, to be open and transparent with service users about their care and treatment. From November 2014 the regulations also imposed a more specific and detailed Duty of Candour on all providers where any harm to a service user from their care or treatment is above a certain harm-threshold.

Where there is a clinical incident involving a patient, the consultant (or nominated deputy) responsible for the patient, together with the appropriate divisional general manager, senior nurse or nominated deputy, will be responsible for ensuring the communication of what has happened, and the action intended to the patient and the patient's family in accordance with the Trust's Duty of Candour requirements.

Where it comes to light, following a concern or complaint raised by the patient or person acting on their behalf, that a patient has been exposed to harm, the Divisional Clinical Governance Facilitator, will be responsible for assessing the level of harm and type of investigation required. The Trust's Patient Safety Incident Response Framework provides guidance and criteria for investigations/actions, including After Action Review (AAR), Patient Safety Incident Investigations (PSII) and external investigations (e.g. Healthcare Safety Incident Branch, Perinatal Reviews and Child Death Reviews).

If an internal incident review or external review is opened, following assessment of the issues raised in a complaint, the complaint file will be closed due to the higher-level investigation being undertaken.

The complainant will be contacted by the complaints team to advise them that their issues will be addressed as part of the Patient Safety Incident Response Framework and the complaint will be immediately closed.

The Duty of Candour letter will be sent directly from the Division to the complainant. However, if the complaint includes issues outside of the remit of PSIRF these will be addressed either through a formal complaint or PALS response.

17 Parliamentary and Health Service Ombudsman (PHSO) / Local Government Ombudsman (LGO) (Appendix 12)

The Complaints Service Manager will initially respond to enquiries from the PHSO and the LGO. The Complaints Service Manager acts as the main contact for the Ombudsman and, when required, will provide relevant documentation and liaise with divisional colleagues regarding PHSO/LGO investigations, findings and recommendations.

The Complaints Team will liaise with other Trusts/organisations regarding joint investigations, responses, recommendations, actions and learning from Ombudsman cases, in line with the local agreement for the joint handling of health and social care complaints.

Actions and learning from PHSO/LGO cases are inputted directly into DATIX/DATIX IQ. Upheld cases with significant findings and recommendations are reviewed at the Complaints Review Group (CRG) and Operational Patient Experience Group (OPEG) to ensure that actions and learning are robust. They are also reported to the Integrated Care Board as part of the Quality Schedule.

18 Staff training and learning resources

Staff training in handling concerns and complaints is crucial to developing a culture within the organisation, which values and encourages complaints/concerns. Every single member of staff and volunteer has a role to play in compliments, concerns and complaint management. Staff need to be confident that they have the necessary skills to respond to concerns and complaints at an early stage with courtesy and sensitivity.

Training is provided by the Head of Patient Experience and Insight/Deputy General Manager for Patient Experience and Insight/Complaints Service Manager/ PALS Service Manager. This is provided to LI's and SI's and covers good complaints handling and the complaints process. In addition, specific training and awareness sessions are delivered to key staff on new developments, for example changes to processes or systems.

The Trust has a resource page for Lead and Support Investigators on the Complaints/PALS intranet portal, containing information to support staff involved in handling complaints and concerns. This contains all learning material and useful documents and tools to assist in investigating and responding to complaints.

Training is shaped by the organisational learning from previous concerns and complaints. This allows the Trust to continually improve its approach to managing both informal and formal complaints, to ensure we are able to provide the best possible quality care and experience.

19 Media

If, at any stage, there is indication that the complainant intends to contact the media, staff must notify the Head of Patient Experience and Insight, their Deputy, the Complaints and PALS Service Managers and the Communications Team, to enable appropriate action to be taken to manage the potential reputational risk to the Trust. Appropriate measures will then be taken if required to inform the Chief Executive Officer and Executive Chief Nurse.

20 Complaints about a private provider

20.1 All complaints received relating to private care provided by Derby Private Health will be managed in accordance with this policy and in line with Independent Sector Complaints Adjudication Service (ISCAS) guidelines.

20.2 Exceptions include:

- Any complainant who is unhappy with their complaint investigation or response will be directed to the ISCAS. Information can be found on the ISCAS website: www.iscas.cedr.com or write to ISCAS, CEDR, 3rd Floor, 100 St. Paul's Churchyard, London, EC4M 8BU or by telephone on 020 7536 6091
- Timescales for complaint responses will be delivered in line with ISCAS guidelines

20.3 If the complaint relates solely to private healthcare, apart from that provided by Derby Private Health, we will direct the complainant to the relevant process.

20.4 Where we outsource the provision of NHS Services to a contractor, or private provider, we will make sure they follow these same complaint handling procedures. We will maintain meaningful strategic oversight of the performance of these organisations to make sure they meet the expectations set out in the NHS Complaints Standards.

21 Complaining to the commissioner of our service

21.1 Under section 7 of the 2009 Regulations, the person raising the complaint has a choice of complaining to us, as the provider of the service, or to the commissioner of our service, NHS Derby and the Derbyshire Integrated Care

Board or Staffordshire and Stoke-on-Trent Integrated Care Board. If a complaint is made to our commissioner, they will determine how to handle the complaint in discussion with the person raising the complaint.

21.2 In some cases it may be agreed between the person raising the complaint and the commissioner that we, as the provider of the service, are best placed to deal with the complaint. If so, they will seek consent from the person raising the complaint. If that consent is given, they will forward the complaint to us, and we will treat the complaint as if it had been made to us in the first place.

21.3 In other cases, the commissioner of our services may decide that it is best placed to handle the complaint itself. It will do so following the expectations set out in the Complaint Standards, and in a way that is compatible with this procedure. We will co-operate fully in the investigation.

Appendices

Appendix 1

Roles and responsibilities

The roles and responsibilities of staff within our organisation, when dealing with complaints are set out below.

Role	Responsibility
Chief Executive 'Responsible Person'	Has overall responsibility for making sure we: • Comply with the 2009 and 2014 Regulations • Comply with the NHS Complaints Standards and this procedure • Take any necessary remedial action • Report annually on how we learn from complaints Also responsible for: • Signing the final written response to the complainant (unless delegated to an authorised person(s)).
Executive Chief Nurse	Board level responsibility for concerns and complaints.
Head of Patient Experience and Insight (or deputy)	Responsibility for policy development and implementation. Overseeing the training and education of staff, compliance to standards, guidelines and legislation.
Complaints Service Manager and PALS Service Manager	Operational responsibility for their respective areas. They are responsible for Ensuring the procedures within their areas are kept up to date and are undertaken accordingly. Key Performance Indicators (KPI) compliance within their areas. Providing data and preparing reports for the Trust governance groups. Responding to requests from the Parliamentary and Health Service Ombudsman (PHSO) and Local Government

	Ombudsman (LGO). Providing information upon request. The provision of training and support for Lead Investigators and Support Investigators to provide them with the skills to investigate complaints and provide meaningful responses. The Complaints Service Manager will chair the Complaints Review Group, in their absence this role will be undertaken by the PALS Service Manager.
Divisional Directors / Divisional Nurse Directors / Director of Midwifery / Director of Allied Health Professionals (or deputies)	Divisional oversight of complaints. Responsibilities include: Upon receiving a query from LI within three working days of allocation of complaint, if deemed incorrect, negotiating the reallocation of that complaint to another LI or Business Unit (if within division) or to another Division within two further working days. These will be DND to DND conversations. The original allocation will remain if they do not adhere to timescales. Quality assuring response letters within four working days. Monitoring the quality and effectiveness of the investigation through the QA process. Assessing which aspects of the complaint are justified and which are not. The reason will be provide to the complaints team along with the outcome to the as to whether the complaint is upheld, partially upheld or not upheld. Seeking advice from the Trust's Legal Services department if they believe there are legal implications for the organisation. Providing support to LI's. Ensuring that complaints and concerns data, trends and case reviews are used to inform learning, improvements and changes in practice. Reporting to the Patient Experience, Engagement and Insight Group on the divisional position in relation to complaints and concerns.
Safeguarding Lead	Responsible for investigations into any Section 42 enquiry.

	Assisting the complaints team where there are safeguarding issues identified as part of the complaints process.
Lead and Support Investigators	Lead Investigators and Support Investigators may comprise of: • Matrons • General/Deputy General Managers • Senior AHPs and Healthcare Scientists • Other Clinical Managers/Heads of Departments • Service Managers • Senior Sisters/Charge Nurses/AHPs • Other Managers/Co-ordinators Should there be requirement for escalation the following groups can be called upon to act as LI: • Clinical Directors and Associate Clinical Directors • Divisional Medical Directors/Deputy • Divisional Nurse Director/Deputy • Director of Midwifery/Deputy • Director of AHPs • Directors of Nursing • Divisional Director/Deputy • Clinical Governance Facilitators Responsibility for: If requested, contacting the complainant at the beginning of the investigation to introduce themselves and discuss the complaint; clarifying the issues and outcome sought. Assessing the complaint, in liaison with the Divisional Clinical Governance Facilitator to determine if the complaint falls within the Patient Safety Incident Response Framework (PSIRF). This has to be undertaken within 3 working days of receipt within the division. Escalating to the DND, DoM, DAHP if there are challenges to the allocations of the complaint within 3 working days. If this timescale is not adhered to the allocation will remain. Investigating concerns raised comprehensively.

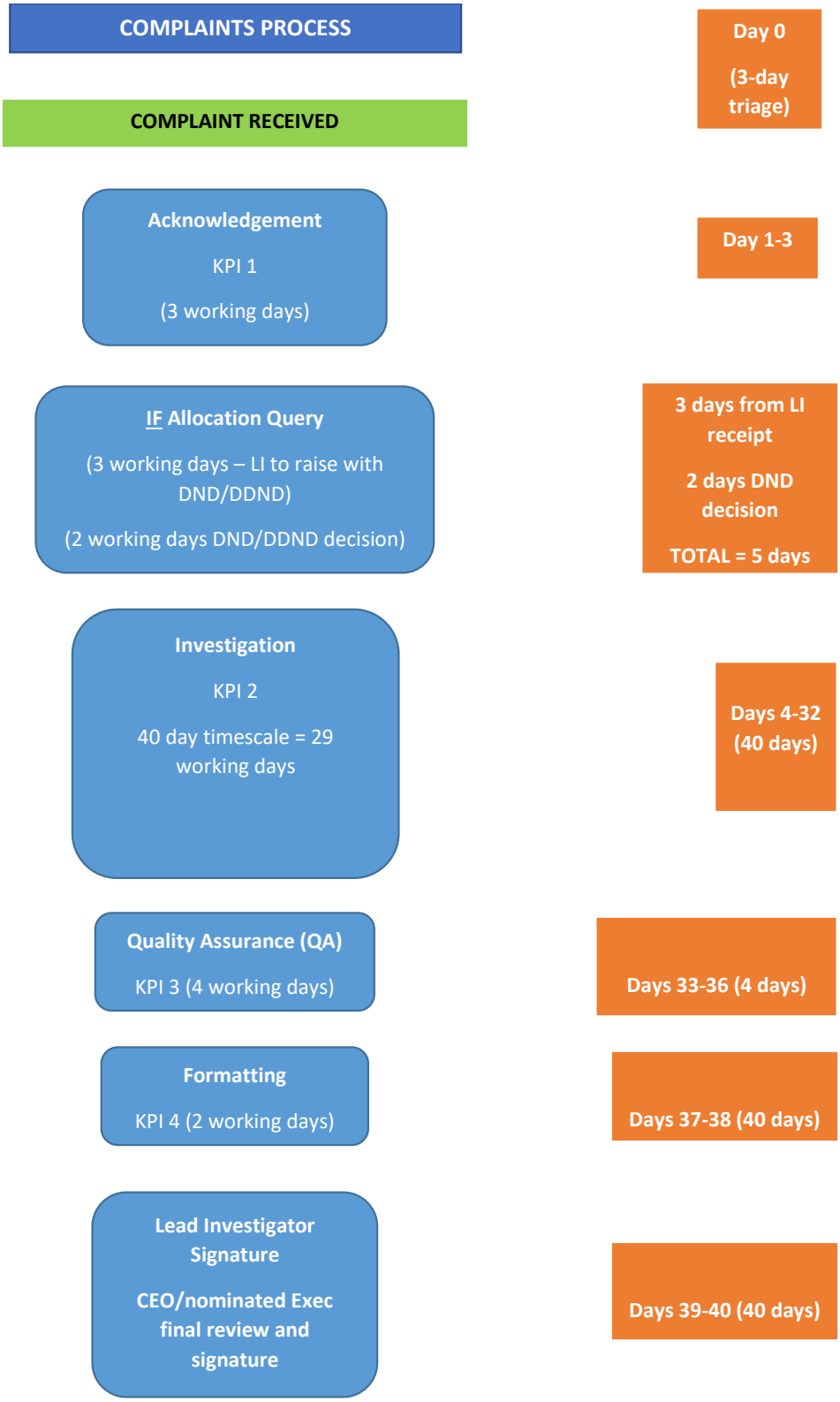
	Coordinating, obtaining and collating comments, information, emails and statements as part of the investigation. Uploading evidence to the complaint file held on DATIX / DATIX IQ within the timescales set (29 working days (40 day written response)). Ensuring correspondence is factual and does not contain personal opinion or subjective comments. Seeking information from clinicians, professional leads, divisional directors and where appropriate from independent experts. Considering if any aspect of the complaint may require legal review and discussing this with the DND/DoM/DAHP. Ensuring that if a clinician identified in the complaint has left the Trust that they speak to the Lead Clinician in that area. Keeping the complainant informed on the progress of the complaint investigation and advising them of delays if the deadline cannot be met. This can be via telephone or email. Ensuring complaints / local resolution meetings are held within the agreed timescales. Provide the list of attendees to the complaints team following review of the complaint within 5 working days. The LI is responsible for escalating any issues regarding clinician availability to the CD/ACD. Charing the local resolution meetings and providing the post-meeting letter which should summarise the issues discussed and outline any actions identified. This will be provided within the agreed timescales (10 working days or 25 working days if further issues are raised in the meeting). Complete actions plans and identifying learning, recording this on DATIX on completion of the draft response. Taking part in case reviews alongside the Complaints Service Manager, attending Complaint Review Group to discuss these, actioning the learning identified during these reviews.
PALS Team	The team are responsible for:

	Assessing, triaging and agreeing the route for handling issues raised. Assisting with concerns by liaising with senior staff on behalf of the public. Advising complainants on services the Trust provides and general information about the NHS. Providing information and signposting to other organisations. Listening to suggestions and taking action to improve services. Provide information on advocacy services and the formal complaints process. Liaising with Divisions / BU's to find provide answers to the individual raising the concern. Will respond to complainants either via email or telephone with responses received from Divisions / BU's. Aiming to respond to informal concerns within 5 / 10 working days dependent upon the complexity and seriousness of the issues raised. Onward referral to the complaints team if this process does not provide a satisfactory outcome for the complainant.
Complaints Team	They are responsible for: Assessing and triaging complaints and contacting all complainants to agree the correct route through which their concerns will be handled. The triaging process will be carried out within three days of receipt, prior to the commencement of the KPI clock starting. Acknowledging the complaint within 3 working days. They will call the complainants to agree the method of response which can be written or a resolution meeting. As part of this initial call the team will explain the complaints process, agree the timescale, explain the consent process and gain an understanding of the expected outcome from the

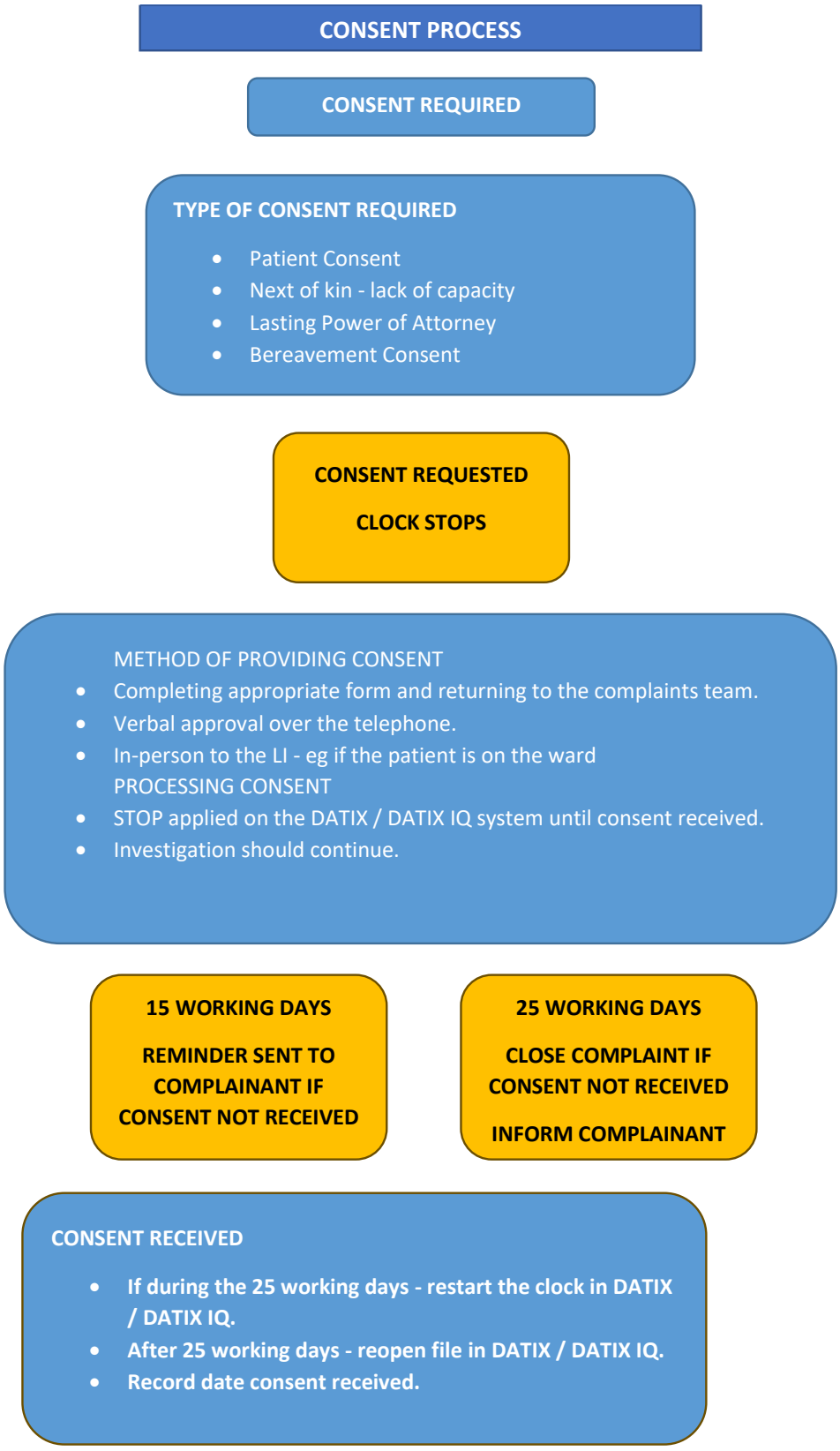
	complaint response. Consider if the complaint is suitable for early resolution. Determining if the complainant requires any additional support which can include providing information on advocacy services, reasonable adjustments such as help from interpreter services, learning disability team or if they require wheelchair access when attending. Assessing which Division / BU should lead and who the LI should be. They will liaise with Divisions where this is not clear. Providing an initial grading for the complaint which can be amended if deemed necessary following investigation. Producing a Management Plan which will provide information required to write a Trust Acknowledgement letter to be sent to the complainant which will outline the conversation taken place. Consent will be requested at the same time where required. Completing the 'Subjects' on DATIX / DATIX IQ to ensure that themes / trends can be captured. Liaising with Safeguarding and Legal Services if appropriate. Liaising with other organisations when required. Monitoring the KPI's and supporting the divisions to ensure efficient handling of complaints. Escalation of issues regarding KPI's as per the escalation process. Assisting in data collection and in identifying trends / themes. Identifying Executive availability and producing the Executive cover letter that goes with all Trust responses. Completing the necessary actions on DATIX / DATIX IQ at each KPI point to ensure Divisions are aware of the stage of each complaint.

	Ensuring timely receipt of Trust letters to complainants, adhering to data protection requirements.
Divisional Complaints Coordinators	Responsible for: Being the liaison between the Complaints Team and the Division, including the Divisional Leadership Team and the Lead Investigators. Attend regular meetings with the Complaints Team, going through all open complaints. Being the main link between their own Division and other Divisions. Providing support to Lead Investigators to ensure they know what complaints they have open and the current position of each complaint. Assisting Lead Investigators in obtaining information required to address questions raised within complaints.

Appendix 2


COMPLAINTS PROCESS
Day 0
(3-day triage)
COMPLAINT RECEIVED
Acknowledgement
KPI 1
(3 working days)
Day 1-3
IF Allocation Query
(3 working days – LI to raise with DND/DDND)
(2 working days DND/DDND decision)
3 days from LI receipt
2 days DND decision
TOTAL = 5 days
Investigation
KPI 2
40 day timescale = 29 working days
Days 4-32 (40 days)
Quality Assurance (QA)
KPI 3 (4 working days)
Days 33-36 (4 days)
Formatting
KPI 4 (2 working days)
Days 37-38 (40 days)
Lead Investigator Signature
CEO/nominated Exec final review and signature
Days 39-40 (40 days)

Appendix 3


CONSENT PROCESS
CONSENT REQUIRED
TYPE OF CONSENT REQUIRED
Patient Consent
Next of kin - lack of capacity
Lasting Power of Attorney
Bereavement Consent
CONSENT REQUESTED
CLOCK STOPS
METHOD OF PROVIDING CONSENT
Completing appropriate form and returning to the complaints team.
Verbal approval over the telephone.
In-person to the LI - eg if the patient is on the ward
PROCESSING CONSENT
STOP applied on the DATIX / DATIX IQ system until consent received.
Investigation should continue.
15 WORKING DAYS
REMINDER SENT TO COMPLAINANT IF CONSENT NOT RECEIVED
25 WORKING DAYS
CLOSE COMPLAINT IF CONSENT NOT RECEIVED
INFORM COMPLAINANT
CONSENT RECEIVED
If during the 25 working days - restart the clock in DATIX / DATIX IQ.
After 25 working days - reopen file in DATIX / DATIX IQ.
Record date consent received.

Patient's with Capacity

Complainant who are not the subject of the complaint will be required to obtain the patient's consent before confidential information relating to the circumstances of the complaint is disclosed. For a living patient with capacity to make their own decisions on complaints / disclosure of information, the patient's decision is final.

Other Organisations

If the complaint involves another organisation or agency, consent will be sought for permission to pass on or share information to enable a co-ordinated response or for the other organisation to respond separately. If the complainant does not provide consent for the complaint to be passed onto the other organisation(s), the Complaints Team will inform them of their right to contact the other provider direct.

When other organisations act on behalf of a patient to raise concerns or a complaint, evidence of consent must be received by the Trust before a response can be given.

Consent Not Provided by Patient

When the patient has not authorised the complainant to act on their behalf this does not preclude the Trust from undertaking a full and thorough investigation into the concerns raised. Specifically, if the complaint raises concerns about patient safety or the conduct of staff, the relevant Trust policies will be evoked. A response to the third party will be limited, only including any matters of a non-personal or non-clinical nature and will not include the outcome of any HR investigation. The response to the complainant will explain why this is the case.

Lack of Mental Capacity

When a patient does not have the mental or physical capacity to consent about whether or not to pursue a complaint, it is important to consider if that capacity is decision specific. It is possible that a patient who lacks capacity for a particular medical treatment decision may still have capacity to make their own decisions about whether or not to pursue a complaint, or how their confidential information should be shared. In such circumstances, the Lead Investigator will liaise with clinicians for advice on the patient's capacity.

Consideration should be given for independent advocacy and support. The test for capacity is whether or not the patient can understand, retain and weigh up what the complaints process is, how it works, their right to make a complaint and the circumstances that may give rise to it.

Patients should be given appropriate support to attain capacity for the decision of consenting to a complaint. If they have capacity, it is their decision whether a complaint about their care/treatment is pursued. A complaint from a family

member/carer should not be pursued if the patient does not want this. However, where the complaint indicates potential abuse or neglect by an individual in a position of power and trust, advice should be sought from the Trust Safeguarding Lead as this will require investigation.

For patients who lack capacity to provide consent, they must still be involved as much as possible in any decision, and their wishes must be given proper weight in any decision in their best interests. This means that it is not the patient's decision whether the complaint is pursued, but their wishes must be taken into account as follows:

- Explain to the patient, where appropriate, that a complaint has been made.
- Explain what the complaint is about.
- Establish the patient's wishes about the complaint, as far as reasonably possible, using appropriate means of communication. This may involve a clinician led best interest decision.
- Where appropriate, the Lead Investigator / Complaints Team will provide the patient with information about the complaint itself and the complaints process in a format that is easy for them to understand.
- Before making a best interest's decision, consideration for the following should be made:
- Whether the patient's lack of capacity for this decision is temporary and, therefore, the Trust can reasonably wait to obtain consent.
- The views of anyone who has legal authority to act on behalf of a patient (Lasting Power of Attorney or Court Appointed Deputy).
- The views of people close to the patient (those engaged in caring for the patient or have interests in their welfare).

The Complaints Team will check (with the Office of Public Guardian) whether there is anyone with a registered power of attorney for health and welfare decisions, to enable them to act on behalf of the incapacitated patient and consent to disclosure on their behalf. A Lasting Power of Attorney (for health and welfare) will only become effective at the point of a lack of capacity for that particular decision.

A copy of the Lasting Power of Attorney or Court Appointed Deputy should be provided, and to be effective it must bear the seal of the Office of the Public Guardian to show that it has been registered.

If the Trust has concerns about the representative making a complaint on behalf of the incapacitated patient (possibly due to their motives) then the Trust can refuse disclosure, with regard to their duties and responsibilities as data controller under the Data Protection Act 2018 and, will record the reason for this. It would be appropriate

to raise any such concerns with the Office of the Public Guardian (agency appointed by the Government to protect people in England and Wales who may not have the mental capacity to make certain decisions for themselves).

Deceased Patients

For a deceased patient, the duty of confidentiality remains. In order to ensure that confidentiality of patient information is maintained, the Complaints Team will issue a consent form, requesting confirmation of the complainant's status and supporting documentation to disclose confidential patient information through the complaint response:

Examples of supporting documentation include:

- For an Executor of the Will of the deceased person – a copy of the Will is required.
- For complainants with a claim or potential claim arising from the patient's death, the information disclosed should be relevant to the period of time of their claim. The Complaints Team will request documentation from the complainant to confirm they are an Executor of the Will or have a claim resulting from the death.
- Granted letters of administration by the Probate Registry.
- A person nominated as Next of Kin or point of contact for the deceased patient within the health records for the period specified in the letter of complaint.

Factors relevant to the decision to disclose confidential information through a complaint response are as follows:

- Wishes expressed by the patient before their death (which should ordinarily be respected).
- Potential disclosure of information about a patient's family or third party (third party information should be redacted).
- Whether the information is already public knowledge or can be anonymised.

One family member has no particular right to deny access to information to another. All of those entitled to information/to make a complaint about a deceased patient are entitled to it, and one of them cannot properly deny that information from others who are also entitled.

Exception to the above: not all family members would be entitled to information/records as part of their complaint. If the Trust is aware of a family dispute or information that indicates that the patient would not want any information to be passed to an individual (this can include views from other family members) it will take a decision on whether it is appropriate to respond by consulting with the Trust

Caldicott Guardian. In these cases, the Trust will write to the complainant to confirm and explain this. Should the complainant disagree with the decision not to respond, a complaint can be made to the Parliamentary and Health Service Ombudsman.

Exception to the above: if one family member is the sole Executor, for example, and other family members are not entitled to information as a result of the Access to Records Act or otherwise, it is up to the Executor to decide whether information should be shared. The Executor is bound by the same duties of confidentiality towards the deceased as anyone else.

If complaints are made by multiple family members raising the same issues, it is not reasonable to provide separate responses and the Complaints Team will liaise with the family to come to an agreement to agree a nominated lead for the complaint. All communication and information with be with the nominated person.

People Detained under the Mental Health Act

In such cases, the complaint investigation will be put on hold. People who are detained under the Mental Health Act (MHA) should be made aware of their entitlement at any stage to contact the Care Quality Commission (CQC) and be helped to do so if necessary. The CQC has the power to investigate complaints in relation to detention under the MHA and can also support and advise detained people through the NHS complaints process, advising them of their rights and corresponding on their behalf with the Trust.

Complaints Received from Members of Parliament or a Third Party

Third party complaints require the patient's consent in order to disclose personal information through the complaint response.

Where the complainant is communicating through a third party (an independent advocacy service provider, MP or solicitor), the Complaints Team will establish the boundaries of communication e.g. does the complainant wish to be copied into correspondence, would they like a face to face meeting, and what amount of clinical information can be released to the third party?

Complaints with Safeguarding Implications.

Consent is not required if the complaint includes information which is needed to be passed on in accordance with safeguarding procedures. In such cases, a letter should be sent to the complainant explaining the Trust's duty of care and its obligation to pass on the information. The Lead Investigator should seek advice from the Trust Safeguarding Lead prior to raising this.

Children Under 16

For a child under the age of 16 a complaint can be made on their behalf if the child is unable to make the complaint themselves. If the child is considered competent to make the complaint themselves, this would properly be assessed by the Gillick competence test rather than the Mental Capacity Act, which does not apply below the age of 16. The child should be advised to do so or their consent for a nominated person to complain on their behalf should be obtained.

The identity of the mother and father and their parental responsibility are presumed to have been established at the outset of treatment of a child.
A mother automatically has parental responsibility from the child's birth. For children whose births were registered from 1 December 2003 in England and Wales (or from 15 April 2002 in Northern Ireland, and from 4 May 2006 in Scotland), parental responsibility rests with both parents, provided they are named on the birth certificate, regardless of whether they are married or not.
For children whose births are registered prior to these dates, the father would only automatically have parental responsibility if he was married to the mother. Otherwise, he could acquire parental responsibility through a Parental Responsibility Agreement with the mother or a Parental Responsibility Order through the courts, and sealed copies of these should always be obtained by the Trust before they are relied upon.

The Court can remove a parent's parental responsibility if it has been acquired through a Parental Responsibility Agreement or Parental Responsibility Order. It is rare for a Court to do this and the circumstances where this might be appropriate are exceptional.

Parental Responsibility cannot be taken away from a parent who has it automatically (e.g. a mother) except through an Adoption Order. It may however be delegated. This means that a person with Parental Responsibility can arrange for another person to meet some or all aspects of it in relation to a child. A parent's views/complaint should not be disregarded if they do not have access to their child.

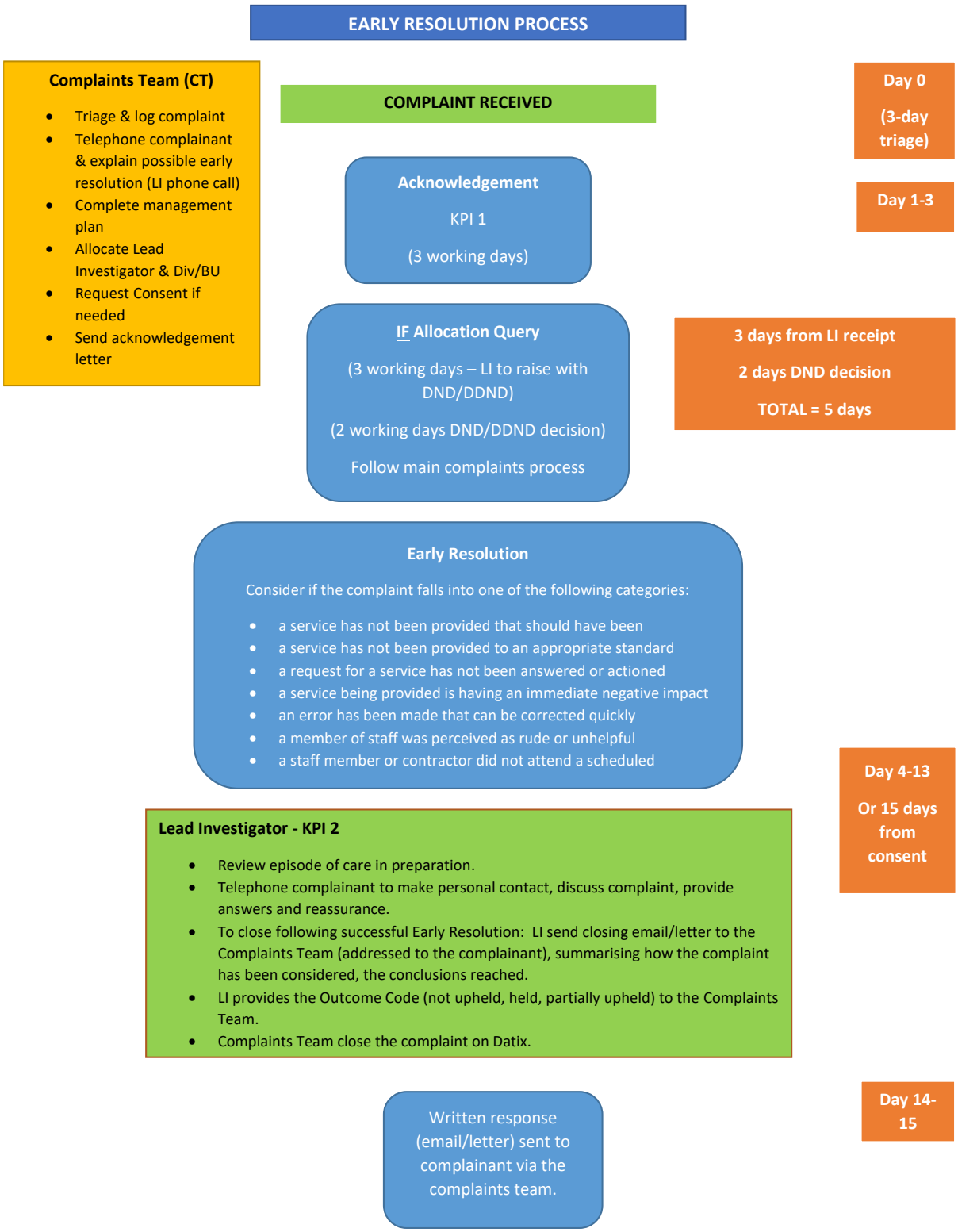
Divorce does not remove either parent of parental responsibility, and so neither would separation.

A stepparent can only acquire parental responsibility for a child when the Court makes a Child Arrangements Order or through the signing of a Parental Responsibility Agreement which is a formal document, signed by all other people with parenteral responsibility consent and then registered at court. When a stepparent adopts a child this puts them in the same position as a birth parent.

Generally, consent from only one person with parental responsibility is needed. However, it is good practice to consider the views of both parents and, if one parent strongly objects, then the Trust should consider the objections. If agreement cannot be reached, the Trust must decide how to deal with the complaint and whether pursuing the complaint is in the best interests of the child. In addition, the Trust will consider whether the child has Gillick competency, in which case their own direct consent will be required for their personal information to be provided to the complainant.

Advice will be sought as appropriate from the Safeguarding Team, senior clinicians responsible for the child's care and Legal Services in order to determine whether pursuing the complaint is in the child's best interest. If necessary, the Court can be asked to adjudicate on the dispute between the parents. In such cases, the Complaints Team will enquire about and request documentation to confirm parental responsibility.

Appendix 4


EARLY RESOLUTION PROCESS
Complaints Team (CT)
Triage & log complaint
Telephone complainant & explain possible early resolution (LI phone call)
Complete management plan
Allocate Lead Investigator & Div/BU
Request Consent if needed
Send acknowledgement letter
COMPLAINT RECEIVED
Day 0
(3-day triage)
Acknowledgement
KPI 1
(3 working days)
Day 1-3
IF Allocation Query
(3 working days – LI to raise with DND/DDND)
(2 working days DND/DDND decision)
Follow main complaints process
3 days from LI receipt
2 days DND decision
TOTAL = 5 days
Early Resolution
Consider if the complaint falls into one of the following categories:
a service has not been provided that should have been
a service has not been provided to an appropriate standard
a request for a service has not been answered or actioned
a service being provided is having an immediate negative impact
an error has been made that can be corrected quickly
a member of staff was perceived as rude or unhelpful
a staff member or contractor did not attend a scheduled
Day 4-13
Or 15 days from consent
Lead Investigator - KPI 2
Review episode of care in preparation.
Telephone complainant to make personal contact, discuss complaint, provide answers and reassurance.
To close following successful Early Resolution: LI send closing email/letter to the Complaints Team (addressed to the complainant), summarising how the complaint has been considered, the conclusions reached.
LI provides the Outcome Code (not upheld, held, partially upheld) to the Complaints Team.
Complaints Team close the complaint on Datix.
Written response (email/letter) sent to complainant via the complaints team.
Day 14-15

Appendix 5

Complaints Initial Triage Process

BEFORE CONTACTING THE COMPLAINANT

- Receiving attention email.
- Request for consent (pause the process).
- Request any missing patient identifiable information for clarification.
- Contact Legal services to confirm if the complaint is linked to a claim/inquest and query if there is any reason for a stop moment to be applied.
- Thoroughly assess the complaint.
- Determine if other organisations are involved and liaise with them to agree a joint approach and timescales.
- Contact Divisional colleagues if it is not clear who should be leading the complaint.
- Contact Divisional colleagues if PSIRF indicated.
- Produce a Management Plan.
- Determine appropriate grading
- Complete 'Subjects' in DATIX / DATIX IQ.

CONTACTING THE COMPLAINANT

- 3 attempts will be made (less in exceptional circumstances):
    - explain the process, discuss / agree timescales, advise who will be leading the investigation, discuss any further additions to the complaint, agree how they would like to be contacted, discuss any reasonable adjustments or support needed.
- Addition of further subjects on DATIX if required.
- Create and send Trust Acknowledgement letter outlining the discussion and confirming the agreed timescale and method of response.
- Send complaint and management plan to the Business Unit / Lead Investigator.
- Contact safeguarding if appropriate.

Grading

When a complaint is received in the Trust a provisional grading is completed by the Complaints Team in triage according to the categories below. This is a preliminary rating and the Investigation Lead will confirm / amend this provisional grading.

Complaints that are graded as Severe Harm or Death are escalated to the Lead Investigator and Clinical Governance Facilitator (CGF) to determine within 4 working days whether this should be managed under the Patient Safety Incident Response Framework (PSIRF) or if an Internal Investigation is required. The CGF will determine which elements of the complaint will be addressed through PSIRF and which elements will not be addressed and therefore will be continued through the complaints process and timeline. Where all issues are to be investigated through PSIRF, the complaint will be closed and the complainant will be informed by the Lead Investigator of the process.

Complex complaints involving multiple divisions will be shared with the appropriate Divisional Nurse Directors at the beginning of the process of allocating a Lead Investigator.

Appendix 6

Complaint Investigation Guide

Planning the Investigation

- Include an agreed communication plan, set out how and when you will update parties involved and include any reasonable adjustments that might be required.
- Set out issues to be investigated, which you have agreed with the person making the complaint.
- Set out the outcomes requested by the person making the complaint.
- Includes an assessment of risk and consideration of any broader patient safety or public interest concerns (taking account of other individuals who may be affected by the same issues, and any systemic concerns).
- Sets out the evidence you will need to obtain and consider in order to address each issue. This will always include:
    - Evidence to establish what happened.
    - Evidence to establish what should have happened.
- If you are delegating the investigation or any part of it to somebody else:
    - Details of who that is.
    - What exactly you are asking them to investigate and how.
    - The agreed timescale for completion and submission of their response / report.
- If the complaint involves clinical matters, includes details of who will provide you with a view, on behalf of your organization, on whether the care of service provided was appropriate. This should be someone who is suitably qualified but who has not been directly involved in the care of the person affected.
- Includes estimated timescales for:
    - Sharing what you have found with the parties involved and asking for their comments.
    - Completing your investigation and drafting your final response to the complaint.
    - Securing quality assurance.

Identifying and gathering evidence

- Look at what happened, then look at what should have happened.
    - If there is a difference look further into the cause of any identified failings.
    - What can be done to put any failings right?
    - What was the impact of these failings on the patient / person making the complaint?
    - How can that impact be put right for the person and others who may have been affected?
- Evidence that will explain **what happened** could include:
    - Evidence from the person making the complaint to support what they are saying.
    - Evidence from witnesses to the events.
    - Staff interviews or statements and evidence to support what they say.
    - Information from relevant clinical records / systems.
    - Information from other sources if necessary e.g. CCTV, phone records.
- Evidence that will explain **what should have happened** could include:
    - Relevant national policies, standards, procedures and guidance.
    - Local policies, standards, procedures and guidance.
    - If the complaint involves clinical matters, a view, on behalf of the organisation on whether the care or service provided was appropriate and in keeping with the relevant policies, procedures, standards and guidance. This should be a suitably qualified person who has not had direct in the care of the person affected.

Acting fairly during the investigation

- The person who made the complaint and anyone complained about should have the opportunity to:
    - Say what they believe happened in relation to the complaint.
    - Provide evidence to support what they say.
    - Say whether they agree with any initial findings before you reach a conclusion.
- The investigator should not prejudge the outcome of the complaint.
- The investigator should not favour the complainant or person complained about.
- Where possible the person investigating should not have had any previous involvement in the issues complained about. If this is not possible this must be explained at the start of the process. Explain to the complainant that you will:
    - Investigate thoroughly.
    - Make sure you provide a balanced account of what happened.
    - Reach conclusions based only on the evidence.
- The complainant should be kept informed and updated throughout the process.
- The complainant should be given an opportunity to comment on initial findings before issuing a final response.
- Supply the person who has complained and anyone complained about information regarding support they can access during the process, including advocacy services.

Good investigation record keeping

Keeping good records of the complaint and all relevant evidence is important. This will provide a good audit trail of what you have done and how you have reached a conclusion. This information is subject to request if referred to the Ombudsman, a regulator or if a legal claim is pursued. Key documents that could be included in the complaint file on DATIX / DATIX IQ are:

- A copy of the original complaint or complaint statement.
- The investigation plan.
- A log of all telephone calls, meetings and interview notes or recordings with the date, time and names of those present.
- Any statements from staff.
- Any statements from witnesses.
- Copies of any relevant extracts from the clinical records.
- Notes of any updates provided or discussions about the case.
- Copies of all evidence reviewed in the course of the investigation.
- A copy of any advice received including reference to any relevant policies, standards and guidance.
- Emails received / sent throughout the course of the investigation.
- Comments received regarding initial findings from all parties.
- The final written response.
- Action plan / learning uploaded to the complaints file and evidence that actions have been carried out.
- Details on how the person making the complaint will be updated (if appropriate) on the necessary actions when completed.

Writing your response

- Set out the issue the person has complained about and what they wanted to happen as a result of their complaint.
- Explain how you have looked into the complaint including, who you spoke to, the records you looked at to answer the complaint.
- Present the evidence you have considered as part of the investigation. This should, where possible, include the evidence received from the complainant themselves.
- Explain why and how you considered the evidence and be clear about everything you found regardless of whether it supports their complaint.
- Explain the outcome and if something went wrong. You will explain what happened weighed against what should have happened, stating the relevant policies, procedures and guidelines. Discuss whether guidance was followed and the impact that this may have had.
- If something went wrong, provide details of the failing and any impact it had. Take into account any impact explained from the complainant.
- Reflect the language used in the original complaint.
- Empathise with the complainant and if they talk about feeling a certain way, mirror that in your response.
- Provide a meaningful apology where appropriate. If something has gone wrong, apologise. An apology is not an admission of guilt, it is an acknowledgement that something could have gone better.
- Explain how we are able to remedy any failing. Describe actions to be taken or actions that have already been undertaken. Remedy can include:
    - Reviewing or remaking a decision.
    - Revising published material.
    - Revising policies and procedures to prevent the same thing happening again.
    - Training or supervising staff.
    - A combination of the above.
- Financial remedy can also be considered in line with the PHSO's Severity of Injustice Scale.
- Explain how the organization is using learning from the complaint to improve services. Thank them and explain how their speaking up will help improve experiences for others.
- Explain how the organization will demonstrate it has learnt from the complaint and offer to keep them involved / updated until all actions have been completed.
    - You may want to invite the individual in to see changes made.

    - You could share changes to policy.
    - You may want to invite them to share their story.
- Set out their right to refer their complaint to the Ombudsman if they are not happy with the outcome of their investigation. Provide information on how to contact the Ombudsman.

Appendix 7

STOP Moments

STOP Applied	**Guidance**
Awaiting Consent	Initial 15 working days - maximum 25 working days. Complaint to be closed if not received at this stage.
Coroner's Referral	When asked to pause by the Coroner timescale can be open-ended.
Safeguarding Review	Open-ended, to be guided by the Safeguarding team.
Trust Legal Review	10 working days.
Complainant Cannot Meet Within 40-day Timescale	To be guided by the complainant.
Seeking Legal Advice / Guidance regarding Vexatious and Habitual Complainant	In line with the guidelines to allow careful consideration.
Exceptional Stops	To be agreed in liaison with one of the following: • Head of Patient Experience and Insight • DGM for Patient Experience and Insight • Complaints Service Manager

Appendix 8

Meetings Guidance

Before the meeting

- Follow the complaint investigation guidance in the first instance.
- Determine who the attendees will be.
- Provide list of attendees to the complaints team within 5 days of receipt of the complaint in the Division.
- Determine who will chair if not the Lead Investigator.
- Determine the purpose of the meeting - fact finding or feeding back following investigation.
- Consider setting a timeframe for the meeting e.g. 1 hour 30 minutes.
- Arrange for staff to meet prior to the meeting to go over the complaint and identify who will address what during the meeting.
- Ensure staff are briefed and supported.

During and at the end of the meeting – Chair's responsibility

- Begin with introductions and the understanding of the reasons for the meeting – use the meeting script provided (this will be in the meeting file) to introduce the meeting and commence the recording.
- Listen and give the complainant an opportunity to outline their complaint and key issues, clarifying what is going to be covered and how the meeting is going to be run.
- Establish with the complainant that they are happy with this approach.
- Apologise and/or offer condolences, if appropriate, at the beginning of the meeting.
- At the end of the meeting summarise the key points, any actions agreed, who will undertake them and by when.
- Tell the complainant what will happen next and when, e.g. a follow-up letter summarising the key points discussed and actions taken will be sent to them within 10 working days.
- Check with the complainant if they wish to have a copy of the recording – if they do this will be sent by the complaints team.

Post-meeting

- Chair of the meeting to summarise the meeting and actions on the template letter, this letter will be signed by the meeting Chair. It is the Chair's responsibility to ensure this happens within four working days for a 10 day response and 19 days for a 25 day response.
- The post meeting letter will be sent to the complaints team for a

covering letter to be produced from the Executive identified (1 working day – complaints responsibility).

- It will then be sent to the Divisional Nurse Director (or Deputy) for quality assuring within two working days.
- The correspondence will be returned to complaints team to be sent to the Chief Executive for final signature.
- For the majority of meetings held with complainants the complaints team will not be present. However, there are circumstances when it is appropriate for example:
    - If the complainant has requested the attendance of a Complaints Officer.
    - If there is only one Trust representative and support is required.
    - Reopened complex complaint.

This list is not exhaustive but to be used as a guide

Appendix 9

STANDARD OPERATING PROCEDURE FOR HABITUAL OR VEXATIOUS COMPLAINTS HANDLING

Procedure	Resolving complaints and concerns for people considered habitual, vexatious, abusive or persistent as referenced in the Trust policy and procedures on handling concerns and complaints

SCOPE

This Standard Operating Procedure is aimed at all healthcare staff, including those who work in corporate or governance teams as well as those who are involved in dealing with the resolution of patient, carer and family complaints or concerns.

The process can only be implemented by the Complaints and Patient Experience Team following Executive approval.

POLICY

This Standard Operating Procedure is supported by Trust Policy and Procedures on Handling Concerns and Complaints.

PROCEDURE

Definitions

All complaints will be processed in line with the Trust Policy and Procedures on Handling Concerns and Complaints. When an individual's behaviour, contact or conduct is considered habitual vexatious, persistent or unreasonable an initial review of the complaint and supporting evidence will be undertaken.

To be identified as habitual and/or vexatious, a complainant (and/or anyone acting on their behalf) must satisfy certain criteria. These must be applied with judgement and discretion. The habitual and/or vexatious complainant could be categorised as such if during current or previous contact with the Trust, they meet **two or more** of the following criteria:

- Unreasonable behaviour of anyone making a request or complaint in an abusive, threatening or offensive manner or unreasonably persistent manner in the frequency of requests and complaints. (Unreasonable persistence will be demonstrated where the Complainant is in frequent contact with the Trust,

for example, multiple contacts per day/week). Contact can include telephone calls, emails or by physically attending.

- Complainant persists in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted
- The substance of an on-going complaint is changed or new issues are raised and the issues raised appear to be personal against particular members of staff, have already been addressed or are unable to be investigated e.g. reflect personal views of complainant.
- Complainant does not clearly identify the precise issues they wish to be investigated despite all reasonable efforts being made to assist in this process, by Trust staff and/or external advocacy services
- Any form of abuse threatening, discriminatory or offensive conduct or language towards staff, their families or associates; this includes verbal aggression, homophobic, racist or sexist language or behaviour (this list is not all inclusive or exhaustive)
- Excessive behaviour (multiple contacts per day/week), considered to have been demonstrated where the complainant moves to contact with key staff or Trust Officers outside of the process whilst the investigation is ongoing.
- Complainant is known to have electronically recorded meetings or discussions without the prior consent of the other party/parties involved
- Complainant has made defamatory comments to the press about the Trust or its staff
- Complainant seeks an unrealistic outcome and/or displays unreasonable demands and/or intends to continue until that outcome is achieved. Examples could include wanting to have a member of staff dismissed
- Complainant dictating who they will and will not speak/correspond with e.g., wanting to speak/correspond directly with the Chair of the Trust or the Chief Executive
- Stating they wish to meet with a person and then either refusing to arrange a date or not attending after the meeting has been arranged
- Making the same, or a slightly different, complaint to other people, e.g., the Press, the local Member of Parliament, the Health Secretary, NHS England, ICB, Advocacy Services

Escalation

The complainant will be escalated for consideration of whether this SOP should be applied when they meet the definitions criteria described above. Levels of escalation are:

1. Identification of habitual or vexatious complainant. Support to be given by the Complaints and PALS Lead

2. Escalation to the Divisional Nurse Director/equivalent for review and opinion as to whether the criteria are met
3. Escalation to Executive(s) for a decision and to confirm habitual or vexatious status
4. Escalation to other organisations

(See annexe 1 for flow chart)

Level 1: Identification of habitual or vexatious complainant:

Staff should liaise with the Complaints and PALS Lead in the first instance if they feel their contact with an individual has become habitual or vexatious.

If the individual is a service user, the Complaints and PALS Lead will liaise with the Business Unit Leadership Team (General Manager, Matron and Clinical Director) to establish whether it is appropriate to implement this policy. The Business Unit Leadership Team will not be expected to discuss the service user's diagnosis or treatment to maintain the individual's confidentiality, however, they will be given the opportunity to advise whether this is an appropriate course of action with a consideration to our duty of care to all patients as well as in consideration of our Trust Values.

Where a person(s) has been identified as potentially habitual, vexatious, persistent or unreasonable, the Complaints and PALS Lead will undertake a full review of the complaint file to identify opportunities or alternative approaches for resolution and action these. Where there are concerns regarding the behaviour of a complainant, which could be classed as abusive, threatening, discriminatory or offensive and where there is the potential for harm to members of staff, the option of a meeting will be withdrawn. This decision will be made in liaison with the Divisional Lead.

The Complaints and PALS Lead will liaise with the individual throughout the review to explaining they will be the central point of contact for them throughout the complaints handling process. If these further attempts to resolve the complaint effectively are unsuccessful, the complaint will be escalated to the Divisional Nurse Director.

Level 2: Escalation to the Divisional Lead for review:

The Divisional Lead for Complaints will undertake a review of the complaint and supporting evidence. They will then work with the Complaints and PALS Lead to prepare a briefing with recommendations for Executive review.

Level 3: Escalation to Executive/s for a decision and to confirm habitual or vexatious status:

Executives will provide a decision on whether a complainant can be given habitual or vexatious status within local complaints handling procedures.

If Executive authorisation is given, the individual will be notified in writing that the Trust considers them to be a habitual and/or vexatious complainant (Stage 1).

The Complaints and Patient Experience Team will ensure that all relevant staff are made aware of the Executive review outcome and facilitate gathering further supporting evidence.

Level 4: Escalation to other organisations:

If appropriate, notifications under this policy may be copied for the information of others already involved e.g. General Practitioners, Advocacy Service, Commissioners, Partner Agencies, Members of Parliament and the Parliamentary and Health Service Ombudsman.

Escalation documentation and supporting evidence:

Records and documentation will be kept of the reasons why an individual has been classified as "habitual or vexatious" as part of the central complaints file and Datix record.

Operational services should send supporting evidence to the Complaints Team so all information can be centrally kept. Supporting evidence includes:

- Emails
- Letters
- Online comments e.g. blog/social media entries when can be captures as a screenshot or printout
- Telephone calls
- File notes of any other interactions
- Staff statements or reflective summaries
- Incidents reported on Datix
- Contact Log (Annexe 3)

All staff should maintain a written record of any concerns about interactions with the individual. For example, incident forms, emails raising concerns with managers or attendance notes of discussions.

Any record of an interaction with an individual should be detailed, including full information about the circumstances of the interaction (date, time, place, those

involved, background as to how the interaction came about), exactly what was said (and the context) and the response that was provided, including the individual's reaction. Staff should include information about the impact any interaction had upon them. All records should be contemporaneous, professional, objective and factual. Staff will be provided with example scripts (annexes 4 and 5) to effectively deal with further contact and a contacts log.

All supporting evidence gathered will be considered at each stage of escalation and reviewed by Executives before a decision is reached. Habitual or vexatious status will only be given to a complainant when confirmed by an Executive and the following operational procedure will then be followed.

See annexe 2 for *Habitual or Vexatious Complaints Handling Tasks*

Stage 1

In all cases where it is decided that an individual's contacts, interactions, conduct or behaviour is habitual, vexatious, persistent or unreasonable, a letter will be sent to them by an Executive to:

- explain why their behaviour or actions fall into this category
- advise them of what action could be taken against them
- tell them how long that action would last (a minimum of six months)
- encourage them to refrain from unacceptable contact, interaction, conduct or behaviour in the future
- explain restrictions or exclusions may be considered including the withdrawal of the option of a meeting

The **Stage 1 Letter** (Annexe 6) is intended to inform the individual, in writing, that their conduct or behaviour is unacceptable and that they have been classified as habitual, vexatious, persistent or unreasonable by the Trust.

The letter must clearly state which elements of their contacts, interactions, conduct or behaviour are unacceptable and be accompanied by a copy of the Habitual and Vexatious Complainants Policy. Reference to supporting evidence should be included.

The individual should also be advised in relation to the escalation process available in any other relevant Trust policy. For example, the Health Service Ombudsman under the Complaints Policy or the Information Commissioner under the Freedom of Information Policy and the Data Protection, Caldicott and Confidentiality Policy.

The letter should include information and advice in relation to acceptable behaviours and should encourage the individual to change their behaviour and future contact with the Trust and staff.

The letter will inform the individual that they have the right to appeal the decision within five working days.

Where behaviour, contact or conduct threatens the immediate safety (physical and/or psychological safety) and welfare of others, including Trust staff, service users and members of the public, additional options will be considered including the option to withdraw the offer of a meeting, responding only in writing or via Teams meeting.

These may include reporting the matter to the Police, the Trust Security Management Team or taking legal action. In such cases the individual may not be given warning of that action.

If the individuals unacceptable contacts, interactions, conduct or behaviour or continues, complaints handling will be escalated to Stage 2 of the procedure.

The Complaints and Patient Experience Team will ensure that all relevant staff are made aware a Stage 1 Letter has been sent and facilitate gathering further supporting evidence should further escalation be needed.

Stage 2

If the habitual and/or vexatious behaviour continues following the initial warning letter provided in Stage 1, an Acknowledgement of Responsibilities Agreement (ARA - Annexe 8) will be issued as part of the **Stage 2 Letter** (Annexe 7).

If the terms of the ARA are contravened, consideration will be given to implementing Stage 3 of the procedure.

Depending on the circumstances, it may be appropriate to progress directly from Stage 1 to Stage 3. If this approach is adopted, the reasons as to why it was not appropriate to implement Stage 2 will be fully documented.

At Stage 2, opinion will also be sought from the Trust Security Management Team for expert advice and support with the development of the ARA.

Further contact with the individual may be undertaken by the Complaints and PALS Lead to discuss the events that have occurred and to prevent further escalation. Where appropriate, if necessary, a multi-agency meeting (including the Trust Safeguarding Team if required) will be arranged to agree a unified course of action/support.

The ARA will include the following – this is not an exhaustive list and often local factors will be relevant in deciding what might be appropriate action for inclusion:

- An agreement relating to appropriate behaviour and conduct. Any such agreement should normally not extend beyond six months
- Restricting contact to one or two individuals within the Trust. It is recommended that a central named point of contact is identified, usually the Deputy General Manager for Complaints and Patient Experience
- Restricting the method of communication (e.g. by letter only, not fax/email)
- Restricting the number of telephone calls that will be accepted (for example, one call on one specified morning/afternoon of any week)
- Requiring any personal contacts to take place in the presence of a witness
- Refusing to register and process further contacts, complaints, concerns or requests for information about the same matter where a decision on the contact, complaint, concern or request for information has been made, limiting further contact to acknowledgement only of letters, faxes, or emails
- Reiterating the Trust's "zero tolerance to violence, aggression and harassment of staff" approach and what this means withdrawal of the offer of a meeting with responses only provided in writing

The Trust may take further action and apply the following restrictions and exclusions to address continued habitual and/or vexatious behaviour by:

- Placing time limits on telephone conversations and personal contacts
- Restricting the number of telephone calls that will be taken (for example one call on one specified morning/afternoon of any week)
- Limiting the individual to one medium of contact (telephone, letter, e-mail etc.) and/or requiring the person to communicate with only one specified member of staff
- Requiring any personal contacts to take place in the presence of a witness
- Refusing to register and process any further complaints about the same matter
- Where the Trust has responded fully to the points raised by the person and has tried to resolve the issues, without success, and continuing contact on the matter would serve no useful purpose, the individual will be notified that the contact is at an end and that further contact will be acknowledged, but not answered. The person will be informed that all future correspondence will be read and placed on file but not acknowledged
- The Complaints and PALS Lead will act as the designated officer to read any future correspondence

The decision to apply a restriction or exclusion shall be taken by an Executive with advice from the Divisional Nurse Director and Complaints and PALS Lead.

The Trust may also temporarily suspend all contact with the individual and/or investigation of a complaint/concern and/or responding to a request for information whilst seeking legal advice or guidance from other relevant agencies.

The Complaints and Patient Experience Team will ensure that all relevant staff are made aware a Stage 2 Letter has been sent and facilitate gathering further supporting evidence should further escalation be needed.

Stage 3

In rare cases, or where the safety of staff is at risk, the individual will be informed that the Trust reserves the right to pass vexatious, habitual, persistent or unreasonable behaviour to their solicitors or the Police if the behaviour constitutes harassment or threats of harm (Annexe 9).

All contact with the person and/or investigation of the complaint will be suspended whilst seeking legal advice or guidance.

There are a range of sanctions that can be applied to people who commit crimes against the National Health Service, whether they are patients, members of the public or staff. In terms of patients and the public, this primarily consists of criminal and civil law.

Where staff have been assaulted, verbally abused, received threats of harm, or harassed the matter will be reported to the Police. If the Crown Prosecution Service decides not to prosecute, the Trust will advise its staff to consider the commencement of a private prosecution.

The Trust will also advise its staff as to the commencement of appropriate civil action such as an injunction if appropriate. The Trust will provide the member of staff with the appropriate support in taking such action.

Withdrawing Habitual and/or Vexatious Status

All individuals designated habitual and/or vexatious will have this status reviewed by the Complaints and PALS Lead, and Executive within the agreed review date.

The outcome of the review will be communicated to the individual by an Executive in writing and will include an indication of the next review date if the status is not withdrawn.

Any such review shall include consideration as to whether it is necessary and proportionate to maintain any sanctions/exclusions/restrictions implemented in accordance with the procedure outlined in Stage 2.

Appeals

If an individual is deemed to habitual and/or vexatious, they have a right to appeal their status as such within 14 days of being notified of being so deemed, or upon notification of the outcome of a review of such status (Flow chart in Annexe 10, Review Template in annexe 11).

Any appeal will be considered by an Executive who has not been involved in the original decision to deem the individual to be habitual and/or vexatious or any review of such status.

In considering the appeal, Executives must consider whether the procedural requirements of the Habitual and Vexatious Complainants Policy have been properly implemented and whether the decisions undertaken were reasonable, necessary and proportionate.

The individual will be notified of the outcome of the appeal within five working days of Executive review (Annexe 12).

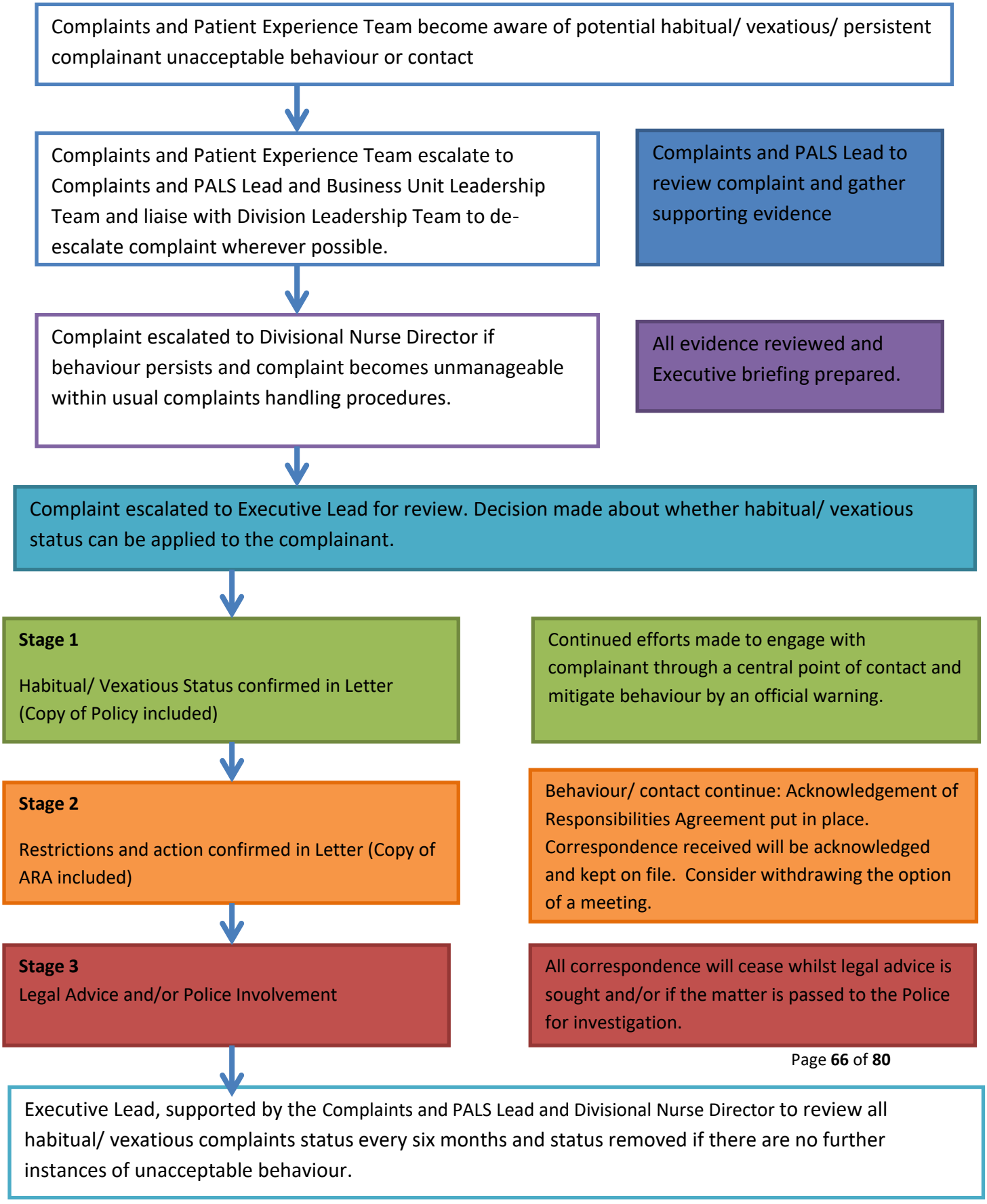
Correspondence with the individual in Stage 1 of the procedure will include information about of how they can appeal the decision to give them habitual or vexatious status.

Ongoing Monitoring and Review

All habitual or vexatious complaints will be reviewed every six months to determine whether the status needs to be removed and the complainant updated.

Annexe 1

Habitual and/or Vexatious Status Escalation Process Chart



Annexe 2 - Habitual or Vexatious Complaints Handling Tasks		
Task	**By Who**	**When**
Escalation		

1. Identification of habitual or vexatious complainant	**Complaints Team Complaints and PALS Lead and Divisional Nurse Director**	**Complete review with two weeks of being notified**
• Complaints Team identify potentially habitual or vexatious complainant through direct contact with the complainant or alerted by operational services • Complaints and PALS Lead to work in partnership with Business Unit/Division to explore alternative options for local resolution • Complaints and PALS Lead undertake a review of the complaint, contacts and supporting evidence • If further evidence needed, Complaints and PALS Lead will facilitate gathering information through contacts log, incidents and other documentation e.g. file notes • Complaints and PALS Lead to prepare briefing for Divisional Nurse Director and prepare case review template and timeline of events		
2. Escalation to Complaints and Patient Experience Lead	**Deputy Complaints & Patient Experience Lead**	**Complete review within 1 week of escalation**
• Complaints and Patient Experience Lead to undertake a review of the complaint, contacts, supporting evidence and case review timeline. • Complaints and Patient Experience Lead to provide advice and suggestions on any further options for local resolution. If all attempts have been unsuccessful in engaging with the individual to achieve local resolution and there is supporting evidence of contacts, interactions, conduct or behaviour that is habitual, vexatious, persistent or unreasonable, Complaints and Patient Experience Lead to prepare briefing and escalate complaint for Executive Review • Complaints and Patient Experience Lead should meet with the Executive at the earliest opportunity to discuss the timeline, supporting evidence and agree next steps within procedure		
3. Escalation to Executive	**Complaints &Patient Experience Lead**	**Meet at the earliest opportunity to review case**
• Complaints and Patient Experience Lead to provide Executive with briefing and supporting information, including timeline and evidence of contacts, interactions, conduct or behaviour that is habitual, vexatious, persistent or unreasonable in nature • Complaints and Patient Experience Lead to arrange to meet/discuss the complaints with the Executive at the earliest opportunity • Executive to make a decision on whether habitual or vexatious status will be given to the individual		
4. Escalation to other organisations	**Executive**	**When considered appropriate**
• Executive will advise on whether escalation to other organisations is needed as part of their review		
Procedure		
1. Stage 1	**Executive**	**Within 5 working days of review**
• Complaints and Patient Experience Lead to draft Stage 1 Letter and submit to Executive for approval and signature. Letter to include confirmation of habitual or vexatious status with supporting evidence		
2. Stage 2	**Executive**	**If behaviours continue**
• Complaints and Patient Experience Lead to draft Stage 2 Letter and submit to Executive for approval and signature. Support will also be obtained from the Local Security Management Specialist • Acknowledgement of Responsibilities Agreement outlining restrictions and exclusions		
3. Stage 3	**Executive**	**In rare/ extreme cases**
• Case reported to the police and/or shared with Trust Legal Team		
4. Appeal process	**Executive**	**Stage 1 - within 14 working days**
• Appeal should be reviewed by Executive with no prior involvement in case within five working days and the outcome communicated to the individual		
Habitual and Vexatious Complaints reviewed every six months		

Annexe 3 - Example Contacts Log

Habitual and/or Vexatious Person/s Contact Log:

Name of Habitual and/or Vexatious Person/s:	
Complaint Reference:	

Date (dd.mm.yy)	Time (00:00 hours)	Type of Contact (telephone/ email/ in person)	Staff Member Name & Job Title	Summary of Contact	Action Taken

Annexe 4 - Example Scripts

Script 1

Receiving calls from [Complainants Name] in relation to their ongoing complaint [reference xxx] following application of the habitual and vexatious element of the policy

We have been made aware that [complainant's name] has been in contact with several members of staff [add details of frequency of contact].

[Complainant's name] is now considered to be habitual and/or vexatious under the Trust's Habitual and/or Vexatious Complainants Policy. Please be assured that we are continuing to engage with [complainants name] to resolve their complaint as quickly as possible.

We need your help to ensure we can implement the restrictions as set out in Stage 1 of the Standard Operating Procedure by following this script should you get any contacts in your service.

1) Explain to them that the Complaints / PALS Service Manager is their **central point of contact.** They can telephone 01332 xxxx to discuss their concerns and to get further support and advice.
2) Try ending the call as quickly and politely as possible. Explain and repeat that the Complaints / PALS Service Manager will be the best person to speak to about their concerns.
3) Should they become abusive or aggressive towards you, try to explain that this behaviour/language is not acceptable, and you will be ending the call. Try to explain the reasons why you are ending the call before hanging up. You should give three warnings before ending the call.
4) If you feel you need to terminate the call sooner than this, then do so.
5) Complete a Datix entry to document the incident and inform the Complaints / PALS Service Manager of the Datix incident reference number.
6) If you are getting increased contact in your service document this information on the Contact Log and return this to the Complaints / PALS Service Manager each week.

You need to notify the Complaints / PALS Service Manager if this behaviour persists. Call extension xxxx or email xxxxx

Annexe 5

Script 2

If the behaviour persists, we will notify staff to use the following script.

Responding to calls from [Complainant's Name] in relation to their ongoing complaint [reference xxx]

1) Explain, as detailed in the letter from the Chief Executive, we request that correspondence is made by [detail the restrictions in method of communication]
2) **Explain that you are ending the call and hang up.**
3) Should they become abusive or aggressive towards you, in line with our incident reporting policies you must raise it as an incident on Datix.
4) Complete the Contact Log for every contact (call/ email) you receive.

Annexe 6 - Stage 1 Letter Template

Our Ref:

Date:

Strictly Private and Confidential

[Name and address of complainant]

Dear [name of complainant]

I am writing in response to your recent contact with University Hospitals of Derby and Burton NHS Foundation Trust on [insert date/s] regarding your complaint or topic of concern. You have raised continued concerns about [details]

Whilst I appreciate this must be a frustrating time for you, I would ask for your patience whilst we complete our investigation *and/or* review of your on-going enquiries. We want to ensure that we fully look into your complaint and do everything we can to try to resolve all of your concerns. We, therefore, need some time to do this and have informed you that we aim to do this by/within *** (delete as appropriate, insert the timescale/date).

After careful consideration, the Trust has taken the decision that your [contact/conduct/behaviour] is [persistent/habitual/unreasonable/vexatious] under our policy for the following reasons:

> *Insert criteria of each relevant definition which might apply along with justification as to why is does]. List **ALL** relevant definitions that apply*

(Optional) We have reports and evidence that your behaviour has been [insulting, hurtful, abusive] and this letter acts as an official warning that this will not be tolerated and may lead to further action as detailed below.

(Optional) I have been informed that you have been contacting many different members of staff [insert how often, e.g., daily/hourly, through what methods etc] about your complaint. This is quite disruptive to services. Additionally, the staff you are contacting are not necessarily the staff who are knowledgeable about the complaints process.

I enclose a copy of our Complaints Policy which includes an appendix on Habitual and/or Vexatious Complainants for your information. I would like to draw to your attention that if your [contact/conduct/behaviour] continues to be [persistent/habitual/unreasonable/vexatious], Stage 2 or Stage 3 of the policy may be

implemented. This policy also describes how you can appeal this decision. You have the right appeal within the next 14 days.

Yours sincerely

Signed by Executive Lead

Annexe 7 - Stage 2 Letter Template

Our Ref:

Date:

Strictly Private & Confidential

[Name and address of complainant]

Dear [name of complainant]

I am writing further to my previous letter dated [insert date], in which I advised you that the Trust considered your behaviour to be [persistent/habitual/unreasonable/vexatious].

I explained the Trust had taken this decision after careful consideration and once all efforts had been exhausted in engaging with you through the complaints handling process. Your behaviour was [describe the impact of behaviour].

I explained that if your behaviour continued that the Trust would instigate Stage 2 of our Habitual and/or Vexatious Complainants Policy.

During the period [insert date/s] you have called the Trust on [X] occasions, you have sent in [X] of emails and you threatened staff [X] times, which staff reported through our Datix Incident Reporting System.

Going forwards, the Trust is implementing an Acknowledgement of Responsibilities Agreement (ARA) for all correspondence and communication between yourself and the Trust. A copy of the ARA is enclosed with this letter.

In addition, in accordance with the Complaints Policy, the Trust is exercising its discretion and applying the following restrictions/exclusions for the duration of the time that your [contact/conduct/behaviour] is deemed to be persistent/habitual/unreasonable/vexatious]:

Insert details of restrictions/ exclusions being implemented and how the duration these will be in place for e.g., single point of contact for calls

Enclosed are two copies of an Acknowledgement of Responsibilities Agreement (ARA) for your attention. I would be grateful if you could sign both of these copies, please return one copy in the prepaid envelope provided, and keep the other copy for your own records.

Should you choose not to respond, these will be signed by our Security Management Team and a witness, indicating your unwillingness to co-operate with this process.

If you do not comply with the ARA, or the restrictions/exclusions outlined above, the Trust will consider implementing Stage 3 of its Habitual and/or Vexatious Complainants Policy and consideration will then be given to taking further action against you.

Such action may include the following:

- Providing NHS services at a different location or withdrawing services
- Reporting to the police where your behaviour may constitute a criminal offence and fully supporting any prosecution they might pursue
  Seeking a court order to restrict your behaviour

If any legal action is necessary, any costs incurred will be sought from you and these may be considerable.

[insert wording about the escalation process available in any other relevant Trust Policy – for example, the Parliamentary and Health Service Ombudsman under the Compliments, Concerns & Complaints Policy or the Information Commissioner under the Freedom of Information Policy and Data Protection, Caldicott and Confidentiality Policy.

Application of the Trust's Policy [and the restrictions/exclusions outlined above] will be reviewed in 12 months on [insert date]. You will be advised in writing of the outcome of this review and any reference will be removed from your records.

If you do not agree with what has been set out in this letter or have any comments to make, please feel free to do so and be advised that should you wish to challenge this decision you may do so in line with the Trust's Complaints Policy.

Yours sincerely

Signed by Executive Lead

Annexe 8 - Stage 2 Acknowledgement of Responsibilities Agreement

Acknowledgement of Responsibilities Agreement (ARA) between University Hospitals of Derby and Burton (UHDB) and [full name of complainant] [DoB].

The NHS has a duty to protect all staff from abusive and violent behaviour as well as to ensure resources are not misused.

Threats, abuse, insulting words, inappropriate language or behaviour towards those staff who are trying to care for you will not be tolerated. UHDB has a zero-tolerance culture towards violence, aggression and harassment of our staff. The Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Such behaviour also deprives the Trust of staff time and resources, makes other patients have to wait longer, and ultimately deprives the wider local community of the resources required for safe and effective healthcare provision.

Just as the NHS has a responsibility to you, so you have a responsibility to use its resources and treat staff in an appropriate way.

I, [full name of complainant], agree to the following in respect of my future behaviour and contact with the Trust:

- I will follow all reasonable instructions from staff, where this concerns my care. Should I disagree with any aspect of said care or wish to raise any issue with a member of the team caring for me, I will do so rationally and not in a manner which is insulting, threatening or abusive
- I will not use violence, foul or abusive language, or threatening behaviour towards any member of NHS staff tasked with my care and treating me on UHDB hospital premises.
- I will treat NHS staff with courtesy and respect whether this be at my home, on any NHS premises or contacting any NHS services by telephone
- Should I have any complaints about my care or concerns about any NHS Staff member I will raise this complaint through the normal channels

I confirm that I have read and understood the attached letter as well as this agreement and that I accept the condition/s set out above and agree to abide by them.

Signature:	
Name:	
Date:	

Annexe 9 - Stage 3 Letter Template

Our Ref:

Date:

Strictly Private and Confidential

[Name and address of complainant]

Dear [name of complainant]

I am writing further to my previous letter dated [insert date], in which I advised you that the Trust considered your behaviour to be [persistent/habitual/unreasonable/vexatious] and attached an Acknowledgement of Responsibilities Agreement (ARA).

The Trust is now implementing Stage 3 of the Policy.

[insert reasons as to why Stage 3 is being implemented]

Any further contacts, complaints or concerns received from you in relation to this matter will be acknowledged but not answered.

Any new contact, complaint or concern will be subject to a reasonable investigation as deemed necessary by the Chief Executive in conjunction with advice received from staff dealing with contacts.

Following legal advice and in accordance with Section 9 of the Policy, the Trust is exercising it's discretion and applying the following sanctions in line with our Maintaining a Safe Environment Policy.

[insert details of the sanctions e.g. staff will terminate call immediately]

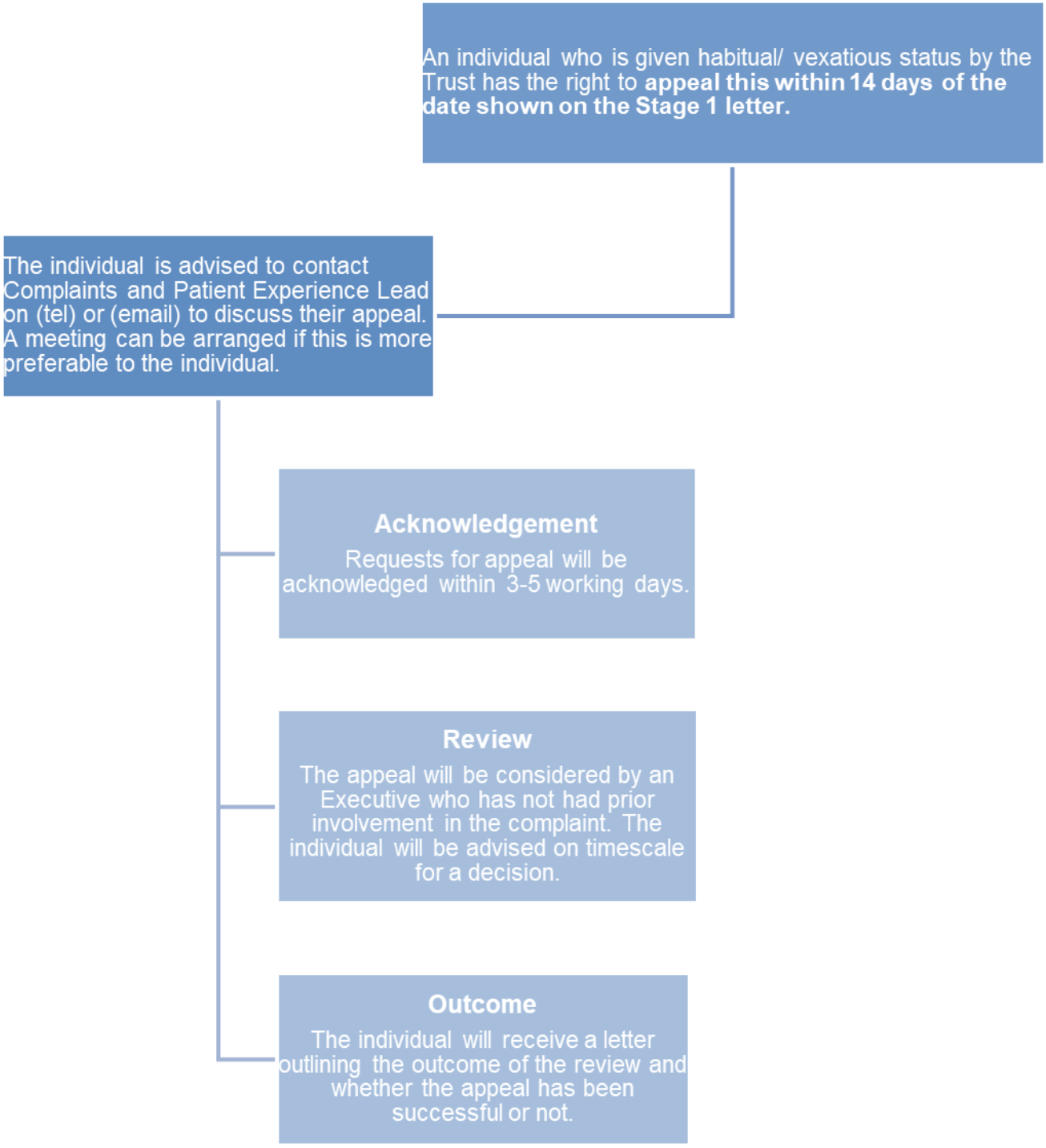
OR

We will be referring this matter to the Police for further investigation and who will be in contact with you soon.

Yours sincerely

Signed by Executive Lead

Annexe 10 - Appeal Process Chart



Annexe 11 - Appeal Review Template

Our Ref:	
Date Appeal Acknowledged:	
Date Appeal Outcome Due:	
Appeal Review Panel	**Executive Member Name, Job Title**
Appeal Outcome:	
Date Complainant Notified of the Appeal Outcome:	

1. Scope of the appeal process
Include background details and how the appeal was undertaken. Also provide details of all the evidence reviewed.
2. Findings of the appeal review process
Summary of the appeal process findings. All statements must be supported by evidence.
3. Appeal process outcome and recommendations
Confirm what the outcome of the appeal is. Provide clear reasons for the outcome and recommendations for the Trust to consider.
Draft findings of the appeal process must be discussed with the Chief Executive and relevant staff before the final decision is shared with the complainant.

Annexe 12 - Appeal Outcome Letter Template

Our Ref:

Date:

Strictly Private and Confidential

[Name and address of complainant]

Dear [name of complainant]

I am writing further to your request for an appeal of the Trust's decision in considering your behaviour to be [persistent/habitual/unreasonable/vexatious].

A review of your case has been undertaken by a Trust Executive who has not been involved in your complaint and has not had any correspondence with you prior to this review.

The review included [summary of scope of review e.g., review of complaints file, interviews with staff etc.]

The Executive Member who has reviewed your case is [name and job title].

This review has concluded [summary of review conclusion/ outcomes]

It has been recommended that the Trust keeps the status in place for the time specified **OR** reviews this status in six months' time **OR** apologies for taking this decision as the Executive Team consider the decision to be wrong.

If the Executive reviewing the appeal disagrees with the initial decision, a full explanation must be given with recommendations for next steps.

If you would like to discuss the outcome of the appeal process, please do not hesitate to contact me on (tel) xxx or (email) xxx.

Yours sincerely

Signed by Appeal Review Executive Lead