Complaints and Feedback Policy (N-047)

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Executive Lead (name and job title):	Dr John Byrne, Executive Medical Director
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
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Date EMT as approving body notified for information:	*January 2022*

Policies should be accessed via the Trust intranet to ensure the current version is used

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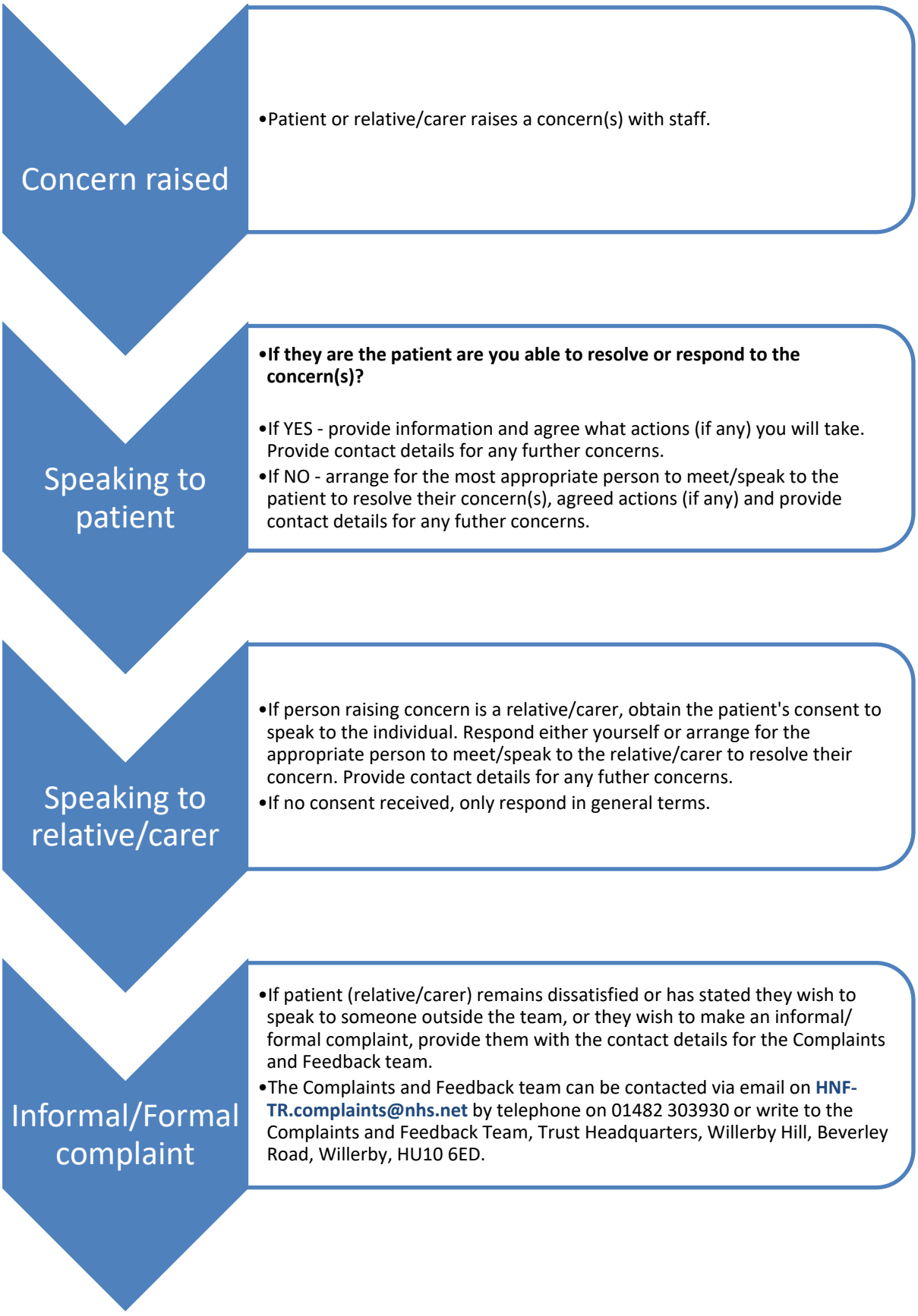
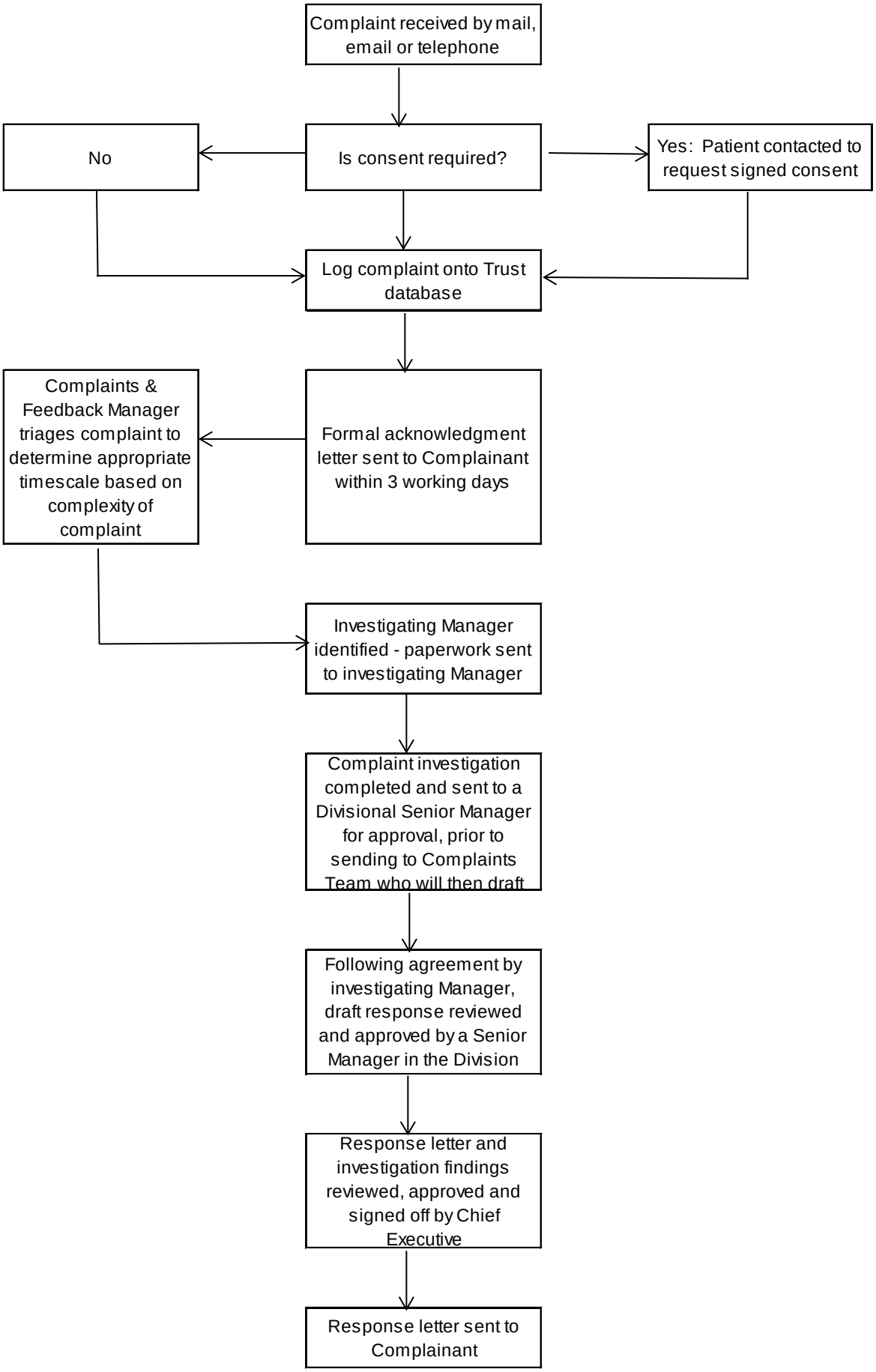


Formal Complaint Process Pathway



1. INTRODUCTION

This policy and procedure identifies the process of making a complaint or raising a concern or making a comment. It highlights the roles and responsibilities of those involved in dealing with complaints and feedback. It is written in line with the relevant national guidance and legislation.

2. SCOPE

The policy applies to all groups of staff and anyone using the Trust's services.

A complaint can be made by:

- A person who receives or has received services from the Trust; or a person who is affected, or likely to be affected, by the action, omission or decision of the Trust which is the subject of the complaint.
- Someone acting on behalf of the patient may make a complaint, with the patient's written consent. (e.g., an advocate, relative, Member of Parliament).
- Parents or legal guardians of children.
- Someone acting on behalf of a patient who is unable to represent his or her own interests, provided this does not conflict with the patient's right to confidentiality or a previously expressed wish of the patient.

3. DEFINITIONS

- The Local Authority Social Services and National Health Service Complaints (England) (Amendment) Regulations 2009
- Statutory Instrument 2009 No: 1768
- Listening, responding, improving – a guide to better customer care
- Parliamentary and Health Service Ombudsman; February 2009; Principles of Good Complaint Handling
- Parliamentary and Health Service Ombudsman; February 2009; Principles for Remedy
- Parliamentary and Health Service Ombudsman; February 2009; Principles of Good Administration

Related Trust documents

- Risk Management Strategy
- Patient and Carer Experience Strategy
- Complaints and Feedback staff guide
- Complaints and Feedback "We want to hear your views" leaflet
- How to make a complaint leaflet

4. DUTIES AND RESPONSIBILITIES

Chief Executive is responsible for ensuring that an effective and appropriate complaints system exists.

The Medical Director is the executive director responsible for the operational delivery of the described complaints system, supported in the delivery by the Chief Executive.

Head of Patient and Carer Experience and Engagement is the responsible senior manager who oversees the complaint process and has specific responsibilities as detailed in the job description.

Division General Managers/Divisional Clinical Leads/Service Managers are responsible for ensuring that complaints received are disseminated to appropriate management teams; there is a thorough investigation which is then forwarded to the complaints team for a response letter to be compiled covering all issues.

Complaints and Feedback Manager is responsible for the day-to-day operational management of the Complaints and Feedback team and processes ensuring that complaints and feedback are responded to in a timely manner (refer to Appendix 3).

Complaints and Feedback Team
The Complaints and Feedback team will undertake a central role in communicating with the complainant, ensuring an investigation is initiated by the division in which the complaint originated, and that the response is comprehensive and compliant with the expected standard for the response letter. The head of patient and carer experience and engagement is made aware of any problems in meeting the plan to resolve the complaint.

The Complaints and Feedback team is responsible for the collection of data in relation to complaints and for entering the data onto the Trust's database.

All staff are responsible for the effective implementation of the policy. This includes:

- Cooperating fully with the investigation of each complaint and ensuring that any staff for which they have responsibility respond to investigations in a timely and appropriate manner.
- Ensuring that action is taken, and an action plan implemented following any complaint which gives rise to the need for wider scale implementation of change.
- Ensuring that any lessons learnt, arising from the complaint, are used to improve future service delivery.
- Ensuring that complaints are responded to within the agreed timescale
- Releasing staff for relevant training events.

All staff have a role to play in resolving issues locally by ensuring: -

- Any issues raised are dealt with courteously and efficiently.
- Good quality records are maintained
- Any issues raised outside of an individual's remit are referred on to the most appropriate manager.

5. PROCEDURES RELATING TO THE POLICY

The Trust will ensure that procedures are in place for managing formal complaints and feedback contacts.

Complaints can be made verbally, in writing or electronically and will be acknowledged within three working days. This will be done in writing and is undertaken by the Complaints and Feedback team.

Complaints can be made by a third party (e.g., relative, advocate, MP); however, signed consent is required on the Trust's consent form. This will be sent to the patient/complainant by the Complaints and Feedback team. The timescales for the complaint will not commence until the signed consent form is received. Where there is a query around consent, the Trust's Caldicott Guardian will review the case and provide guidance to the Complaints and Feedback team.

Under this policy, the Trust advocates the following processes:

- **Local** - by the staff within the team, unit or ward, or referred to a senior person within the service area
- **Informal** - via the informal Complaints Process
- **Formal** - using the NHS Complaints Procedure

All complaints and concerns that cannot be resolved locally will be recorded as informal or formal complaints.

For informal complaints, the issue(s) will be sent to the Team Manager/Charge Nurse, copied to the Service Manager with a request that the most appropriate person contacts the complainant to try to resolve the issue(s) raised. Once this has been done, the Complaints and Feedback team are provided with the resolution and the contact is closed.

If the complainant remains dissatisfied with the informal response, they have the right to have their issue(s) investigated formally.

For formal complaints, a letter or email will be sent acknowledging the complaint. A leaflet will be included in each letter advising the complainant of the complaint process, sources of support (e.g., independent advocates) and details of the Parliamentary and Health Service Ombudsman's review process.

Once the timeframe for the method of resolution has been acknowledged with the complainant, the Trust will aim to achieve this unless exceptional circumstances prevail. If the timescale cannot be achieved, the investigating manager must inform the Complaints and Feedback team who will inform the complainant of the delay and when they may expect to receive the final response.

The response letter includes a hard copy of a questionnaire and link to the same questionnaire where complainants are given the opportunity to feedback on how they felt their complaint was handled.

Refer to Appendix 3 which highlights the procedure to support the complaints and feedback process.

6. EQUALITY IMPACT ASSESSMENT

.An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

7. CONSULTATION

The policy was reviewed through a consultation process including the Trust's Information Governance/Legal team and representatives from the Trust's Patient and Carer Experience Forums (Hull and East Riding, Whitby and District and Scarborough and Ryedale). Followed by consultation with the Trust's Quality and Patient Safety Group and the Quality Committee

8. IMPLEMENTATION AND MONITORING

Implementation of this policy is the responsibility of all staff working in the Trust and monitoring of the implementation of this policy will be through internal audit processes.

9. TRAINING AND SUPPORT

Support and training are available for all staff and can cover the Complaints and Feedback processes and guidance on investigating both informal and formal complaints. Training needs for staff are identified via PADR/supervision and can be delivered on a 1:1 or group basis.

10. REFERENCE TO SUPPORTING DOCUMENTATION

- Caldicott and Data Protection policy
- Information Governance Policy
- Information Sharing with Carers and Significant Others SOP
- Issuing warning letters due to violent and aggressive behaviour SOP
- Serious Incidents and Significant Events Policy and Procedure

11. MONITORING COMPLIANCE

There are designated groups and committees with operational responsibility for oversight and monitoring of the complaints process. The Senior Operational Management Team reviews the number of ongoing complaints and cases of specific concern are discussed if required.

Complaints and compliments are included in the monthly Integrated Board Report (IBR) under strategic goal 6 that goes to the public Board

The Quality Committee receives information on complaints through the Quality Performance Report.

At a divisional level, governance meetings are held within each division and complaints should be included as a standard agenda item for these meetings. The learning from complaints should be incorporated on the agenda and discussed within these meetings.

Complaints and feedback are reported in the Patient and Carer Experience annual report (including Complaints and Feedback) and is discussed, approved and ratified through the Trust governance structures and published on the Trust website as required by statutory regulation.

Appendix 1: Document Control Sheet

Document Type	Complaints and Feedback Policy		
Document Purpose	This policy details the process to be used for formal complaints and feedback contacts.		
Consultation/Peer Review:	Date:	Group/Individual	
	10.11.21 to 23.11.21	Consultation via email sent 10.11.21 to the Trust's Information Governance/Legal team and representatives from the Trust's Patient and Carer Experience Forums (Hull and East Riding, Whitby and District and Scarborough and Ryedale).	
	27.1.22	Quality and Patient Safety Group	
Approving Committee:	Quality Committee	Date of Approval:	1 August 2018
Ratified at:	Trust Board	Date of Ratification:	29 September 2018
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	There are no training requirements for this document	Financial Resource Impact	There are no financial resource impacts
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below – to be delivered by the author:*		
Implementation will consist of: • Ratified policy to be shared with all staff across the Trust • All staff email with a link to the full policy			
Monitoring and Compliance:	Monitoring and compliance of the policy will be evidenced through six monthly Patient and Carer Experience reports which will be shared at QPAS meetings for discussion and Quality Committee meetings for assurance.		

Document Change History:			
Version Number/Name of procedural document this supersedes	*Type of Change e.g., Review/Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
5.00	*Review*	*Nov 10*	*Reviewed for NHSLA compliance*
5.01	*Review*	*Mar 11*	*Minor changes*
5.02	*Review*	*July 16*	*Reviewed minor changes* • *Remove point 10 from Appendix 1 regarding conciliation as no longer applicable* • *Added communication and Duty of Candour to procedures section 5* • *Added CQC regulation*

6.00	*Major review*	*Jan 17*	*Amended following QPaS review. Further amendments following consultation*
7.00	*Review*	*Jan 18*	*Full review and update* *Approved at Quality Committee 1 Aug-2018 and ratified at Trust Board Sept-18*
7.01	*Minor amendment*	*April 19*	*Minor amendment* *Approved Quality Committee 3 Apr-19*
7.02	*Minor amendment*	*Mar 20*	*Minor amendment to Appendix 3 (items 7 and 8) and operational structure terminology changes* *Approved QPaS 5 March 2020*
7.03	*Minor amendment*	*Oct 20*	*Minor amendment to process and Appendix 2 to highlight the informal complaints process (formerly PALS)* *Approved at QPaS Nov-20*
7.04	*Major review including minor amendments*	*Nov 21*	*Review to include minor amendments.* • *Minor enhancement to the section 5 (Procedures Relating to the Policy)* • *Minor enhancement to section 9 (Training and Support)* • *Minor amendment to section 10 (Reference to Supporting Documentation)* • *Minor enhancement to section 11 (Monitoring Compliance)* • *Minor addition to Appendix 3, item 11 (Complaints and Feedback Procedure to include virtual meetings with a complainant)* *Approved at QPaS 27 January 2022*

Appendix 2: Equality Impact Assessment (EIA)

Screening pro forma for strategies, policies, procedures, processes, tenders, and services

1. **Document or Process or Service Name**: Complaints and Feedback Policy
2. **EIA Reviewer (name, job title, base and contact details)**: Mandy Dawley, Head of Patient and Carer Experience and Engagement, Trust HQ, 01482 301819 and Susan Cameron, Complaints and Feedback Manager, Trust HQ, 01482 303930
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other**? Policy

Main Aims of the Document, Process or Service This main aim of this policy is to outline the process to be used for formal complaints and feedback contacts.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern (Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with? b) what have they said? c) what information or data have you used? d) where are the gaps in your analysis? e) how will your document/process or service promote equality and diversity good practice?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	This policy is consistent in its approach regardless of age.
Disability	Where the impairment has a substantial and long-term adverse effect on the ability of the person to carry out their day-to-day activities: Sensory Physical Learning Mental Health (and including cancer, HIV, multiple sclerosis)	Low	This policy is consistent in its approach regardless of disability.
Sex	Men/Male Women/Female	Low	This policy is consistent in its approach regardless of gender.
Marriage/Civil Partnership		Low	This policy is consistent in its approach regardless of marital status.

Pregnancy/Maternity		Low	This policy is consistent in its approach regardless of maternity status.
Race	Colour Nationality Ethnic/national origins	Low	This policy is consistent in its approach regardless of race. It is acknowledged however that for any complainant whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	This policy is consistent in its approach regardless of religion or belief.
Sexual Orientation	Lesbian Gay Men Bisexual	Low	This policy is consistent in its approach regardless of sexual orientation.
Transgender and/or Transsexual	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This policy is consistent in its approach regardless of the gender the individual wishes to be identified as.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above All individuals raising a complaint or concern are responded to in the same way regardless of their protected characteristic.	
EIA Reviewer **Mandy Dawley, Head of Patient and Carer Experience and Engagement** **Susan Cameron, Complaints and Feedback Manager**	
Date completed: **December 2021**	Signature: **M Dawley** **S Cameron**

Please return the completed form to: HNF-TR.policymanagement@nhs.net

Appendix 3: Complaints and Feedback Procedure

1. Timescales for Response

The Trust will investigate the complaint in a manner proportionate to the nature of the issues it raises, aim to resolve it speedily and efficiently and, during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation and any delays. The Trust will aim to resolve non-complex complaints about one team/service area and up to six straightforward issues within 30 working days and for more complex cases with more than six issues and/or complex issues the timescale will be 40 working days. Should this take longer, for example where there are very complex cases or if information is needed from external third parties, the Trust will aim to investigate these complaints within 60 working days. The focus will be on quality, open candid investigations and responses which sometimes may necessitate a longer time period.

Following investigation, the complainant must be sent a written response signed by the chief executive and in their absence, responses will be signed off by the chief operating officer or an executive director.

The normal time limit whereby people can raise their complaint is 12 months, however, the Trust will give consideration to responding to complaints outside of this time frame if it is felt there is a reasonable chance of being able to investigate and respond.

Should the complainant be dissatisfied with the response to the complaint they should contact the complaints and feedback manager who will discuss and agree a way forward with the division and inform the complainant accordingly.

2. Safeguarding

Where there are safeguarding issues related to the complaint this should be reviewed and discussed with the Safeguarding Team. The team will give advice on whether a concern needs to be raised to the local authority and whether there are actions required from a safeguarding perspective. The team will also advise on protection planning and risk management for the adult or child at risk.

Please refer to the following policies for further information and guidance.

- Safeguarding Adults Policy
- Safeguarding Children Policy

3. Process for ensuring patients or their relatives/carers are not disadvantaged or treated differently as a result of a complaint

Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service or body which may serve to enhance the communication of the complaint to the Trust.

Please refer to the link below regarding the Accessible Information Standard
https://www.england.nhs.uk/ourwork/accessibleinfo/

Patients must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint. Making a complaint/raising a concern does not mean that a patient/complainant will receive less help or that things will be made difficult for them.

Everyone can expect to be treated fairly and equally regardless of gender, sexual orientation, age, race, religion/belief, marriage, civil partnership or disability.

Within the acknowledgement letter the complainant will be advised that the Trust does not expect any patient to be treated differently as a result of making a complaint and explaining that no record of the complaint will be held in their medical records. The complainant is asked to inform the complaints and feedback manager if they feel this has occurred, who will then alert senior managers within the Trust.

4. Duty of Candour Requirements

The regulations for duty of candour require all providers who are registered with the CQC, both healthcare and adult social care, 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 it comes to light following a concern or complaint that a patient has been exposed to moderate harm and above, the manager/lead clinician leading the complaint will inform the medical director and/or the director of nursing who will be responsible for ensuring that the patient and their relatives are informed. This will be coordinated by the safeguarding lead.

The Trust's duty of candour policy must be utilised, and actions meet the requirements under duty of candour. The requirements are also outlined in more detail in the incident reporting and incident and complaints investigation policy.

Please refer to the following policies for further information and guidance:

- Duty of Candour Policy
- Incident Reporting and Incident and Complaints Investigation Policy

5. Joint Agency Handling of Complaints

The Trust will co-operate in resolving complaints that relate to more than one body with the relevant organisations and will agree with the complainant whether they wish to receive one response from all agencies involved or if they would prefer to receive individual responses from each organisation.

6. Risk Management of Complaints Received

Each complaint will be triaged and graded by the complaints and feedback manager based on the level of known harm; all complaints that are deemed to be high risk will be passed to the general managers. This will determine the level of investigation required and whether any additional actions need to be taken. It will also contribute to the Trust's body of feedback evidence for service improvement.

In exceptional circumstances, a complaint may be considered to be so serious that all or part of the investigation of the complaint needs to be undertaken with the assistance of external agencies such as independent clinical advisers or legal advisers. If such a complaint is received, the medical director will usually determine the reporting requirements, determine which agencies are to be involved and coordinate the utilisation of the external body in the complaint process. Complainants will be informed of the process.

7. When the Complainant is not the Patient

Every complaint will be dealt with on a case-by-case basis. If the complainant is not the patient and the complaint is about the care of the patient written consent is needed unless it is confirmed by the clinical team that the patient lacks capacity in which case the complaint will be investigated under best interest. On occasion, a patient may have fluctuating capacity; in such cases the

complaint will be placed ‘on hold’ until the patient is able to consent or decline consent to have the complaint investigated.

If consent is not given by the patient with capacity, the Complaints and Feedback team will pass the issues raised to the relevant clinical team(s) to ensure that the team is aware of the issues being raised so they can take account of the issues in the delivery of their care to the patient. The Trust welcomes complaints from children and young people. However, if the complaint is raised by a parent or guardian about a young person, the young person must be assessed for Gillick competence and where Gillick competence is established signed consent will be requested from the young person (age 12 and over). If the child is not Gillick competent the complaint will be managed with the parent or guardian under guidance from the clinical team involved in the young person’s care.

The complaints and feedback team issue a standard form to the patient requesting their consent to investigate the issues raised and release confidential information to the complainant. The investigation will only commence when consent is received either through the patient agreeing to the complaint being investigated and reported back to the complainant or through best interests.

8. Listening to Loved Ones, Family Members and Carers

Whilst the duty of consent must be applied, the Trust must also ensure it listens to and responds to concerns raised by family and carers of patients. Guidance should always be sought from the general manager or divisional clinical lead if there are concerns which require investigation where consent is not possible/received.

9. When the complainant requests access to health care records

Some complainants request access to healthcare records in the context of their complaint. Should such a request be made, and Complaints and Feedback Team will send a “Subject Access Request Form”.

10. Role of the Investigating Manager and Process of Investigation

For each complaint, an investigating manager will be identified. This will normally be an experienced manager or clinician who has experience in the management of complaints.

The investigating manager may delegate all or part of the investigation to a suitably qualified and/or experienced colleague but will retain overall responsibility for the quality and content of the investigation and complaint response.

An investigation will be overseen by the investigating manager and may involve collecting verbal or written statements from current or former staff, and examination of the relevant documentation and other sources of evidence. It is important that data is collected systematically, recorded at an appropriate professional standard, and filed according to a logical system. The data used in the investigation of a complaint is always requested when the Ombudsman undertakes a second stage independent review.

Once the investigation has been completed the investigating manager should send the completed paperwork to the service manager or equivalent for review to ensure the investigation is complete. Following review and approval the completed investigation paperwork should be sent to the Complaints and Feedback Team for a draft letter and investigation findings to be produced.

Once the complaint response is completed, the investigating manager will ensure that any action and learning is progressed and developed and shared with the relevant staff.

11. Meeting a Complainant

If a meeting is arranged with the complainant (virtual or face to face) at any point in the process of dealing with a complaint, staff need to ensure that; an appropriate time and setting for the meeting has been arranged, the complainant is advised they can bring a friend, relative or advocate for support and the meeting will normally form part of or be incorporated into the investigation findings report for the complaint.

12. Complaints giving rise to issues which are the concern of other agencies

Occasionally, concerns may arise from complaints which need to be referred to other agencies, e.g. the police, professional regulatory bodies, the coroner, or the child or safeguarding adult protection structures. In such cases, the advice of the medical director should be sought.

13. Complaints about the Freedom of Information or Data Protection Act

Complaints about the operation of the Freedom of Information Act and the Data Protection Act are dealt with via separate structures and procedures.

The head of information governance and legal services is responsible for the operation of these structures and should be contacted in the first instance.

14. Responding to the complainant and concluding the complaint process

The complaints and feedback manager will produce a draft letter of response, on behalf of the chief executive in sufficient time to meet the response deadline. This will be written on behalf of the Chief Executive and is reviewed and signed off by the chief executive or their deputy.

The response will indicate what action the complainant can take if not satisfied. It will respond to all of the issues raised by the complainant and will include apologies where appropriate. It will also describe how the complaint has been considered, what conclusions have been reached and what actions, if any, have or will be taken as a result.

The draft final response is reviewed and approved by the general manager/divisional clinical lead and then passed to the chief executive for review, approval and sign off.

15. Defining Outcomes

We use the following criteria for defining outcomes:

Upheld	Complaints in which the issues raised were well founded.
Partly Upheld	Complaints in which at least one of the issues raised was determined to be well founded.
Not Upheld	Complaints in which it was found that the Trust had acted appropriately or could not have done anything differently.

16. Closure of Complaints

It may not be possible to resolve a complaint where the complainant's expectations of the outcome are unrealistic, or a matter of opinion and complaints should only be re-opened where evidence can be provided that the original issues raised have not been addressed. In this case the complaint is referred to as a 'second investigation' and should be investigated as soon as possible and the investigation and letter should follow the process flow as for the original complaint. The expectation

of the Trust is that the response should be sent as soon after receipt of the further letter but should aim to give a timescale based upon the level of further investigation detail, though further extension may be needed depending on the further issues.

17. Learning from Complaints

The Trust is strongly committed to organisational learning and each complaint provides opportunities for organisational learning to occur.

Each investigating manager produces an action plan for each formal complaint following completion of the investigation in order to improve the service and avoid repetitions of the incidents giving rise to the complaint. If no actions are identified a nil return is submitted. All actions from upheld and partly upheld complaints are added to a tracker to provide assurance that relevant actions are being taken to address the issues identified. This process also ensures that evidence is provided to the Complaints and Feedback Team to confirm the actions have been completed. Once received, the complaint file is closed.

18. Requests for Compensation

All requests for compensation and losses will be considered in accordance with the:

- NHS Finance Manual
- PHSO Principles of Redress
- Civil Litigation Protocols that are in place

All requests for compensation must be discussed with and considered by the head of patient and carer experience and engagement or a nominated deputy and be in line with Standing Financial Instructions.

19. Complainants who are not satisfied by the Trust's procedure

Occasionally a situation may arise where, despite every effort made by the Trust, the complainant remains dissatisfied and continues to be dissatisfied. The complainant will be sent a letter from the chief executive informing them of their right to request an independent review from the Ombudsman and that no further action will be taken by the Trust on their complaint.

20. Habitual and Persistent Complainants

The chief executive, in consultation with the relevant senior managers may deem a complainant to be "habitual and persistent", that is, a complainant who does not intend that his complaint should ever be resolved and is pursing the complaint for other reasons.

The chief executive will write to the complainant informing them of this decision, and that no further action will be taken by the Trust on their complaint, but reiterating the alternatives open to the complainant.

The Complaints and Feedback team will keep a record of all habitual and persistent complainants and share the names with the Foundation Trust Membership Office, since such complainants are not allowed to hold membership of the foundation Trust.

21. Ombudsman Investigations

A complainant who remains dissatisfied has the right to request an independent review of their case by the Ombudsman.

This advice is contained in the complaints leaflet given to all persons making a formal complaint and is enclosed with the acknowledgement letter to all complainants; it is also included in a letter to complainant sent one month after the final letter of response confirming that the Trust has closed the case.

The Trust will provide every assistance to the Ombudsman, and in particular will ensure that all requested information is provided within stated deadlines and that all the principles of redress are considered.

22. Management and Storage of Complaints Files

A complaint file has the same status as any other created by a healthcare organisation and is thus a confidential record.

The Trust will therefore at all times provide facilities for the storage of complaints files (either hard copy or electronic) which enable complaints files to;

- be easily located by appropriately authorised individuals
- be retained safely, without danger of damage or corruption, and in a complete state
- be easily retrieved and understood, in the event of further inquiry
- contain relevant items such as statements or investigation notes, or to clearly identify where such materials are located
- be kept for ten years from the date upon which the complaint was completed
- be disposed of confidentially when they have expired and
- be kept separately from the healthcare record – similarly, the healthcare record should contain no material from or reference to a complaint or its investigation.

The Trust will ensure that its management and storage of complaints files is consistent with any relevant guidance which may apply. All complaints will be logged on the Trust risk management database.

Should any material relating to a complaint be discovered in a health care record, it will be removed and reconciled with the complaint file.

The person misfiling the material will be reminded of Trust policy if they can be identified.

Appendix 4: Procedure for Handling Habitual and/or Persistent Complainants and/or Habitually Demanding or Vexatious Behaviour

1. INTRODUCTION

Habitually demanding or vexatious complainants, and/or people who exhibit habitually demanding or vexatious behaviour, are an increasing problem for NHS staff. Handling such people or complainants could place a strain on time and resources and cause unacceptable stress for staff, who may need support in difficult situations. The following procedures set out the Trust's policy in dealing with such people or complainants. It must be stressed that the vast majority of people who do come into contact with staff employed by Humber Teaching NHS Foundation Trust do not display such behaviour. This procedure is for the small minority who do. Execution of this procedure would only take place in exceptional circumstances.

Habitual and/or persistent complainants can also be individuals who decline to engage with the NHS complaints procedure but contact the complaints and feedback team a disproportionate amount of time.

Whilst staff are trained to respond to the needs of all complainants, there are times when there is nothing further that can be reasonably done to assist them or rectify a real or perceived problem. At this point any Trust may wish to review the situation and at times withdraw from ongoing debate.

For some mental health patients this ongoing linkage can exacerbate their mental health condition and encourage deterioration of their illness. However, allowances should be made for patients suffering from serious and enduring mental illness and appropriate clinical advice should be obtained before this procedure is invoked for such patients.

2. PROCEDURE

The following procedure has been identified to support staff where there is a view that a difficult situation should not continue.

2.1 Purpose of procedure

To identify situations where someone might be considered to fall into these categories and establish a procedure whereby, they can be treated equitably and fairly.

To protect staff from the nuisance, abuse and threatened or actual harm, which may be caused by such behaviour.

2.2 STAGE 1 – Determining who is a habitual and/or persistent complainant and/or habitually demanding or exhibiting vexatious behaviour

Definition of a habitual and/or persistent complainant – "someone who continually contacts the complaints department with a request to review a regular complaint issue. This may also include rude and abusive behaviour or language during contact with Trust staff". To support this decision, staff should assess two key considerations:

- The complaints and feedback manager and head of patient and carer experience and engagement should initiate a review of the complaint file and ensure that the complaints procedure has been correctly implemented as far as possible and that no element of the complaint has been overlooked or inadequately addressed.
- Through the review there should be an obvious stage where the complaint and responses have become repetitive, habitual and/or persistent. Judgement and discretion should be applied to the criteria in the review of the individual case. There should be evidence available to demonstrate the habitual and persistent nature of the complaint.

- If the review concludes that reasonable steps have been taken to resolve the complaint, it should then be discussed with the medical director who has responsibility for the complaints function.
- The next stage should only be implemented following careful consideration and discussion and authorisation by the chief executive (or deputy in his/her absence).

Definition of habitually demanding or exhibiting vexatious behaviour:

- to harass, distress, annoy, tease, cause trouble, agitate, disturb or pursue issues excessively.
- has threatened or used actual physical violence towards staff or their families or associates. This will, of itself, cause personal contact with the person and/or their representatives to be discontinued and the issue will, thereafter, only be pursued through written communication.
- has harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their issue or their families or associates. However, staff must recognise that people may sometimes act out of character at times of stress, anxiety or illness and should make reasonable allowances for this.
- has had, in the course of addressing an issue, an excessive number of contacts with the Trust, placing unreasonable demands on staff time or resources. (A contact may be in person, or by telephone, letter, fax or e-mail.) Judgement must be used in determining what is an "excessive number" of contacts and this will be based on the specific circumstances of each individual case.
- has electronically recorded meetings or face to face/telephone conversations without the prior knowledge or consent of the other parties involved.
- displays unreasonable demands or expectations and fails to accept that these may be unreasonable (e.g., insists on responses to enquiries being provided more urgently than is reasonable or normally recognised practice).

2.3 STAGE 2 – Options for dealing with habitual and/or persistent complainants and/or habitually demanding or exhibiting vexatious behaviour

Where complainants/individuals have been identified as habitual, vexatious and/or persistent in accordance with the above criteria, the chief executive (or deputy in his/her absence) will determine what action to take. The chief executive (or deputy) will implement such action and notify complainants/individuals in writing of the reasons why they have been classified as habitual, vexatious and/or persistent and the action to be taken. This notification may be copied for the information of others already involved in the complaint e.g., practitioners, advocates, Clinical Commissioning Groups and Members of Parliament. A record must be kept for future reference of the reasons why a complainant has been classified as habitual and/or persistent.

The chief executive (or deputy) may decide to deal with complainants/individuals in one or more of the following ways:

- Try to resolve matters before invoking this procedure, by drawing up a signed agreement with the complainant (and if appropriate involving the relevant clinician/team in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.
- Once it is clear that the individual meets **one** of the criteria for being classed as habitual/persistent, it may be appropriate to inform them in writing that they may be classified as habitual/persistent/vexatious; copy this procedure to them and advise them to take account of the criteria in any further dealings with the Trust.
- Decline contact with the individual either in person, by telephone, fax, letter, email, or any combination of these, provided that one form of contact known to the individual is maintained, or alternatively to restrict contact to liaison through a third party. (If staff are

to withdraw from a telephone conversation with an individual an appropriate statement will be available for use at such times.)

- Notify the complainant in writing that the chief executive has responded fully to the points raised; has tried to resolve the complaint; that there is nothing more to add, and that continuing contact on the matter will serve no useful purpose. The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.
- Inform the individual that, in appropriate circumstances, the Trust reserves the right to pass unreasonable or persistent complaints/behaviour to its solicitors.
- Temporarily suspend all contact with the individual or investigation of a complaint whilst seeking legal advice or guidance.

2.4 STAGE 3 – Withdrawing habitual, vexatious and/or persistent status

Once individuals have been determined as habitual, vexatious and/or persistent, there needs to be a mechanism for withdrawing this status at a later date if, for example, the individual subsequently demonstrates a more reasonable approach or if they submit a further complaint for which the normal complaints procedure would appear appropriate.

Staff should previously have used discretion in recommending habitual, vexatious and/or persistent status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate.

Where this appears to be the case, discussions will be held with the chief executive (or their deputy). Subject to their approval, normal contact with the complainants and application of the NHS Complaints Procedure will then resume.

2.5 FREEDOM OF INFORMATION ACT 2000

Where a freedom of information act request is made by a complainant or person who has been designated as habitually demanding or vexatious, the Trust may, in assessing whether that individual request is a vexatious request, take into account the habitually demanding or vexatious complainants/behaviour if it considers this to be relevant. In doing so, the Trust will also follow information commissioner guidance on vexatious requests.

3. LISTENING TO CARERS

Whilst the duty of consent must be applied, the Trust must also ensure it listens to and responds to concerns raised by family and carers of patients to protect them from harm. Guidance should always be sought from the division if there are concerns which require investigation where consent is not possible/received.

4. REVIEW OF PROCEDURE

This procedure will be reviewed and revised as and when appropriate.

5. DEFINITION OF HABITUAL AND/OR PERSISTENT COMPLAINANT

A complainant and/or anyone acting on their behalf may be deemed to be habitual and/or persistent complainant where previous or current contact with them shows that they meet two or more of the following criteria. Where complainants:

- Persist in pursuing a complaint where the NHS Complaints Procedure has been fully and properly implemented and exhausted.
- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues,

which are significantly different from the original complaint. These may need to be addressed as separate complaints.)

- Are unwilling to accept documented evidence of treatment given as being factual, e.g., drug records, computer records and nursing records or deny receipt of an adequate response in spite of correspondence specifically answering their question or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.
- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the Trust staff and, where appropriate, independent advocates to help them specify their concerns and/or where the concerns identified are not within the remit of the Trust to investigate.
- Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what a 'trivial matter' is can be subjective and careful judgement must be used in applying this criterion.)
- If, during the process of complaining, threatened or actual physical violence is used towards staff or their families or associates at any time, reference should be made to the policy for the Management of Violence and Aggressive Behaviour.
- Have, in the course of addressing a registered complaint, an excessive number of contacts with the Trust thus placing unreasonable demands on staff. (Contact may be in person or by telephone, letter, email or fax. Discretion must be used in determining the precise number of 'excessive contacts' applicable under this section.)
- Show signs of vexatious behaviour for several reasons and may be unaware that their attitude/behaviour is causing unnecessary distress to others. Unacceptable behaviour that continues through several contacts, however, should be considered against this policy.
- Are known to have recorded meetings or face-to-face/telephone conversations without prior knowledge and consent of other parties involved.
- Display unreasonable demands or patient/complainant expectations and fail to accept that these may be unreasonable (e.g., insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised).