Policy Number	SA06

COVID-19 DOCUMENT CHANGE FORM

NHS Mersey Care NHS Foundation Trust
Community and Mental Health Services

In light of the COVID-19 outbreak it has been necessary to make temporary changes to this Policy Document. Therefore when reading the policy document please take account of the changes highlighted in Part B and C of this form.

PART A – INFORMATION ABOUT THIS POLICY DOCUMENT

Policy Name	**Management of Complaints / Concerns**				**Reference No**	**SA06**	
Executive Lead *(Trust-wide policies)*	**Executive Medical Director**						
Chief Operational Officer *(Clinical Division policies)*							
Policy Document *(Tick only one)*	Trust-wide (Board approved)	☒	Trust-wide (Executive Director approved)	☐	Secure & Specialist Learning Disabilities Division	☐	
	Community Division	☐	Local Division	☐			
Type of Policy *(Tick only one)*	Clinical Policy	☐	Non-clinical Policy	☒			
Clinical Policy Only *(Tick only one)*	Minor Change *(Not referred to the Clinical Cell)*	☐	Major Change *(Referred to Clinical Cell, then to SCG for approval)*	☒			
Approving Body *(Tick only one)*	Board of Directors	☒	COVID-19 Strategic Coordination Group	☐	Community Division Tactical Coordination Group	☐	
	Corporate Division Tactical Coordination Group	☐	Local Division Tactical Coordination Group	☐	Secure & Specialist LD Division Tactical Coordination Group	☐	

PART B – CHANGES TO THE POLICY DOCUMENT

Section / Paragraph No	Outline of the information that has been amended in this policy document
Paragraph 6.70 (timescales)	In respect of the process for the management of complaints or concerns as defined in this policy, temporary arrangements will be put in place for their management whilst the trust's COVID-19 governance arrangements for policy documents are in place. This means that effectively their will be two categories of complaints / concerns whilst these temporary arrangements are in place: 1) complaints or concerns that relate to patient safety, practitioner performance, safeguarding or staff safety / well-being will be managed in accordance with the timescales outlined in this policy 2) complaints or concerns that do not relate to patient safety, practitioner performance, safeguarding or staff safety / well-being may not be managed in accordance with the timescales outlined in this policy. In effect this means the management of these types of complaints or concerns, whilst acknowledged, will be suspended (or placed of hold)
Paragraph 6.80 (determining the type of investigation)	• As a temporary measure the Complaints Co-ordinator, Complaints Lead, Complaints Team or the Patient Advice and Liaison Service (PALS) will determine which of the above two categories a complaint or concern will be categorised as. They will then determine whether or not the investigation into that complaint or concern will be places on hold. • Where the investigation into a complaint or concern has been placed on hold, this decision will be subject to a review every month. This will be communicated with the complainant.

Policy Number	SA06

COVID-19 DOCUMENT CHANGE FORM

PART C – RATIONALE FOR CHANGES

Please explain why this document needs to be amended during the COVID-19 outbreak
It is recognised that the trust will be facing a range of capacity issues as a result of staff absence and the redeployment of clinical staff from corporate to clinical areas. Taking account of national guidance (see extract overleaf) the intention of this temporary change to the normal process for the management of complaints / concerns is to prioritise, during the COVID-19 outbreak, those complaints / concerns that may impact on patient safety, practitioner performance, safeguarding or staff safety / well-being. As the trust's Board of Directors is responsible for approving the *Reporting, Management of Complaints / Concerns (SA06)* policy, the COVID-19 Strategic Coordinating Group considered these temporary changes and has recommended them to the Board of Directors for approval. These temporary arrangements will be kept under review by the trust.

PART D – APPROVAL (for completion by officer loading policy document onto intranet / website)

Date Referred to the Clinical Cell *(Clinical Policies only)*	
Date Referred by the Clinical Cell to the SCG *(Clinical Policies only)*	
Date Approved by the Approving Body	Board of Directors – 17 April 2020
Date Circulated to Relevant Staff	17 April 2020
Date Published on the Divisional Intranet / Trust Website	17 April 2020

Guidance from Amanda Pritchard, Chief Operating Officer, NHS England / Improvement
Pausing the NHS complaints process

Due to the ongoing COVID19 pandemic NHS England and NHS Improvement are supporting a system wide "pause" of the NHS complaints process which would allow all health care providers in all sectors to concentrate their efforts on the front-line duties and responsiveness to COVID19 this means that:

- all providers should ensure that patients and the public are still able to raise concerns or make a complaint, but that the expectation of an investigation and response in the near future is managed.
- all providers would continue to acknowledge complaints, log them on their respective systems, triage them for any immediate issues of patient safety, practitioner performance or safeguarding and take immediate action where necessary. All complaints would then remain open until further notice, unless an informal resolution could be achieved, or the complainant chooses to withdraw their complaint.
- in secondary care where PALS offices still operate, they could still provide support by email and telephone and this should be encouraged for patients and the public to engage with the organisation.
- CCGs should ensure that they continue to have open channels of communication with patients and the public.
- we would advise the system that consideration should be given to complainants who, at the time of the "pause", have already waited excessively long for their response (specifically those who have waited six months or more) these should be reviewed to ascertain if and how these can be resolved to the complainant's satisfaction.

The initial "pause" period is recommended to be for three months with immediate effect. All health care providers can opt to operate as usual regarding the management of complaints if they wish to do so and this "pause" is not being enforced.

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE POLICY DOCUMENT

MANAGEMENT OF COMPLAINTS / CONCERNS

Policy Number:	**SA06**
Scope of this Document:	**All Staff**
Approving Committee:	**Board of Directors**
Date Ratified:	**27 February 2020**
Next Review Date (by):	**30 November 2020**
Version Number:	**2020 – Version 5**
Lead Executive Director:	**Medical Director**
Lead Author(s):	**Director of Patient Safety**

TRUST-WIDE POLICY DOCUMENT

2020 – Version 5

Striving for perfect care and a just culture

TRUST-WIDE POLICY DOCUMENT

MANAGEMENT OF COMPLAINTS / CONCERNS

Further information about this document:

Document name	**MANAGEMENT OF COMPLAINTS/CONCERNS SA06**
Document summary	**To ensure a consistent and thorough approach to the reporting, management, investigation and satisfactory resolution of complaints and concerns, taking into account the need to provide a clear, efficient and open process.**
Author(s) Contact(s) for further information about this document	**Joanne Bull** **Associate Director of Patient Safety** **Telephone: 0151 478 6578** **Email: Joanne.bull@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Policy and Procedure for the reporting, management and review of Adverse Incidents (including serious untoward incidents and near misses) (SA03)** **Disciplinary Procedures (HR01)** **Policy and Procedure for the reporting, management and investigation of claims/potential claims including property expenses (SA05)** **Policy and Procedure for Safeguarding Adults from Abuse (SD17)** **Freedom to Speak up - Whistle Blowing Policy (HR06)** **Complaints Standard Operating Procedure (SOPS)** **Clinical Governance and Adult Safeguarding (Department of Health 2010)**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
Version 1		March 2015
Version 2		January 2016 June 2016
Version 3	Minor amendments approved by Executive Lead.	January 2017
Version 4	Minor amendments	January 2018
Version 5	Minor Amendments, approved by Board of Directors	February 2020

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child /adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1 PURPOSE AND RATIONALE

1.1 Mersey Care NHS Foundation Trust ('Mersey Care' or the 'Trust') recognises that there will be occasions when service users/carers are dissatisfied with aspects of the care and services provided. The Trust is committed to dealing with any problems that may arise as quickly and as effectively as possible.

1.2 The Trust will operate a fair and accessible procedure which complies with the statutory framework for dealing with complaints set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 The aim and objective of this policy is to:

a) provide complainants with timely resolution of their concerns and complaintsl
b) provide a simple, efficient and open process;
c) empower all staff, where appropriate, with the support of Patient Advice and Liaison Service (PALS) and other advocacy services, to deal with concerns and complaints informally at the point of service delivery;
d) ensure fairness to staff and complainants alike and to ensure confidentiality;
e) ensure an honest approach that is thorough and aimed at satisfying the complainant's concerns. It is important that no individual must be inhibited or disadvantaged when making complaints and that there is confidence that these will be given proper and speedy consideration;
f) resolve complaints, where possible, as they arise;
g) increase service users/carer's trust in Mersey Care;
h) recognise that suggestions, constructive criticism and complaints can be valuable aids in developing and maintaining standards of care;
i) learn lessons from complaints and use them positively to improve services.

2.2 The Trust wishes to adopt the following principles to ensure good complaints handling is embedded in the management of all complaints. The six principles are:-

a) getting it right;
b) being customer focused;
c) being open and accountable;
d) acting fairly and proportionately;
e) putting things right;
f) seeking continuous improvement.

2.3 The Trust will implement this good practice by:

a) publicising its complaints procedures. All services will ensure their teams/units have complaints leaflets available;
b) ward staff attempting to resolve problems locally where appropriate and attending patient/service user forums to address any issues of concern;
c) acknowledging a complaint when it is received and offering to discuss the issues raised;
d) dealing efficiently with complaints and investigating them fully and fairly;
e) respecting the need for confidentiality;

f) enabling a response to the complaint to be made within the required time limits, or where this is not possible, to provide an explanation for any delay;
g) writing to the person who has complained once the complaint has been dealt with, explaining how it has been resolved and what appropriate action has been taken, including informing the complainant of their right to take the matter to the Parliamentary and Health Service Ombudsman if they remain unhappy;
h) ensuring that a senior manager will be responsible for both the complaints policy and learning from complaints;
i) helping the person who is complaining to understand the process;
j) producing an annual report about complaints received and outlining what has been done to improve service as a result.

Openness, Transparency and Duty of Candour

2.4 The Trust and everyone working for the organisation must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest open and truthful. Duty of Candour is the statutory regulation to ensure that Trusts are being open and honest following a patient safety incident. In line with the National Patient Safety Agency (NPSA) strategy and as a requirement under the NHS Standard Contract 2014/2015, the Duty of Candour ensures that service users/their families are told about safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. The Trust is committed to ensuring that the care and treatment provided to service users is of a high standard at all times, and will not suffer as a result of raising a concern or complaint.

2.5 The aim of the regulation is to ensure that providers of healthcare are open and honest with patients when things go wrong with their care and treatment.

2.6 To meet the requirements of the regulation, a provider has to:
a) ensure it has an open and honest culture across and at all levels within its organisation;
b) tell service users and their families in a timely manner when particular incidents have occurred;
c) provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that the organisation will carry out;
d) offer an apology in writing;
e) provide reasonable support to the person after the incident.

2.7 The regulations apply to the service user themselves and, in certain situations, to people acting on their behalf, for example when something happens to a child or to a person over the age of sixteen who lacks the capacity to make decisions about their care.

Being Open

2.8 Being open involves:

a) acknowledging, apologising and explaining when things go wrong;
b) conducting a thorough investigation into the complaint or concern;
c) reassuring service users, their families and carers that lessons learnt will help prevent incidents occurring;
d) providing support for those involved to cope with the physical and psychological consequences of what happened.

3 SCOPE

3.1 This policy complies with the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 and relates to all complaints about health and social care services provided/managed by the Trust.

3.2 This policy does not cover complaints made by:-

a) current or past employees about their employment;
b) persons or companies engaged by or contracted to the Trust;
c) purchasers of Trust services.

4 DEFINITIONS

4.1 The Trust wishes to address any issue raised at the earliest and most local level. Dealing immediately with any concern or complaint made reduces the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem.

4.2 Complaints is this policy are defined as expressions of dissatisfaction from a service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust.

4.3 Concerns in this policy are defined as issues which require only advice and information in order to immediately resolve them or concerns that can be resolved quickly and do not require any form of investigation are best dealt with by the Patient Advice and Liaison Service and/or the service in which the concern originated. When a concern is raised which cannot be satisfactorily resolved without an investigation, then it is to be processed as a complaint.

5 DUTIES

Chief Executive

5.1 As the accountable officer, the Chief Executive must ensure that responsibility to manage complaints within the Trust is delegated to an appropriate Executive Lead.

5.2 The Chief Executive will signed complaint response letters, usually where a formal investigation has been undertaken, except in cases where it is more appropriate for the letter to be signed by another member of staff.

Medical Director

5.3 The Medical Director is the delegated Board executive with responsibility for complaints. They will ensure that an annual report is shared with the Quality Assurance Committee which will include the number and type of concerns/complaints raised and the improvements to practice that have been made to prevent reoccurrence. They will also provide a report on complaints (and the actions taken) and adherence to the complaints policy three times a year to the Quality Assurance Committee. They will also provide any other reports to the Board of Directors and its committee on complaints as and when requested.

Director of Patient Safety

5.4 The Director of Patient Safety is directly responsible to the Medical Director and accountable for the operational and strategic management of complaints and concerns within the Trust.

Complaints Lead/Complaints Co-ordinator.

5.5 The Complaints Lead/Complaints Co-ordinator are responsible for managing the complaints process on a day to day basis. They will analyse all complaints and concerns and ensure the Trust's process for recording, acknowledging and investigating complaints/concerns is followed. They will assess and grade each complaint for severity of harm and likelihood of recurrence using the Trust's Risk Management matrix. They will also identify any complaint which initially indicates abuse, harm or neglect may be and/or has taken place, will be subject to a review to identify possible safeguarding concerns and the grading will be revisited following investigation of the complaint. They wil be responsible for the provision of information, both on a formal and ad hoc basis. Any complaint received which indicates potential fraudulent activity, the Complaints Lead will seek guidance from the Local Counter Fraud Specialist in accordance with Local Counter Fraud Specialist and Complaints Lead Protocol.

Complaints Officers

5.6 Complaints Officers are responsible for the day to day implementation of the Trust's complaints procedure, including:

a) recording of complaint information;
b) communication with all persons involved in complaints;
c) arranging for complaints to be investigated; and
d) the formulation of complaint response letters.

Complaint Investigator

5.7 An individual leading an investigation should have completed the Root Cause Analysis (RCA) course. There may be exceptions to this, where the experience of the staff chosen to investigate outweighs the need for them to train in RCA. When this is the case, they will be offered support and guidance from the PALS and Complaints Team. They can be a member of Trust staff, usually with a clinical background, an

independent investigator employed to undertake investigations, or a specifically trained and supervised service user/carer.

5.8 They are responsible for: -

a) liaising with the complainant to clarify the issues raised and the outcomes required;
b) undertaking a rigorous review of the issues raised and care provided based on an awareness of the latest accepted practice;
c) completing a report within the agreed timescales.

Patient Advice and Liaison Services (PALS)

5.9 This service is vitally important in helping services and carers gain resolution of their concerns and complaints. The team can be contacted directly by service users/carers or on their behalf by clinical staff or the PALS and Complaints Team. They can:-

a) set up meetings with clinical staff and attend in support;
b) explain systems and processes;
c) advise on further external support available;
d) address issues that can be resolved quickly without the need for investigation.

5.10 The PALS team can be involved at the very initial stage of a service user/carer raising a concern to try and locally resolve issues or to support them throughout the complaint investigation.

Chief Operating Officers and Clinical Directors

5.11 As the senior managers leading the Division and Service Lines they are responsible and accountable overall for ensuring that:

a) the complaint policy is available to staff and implemented in full.
b) there are sufficient qualified investigators available within their services.
c) systems are in place to monitor the implementation of recommendations that emanate from complaints investigations.
d) timescales are adhered to.
e) senior managers and clinicians become actively engaged in the resolution of complex complaints.
f) a senior manager is available and responsible for complaints management on a day to day basis.
g) the response letter is open and fully explains what happened in relation to the complaint or concern raised and also advises what action will be taken to prevent a further re-occurrence.
h) that details regarding all complaints for their area are shared by the Service Managers with staff for learning purposes and that recommendations and trends are acted upon and understood; *together with*
i) acting as a role model for responding to concerns raised by service users and carers promptly and fully.

Division and Service Lines – Service Manager (inc. Deputy Chief Operating Officers)

5.12 Deputy Chief Operating Officers are responsible in each of their areas for managing complaints and leading on learning from complaints. Each division and service line will have a senior manager who is responsible for complaints management on a day to day basis which will include overseeing the timely resolution of complaints, training of staff to understand, how to resolve complaints and implement a system to learn from them. Sharing all complaints with staff on a regular basis; to facilitate learning from the issues raised.

Service Manager, Complaints Manager - Local Authority

5.13 Officers of the Local Authorities will offer guidance and advice in relation to complex cases that involve staff seconded into the Trust. They will specifically provide direction as to the most appropriate investigatory processes to use where mal-administration and or disciplinary action are a possibility.

Front Line Staff

5.14 It is the responsibility of front line staff (where it is possible) to quickly resolve the concerns that are raised with them by service users and carers in a timely, efficient and open manner. They should always evaluate their actions by checking with the service user/carer that the issue has been resolved to their satisfaction.

5.15 Staff must, however, remember that their responsibility is to ensure the service user's health care needs are being adequately met. Therefore any conflict that arises between managing the concerns raised by the service user/carer and the provision of a high quality and safe service should be discussed within the multi disciplinary team. The reason for any delay in responding should be shared with the service user and carer. Where possible the service user/carer should be involved in all discussions that take place with the aim of achieving a mutually acceptable outcome.

5.16 Concerns and complaints may be made to any member of staff in the Trust. All members of staff must take any concerns, however minor it may seem at the time seriously and consider resolution a high priority taking on the responsibility of aiming to resolve the stated problem.

Ward and Team Managers

5.17 This post holder has the responsibility for ensuring that:

a) all their staff are aware of the importance of taking all the concerns that service users and carers raise seriously with the aim of finding a resolution;
b) staff undertake the Trust's complaints online learning module;
c) they are available to advise staff on actions that can be taken to resolve a concern;
d) they make themselves available to meet with service users and carers to provide further clarification regarding concerns and/or explore the issue further with them;
e) information is available in their area that informs service users and carers on how to raise a concern or make a complaint;

f) feedback to the team on the concerns and complaints that have been raised and how they have been resolved with the aim of preventing further reoccurrences.

Modern Matrons and Community Managers

5.18 As group or unit leaders they are pivotal in ensuring that all concerns raised/complaints made are explored and investigated fully. This is achieved by:

a) discussing concerns raised and complaints investigated during supervision;
b) being available to meet with service users/carers to aid the resolution process;
c) monitoring trends across their area of responsibility and overseeing the implementation of any changes to practice that are required;
d) ensuring ward and team managers feedback to the team all complaint issues raised and the outcomes to enable learning.

Responsibilities of all Members of Staff

5.19 All members of staff must take all issues raised by service users and carers seriously. They must consider resolution a high priority and consider it within their sphere of responsibility to undertake the actions required or share with those colleagues who can deal with the situation.

5.20 All staff will be required to follow the Trust's written procedures and to cooperate in the investigation of complaints. They must make every effort to achieve the performance targets set by the Trust.

5.21 Staff must ensure that service users/carers are assured that they will not be treated adversely as a result of making a complaint.

6 PROCESS

Policy Statement

6.1 All service users, relatives, carers or any person who has been affected by a decision, action or omission of the Trust has the right to make full use of the Mersey Care NHS Foundation Trust complaints/concerns procedure. Complainants will be encouraged to speak openly and freely about their concerns and complaints. They will be assured that whatever they say will be treated with appropriate confidence and sensitivity. All concerns and complaints will be treated seriously and investigated promptly in accordance with the agreed procedures. All front line staff will be adequately trained in dealing with concerns and complaints and will ensure that all service users/carers have access to guidance on the procedures for raising a concern or making a complaint. The Trust is committed to ensuring that everyone is able to raise their concerns or complaints.

6.2 The Trust will ensure that complainants are assured that any concern or complaint they make will not prejudice the treatment and care provided to them. The Trust will not discriminate on grounds of gender, marital status, race, ethnic origin, colour, nationality, national origin, disability (both mental and physical), sexuality, religion or age. The Trust will oppose all forms of unlawful or unfair discrimination. This will be

achieved by the training of staff who manage and investigate complaints. Training will include Equality and Diversity training.

6.3 Any issue regarding possible discriminatory behaviour by staff arising from a complaint will be dealt with through the disciplinary procedure.

6.4 The Trust is committed to ensuring that lessons learned from concerns and complaints are used as a means of improving the quality of care and services to service users.

6.5 Any recommendations made as a result of a concern or complaint will be shared with the services involved in order that changes can be considered and implemented where appropriate. Consideration will also be given to applying recommendations in other relevant areas of the Trust as well as sharing with other NHS Trusts.

General Guidance

6.6 We use the term 'service users', in this policy. This term includes any individual who uses the Trust's services.

6.7 This policy covers care and treatment provided by NHS staff and social care/social work provision provided by staff seconded into the Trust.

6.8 Complaints involving the Trust and other agencies will be processed as outline below.

6.9 Complaints received by the Trust that relate to another organisation may be redirected to the appropriate organisation, on behalf of the complainant with their agreement, and the complainant notified accordingly.

Who Can Complain/Raise a Concern?

6.10 A complaint can be made by a service user, relative, carer or any person who is affected or likely to be affected by the action, omission or decision of the Trust.

6.11 Where the complaint is made by a representative on behalf of the service user, the service user's consent should be obtained, unless the service user does not have capacity to give consent. In that case, a representative who makes a complaint on behalf of a child, or on behalf of a person who lacks capacity within the meaning of the Mental Capacity Act 2005, can be accepted as the service user's representative by the Trust, provided that the Trust is satisfied that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made. The representative can be, for example, a family member, friend, solicitor or advocate or member of the Care Quality Commission (CQC).

6.12 The Trust has the authority not to respond to a complaint made by a representative on behalf of a child or a person who lacks capacity. However the Trust may only do this where it is satisfied that the representative is not conducting the complaint in the best interests of the person on whose behalf the complaint is made. This power is given to the Trust under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. The Trust will notify the

representative in writing and state the reasons for its decision not to respond the complaint. All concerns should still be considered to ensure there are no causes for concern or to identify learning.

6.13 Advocacy organisations also provide a useful service in assisting service users, relatives and carers to make a complaint, especially where a complainant is unable to make, or is disadvantaged in being able to make a complaint personally. Healthwatch Advocacy has a statutory role in advising complainants and, where appropriate, assisting them in making complaints.

Situations where the Complainant's Mental Health is Stated as the Root Cause of a Complaint

6.14 Where it is clear on investigation that the complainant's mental health is predisposing them to make complaints, the following steps should be taken:-

6.15 The complaint should initially follow the usual complaints process.

6.16 The concern that the illness is the root cause of the complaint and that responding to it would adversely affect the service user's mental health should be considered by the service user's care team. If, based on clinical opinion that is judged to be the case, they will advise the complaint lead on what management arrangements might be made. These could include:-

a) delaying the investigation until the complainant is well;
b) not pursuing the investigation as the complaint is part of the service user's pathology;
c) informing the service user of the care team's advice and resulting action unless there is good reason not to;
d) advising that it would not be in the service user's best interests to respond to the complaint. This decision must be clearly documented in the complaint file supported by the rationale for it. This decision can only be made by the complaints lead in conjunction with the service user's care team. It should be noted that not to make any response whatsoever to a complaint is an exception and should only occur after careful consideration and with good reason.

6.17 All correspondence relating to the complaint must be discussed with the senior manager with responsibility for complaints so that the issues can be assessed and where appropriate investigated, to ensure there are no omissions or causes for concern.

6.18 Each issue raised must be considered separately to ensure that appropriate concerns are not missed.

Staff Complaints and Concerns

6.19 Staff may wish to raise complaints regarding patient care and a decision will be made as to how they will be taken forward, whether through the Complaints procedure, Safeguarding or Freedom to Speak Up - Whistleblowing policy.

6.20 The Trust wishes to encourage an open and honest reporting culture in which the raising of concerns is welcomed and the staff who raise them are valued and supported in line with the recommendations of 'Freedom to Speak Up', the review commissioned by the Secretary of State and chaired by Sir Robert Francis QC.

6.21 Staff who may have concerns about service user care have a responsibility to make their concerns known. Such concerns should be raised in the first instance through the normal line management structures. Any remaining concerns can be raised in accordance with the Freedom to Speak up Policy.

6.22 **Complaints which are not required to be dealt with under the statutory complaints regulations (Local Authority Social Services and National Health Services Complaint (England) Regulations 2009**

a) A complaint by an employee about any matter related to their employment.
b) A complaint which has been made verbally and is resolved to the complainant's satisfaction, not later than the next working day after the day on which the complaint was made.
c) A complaint the subject matter of which is the same as that under which has been resolved.
d) A complaint which has been investigated by a Local Commissioner under the Local Government Act or by the Care Quality Commission under the Mental Health Act 1983 as amended.
e) A complaint arising out of the alleged failure of the Trust to comply with a request for information under the Freedom of Information Act 2000.
f) Privately funded healthcare (e.g. services purchased from the Trust by direct payment). However, a complaint can be made to the Local Authority about the allocation of funding or the support provided by the Local Authority to enable the purchaser to manage the direct payment.
g) A complaint about fraudulent or disciplinary action.

6.23 If the complaint falls outside the scope of the complaints regulations, the Trust will inform the complainant of this and provide the reasons why the Trust considers this to be the case. The Trust will also, where practicable, provide information to the complainant as to how they can get their concerns and complaints dealt with.

What Information Should the Complainant Provide?

6.24 In order to help the investigation of the complaint, the complainant is requested to provide as much information as possible including:

a) the date, time and place (if appropriate) of the incident that gave rise to the complaint;
b) the names of the persons involved or who witnessed the incident (if applicable);
c) a brief but full account of the complaint;
d) provide information on what outcomes the complainant wishes to achieve;
e) provide a point of contact for correspondence from the PALS and Complaints Team;
f) be agreeable for the investigator to access relevant documentation and clinical notes.

Time Limits on Initiating Complaints

6.25 A complaint should be made as soon as possible after the incident giving cause for concern.

6.26 Normally, a complaint should be made within twelve months of the event giving rise to the complaint. The time limit can and should be extended beyond twelve months, where the complainant has a good reason for not making the complaint within the time limit and, where, despite the delay, an effective and fair investigation is still possible.

Who Deals With Complaints/Concerns

6.27 Service users and carers should be encouraged to raise issues of dissatisfaction as they arise at ward and departmental level. Responses to complaints and concerns are best made close to the point of care delivery by those staff involved in the delivery of care or by those directly responsible for it.

6.28 All members of staff are empowered with the responsibility to deal with verbal complaints as they arise and must consider the resolution of the complaint to the satisfaction of the complainant a high priority. The intervention of the Patient Advice and Liaison Service (PALS) and modern matrons can greatly aid this process.

6.29 A brief record documented on a local resolution form, including actions to prevent recurrence, (see Appendix 6) should be made by the staff member who is dealing with the complaint. The form should be sent to the PALS and Complaints Team to be recorded to include within the review of complaints, to look at trends, issues arising and any learning.

6.30 Where a concern cannot be dealt with immediately or when the complainant requires further advice, the member of staff involved should explain to the complainant the routes available to deal with their concerns. The provision of a complaints information leaflet will aid this process.

6.31 If the complainant wishes to pursue the matter more formally the complaint should be passed to the PALS and Complaints Team.

Service User Confidentiality and Consent

6.32 The consent of the service user who has capacity to give consent to disclose his/her personal information should be sought prior to disclosing any outcomes of investigations into complaints raised by carers or family members, or any other representative. A consent form will be sent to the service user and the person making the complaint, however this does not prevent the investigator from commencing the investigation. The investigator can meet with the complainant to discuss the concerns raised without disclosing any confidential information. The clinical entries can also be reviewed and interviews with staff integral to the complaint can be undertaken. If consent is not given, it may not be possible to disclose all of the findings, however certain information may be provided it does not breach the confidentiality of the service user. The complainant must be informed of this and the reason why consent is required.

6.33 Care must be taken at all times throughout the complaints process to ensure that any information disclosed about the service user is confined to that which is relevant to the investigation of the complaint and only disclosed to those people who are entitled to receive it for the purposes of the investigation. It must be explained to the service user that information in his/her records may need to be disclosed to relevant personnel dealing with the complaint. In serious complaints, it may be lawful to process personal information without consent, but legal advice must be sought prior to taking such a decision.

6.34 It is important that the complaints process and complaint documentation is kept separate from the service user's clinical records, so that the complaint records are not recorded on or stored within the service user's clinical records. On occasion, it may however be appropriate to include information related to complaints within a service user's clinical records.

6.35 If it is felt by those involved in the investigation of a complaint, that issues raised in the complaint have significant implications for the clinical management of the service user, these should be raised with the clinician in charge of the service user's treatment (or the appropriate clinical director if the clinician in charge of the service user's care is the subject of the complaint). Careful consideration should then be given as to how this information can be included in the services user's clinical records. The rationale for this is to provide members of the multi disciplinary team with the relevant information necessary to provide the most appropriate, safe and therapeutic care to a service user based on all the available relevant information. In such case, the rationale for including this information must be clearly documented in the service user's clinical records. The service user who has capacity shall be informed that details of his/her complaint are being placed with their records, unless there are compelling reasons in the service user's best interests (their health and welfare) not to do so.

6.36 Staff involved in the investigation of a complaint will be required to return all papers relating to the complaint to the Trust's Complaints Lead on completion of the investigation.

Separation of Complaints and Disciplinary or Criminal Procedure

6.37 The Complaints Procedure is separate from the Trust's Disciplinary Process and the Local Authority Disciplinary Procedures, where social care staff are involved. During the investigation of a complaint, if there is a primary need for referral to any of the following, the appropriate Director, in liaison with the appropriate Professional/Senior Manager (Social Care) will decide whether to initiate such action:

a) an investigation under the Disciplinary Procedure;
b) referral to one of the professional regulatory bodies;
c) referral to the Local Counter Fraud Specialist;
d) referral to the police.

6.38 If any of the above actions are pursued before the complaints investigation can be completed, the complainant will be informed in writing of the investigation to date.

6.39 Any aspect of the complaint which is not the subject of the referral should continue to be investigated.

6.40 The complainant will be informed when any subsequent disciplinary proceedings are concluded. Under duty of candour, as much information from the findings of the investigation, including the outcome, will be provided to the complainant, however it will not be possible to disclose any action taken against the member of staff, as this is confidential.

6.41 Any decision made to disclose such information outside of the complaints process and the reasons for doing so should be clearly documented. If staff require further assistance they should liaise with the Trust's Legal Management Team.

Disclosure of Information following a Complaint, to the Police, Counter Fraud, or any Regulatory Body

6.42 If as a result of investigating a complaint it becomes apparent that a criminal offence may have occurred, consideration will need to be given to reporting this to the police.

6.43 In most cases the referral should take place with the knowledge and consent of the service user/complainant, but in some cases the referral should be made without informing these individuals where to do so would compromise a criminal investigation.

6.44 In cases where the complainant/service user may be informed, then their consent should be sought before any disclosure is made. If the service user or, as appropriate, other complainant, declines to give such consent then consideration will need to be given as to whether it is nevertheless justifiable to disclose this information in the public interest because it is necessary to protect the service user or another from death or serious harm, or because it would be likely to assist in the prevention, detection or prosecution of a serious crime, especially crimes against the person. The reasons for making any such disclosure where the consent of the service user (and/or other complainant where appropriate) has been refused, should be clearly recorded and, unless there are compelling reasons for not doing so, the service user should be informed that this has been done.

6.45 If the service user does not have capacity to give consent, any welfare attorney, or court appointed deputy should be consulted. If there are no such individuals then consideration should be given to whether such disclosure would be in the service user's best interests, applying the principles in the Mental Capacity Act 2005 and associated Code of Practice and/or the principles outlined above.

6.46 Similar principles will apply to the disclosure of information to regulatory bodies, if the contents of the complaint indicate that a member of staff may have breached their professional code of conduct and or if the complaint raises safeguarding issues.

6.47 In a case where a criminal investigation will be compromised if the service user and/or complainant is informed that the matter has been referred to the police or to counter fraud, then the matter may be referred without seeking the consent of the complainant/service user. However, the decision to divulge personal information

without the knowledge and consent of the individual concerned must be justified and the rationale must be documented.

6.48 The following process must be used prior to referring a matter to Counter Fraud and/or the police:

a) where the serious nature of the incident is identified by the service user's care team at the time of the incident, irrespective of whether there has been a complaint at that stage, the local care team must refer the matter to the appropriate director, so that a decision whether or not to refer to the police or counter fraud will be made at a senior level of the Trust;

b) if there has been no referral to the police or counter fraud prior to the receipt of a complaint by the PALS and Complaints Team and if the matter is sufficiently serious to require referral to be considered, then the Complaints Lead will refer the matter to the appropriate director, together with a recommendation that a referral should be made. The decision whether or not to refer will again be taken at a senior level of the Trust;

c) any decision to refer under (a) or (b) above will be taken after due consideration has been given to whether the referral requires the consent and knowledge of the service user/complainant, or whether there are compelling reasons not to impart the fact of the referral to them;

d) where doubts exist regarding referral to investigatory agencies, seek guidance from the Police Liaison Officer or Counter Fraud Specialist;

e) if the matter is the subject of a complaint, it is important to identify whether the complaint process must continue pending the outcome of the referral;

f) all necessary steps to ensure patient safety must be taken as patient safety takes precedence. Referral to the police must not impede this;

g) agree who will liaise with the Human Resource Department (where staff are involved);

h) if any part of the complaint can be investigated without prejudicing any police or counter fraud investigation, then this aspect of the complaint should be identified and the investigation proceeded with, subject to agreement with Counter Fraud and/or the Police;

i) liaise regularly with Counter Fraud or the Police to identify their progress;

j) inform the complainant of outcome of the police/counter fraud investigation subject to any obligations of confidentiality and subject to what information has or has not been given to the complainant concerning the referral to the police/counter fraud.

Claims of Negligence

6.49 If a complaint reveals a clear case of negligence, or if it is thought that there is a likelihood of legal action being taken, the Complaints Lead shall inform the Trust's Claims Manager. Any investigation of the complaint will not cease.

6.50 If the issue relates to a person seconded into the Trust by a third party organisation their PALS and Complaints Team will be informed so that they can advise on any specific actions which may need to be taken.

6.51 Where there is an indication of an intention to commence legal proceedings, the Trust's Claims Manager will process the claim as appropriate, including liaising with the NHS Resolution and solicitors nominated by that body on behalf of the Trust.

Withdrawal of Complaints

6.52 If an individual wishes to withdraw a complaint, it is important to know why, and discreet efforts will be made to find out the reasons for the withdrawal. The majority of complaints, specifically those where alleged harm has been caused will continue to be investigated and in all other cases, the Complaints Lead/Complaints Co-ordinator will decide whether or not to proceed with the investigation of the complaint.

Anonymous Complaints

6.53 Occasionally anonymous complaints are received and where there is sufficient detail, the complaint should be investigated within this procedure. Each case will require individual consideration. The Complaints Lead in conjunction with the relevant Service Manager will decide whether to proceed with an investigation. In those cases where there is insufficient detail to investigate, the information will still be recorded on the complaints database to ensure inclusion of anonymous non-identifiable data for monitoring and trends analysis purposes.

Systems Used to ensure Service Users or Carers/Relatives are not Disadvantaged

Underpinning Principles

6.54 The method for ensuring that service users, relatives and their carers are not treated differently as a result of raising a complaint is as follows:

a) all concerns and complaints will be dealt with by local resolution, and if necessary formal investigation;
b) concerns can be raised anonymously;
c) individuals can report concerns directly to the service manager/frontline staff or to staff external to that service who can raise issues on their behalf;
d) all complainants have a named complaints officer with whom they can raise any concerns;
e) complaints handling training for Trust staff clearly imparts the complainant's rights and staff responsibilities to them and others;
f) investigations are standardised across the Trust with procedures in place that comply with external standards;
g) the Trust makes it clear to staff, service users and carers that it welcomes complaints and concerns being raised as a measure of how the Trust is performing and a way to improve the services provided.
h) trained service users/carers are available to investigate complaints as part of a two man team.

Process

6.55 The process involves:

a) during initial contact, complainants will be given a detailed verbal explanation of the investigation process to ensure that they and any others involved are aware how any information related to them will be handled;

b) PALS officers are asked to engage with a service user or complainant where they feel they are being victimised or there is a potential for this to happen;

c) the wishes of the complainant regarding how they would like the investigation facilitated and by whom, are considered and where possible agreed;

d) where there are concerns about how a complainant will be treated, or about the objectivity of the staff, then an individual who is external to the unit concerned will be requested to undertake the investigation;

e) the complainant will be contacted regularly and any concerns raised that the investigation is affecting their care will be detected and discussed with them and may then be raised with the complainant's care team;

f) if an individual reports that they have been treated differently as a result of raising a concern or registering a formal complaint this will be investigated and the Service Manager involved immediately;

g) staff are informed via training and through Quality Practice Alerts that any documentation relating to complaints is not filed within the service user's health records:

h) complaint investigations are allocated to a case manager/investigator from a different service/team to enhance impartiality.

Links with Safeguarding Adults Procedures

6.56 All complaints are assessed for possible referral to safeguarding, and this is recorded on the complaints database. A further check is undertaken at the end of the complaints process and a written record is retained.

6.57 Any complaint which initially identifies that abuse, harm or neglect may be and/or has taken place will be subject to a review to identify whether it is a safeguarding concern. This review must take place within 24 hours of the concern being identified. Subject to this review, consideration will be given to whether the matter should be referred to the police, or other regulatory body. A nominated officer for safeguarding, Service Manager, Complaints Lead and other relevant staff will undertake the review. Where necessary on call arrangements will be used to access a management perspective.

6.58 If further information comes to light during an investigation that suggests abuse, harm or neglect has/is taking place then the investigator and Complaint Lead should make a referral through to the Safeguarding Adults Team. Where referral is not clear, guidance should be sought from Mersey Care's Safeguarding Team.

How to Make a Complaint

6.59 Complaints should be made within twelve months of the event giving rise to the complaint. Consideration will only be given to complaints made outside this timescale when the Trust is satisfied that the complainant has good reasons for not making the complaint within the time limit and that, notwithstanding the delay, it is still possible for the complaint to be investigated effectively and fairly.

6.60 Complaints may be made verbally, including via the telephone, or in writing, including via email or using the on-line complaints form on the Trust's website. The Trust will publicise information about how people can raise a concern or make a complaint about the Trust.

6.61 Concerns and complaints can be made known to any member of staff, or directly to the Trust's PALS and Complaints Team.

Concerns/Complaints made to Front Line Staff

6.62 This process will apply to situations where service users, relatives, carers or significant others, indicate directly to front line staff they are dissatisfied or have concerns about aspects of the service.

6.63 All serious verbal complaints and those made in writing should always be referred to the PALS and Complaints Team.

6.64 Many concerns arise out of a need for information. The offer of an explanation or an apology will often achieve resolution. Staff may contact the PALS and Complaints Team to assist in this.

6.65 On receipt of a complaint or concern, the appointed clinician/manager will ensure the service user's immediate health care needs are being met. An apology that a person is dissatisfied with the service and an explanation as to what happened may resolve the concern or complaint. It may be that immediate action is taken by the staff member receiving the complaint to resolve the concern or to try to prevent it happening again.

6.66 All complaints and concerns dealt with in this manner must be recorded at ward/departmental level, separate from any service user records and using an agreed method of recording. The written record must set out details of the complaint, how it was resolved and any further actions required. This information will be documented on a Local Resolution Form and must be shared with the PALS and Complaints Team and will form part of the overall complaints monitoring process. (See Appendix 6 Compliments, Comments and Local Resolution Form).

6.67 Details of resolved complaints at ward level can be forwarded by email in the absence of a Local Resolution Form in order to ensure overall complaints monitoring is achieved.

6.68 Where the complainant remains dissatisfied or the matter cannot be resolved quickly the complaint should be forwarded to the PALS and Complaints Team.

Concerns/Complaints Raised through Social Media

6.69 Any complaint that is raised via social media is identified by the Communications Department and will be referred to the PALS and Complaints Team who will process/liaise with the person raising the concern.

Complaint Investigation and Response

Action on Receipt by the Trust's PALS and Complaints Team

6.70 All complaints which are not resolved by front line staff, regardless of to whom they are addressed, will be passed immediately to the PALS and Complaints Team. Subject to ensuring the confidentiality of the service user, the PALS and Complaints Team will register the complaint, acknowledge it within three working days of receipt and allocate an individual reference number which will be used on all correspondence. The acknowledgement may be either verbally or in writing. If verbally, the Trust will keep a record of this. At the same time an offer to discuss the way the complaint is to be handled (most appropriate level of investigation) and the length of time this may take including the written response regarding the findings, will be made. The outcomes the complainant wishes to achieve will be identified. A reasonable timescale for responding to the complaint will be agreed with the complainant, which will depend on the complexity of the complaint. In less complex cases, the PALS and Complaints Team will aim to achieve a response within twenty-five working days. In those cases which are more complex or where staff integral to the complaint are for example, on annual leave or absent due to illness, the complainant will be advised of this and a longer timescale will be provided on an individual basis, but will be no later than six months from receipt of the complaint, unless there are good reasons for a longer period which must be communicated to the complainant. At all stages, the complainant must be informed if the agreed timescale cannot be complied with and an explanation given for this.

6.71 Striking the right balance between a timely response and one that is informed by comprehensive local action will provide the best response to the service user and the best opportunities for learning within the Trust.

Complaint Resolution

6.72 To achieve this, there are generally two approaches to the resolution of complaints in Mersey Care. The decision of which one to use will be dependant on the outcome the complainant wishes to achieve and the complexity of the issues raised. Once the Complaints and PALS team have an initial understanding of the above information they will decide on which approach should be used with the agreement of the complainant.

6.73 The choice of which approach to use to gain resolution will be based on the following:

a) the type of allegations/concerns that have been made and consequence experienced by the complainant/service user;
b) assessment of risk undertaken by the Complaints Lead/Complaints Co-ordinator. This will use the Trust's Risk Management Matrix which will include the likelihood of the concerns recurring elsewhere in the Trust;
c) outcome required by complainant.

6.74 For example:-
a) if the complainant requires increased understanding of their or their relative's illness, then a formal investigation may not help resolution. Whereas a meeting with staff to provide clarification may do so;
b) if the complainant requires information as to why their mother fell and sustained a fracture, it is only via the use of a formal investigation process that clarification of what happened will be gained.

6.75 The approaches used are:

Local Resolution

6.76 A Team Leader/Ward Manager/Modern Matron or their nominated deputies can undertake a variety of actions, that can be facilitated by PALS. This could include the following:-
a) meet with the complainant, service user and clinical staff;
b) facilitate a local discussion with staff to review care plan;
c) facilitate a meeting with staff and the complainant/service user;
d) make changes to care or service.

Formal Investigation

6.77 Mersey Care is committed to undertaking complaints investigations that consider the quality of care provided in a rigorous and challenging manner. When an investigator or Service Lead is involved in this process they must adopt a questioning approach that considers the appropriateness of the care provided based on the most current research/evidence available as opposed to custom and practice delivery. Whilst the investigation should be proportionate to the needs of the complainant and the risks associated with the issues raised, poor care of an inferior quality should never be tolerated.

6.78 A qualified complaints investigator will be nominated by the service manager and will:
a) use a Root Cause Analysis methodology to identify the causes and/or validity of the concerns raised;
b) analyse clinical records, checking for evidence regarding issues raised;
c) interview the complainant to clarify the desired outcomes and the complainant's factual account and views of what happened;
d) interview staff involved;
e) develop a chronology/tabular timeline;
f) identify deficits in care/service provision;
g) identify Root Causes/Contributory factors;
h) make recommendations that would help prevent recurrence / improve service (See section 12 *"Learning from Complaints and Improvements to Services*").

6.79 The investigator will recommend whether the complaint should be upheld, partially upheld, not upheld or unproven. This decision will be based on whether the investigator can find evidence that the issues/concerns raised by the complainant occurred.

Determining the Level/Type of Investigation

6.80 The Complaints Co-ordinator or Complaints Lead will risk assess all complaints processed through the department and grade in accordance with the seriousness and likelihood of recurrence. The level of investigation should be proportionate with the level of risk. The complaint may be re-graded during the investigation.

6.81 Where there are concerns or issues alluding to potential fraudulent matters it should be considered whether these will be reported to the Local Counter Fraud Specialist.

6.82 The Complaints Lead will ensure that all complaints are investigated in conjunction with the relevant Service Manager who will identify a member or members of staff to investigate the complaint. The investigation report must respond fully to each aspect of the complaint.

6.83 Early consideration should be given to appropriate measures that may prove effective for resolving a complaint. If for example the investigating officer feels a meeting would be useful in addressing the concerns, and the complainant agrees, this should be pursued. Consideration may also be given to the use of conciliation.

6.84 If deemed applicable, an apology should be given to the service user, relative/carer as soon after the event as possible, with assurance that a full explanation of what has gone wrong will be provided in writing, together with any learning/recommendations to prevent recurrence.

Use of Internal and External Investigators

6.85 The Complaints Lead, in conjunction with the Director of Patient Safety, will be responsible for deciding whether an independent professional, either external to the Directorate where the complaint originated, or independent of the Trust, should investigate any issues which are considered to be of a serious nature. Consideration must be given to any issues where there is high probability of litigation, insufficient expertise within the organisation, political considerations, allegations of assault or serious theft (which have previously been subject to a review to identify whether it is a safeguarding concern) or patterns that emerge during the complaint.

Partnership Arrangements

6.86 Complaints involving the actions of seconded staff will be discussed with the senior managers representing the Local Authority. The complaints investigation will generally be undertaken by the Trust under this policy, except in instances where it is necessary to invoke the Disciplinary Procedure of the Local Authority. Under these circumstances the method of investigation will be agreed with the Local Authority concerned. Similarly if the complaint relates to equipment or premises provided by the Local Authority, a discussion will take place to determine if the complaint should be investigated under the Local Authority's complaints procedure. Claims of

negligence relating to Local Authority seconded staff or premises will be subject to discussion with the appropriate Local Authority.

Medical Examination

6.87 In all cases of alleged ill treatment a medical examination will be required. If the issue is raised whilst the person is an in-patient, then the person's medical team or on call Doctor should be asked to do this. The intention is that assessment will be carried out within a four hour timescale or as soon as is practical. For those cases referred to the Police/Safeguarding Team, the type and timescales for medical assessment will be guided by their policies.

Other Actions

6.88 All relevant staff will be informed of the complaint, outlining the nature of the complaint and the investigation process. Letters informing staff that they are the subject of a complaint will be delivered, where practical/appropriate, in person by their Line Manager. Where appropriate all members of the service user's care team will be informed that a complaint has been received.

6.89 Service users who make a complaint and staff who are the subject of a complaint, will be advised of their right to be assisted by an advocate, friend or representative. Assistance should be supportive rather than representative. Investigation of a complaint will not be delayed because the question of representation is unresolved.

6.90 It may be appropriate to transfer a service user or member of staff involved in a complaint to another ward until the complaint has been investigated. Such action would be recommended by the appropriate Director, or, out of hours, the Trust's senior manager on call, following advice from other relevant senior colleagues including the service user's Responsible Clinician.

6.91 Where the Complaints Lead considers that an adverse incident has occurred and an incident form has not been completed, then the adverse incident manager must be informed.

6.92 Anyone making a complaint, and members of staff involved in a complaint, will usually be interviewed. The investigating officer carrying out the interview will take notes throughout for the purpose of informing the investigation. At the end of the interview the investigator will summarise the information obtained to check the accuracy of the notes with the interviewee. A copy of the notes can be provided on request by the interviewee.

6.93 Staff may be asked to provide a written statement. Guidance on producing a statement is provided at Appendix 6.

6.94 During the investigation the complainant (and any member of staff complained about) will be kept informed, as far as reasonably practicable, as to the progress of the investigation.

Action Following Completion of the Investigation - Written Response

6.95 Once the complaint issues raised have been fully addressed the Trust will send a written response to the complainant which provides:

a) an explanation of how the complaint has been considered; and
b) the conclusions reached in relation to the complaint, including any matters the Trust considers need remedial action;
c) confirmation as to whether the Trust is satisfied that any action needed as a result of the complaint has been taken or is proposed to be taken;
d) the response will request the complainant, if they are dissatisfied with the outcome, to contact the PALS and Complaints Team. This will enable the Trust to ensure all possible avenues of local resolution are explored;
e) details of the complainant's right to take their complaint to the Parliamentary and Health Service Ombudsman.

6.96 Everyone directly involved in a complaint will receive a written response. The service user's care team will be informed of the outcome on request to the PALS and Complaints Team.

6.97 Where it is not possible to complete an investigation and provide a written response to the complaint within six months a letter will go to the complainant explaining the delay by the PALS and Complaints Team. A written response will be provided as soon as reasonably practicable to do so.

Signatories to the Letter of Response

6.98 All complaints are risk assessed to determine the most appropriate level of investigation, (green, immediate resolution, Amber, fact finding to determine the cause, Red, formal investigation into issues where the facts are disputed).

6.99 The following guidelines should be observed:-

a) Red Complaints - Should be signed by the Chief Executive or their Deputy;
b) Amber Complaints - Can be signed by the above, Director of Patient Safety or Senior Manager in the Division;
c) Green Complaints/Concerns - Can be signed by all of the above and the Complaints Lead/Complaints Co-ordinator.

6.100 It is generally expected that all Red complaints will be signed by the Chief Executive or their Deputy. It is though accepted that there will be occasions when the leaders of the involved Division and Service Line, the Director of Patient Safety or other senior managers will be appropriate. The rationale will include:

a) the senior manager/division and service line lead has had direct contact with the complainant during the complaint investigation and there is a positive working relationship;
b) future discussion/explanation may be required from a senior manager who has direct accountability for making changes to services following the complaint.

6.101 Amber and Green complaint closure letters should be signed by the Director of Patient Safety, the Complaints Lead/Complaints Co-ordinator or a manager/clinician who has an understanding of the circumstances and who will be able to work with the complainant on providing more information to achieve closure if this is required.

Complaints of a Serious Nature

6.102 On occasion the Trust receives complaints which raise serious concerns about patient safety and may require urgent action or escalation.

6.103 On receipt of all complaints, the complaint details are shared with the relevant division's Deputy Chief Operating Officer by email to determine the level/type of investigation required. In addition, all complaints are discussed at the weekly safety huddles.

6.104 Where a complaint is raised of a serious nature, the Complaints Lead will alert the Deputy Chief Operating Officer as a matter of urgency. The Trust's Director of Patient Safety will also be informed to keep an overview of the progress of the complaint.

6.105 Where concerns of a serious nature are raised, the PALS and Complaints Team must establish whether an Adverse Incident form has been completed and whether an Incident Review will be undertaken. If an Incident Form has been completed, the PALS and Complaints Team will communicate with the complainant to explain how the findings of the investigation will be fed back to the complainant. In circumstances where for example, a service user has died or serious failings have been identified, the investigator's findings should be shared in person, and a senior manager/director from the division should attend to apologise on behalf of the Trust, in accordance with Duty of Candour.

Stage Following Letter of Response

6.106 If the complainant is dissatisfied following the letter of response, he/she has the right to take the matter directly to the Parliamentary and Health Service Ombudsman, but if the complainant is agreeable to the Trust making further efforts to seek resolution as a high priority then the Trust may, with the complainant's agreement, consider and implement any appropriate measure, with the involvement of:

a) the Director Patient Safety;
b) an independent conciliator;
c) an independent adviser/investigator.

6.107 If the complainant still remains dissatisfied following any further effort at local resolution they have the right to take their complaint to the Parliamentary and Health Service Ombudsman. Staff in the PALS and Complaints Team will ensure that all complainants are aware of this and provide guidance where necessary.

Out of Hours Procedure

6.108 Advice and support when a complaint is made out of office hours are available via the Service Manager on call.

Joint NHS and Multi-Agency Complaints

Underpinning Principles

6.109 Where complaints are multi-agency, for example, complaints relating to the care of an individual who is receiving shared care between the private sector and an NHS provider, or a complaint which relates jointly to NHS and Social Care provision, there is a statutory duty of collaboration on the agencies to provide a coordinated response.

6.110 There will be an initial discussion with the Complaint Lead and the other agency to decide how it will be managed. Both agencies will consider a joint meeting with the complainant if is felt this will facilitate a more effective outcome. Where it is felt appropriate, and with the agreement of the complainant, the use of an external conciliator will be considered. An inter-agency investigation will be conducted and the lead will be taken by the agency to which the greater part of the complaint relates.

6.111 Once the the lead organisation has been identified, as a minimum the Trust would expect:-

a) sending acknolwedgement letters to the complainant;
b) agreeing with the complainant and monitoring timescales;
c) sending a closure letter;
d) monitoring recommendations.

6.112 If the complainant does not want the details to be shared, they will be advised on the parts of the complaint the Trust is able to deal with, and informed that if they want to pursue the parts of the complaint that involves another organisation, they should approach that body.

6.113 Organisations involved will agree the investigation process:

a) Joint investigation;
b) Separate investigations with joint preparation of response.

with a

i) final meeting will be held between PALS and Complaints Teams to identify actions and agree how these will be achieved;
ii) letter of response written and agreed by both organisations;
iii) letter of response will be signed by lead organisation's nominated officer.

6.114 Where the complaint involves social care/social work staff seconded in to Mersey Care's employment this policy and procedure will be used.

Learning from Complaints and Improvements to Services

6.115 Where a complaint highlights deficiencies in treatment, care or services, the relevant manager must take action to prevent such events occurring in the future. Details of any action taken, or proposed action, must be submitted to the Complaints Lead.

6.116 The PALS and Complaints Team will log all actions taken in pursuit of actioning the recommendations onto the Trust's Risk Management database. The Complaints Team will request evidence of the actions taken by the service in carrying out the recommendations.

6.117 The Trust is committed to learning from all forms of service user/carer feedback. Complaints are a positive aid to informing and influencing service improvements.

6.118 Where appropriate, an action plan should be drawn up at each stage of the investigation of each complaint. This should be monitored by the service and updates provided to the Complaints Lead. Complainants will be offered the option of being provided with information on proposed service improvements.

6.119 Where learning can be across organisational boundaries the Complaints Lead will discuss the most appropriate method of sharing proposed service improvements with the Senior Manager with responsibility for complaints.

6.120 Learning will also be shared throughout the Trust by the use of Quality Practice Alerts and Oxford Model Events.

6.121 Following the recommendations from the Francis Report into the Mid Staffordshire enquiry, all complainants are advised that if their complaint is upheld the Trust will publish an anonymised summary of the complaint on the Trust website. They are given the option not to have their complaint included. Summaries are published every month.

6.122 Issues arising from complaints should be a standard agenda item for discussion at service team meetings.

6.123 In order to support learning from complaints, any identified risk will result in action being taken to mitigate the risks and prevent recurrence.

Sharing Safety Issues

6.124 If an investigator finds that the practices used to deliver care are substandard and put service users and staff at risk, then they must:-

a) Alert the Service Manager immediately - any risks identified should always be shared without delay. Waiting for the investigation to be completed can put service users/carers and staff at risk.

b) Alert the PALS and Complaints Team.

6.125 The Service Manager and Clinical Director will make decisions on how best to improve the safety of the services provided. Any remedial action required will be undertaken without delay. Ongoing risks will be entered onto each Division and Service Line's risk register which is used to monitor the appropriateness of management arrangement.

6.126 The PALS and Complaints Team, via the Senior Manager will inform the Director of Patient Safety who will monitor and, where appropriate, direct the action(s) to be taken. A Quality Practice Alert (QPA) can be sent out to inform other services of the issues raised and provide guidance regarding actions to be taken.

6.127 If the issues raised are not identified as requiring urgent dissemination then the PALS and Complaints Team will liaise with the service when the report is completed to identify how learning points will be shared across their service and where appropriate to other services in the Trust. The Trust's Oxford Model Events, and QPAs are mechanisms that can be used to do this.

6.128 NHS England can be informed and asked to share concerns with other Trusts if it is felt that the issues raised are not just locally based.

Infrastructure within Division and Service Lines

6.129 Each division and service line will monitor the number and type of complaints they receive on a monthly basis. They will be provided with monthly and quarterly qualitative and quantitative data by the PALS and Complaints Team with the aim of enabling the division and service lines to identify trends and implement remedial action to prevent a further reccurrence.

6.130 Each division and service line will have a specific forum within their meeting schedule when complaints are discussed and analysed. It is expected that:-

a) findings from the divisions and service lines analysis of trends are shared with staff through the division and service lines newsletter;
b) Oxford Model Events are facilitated to share trends with staff.

6.131 Each division and service line must have a senior manager who is responsible for the management and resolution of complaints within their service.

Reporting Arrangements

6.132 On an annual basis a complaints governance assurance paper will be prepared for the Trust Board by Complaints Lead. Quantitative and qualitative complaints information will be included in this report. The period covered by the report will be the twelve months ending with 31st March it will:

a) specify the number of complaints and concerns received;
b) specify the number of complaints the Trust decided were upheld, partially upheld, resolved, not upheld and un-proven;
c) specify the number of complaints which the Trust has been informed have been referred to the Health Service Ombudsman;
d) and summarise:-
    i) the subject matter of complaints and concerns that the Trust receive;.
    ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
    iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

6.133 A copy of this report must be sent as soon as practicable after the end of the reporting period to the relevant Clinical Commissioning Group. It must also be made available to any person on request.

6.134 Bi-annual reports will be submitted to Commissioners by the PALS and Complaints Team.

6.135 A bi-monthly report that provides details of compliance with this policy will be submitted to the Quality Assurance Committee by the Executive Director.

6.136 A weekly concerns log will be produced which included any complex complaints and is shared at the weekly quality surveillance meetings.

6.137 A quality report report provides an overview of complex complaints for the Executive Committee (or relevant forum)

Publicity

6.138 The organisation will ensure full information is provided about the Complaints Policy and Procedure in the form of leaflets and posters that are available throughout the Trust, including all service user and visitor areas. The information will be available in different styles and languages where this is appropriate.

6.139 Information relating to complaints is available on the Trust's website and includes the following information:

a) Complaints Policy and Procedure;
b) on how to make a complaint and how it will be handled;
c) useful contacts and links;
d) an electronic complaints form;
e) an electronic compliment form.

Compliments

6.140 Positive comments and letters of praise are welcomed by the Trust and will be fed back to the staff concerned. Copies of any documents of this nature should be forwarded to the PALS and Complaints Team in order to ensure this information is captured and included in the reports to the Board of Directors

Discriminatory Complaints

6.141 These are complaints made against an individual because of their gender, marital status, race, ethnic origin, colour, nationality, national origin, disability, sexuality, religion or age. Some complaints will be easily identifiable from the outset; others may come to light during the investigation process. The Trust will endeavour to identify any complaint which amounts to harassment and ensure that the person concerned is not put through the process of an investigation.

6.142 The Complaints Lead will discuss any possible discriminatory complaints with the Senior Manager with responsibility for complaints, and determine whether the complaint should be progressed through the complaints process. If a decision is taken not to progress the matter the complainant will be notified in writing and informed that harassment against any person will not be tolerated.

6.143 The relevant service manager will be contacted to provide support to the subject of the complaint.

6.144 Where a complaint contains discriminatory language, but does raise some legitimate issues about clinical practice, procedures and communication, these will be

investigated using the complaints process, without prejudice to the outcome of the investigation. The complainant will be advised that discriminatory language will not be tolerated.

Cultural/Gender Issues

6.145 It is recognised that people from different cultures may have diverse views on, why a complaint should be made, how it should be dealt with and how long it should take. It is possible that the cultural values of individuals could reduce a service user's/carer's ability/desire to use this policy.

6.146 The Trust also recognises that the gender of service users/carers may also have an effect on their tolerance and their ability to feel able to raise concerns with staff, particularly with those who are of a different gender than themselves. The Trust will undertake the following actions to ensure that the process is as accessible as possible to all groups of people:

a) monitor ethnicity of complainants to ensure that there is an equitable distribution, share information with the Ethnicity and Inclusion Team;
b) identify the involvement in complaints of all equality strands and recognise patterns relating to these, information will be shared with the Ethnicity and Inclusion Team for monitoring;
c) monitor the contents of complaints/concerns to identify if discrimination is part of the issues raised;
d) ensure that PAL's staff attend wards/departments regularly to listen and work with individuals to identify any problems they have;
e) liaise with advocacy services/support groups to ensure that they are aware of how complaints can be made and gain a further understanding of how the potential stresses of making a complaint can be reduced;
f) complaints and PALS staff will attend support group meetings on request to share information on the complaints process and gain information on the experience of their members;
g) discuss the potential effects of culture and gender on a person's ability to raise their concerns during staff training.

Vexatious and Habitual Complainants

6.147 It is acknowledged that there will be occasions when the prime motive for the complaint is vexatious or malicious. A further factor may be that complaining is an integral part of a service user's clinical presentation and they become habitual complainers.

6.148 Making judgements as to the validity or not of a complaint requires careful assessment and it is important to ensure that no material element of the complaint is overlooked, particularly in cases where complaining is known to be an integral aspect of the service user's psychopathological presentation. It is also important that the fundamental right of a service user to make a complaint is preserved and not compromised.

6.149 In exceptional cases, where the service user's care team consider that special handling arrangements are required, they should contact the Complaints Lead who will arrange for an assessment to take place and, in conjunction with the appropriate Director, will decide upon a subsequent course of action. This action will be planned individually, in the same way as any other aspect of the service user's care and treatment, and will form part of the service users care programme.

6.150 Any individual subject to special arrangements can still access the formal complaints procedure and safeguards will be introduced to ensure that this can take place.

Sensitivity/Support for Staff Involved in a Complaint

6.151 The investigation of a complaint involving allegations of malpractice, assault etc. can be stressful for staff involved. Sensitivity at this time is required. Managers must ensure they provide support to their staff. The Staff Support Services are also available to offer support to staff during this time.

6.152 When a complaint is received about a member of staff, the Complaints Co-ordintator should contact the line manager to ensure they are aware and can provide guidance on how to manage the situation. The Complaints Co-ordinator should ensure that the member of staff understands the process for receiving complaints and that the focus is on understanding what happened, learning, improving practice and not a laying blame. The Complaints Co-ordinator will ensure that the staff member receives feedback from their manager on the outcome as soon as possible. They will also refer any concerns regarding the staff member's well-being to the line manager.

6.153 When a complaint investigation takes place, staff are usually asked to prepare statements, attend interviews. The investigator will ensure that:

a) the staff member is given guidance as to what areas of information they will require from them in a timely manner, allowing time for staff to gain support from colleagues and/or Unions;
b) conduct interviews in a professional and supportive manner;
c) ensure staff know that the review is being conducted as part of a learning and safety culture as opposed to the apportioning of blame;
d) keep staff/managers up to date on review progress.

Storage Of Complaint Related Correspondence

6.154 All complaint casework will be retained electronically by the PALS and Complaints Team for a minimum of ten years. It is a requirement that complaint related correspondence should not, in any circumstances, be retained in the health record of the service user, subject to the need to record information, which is strictly relevant to their health in the service user's health records.

6.155 The Trust will at all times adhere to its legal obligation under the Data Protection Act 1998 (and associated legislation / guidance), so that it will not disclose an individual's personal information except in accordance with that Act.

7 CONSULTATION

7.1 Since ratification, this policy is reviewed and updated where appropriate at least every two years by the Director of Patient Safety and Complaints Lead. All Clinical Divisions have had the opportunity to review the policy.

8 TRAINING AND SUPPORT

8.1 The Trust will provide training to staff on dealing with complaints through the following:

a) mandatory training;
b) induction training;
c) Root Cause Analysis course;
d) local Resolution training;
e) Oxford Model events will be used to share learning from complaints;
f) e-learning.

Training for Complaint Investigations

8.2 The Root Cause Analysis course is for all staff who will undertake any form of formal complaint investigation/resolution process. The course includes:

a) writing barrier analysis;
b) formulation of a tabular timeline;
c) data analysis;
d) questioning skills/interview techniques;
e) reporting.

8.3 Places on the course can be booked via the Learning and Development Department who can supply more information. Further guidance on complaint investigations and report writing is also provided to the investigating officer and can be obtained from the PALS and Complaints Team.

9 MONITORING

9.1 9.1 For the purpose of monitoring the arrangements under the Trust's complaints process in accordance with the Local Authority Social Services and National Health Service Complaint (England) Regulations 2009, the Trust will maintain a record of the following matters:

a) each complaint received;
b) the subject matter and outcome of each complaint; and
c) whether a response has been sent to the complainant within the agreed timescale, or outside of the agreed/amended target date.

9.2 Managers will be expected to monitor complaints within their own services / departments and identify recurring themes, with a view to ensuring improvements where necessary. Summary details of all complaints ie concerns, outcomes and recommendations will be shared with the teams involved (without breaching service user or staff confidentiality) to facilitate learning.

9.3 Complaints information will be analysed both from an individual complaint and trends perspective to identify if discrimination is involved, this information will be shared with the Ethnicity and Inclusion Team.

9.4 The Trust PALS and Complaints Team will provide information regularly to ensure the complaints process is monitored and reviewed by each division and the Board of Directors and that lessons learned from complaints are used to improve the quality of the service.

9.5 Any changes to practice to improve customer satisfaction will be made and reported to the Quality Assurance Committee.

9.6 Complaints are also discussed at the weekly quality surveillance meeting attended by divisional managers. All new complaints received and all upheld complaints closed within the previous week are provided in order to share outcomes and identify any themes or trends. The complaints information is triangulated with information related to adverse incidents, on going disciplinary processes and safeguarding cases.

9.7 High risk compaints are reported on the weekly concerns log which is shared with the divisions.

10 EQUALITY ANALYSIS

Equality Impact Analysis - Relevance screening

A **screening** process can help judge relevance and provides a record of both the **process** and **decision.** Screening should be a short exercise that determines relevance for all new and revised strategies, policies, services and functions.

Completed at the earliest opportunity it will help to determine:

- the relevance of proposals and decisions to equality, and
- whether or not it is necessary to carry out a full equality impact analysis

Division/Programme: Corporate	**Service area/Project: Complaints and PALS**
Lead person: Janine Betley	**Date: 19.2.20**

1. Title: Management of Complaints and Concerns

Is this a:

Change to an existing Strategy / Policy	X	**New Strategy/policy**	
Change to Service(s) / Function (s)		**Other**	

If other, please specify:

2. Summary of the intended outcome of the strategy, policy, Service(s) for function(s) being assessed. Please also detail if this links to a corporate equality objective:

a) To provide complainants with timely resolution of their concerns and complaints.
b) To provide a simple, efficient and open process.
c) To empower all staff, where appropriate, with the support of Patient Advice and Liaison
Service (PALS) and other advocacy services, to deal with concerns and complaints informally at the point of service delivery.
d) To ensure fairness to staff and complainants alike and to ensure confidentiality.
e) To ensure an honest approach that is thorough and aimed at satisfying the complainant's concerns. It is important that no individual must be inhibited or disadvantaged when making complaints and that there is confidence that these will be given proper and speedy consideration.
f) To resolve complaints, where possible, as they arise.
g) To increase service users/carer's trust in Mersey Care NHS Foundation Trust.
h) To recognise that suggestions, constructive criticism and complaints can be valuable aids in developing and maintaining standards of care.
i) To learn lessons from complaints and use them positively to improve services.

The policy links to the following corporate equality objective:

- to improve year on year the reported patient / service user experience for protected groups.

3. Who will be affected?

This policy complies with the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009 and relates to all complaints about health and social care services provided/managed by the Trust.

All service users, relatives, carers or any person who has been affected by a decision, action or omission of the Trust has the right to make full use of the Mersey Care NHS Foundation Trust complaints/concerns procedure.

This policy does not cover complaints made by:-
a) Current or past employees about their employment.
b) Persons or companies engaged by or contracted to the Trust.
c) Purchasers of Trust services

4. Relevance to equality

All the Trusts policies, projects, strategies, services and major developments affect patients, carers, service users, employees or the wider community. These will also have a greater or lesser relevance to equality and diversity.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation, pregnancy and maternity and any other relevant characteristics (for example socio-economic status, social class, income, military veterans, unemployment, residential location or family background and education or skills levels).

Questions	Yes	No
Is there any indication or evidence (including from consultation with relevant groups) that different groups have different needs, experiences, issues and priorities in relation to the proposed policy or proposal?		x
Is there potential for or evidence that the proposed policy or proposal will affect different population groups differently (including possibly discriminating against certain groups)?		x
Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the policy or proposal?		x
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?		x
Could the proposal affect our workforce or employment practices?		x

Does it relate to an area of work with known inequalities?		x
Is there a greater impact on any protected group (that is not consistent with the policy aims?)		x
Is there potential for or evidence that the proposed policy or proposal will discriminate or not promote equality of opportunity or promote good relations between different groups?		x
Is there an opportunity to further advance and promote equality?		x
Is there a communications issue?		x
Is there a sensitivity issue regarding the needs of different cultures?	x	
Is there an impact on the Trusts ability to achieve national targets or to satisfy inspection body standards?		x
Is there a risk of loss of reputation, service restriction or loss of confidence in the Trust?	x	

If you have answered **no** to the questions above please complete **section 6**
If you have answered **yes** to one or more of the above and;

- Believe that the policy or proposal is equality relevant, please complete **section 5** and carry out a full Equality Impact Analysis
- Believe you have already considered the impact of your proposal on equality and diversity and there is little or no relevance, please go to **section 4**
- Believe that whilst the policy or proposal is equality relevant, a full Equality Impact Analysis is not necessary at this stage, please go to **section 4**

4. Considering the impact on equality and diversity
If you have answered yes to one or more of the screening questions and believe that the policy or proposal is not equality relevant or that a full equality impact analysis is not required at this stage, please provide specific details for all three areas below:
• **How have you considered equality and diversity?** (**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected) Ensures access to interpreting and translation services is available, complaints leaflets readily available in the top ten languages and an easy read version and other formats as required. We equality monitor complaints and review and analyse this on a regular basis. Have accessible systems for raising complaints.
• **Key findings** **(think about** any potential positive and negative impact on the different protected characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another)

The complaints are monitored by protected characteristics, the results of monitoring activity has not identified any key findings.
• **Actions** **(think about** how you will promote positive impact and remove or reduce negative impact) **No issues identified**

5. If the policy or proposal is equality relevant, you will need to carry out a full Equality Impact Analysis	
Date to scope and plan your equality impact analysis:	
Date to complete your equality impact analysis:	
Lead person for your equality impact analysis: (Include name and job title)	<Name> <Job Title>

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Joanne Bull	Associate Director Patient Safety	19/02/2020

For use by the Equality Impact Analysis Sub Group:

Governance, ownership and approval State here which members of the Equality Impact Analysis Sub Group Quality assured the actions and outcomes from the equality impact analysis relevance screening.		
Name	Job Title	Date
Andrea Smith	Interim Equality & Inclusion Manager	19.2.20

Appendix 1

Guidance Notes for Complaint Investigation

The Role of the Investigating Officer

To provide a fair, unbiased consideration of the complaint through:

- Sensitive and thorough interviewing of the complainant, staff and other people relevant to the complaint.
- Working to tight timescales – a timescale for the provision of a response to the complaint is to be agreed with the complainant at the outset for the report or update. It must be completed in the timescale provided by the PALS and Complaints Team or agreed with the complainant. In any case it must be completed in a timescale less than six months unless there is a good reason for a longer period which must be explained to the complainant.
- Writing a clear investigation report in plain language.
- Liaising with the complainant and the PALS and Complaints Team as appropriate.
- Identifying solutions and recommending courses of action to resolve problems and improve services.

Good Practice

- Work closely with the PALS and Complaints Team and the Service Manager on all aspects of the investigation and report writing, including ensuring any reasons for delay are shared so the complainant can be kept informed of the progress.
- If you are aware at the start of your investigation that there will be a delay for any reason (e.g. absence of a key person, complexity of issues raised) immediately notify the PALS and Complaints Team so they can renegotiate a new target closure date with the complainant.
- If appropriate, consider visiting the service area complained about to check normal practice.
- Ensure you adhere to all relevant legislation (e.g. Data Protection Act, Human Rights Act, Health and Safety Act).

Meeting the Complainant

This meeting should explain the investigation procedure and:-

- Clarify the complaint and all its individual parts.
- Obtain as detailed an account as possible of the facts of the complaint.
- Ask what the complainant wants in terms of solution or outcome.
- Remember to check beforehand whether the complainant needs support of any kind e.g. an advocate.
- Allow the complainant to explain how they feel. Accept how they feel – acceptance does not mean agreement.
- Consider whether the complaint could be resolved without further investigation. Discuss this with the complainant to seek agreement, or consider alternative possible resolution by offering a meeting with those involved. If the complainant agrees, immediately notify the PALS and Complaints Team. Arrange meeting and ensure a written record including any agreed resolution/actions. A copy of which must be sent to the PALS and Complaints Team..

Appendix 2

Guidance Notes for Report Writing

1 Complaint details

1.1 Give a brief precis of the complaint – this will help ensure that the investigator addresses all the issues which have been raised

2 Fact finding process

2.1 Interview the client, any staff involved and any witnesses (clients, staff, others). Make a written record of the interview, which must be shared with the interviewee who must be given the opportunity to correct any factual inaccuracies.

2.2 The investigator must ask anyone involved whether they did or said what was alleged.

2.3 Obtain copies of any relevant paperwork, e.g. clinical notes, e-mails, incident reports. These must be included as appendices to the report.

2.4 If the complaint relates to property, copies of any relevant documents should be included. The investigator should ascertain the age, condition and cost of the property, and if possible obtain proof of purchase or receipt. Information must also include when the property was last seen and by whom.

2.5 Where an injury has occurred, the report must include the medical record of the injury, including any medical opinion / GP report or comments.

2.6 Provide a chronological account with details of the facts that are established,

3 Analysis/conclusions

3.1 The outcome should be based on the facts which have been established during the investigation.

3.2 If the investigator has determined conflicting facts, then he/she should say why a factual account has been accepted and the other account rejected. In cases where no other evidence is available and two different accounts are provided, the outcome will be ‘not proven’.

3.3 If any additional information such as mental history, mental state etc are included in the report these should be added at the end, and made clear as such.

3.4 The investigator should advise whether they find the complaint upheld, partially upheld, not upheld or not proven.

4 Recommendations/concerns

4.1 Recommendations relating to the complaint should be detailed in the report to ensure that actions are implemented to improve service delivery and ensure that such issues do not recurr.

5 Appendices

5.1 Notes of interviews held.

5.2 Copies of all relevant documents considered for the purposes of the complaint.

Appendix 3

Guidance on Producing a Written Statement

1. When a complaint has occurred within a Directorate, the Complaints Lead may request witness statements from members of staff involved. These statements will then be included as part of the complaints report.
2. When preparing a statement during an investigation the following should be included:
   - Full name of member of staff, the complaint reference number and the service user's name the statement refers to on each sheet of paper.
   - Post held at the time of the complaint and at the time of making the statement, if different.
   - A Chronological account of the member of staff's involvement with the individual.
   - Where applicable commentary on why decisions were made by the member of staff and/or a course of treatment or plan of support implemented.
3. Statements should be factual: hearsay or second/third hand information should not be included unless necessary.
4. Statements should be written in the first person.
5. The date, time and place (if appropriate) of the incident that led to the complaint.
6. The names (if appropriate of other persons involved or who witnessed the incident
7. A full account of what happened and what was observed (if appropriate) in relation to other persons involved.
8. Any pertinent information relating to events leading up to the incident.
9. All statements should be signed.
10. Statements should be typed if possible and saved electronically.
11. When the member of staff has had extensive involvement with an individual, it would be impractical to transcribe every detail from the case notes for inclusion in the statement. However a description of key events when the member of staff was either directly involved or witness to the event, should be included.
12. Any facts, which the member of staff in their professional judgement, feels to be relevant to the incident, should be included.
13. Staff should retain a copy of their own statement.
14. Extracts from clinical records can be used as supportive information.
15. The Trust embraces a fair and just culture and the complaint does not aim to lay blame at any individual. Staff may find it supportive to bring with them a colleague or Staff Side representative.
16. Staff may seek advice from senior staff that may point out spelling or grammar mistakes, discrepancies, omissions or contradictions. However, instruction cannot be given to change the report, as responsibility for the content of the statements, must lie with the author.
17. If further guidance on producing a statement is required, please contact the relevant Service Manager or their deputy.

Appendix 4

Guidance for Handling Vexatious or Habitual Complainants

Purpose of the guidance

Special handling arrangements should only be used after all reasonable measures have been taken to try to resolve complaints following the NHS complaints procedure.

In determining arrangements for handling habitual or vexatious complaints the Trust must consider:

- Whether the NHS complaints procedure and the Trust's complaints policy have been correctly implemented and that no aspect of a complaint has been overlooked or inadequately addressed. In doing so it should be appreciated that even habitual or vexatious complainants may raise substantive concerns and issues which, even if unable to be resolved, should be approached rationally and sympathetically.

- Whether it can identify the point at which a complainant has become habitual or vexatious.

Definition of a Habitual or Vexatious Complainant

Complainants (or anyone acting on their behalf) may be deemed to be habitual or vexatious where previous or current contact with them shows that they partially meet at least two, or are in serious breach of at least one, of the following: -

a) Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.

b) Seek to prolong contact by changing the substance of a complaint or continually raising new issues and questions whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints).

c) Are unwilling to accept documented evidence of treatment given as being factual e.g. drug records, GP records, nursing notes.

d) Deny receipt of an adequate response despite evidence of correspondence specifically answering their questions.

e) Do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

f) Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Trust staff and, where appropriate, independent advocacy, to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

g) 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 is a 'trivial' matter can be subjective and careful judgement must be used in applying this criteria).

h) Have, in the course of addressing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, E-mail or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section using judgement based on the specific circumstances of each individual case).

i) Are known to have recorded meetings or face to face/telephone conversations without the prior knowledge and consent of the other parties involved.

j) Display unreasonable demands or 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 practice).

k) Have threatened or used actual physical violence towards staff or their families or associates at any time - this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. (All such incidents should be documented in line with the Trust's procedures related to the management of violence and abuse).

l) Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this.) Staff should document all incidents of harassment in line with the Zero Tolerance Procedures, by completing an incident form.

Procedure for Dealing with Habitual or Vexatious Complainants

Careful judgement and discretion must be used in applying criteria to identify habitual and vexatious complainants and to decide what action to take in specific cases. This should only be implemented following agreement by all concerned, including the Complaints Lead, Senior Manager in the Division with responsibility for complaints, the relevant Consultant and the Director of Patient Safety.

The course of action must be agreed by the above and put in writing to the complainant, including reasons why the complainant has been classified as habitual or vexatious, and signed by the Chief Executive. The letter should be copied for the information of those involved in the complaint and a record should be kept by the Service Manager of the reasons why a complainant has been classified as habitual or vexatious and the actions taken.

Habitual or vexatious complainants may be dealt with in one or more of the following ways:

Decline further contact with the complainant, either in person, by telephone, letter or electronically (or any combination of these) whilst ensuring that one form of contact is maintained. Alternatively, further contact could be restricted to liaison through a third party.

Notify complainants, in writing, that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint, that there is nothing more to add and continuing contact on the matter will serve no useful purpose. Complainants should be notified that correspondence is at an end and that further communications will be noted but not answered.

Inform complainants that in extreme circumstances, the Trust reserves the right to refer unreasonable or vexatious to solicitors and, if appropriate, the police.

In certain circumstances consideration can be given to the possibility of referring the matter to the Health Service Ombudsman under Section 10 of the Health Service Commissioners Act 1993.

Withdrawing Habitual or Vexatious Status

Once complainants have been determined as habitual or vexatious there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedure would appear appropriate. Discretion should be used in recommending that this status be withdrawn as appropriate.

Where this appears to be the case, discussion will be held with the Senior Manager with responsibility for complaints. Subject to their approval, normal contact with complainants of the NHS complaints procedure will then be resumed.

Appeal

If a complainant, or someone with authority to act on their behalf, disagrees with the decision to deem him/her habitual or vexatious, they may put their reasons in writing and address them to the Trust Chief Executive. Upon receipt of such a communication the Chief Executive will consider it as a request by the complainant for withdrawal of habitual or vexatious status. The Chief Executive will reconsider the decision to impose such status on the complainant and will do so in consultation with the Director of Patient Safety and the senior manager in the Division, to deem the complainant habitual or vexatious.

Appendix 5

Feedback Methods

There is no way of categorising which feedback method should be allocated to complaints. Every complaint must be judged on its' merit, taking into account not only the issues being raised but also the person(s) who are raising them and the persons who are best placed to respond.

Direct contact:
An issue raised in a ward environment which can easily be resolved by the staff involved in the care of the service user should be addressed by the person receiving the complaint, or if this is not possible, by their manager. The outcomes would be explained to the person raising the issue either in person, by telephone or if necessary, by letter (sent from the service or the Complaint Lead). Provided that the issue is resolved to the person's satisfaction, the issue does not need to be taken any further. A local form must be completed detailing the issue, how it was resolved and any further action which needs to be taken. The form should then be emailed to the PALS and Complaints Team for recording. Details of resolved complaints at ward level can be forwarded by e mail in the absence of a Local Resolution Form in order to ensure overall complaints monitoring is achieved

For complaints which are deemed appropriate for level 2 or 3 investigations, the following feedback methods should be considered and an appropriate method agreed (between the PALS and Complaints Team, the service and the complainant):

A written response:
Formal investigations only will be signed by the Chief Executive. All other investigations will be signed by the Complaints Lead or a Senior Manager. The report would be reviewed and accepted by the service and PALS and Complaints Team and a letter drafted from its contents.

Meeting with staff:
Appropriate staff can include the following:

- Service Manager or appropriate deputy.
- Modern Matron.
- Appropriate manager.
- Clinicians.
- Complaints staff (usually the complaints officer co-ordinating the case) but can also be the Complaint Lead, Complaints Co-ordinator, Director of Patient Safety, Director or Chief Executive
- The investigating officer.
- Anyone else deemed to be appropriate in view of the issues being discussed.

Such a meeting can be utilised at any level during the process but it is anticipated that meetings with senior staff will be more appropriate at level 2 or 3, following an investigation. A summary of the meeting should be sent to the complainant thereafter with a covering letter from either the PALS and Complaints Team or Chief Executive.

Provision of report:
On some occasions, it may be appropriate to provide the complainant with a copy of the investigative report, particularly when an independent report has been obtained or the report is complex or sensitive. Investigators should be informed of this possibility from the outset.

Easy read format:
The response letters are shared with the service user either by the PALS officer, investigating officer, advocate or ward manager and the service user is provided a summary of the response in an easy read format where appropriate.

Appendix 6

Compliment, Concerns and Local Resolution Form

Date			
Name of person making report			
Area where concern is related to (e.g. ward, community or other area)			
Name of complainant and service user involved			
Contact details			
Location of issue/concern/ compliment			
Type of event (please tick box)	Compliment	Concern	Local Issue Raised
Please give a brief outline of the event			
If this was a verbal complaint has it been locally resolved		Yes	No
Please explain what action was taken			
Please email the completed form to palsandcomplaints@merseycare.nhs.uk			

A copy of this form should also be retained on site

Appendix 7

Summary of What You Should Do to Resolve a Concern

- Listen, but don't act defensively ... let them talk.
- Provide a private and quiet area for discussions.
- Ask the service user/carer what solutions he or she may propose.
- Tell the service user/carer you are hearing what they are saying, and you will speak to somebody in authority who may be able to address his or her concerns.
- Provide explanation if there is one, but only once you have listened to all the issues raised.
- Don't cite policy unless policy allows you to be flexible in addressing the concern.
- If the concern needs to be brought to another level, don't tell the service user/carer to do that ... YOU do that (and bring that person, if possible to them).
- Together, after speaking with the service user/carer, you can develop collaboratively proposed solutions to address the person's problem. For example, if the person has a problem about the way a member of staff treated them, then apologise on behalf of the ward/team and privately, share the concerns with the staff in question.
- Clarify the service user's/carer's response to your interventions.
- Keep a log of all concerns/complaints raised to see if there are any patterns. If there are adjust policy/systems/processes to prevent further similar occurrences.
- All staff should be able and willing to work with service users and carers through the initial stages of resolution.
- Provide information on PALS and the complaint process if you feel it cannot be resolved locally.
- Always share any change in practices with service users/ carers straight away and visibly.