

GOP04

Complaint Handling Policy

Contents

Sections	Page
1.0 Policy Statement	2
2.0 Definitions	2
3.0 Accountabilities	2-4
4.0 Policy Detail	5-33
5.0 Financial Risk Assessment	33
6.0 Equality Impact Assessment	33
7.0 Maintenance	33
8.0 Communication and Training	33
9.0 Audit Process	34-35
10.0 References	35

Appendices

Appendix 1: Formal Complaint Investigation Toolkit	36 – 65
Appendix 2: Complaint Monitoring Panel Terms of Reference	66 – 67
Appendix 3: Complaint Monitoring Panel Quality Assurance Matrix	68-69

1.0 Policy Statement (Purpose / Objectives of the policy)

In 2021 Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust were chosen as members of the early adopter group of NHS organisations piloting the new NHS Complaint Standards which came into full effect in December 2022 following a period of review.

Supported by the Parliamentary Health Service Ombudsman (PHSO) our involvement in these pilots was essential in ensuring that the standards worked in practice and helped to build an effective pathway supporting and strengthening how our organisation approaches complaints and learns from them.

The Complaint Standards are based on 'My Expectations',

[My expectations for raising concerns and complaints | Parliamentary and Health Service Ombudsman \(PHSO\)](#)

Which sets out what patients expect to see when they make a complaint about health or social care services.

There are four practice standards – welcoming complaints in a positive way, being thorough and fair, giving fair and accountable responses and promoting a just and learning culture.

As pilot organisations we completed a self- assessment agreed with the PHSO which confirmed the areas for development and created the individualised personal approach to the pilot.

With the pilot and review period now complete we are now recommending formal adoption of the Model Complaint Handling procedure and associated guidance. This procedure will replace the existing policy for the management of Complaints/Concerns.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

We use the following definitions in line with the PHSO Complaint Standards:

Feedback: an opinion, whether invited or spontaneous, that can be positive, negative or neutral.

Complaint: an expression of dissatisfaction - either spoken or written - that requires a response. It can be about an act, omission or decision made, or the standard of service provided.

These definitions should be considered within the context of 'no issue is too big to be a concern and no issue is too small to be a complaint'.

3.0 Accountabilities

The Group Chief Executive has overall accountability for complaints.

The Group Chief Executive is made aware of significant issues and approves and signs the final responses to formal complaints and action taken as a result of the issues raised.

3.1 Chief Nursing Officer

The Chief Nursing Officer for each organisation has overall responsibility for the Patient Relations Team (Complaints and Patient Advice and Liaison Service).

Line management responsibility is held by the Associate Director – Patient Relations.

3.2 Directors – Nursing / Medical and Chief Operating Officer

Will ensure that the policy and associated procedures are followed throughout their lines of responsibility and that lessons are learned acted upon and shared with all appropriate staff.

The Chief Medical Officer is responsible for ensuring that independent investigations are commissioned where complaints involving serious concerns are received where these are aligned to medical care.

3.3 Matrons, Ward & Department Managers/Supervisors

Ensure staff receive training on how to deliver effective customer care and handle difficult situations in order to minimise the number of concerns and formal complaints received and to ensure local resolution of concerns and complaints takes place wherever possible.

Ensure staff are aware of what action to take if a patient, relative, carer or visitor wishes to raise a concern or make a formal complaint to the Trust

Contribute towards the completion of a Reflective Shoes Action Plan for all complaints where relevant and if appointed as a Complaint Officer that the correct process is followed and adhered to.

Ensure appropriate action is taken to ensure service improvement and minimise the risk of recurrence of issues raised in a concern or complaint.

Ensure complainants are not treated differently as a result of raising a concern or making a complaint.

3.4 Head/Deputy Head of Patient Relations (Complaints and PALS)

Is the designated manager for formal complaints as required by the regulations and as such has day to day responsibility for the Patient Relations (Complaints & PALS) Team.

Assesses the severity and significance of the issues contained in complaints and concerns and escalates information appropriately.

Ensures the Patient Relations Department is managed efficiently.

Ensures the administration of the Complaints process is carried out appropriately and in a timely fashion, including dealing with enquiries and concerns and responding to formal complaints

Ensures formal written responses to complaints are of an acceptable standard.

Ensures all queries around the legalities of dealing with complaints are dealt with appropriately.

Ensures the Patient Relations Team liaises with appropriate managers in order to initiate and monitor a thorough investigation of matters raised.

Provides advice where appropriate to services in the formation and development of action plans

3.5 Patient Relations Team (Complaints)

The Patient Relations Team provides day-to-day support to the Head/Deputy Head of Patient Relations and has the responsibility to ensure that:

- All complaints are registered on the database (Datix).
- Relevant paperwork and databases are up to date and available for the Head of Patient Relations.
- Acknowledgement letters are sent to complainants within the specified time scale.
- Complaints are sent for investigation to the appropriate Divisional / Directorate Team.
- The complaints process is carried out appropriately, offering support to complainants, the Head of Patient Relations and Divisional Teams where required.

3.6 Patient Relations Team (PALs)

The PALS function is available and accessible to anyone receiving healthcare within the Trust and will be dealt with via the integrated Complaints and PALS team now known as the Patient Relations Team. Issues brought to the Trust which relate to services of other NHS Trusts/organisations will be signposted to the relevant health contact in the appropriate organisation.

The Patient Relations Officers will clarify with patients, relatives, carers and visitors to the Trust, their role and limitations.

They provide the following services:

- Listen to concerns, suggestions or queries
- Provide information on NHS services
- Advise and support patients, carers, relatives and visitors
- Help to sort problems promptly on patient's behalf
- Support patients, relatives, carers and visitors to access the formal complaints process
- Support patients, relatives, carers and visitors to access independent advocacy
- Provide information about and support local patient and public involvement activity
- Act as an interface between Walsall Healthcare NHS Trust and NHS Walsall.
- Provide support and assistance to staff when dealing with difficult situations
- Identify trends and gaps in services
- Provides monthly reports to the Divisional Quality Teams, highlighting themes, types of concerns and concerns by area.

NHS Complaint Standards

Model Complaint Handling Procedure for providers of NHS services in England

December 2022



Contents

1. Introduction	3
2. How to use the model procedure	3
3. Where do we go if we need more information?	3
Model Complaint Handling Procedure	4
4. Who can make a complaint	7
5. Timescale for making a complaint	7
6. Complaints and other procedures	8
7. Confidentiality of complaints	9
8. How we handle complaints	9
9. Complaints involving multiple organisations	16
10. Monitoring, demonstrating learning and data recording	16
11. Complaining to the commissioner of our service	17
Annex	19

1. Introduction

- 1.1 This Model Complaint Handling Procedure is one of a number of supportive tools and guidance modules designed to assist NHS organisations (and independent organisations who provide NHS services) in England in embedding the [NHS Complaint Standards](#) in practice.
- 1.2 As with the Standards themselves, the model procedure puts existing good practice in one place, providing a more consistent approach to complaints handling across the NHS in England. The procedure also follows the relevant requirements as given in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (referred to in this guidance as the 2009 and 2014 Regulations).
- 1.3 The model procedure is aimed at supporting organisations to deliver [what service users say they want](#) when they make a complaint.

2. How to use the model procedure

- 2.1 The model procedure can be used as a template by organisations who do not currently have a complaint procedure in place or wish to refresh what they currently do. It can also be used as a comparison model to help organisations evaluate their current procedures. This will help them work towards meeting the expectations set out in the Standards and the requirements of the Regulations.
- 2.2 The model procedure is not mandatory. It can be tailored to work in the diverse operating procedures that exist across the NHS in England from front line primary care services to secondary care services. Each organisation is free to develop its own policy and procedures that best reflect its service (including size and how it is structured) while using the model procedure as a benchmark to ensure consistency in practice.

Organisations can also find further help and support for people working in or for the NHS in England to deliver the Standards via the [Good complaint handling guidance modules](#).

3. Where do we go if we need more information?

- 3.1 You will find all the available Complaint Standards materials on the [Ombudsman's website](#).
- 3.2 If you have any questions or feedback on this document, or any of the NHS Complaint Standards materials please contact the Ombudsman's Liaison Team liaisonmanagers@ombudsman.org.uk. You can also contact the Liaison Team if you require any assistance in embedding the Standards in your organisation.

Model Complaint Handling Procedure

1. Introduction

- 1.1 Co-developed with organisations from across the health sector and advocacy and advice services the [NHS Complaint Standards](#) provide a single vision of good practice for complaint handling. This complaint handling procedure describes how we will put into practice the core expectations given in the Standards.
- 1.2 This procedure sets out how we handle complaints and the standards we will follow. This procedure follows the relevant requirements in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations).
- 1.3 It should be read in conjunction with the more [detailed guidance modules](#) available on the Parliamentary and Health Service Ombudsman's website.
- 1.4 The Complaint Standards and this procedure also support delivery of our Trust values of Respect, Compassion, Professionalism and Teamwork.

2. Accountability, roles and responsibilities

- 2.1 Overall responsibility and accountability for management of complaints lies with the 'Responsible person' (as defined by the 2009 Regulations). In our organisation this is the **Group Chief Executive**.
- 2.2 We have processes in place to make sure that the responsible person, **Associate Director – Patient Relations, the Head/Deputy Head of Patient Relations** regularly review insight from the complaints we receive, alongside other forms of feedback on our care and service. They will make sure action is taken on learning arising from complaints so that improvements are made to our service.

2.3 They demonstrate this by:

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

Complaints management, roles, and responsibilities

2.4 Our Complaints Manager (as defined by the 2009 Regulation) is the **Associate Director – Patient Relations**. They are responsible for managing this procedure and for overseeing the handling and consideration of any complaints we receive.

2.5 The 2009 Regulations allow us to delegate the relevant functions of the Responsible Person and Complaints Manager to our staff where appropriate. We do this to ensure we can provide an efficient and responsive service. The day-to-day delivery of the service is overseen by the **Head/Deputy Head of Patient Relations with support from the Senior Patient Relations Officers**. Divisional / Directorate support is provided by the Divisional / Directorate “Team of Three” (TOT) in terms of the allocation of complaint handlers and the validation of final response letters.

3. Identifying a complaint

Everyday conversations with our users

3.1 Our staff speak to people who use our service every day. This can often raise issues, requests for a service, questions or worries that our staff can help with immediately. We encourage people to discuss any issues they have with our staff, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

When people want to make a complaint

3.2 We recognise that we cannot always resolve issues as they arise and that sometimes people will want to make a complaint. The NHS Complaint Standards define a complaint as: an expression of dissatisfaction, either spoken or written, that requires a response. It can be about:

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

Feedback and complaints

3.3 People may want to provide feedback instead of making a complaint. In line with [DHSC's NHS Complaints Guidance](#) people can provide feedback, make a complaint, or do both. Feedback can be an expression of dissatisfaction (as well as positive feedback) but is normally given without wanting to receive a response or make a complaint.

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

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

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

3.7 Complaints can be made to us:

Walsall Healthcare NHS Trust

- in person
- by telephone: 01922 656463
- in writing:

Patient Relations Team
Route 136
Walsall Healthcare NHS Trust
Moat Road
Walsall
WS2 9PS

- by email: Pals.officer@nhs.net

- Via the online portal situated on the Trust webpage

The Royal Wolverhampton NHS Trust

- in person
- by telephone: 01902 695368
- in writing:

**Patient Experience Team
New Cross Hospital
Zone C, location C2
Wolverhampton Road
Wolverhampton
WV10 0QP**

- by email: rwh-tr.complaints@nhs.net

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

- 3.8** We will acknowledge a complaint within three working days of receiving it. This can be done in writing, electronically or verbally.
- 3.9** We may receive an anonymous or general complaint that would not meet the criteria for who can complain (see below). In this case we would normally take a closer look into the matter to identify if there is any learning for our organisation unless there is a reason not to.

4. Who can make a complaint

- 4.1** As set out in the 2009 Regulations, any person may make a complaint to us if they have received or are receiving care and services from our organisation. A person may also complain to us if they are not in direct receipt of our care or services but are affected, or likely to be affected by, any action, inaction, or decision by our organisation.
- 4.2** If the person affected does not wish to deal with the complaint themselves, they can appoint a representative to raise the complaint on their behalf. There is no restriction on who may represent the person affected. However, they will need to provide us with their consent for their representative to raise and discuss the complaint with us and to see their personal information (including any relevant medical records).

- 4.3** If the person affected has died, is a child or is otherwise unable to complain because of physical or mental incapacity, a representative may make the complaint on their behalf. There is no restriction on who may act as representative but there may be restrictions on the type of information, we may be able to share with them. We will explain this when we first look at the complaint.
- 4.4** If a complaint is brought on behalf of a child, we will need to be satisfied that there are reasonable grounds for a representative bringing the complaint rather than the child. If we are not satisfied, we will share our reasons with the representative in writing.
- 4.5** If at any time we see that a representative is not acting in the best interests of the person affected we will assess whether we should stop our consideration of the complaint. If we do this, we will share our reasons with the representative in writing. In such circumstances we will advise the representative that they may complain to the Parliamentary and Health Service Ombudsman if they are unhappy with our decision.

5. Timescale for making a complaint

- 5.1** Complaints must be made to us within 12 months of the date the incident being complained about happened or the date the person raising the complaint found out about it, whichever is the later date.
- 5.2** If a complaint is made to us after that 12-month deadline, we will consider it if:
- we believe there were good reasons for not making the complaint before the deadline, and
 - it is still possible to properly consider the complaint.
- 5.3** If we do not see a good reason for the delay or we think it is not possible to properly consider the complaint (or any part of it) we will write to the person making the complaint to explain this. We will also explain that, if they are dissatisfied with that decision, they can complain to the Parliamentary and Health Service Ombudsman.

6. Complaints and other procedures

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

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

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

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

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

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

- The individual requests or agrees to a delay
- There is a formal request for a pause in the complaint process from the police, a coroner or a judge.

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

6.6 If we consider that a staff member should be subject to remedial or disciplinary procedures or referral to a health professional regulator, we will advise the person raising the complaint. We will share as much information with them as we can while complying with data protection legislation.

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

- 6.7** If the person dealing with the complaint identifies at any time that anyone involved in the complaint may have experienced, or be at risk of experiencing, harm, or abuse then they will discuss the matter with relevant colleagues and initiate our safeguarding procedure by contacting the Trust safeguarding lead.

7. Confidentiality of complaints

- 7.1** We will maintain confidentiality and protect privacy throughout the complaints process in accordance with the UK General Protection Data Regulation and Data Protection Act 2018. We will only collect and disclose information to those staff who are involved in the consideration of the complaint.
- 7.2** Directorates managing complaints will only disclose relevant and proportionate specialty specific information detailed in the complaint to the staff members required to provide statements. If a staff member is noted in a complaint, only information relating specifically to them will be disclosed.
- 7.3** Documents relating to a complaint investigation are securely stored and kept separately from medical records or other patient records. They are only accessible to staff involved in the consideration of the complaint.
- 7.4** Complaint outcomes may be anonymised and shared within our organisation and may be published on our website to promote service improvement.

8. How we handle complaints

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

- 8.1** We publish clear information about our complaints process and how people can get advice and support with their complaint through the local independent NHS Complaints Advocacy service:
- Walsall Healthcare NHS Trust: Pohwer.
The Royal Wolverhampton NHS Trust : Voiceability
- 8.2** We will make sure that everybody who uses (or is impacted by) our services (and those that support them) know how they can make a complaint by having our complaints procedure and/or materials that promote our procedure visible in public areas and on our website. We will provide a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to our complaints process online.
- 8.3** We will make sure that our service users' ongoing or future care and

treatment will not be affected because they have made a complaint.

What we do when we receive a complaint

- 8.4** We want all people, patients, their family members, and carers to have a good experience while they use our services. If somebody feels that the service received has not met our standards, we encourage people to talk to the staff who are dealing with them and/or to contact the Patient Relations Team to see if we can resolve the issue promptly.
- 8.5** We want to make sure we can resolve complaints quickly as often as possible. To do that, we train our staff to proactively respond to service users and their representatives and support them to deal with any complaints raised at first point of contact.
- 8.6** All of our staff who have contact with patients, service users (or those that support them) will handle complaints in a sensitive and empathetic way. Staff will make sure people are listened to, get an answer to the issues quickly wherever possible, and any learning is captured and acted on.

Our staff will:

- Listen to the service user to make sure they understand the issue(s)
- ask how they have been affected
- ask what they would like to happen to put things right
- carry out these actions themselves if they can (or with the support of others)
- explain why, if they cannot do this, and explain what is possible
- capture any learning to share with colleagues and improve services for others.

Complaints that can be resolved quickly

- 8.7** Our frontline staff often handle complaints that can be resolved quickly at the time they are raised, or very soon after. We encourage our staff to do this as much as possible so that people get a quick and effective answer to their issues.
- 8.8** In keeping with the 2009 Regulations, if a complaint is made verbally (in person or over the phone) and resolved by the end of the next working day, it does not need to go through the remainder of this procedure. For this to happen, we will confirm with the person making the complaint that they are satisfied we have resolved the issues for them. If we cannot resolve the complaint within that timescale, we will handle it in line with the rest of this procedure.

Acknowledging complaints

- 8.9** For all other complaints, we will acknowledge them (either verbally or in writing/email) within three working days. We will also discuss with the person making the complaint how we plan to respond to the complaint.

Focus on early resolution

- 8.10** When we receive a complaint, we are committed to making sure it is addressed and resolved at the earliest opportunity. Our staff are trained to identify any complaints that may be resolved at the time they are raised or very soon after. If staff consider that the issues cannot be resolved quickly, we will take a closer look into the matter (see section 8.16 onwards).

- 8.11** When our staff believe that an early resolution may be possible, they are authorised to take action to address and resolve the issues raised and put things right for the person raising them. This may mean giving a quick explanation or apology themselves or making sure a colleague who is more informed of the issues does.

Our staff will resolve complaints in person or by telephone wherever possible.

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

If we can resolve a complaint

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

- 8.14** We will capture a summary of the complaint and how we resolved it and we will share that with the person making a complaint. This will make sure we build up a detailed picture of how each of the services we provide is doing and what people experience when they use these services. We will use this data to help us improve our services for others.

If we are not able to resolve a complaint

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

A closer look into the issues

- 8.16** Not every complaint can be resolved quickly and sometimes we will require a longer period to carry out a closer look into the issues and carry out an investigation. In these cases, we will make sure the complaint is allocated to an appropriate member of staff (or Complaint Handler), who will take a closer look into the issues raised. This will always involve taking a detailed and fair review of the issues to determine what happened and what should have happened.
- 8.17** We will make sure staff involved in carrying out a closer look are properly trained to do so. We will also make sure they have:
- the appropriate level of authority and autonomy to carry out a fair investigation
 - the right resources, support, and time in place to carry out the investigation, according to the work involved in each case.
- 8.18** Where possible, complaints will be looked at by someone who was not directly involved in the matters complained about. If this is not possible, we will explain to the person making the complaint the reasons why it was assigned to that person. This should address any perceived conflict of interest.

Clarifying the complaint and explaining the process

- 8.19** The staff member (or Complaint Handler) dealing with the complaint will:
- Engage with the person raising the complaint (preferably in a face-to-face meeting or by telephone) to make sure they fully understand and agree:
 - the key issues to be looked at.
 - how the person has been affected.
 - the outcomes they seek.
 - Signpost the person to support and advice services, including independent advocacy services, at an early stage.
 - Make sure that any staff members specifically complained about are made aware at the earliest opportunity (see 'Support for staff' below).
 - Share a realistic timescale for how long the investigation is likely to take with the person raising the complaint, depending on:
 - the content and complexity of the complaint.
 - the work that is likely to be involved.

- Agree how they will keep the person (and any staff specifically complained about) regularly informed and engaged throughout.
- Explain how they will carry out the closer look into the complaint, including:
 - What evidence they will seek out and consider.
 - Who they will speak to.
 - How they will decide if something has gone wrong or not.
 - Who will be responsible for the final response.
 - How the response will be communicated.

It is important to inform the complainant how their complaint is shared to ensure fairness and transparency. Also, to clarify with the complainant that as part of the investigation, staff involved will be contacted to obtain their comments / a statement. As part of this process, a copy of the complaint will be shared with the staff involved.

If the enquirer does not consent to this, this is their right, however, it must be clarified that the investigation and the response may be limited.

Carrying out the investigation

- 8.20** Staff who carry out investigations will give a clear and balanced explanation of what happened and what should have happened. They will reference relevant legislation, standards, policies, procedures, and guidance to clearly identify if something has gone wrong.
- 8.21** They will make sure the investigation clearly addresses all the issues raised. This includes obtaining evidence from the person raising the complaint and from any staff involved or specifically complained about.
- 8.22** If the complaint raises clinical issues, they will obtain a clinical view from someone who is suitably qualified. Ideally, they should not have been directly involved in providing the care or service that has been complained about. Where a clinical opinion is required, the complaint handler will liaise with a suitable clinician to obtain this input, with support from the relevant Clinical Director. If an external clinical opinion is required, the Patient Relations Team will seek support from the Chief Medical Officer / Deputy Chief Medical Officer.
- 8.23** We will aim to complete our investigation within the timescale shared with the person making the complaint at the start of the investigation. Should circumstances change we will:
- Notify the person raising the complaint (and any staff involved) immediately.
 - Explain the reasons for the delay.
 - Provide a new target timescale for completion.
- 8.24** Unless we have agreed a longer timescale with the person raising the complaint within the first 6 months, we will inform them if we cannot

conclude the investigation and issue a final response within 6 months.

Our Responsible Person or a Senior Manager will write to the person to explain the reasons for the delay and the likely timescale for completion. They will then maintain oversight of the case until it is completed, and a final written response issued.

- 8.25** Before sending a final written response to the complaint, the staff member carrying out the investigation will share and discuss (by telephone, in a meeting or in writing) the outcome of our investigation and the actions we intend to take, with all the key parties to the complaint.

This will be decided on a case-by-case basis and will be based on the complexity of the issues and the identified impact. We will always consider any comments they receive before issuing a final written response.

Providing a remedy

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

- 8.27** In order to put things right, the following remedies may be appropriate:

- An acknowledgement, explanation, and a meaningful apology for the error.
- Reconsideration of a previous decision.
- Expediting an action.
- Waiving (or recompensing) a fee or penalty.
- Issuing a payment or refund.
- Changing policies and procedures to prevent the same mistake(s) happening again and to improve our service for others.

The final written response

- 8.28** As soon as practical after the investigation is finished, the person carrying out the investigation will co-ordinate a written response and submit this for divisional validation. Following this, the divisional team will submit the response to the Patient Relations Team for further validation prior to the written response being signed by our Responsible Person (or their delegate). They will send this to the person raising the complaint and any other interested parties. The response will include:

- A reminder of the issues investigated, and the outcome sought.
- An explanation of how we investigated the complaint.
- The relevant evidence we considered.

- What the outcome is.
- An explanation of whether something went wrong that sets out what happened compared to what should have happened, with reference to relevant legislation, standards, policies, procedures and guidance.
- If something went wrong, an explanation of the impact it had.
- An explanation of how that impact will be remedied for the individual.
- A meaningful apology for any failings.
- An explanation of any wider learning we have acted on/will act on to improve our service for other users.
- An explanation of how we will keep the person raising the complaint involved and updated on how we are taking forward all systemic learning or improvements relevant to their complaint.
- Confirmation that we have reached the end of our complaint procedure
- Details of how to contact the Parliamentary and Health Service Ombudsman if the individual is not satisfied with our final response.
- A reminder of where to obtain independent advice or advocacy.

Support for staff

- 8.29** We will make sure all staff who look at complaints have the appropriate: training, resources, support, and time to investigate and respond to complaints effectively. This includes how to manage challenging conversations and behaviour.
- 8.30** We will make sure staff specifically complained about are made aware of the complaint and we will give them advice on how they can get support from within our organisation, and externally if required. Refer to [HR48: Workplace Health and Wellbeing Policy](#).
- 8.31** We will make sure staff who are complained about can give their views on the events and respond to emerging information. Our staff will act openly and transparently and with empathy when discussing these issues.
- 8.32** The person carrying out the investigation will keep any staff complained about updated. These staff will also have an opportunity to see how their comments are used before the final response is issued.

Referral to the Ombudsman

- 8.33** In our response on every complaint, we will clearly inform the person raising the complaint that if they are not happy with the outcome of our investigation, they can take their complaint to the Parliamentary and Health Service Ombudsman.
- 8.34** If the complaint is about detention under the Mental Health Act, or a Community Treatment Order or Guardianship we will inform the person making the complaint that if they are not happy with the outcome, they can take their complaint to the Care Quality Commission.

9. Complaints involving multiple organisations

- 9.1** If we receive a complaint that involves other organisation(s) (including cases that cover health and social care issues) we will make sure that we investigate in collaboration with those organisations. The people handling the complaint for each organisation will agree who will be the 'lead organisation' responsible for overseeing and coordinating consideration of the complaint.
- 9.2** The person investigating the complaint for the lead organisation will be responsible for making sure the person who raised the complaint is kept involved and updated throughout. They will also make sure that the individual receives a single, joint response.

10. Monitoring, demonstrating learning and data recording

- 10.1** We expect all staff to identify what learning can be taken from complaints, regardless of whether mistakes are found or not.
- 10.2** Our Senior Managers take an active interest and involvement in all sources of feedback and complaints, identifying what insight and learning will help improve our services for other users.
- 10.3** We maintain a record of:
- Each complaint we receive.
 - The subject matter.
 - The outcome.
 - Whether we sent our final written response to the person who raised the complaint within the timescale agreed at the beginning of our investigation.
- 10.4** To measure our overall timescales for completing consideration of all complaints and our delivery of the NHS Complaint Standards, we seek feedback on our service from:
- People who have made a complaint and any representatives they may have.
 - Staff who have been specifically complained about.
 - Staff who carried out the investigation.

Each complainant receives a "Complaint Satisfaction Survey" which is analysed and reported in our Trust annual report. "Staff Involved" and "Complaint Handler" surveys are also shared with staff as part of the formal complaint process, the feedback of which is shared via the Trust annual report.

- 10.5** We monitor all feedback and complaints over time, looking for trends and risks that may need to be addressed.
- 10.6** In keeping with the 2009 Regulations section 18, as soon as practical after the end of each financial year, we will produce and publish a report on our complaint handling. This will include how complaints have led to a change and improvement in our services, policies or procedures.

11. Complaining to the commissioner of our service

- 11.1** Under section 7 of the 2009 Regulations, the person raising the complaint has a choice of complaining to us, as the provider of the service, or to the commissioner of our service the Black Country Integrated Commissioning Board (ICB). If a complaint is made to our commissioner, they will determine how to handle the complaint in discussion with the person raising the complaint.
- 11.2** In some cases, it may be agreed between the person raising the complaint and the commissioner that we, as the provider of the service, are best placed to deal with the complaint. If so, they will seek consent from the person raising the complaint. If that consent is given, they will forward the complaint to us and we will treat the complaint as if it had been made to us in the first place.
- 11.3** In other cases, the commissioner of our services may decide that it is best placed to handle the complaint itself. It will do so following the expectations set out in the Complaint Standards and in a way that is compatible with this procedure. We will co-operate fully in the investigation.

12. Guidance on the Management of Unreasonable behaviour

- 12.1** We are committed to dealing with all people fairly and impartially and to providing a high-quality service. In order to do this, it is important that we are able to communicate with someone bringing a complaint to us so we can make sure we fully understand it. We therefore do not limit the contact that people have with us.
- 12.2** We do not expect our staff to tolerate any form of behaviour that could be considered abusive, offensive or threatening, or that becomes so frequent it makes it more difficult for us to complete our work or help other people. We will take action under this guidance to manage this type of behaviour, and this applies to all contact with us including the use of social media.
- 12.3** We will make reasonable adjustments to ensure our service is accessible to everyone. It is important to us that we provide a safe environment for our staff to work in, which may mean we decide to restrict how someone can contact us.

- 12.4** If we consider a person's behaviour is unreasonable, we will tell them why and will ask them to change it. If this behaviour continues, we will take action including deciding whether to restrict the persons contact with us. This decision will usually be taken by the Chief Nursing Officer, Associate Director – Patient Relations or the Head/Deputy Head of Patient Relations and may involve a discussion with other colleagues and the Local Security Management Specialist (LSMS).
- 12.5** We will usually only take action to restrict someone's contact with us after we have considered whether there are any other adjustments we could make to prevent unreasonable behaviour from occurring. Any restrictions imposed will be appropriate and proportionate. The options we are most likely to consider are:
- Asking for contact in a particular form (for example, email only).
 - Only allowing contact with a specific member of staff or at specific times.
 - Asking the person to enter into an agreement about their future behaviour; and/or actions designed to specifically meet the needs of the person.

The full narrative of this guidance is available in **Annex 2**

Annex 1

Roles and responsibilities

The roles and responsibilities of staff within our organisation, when dealing with complaints, are set out below. Regulations 4(2) and 4(3) of the 2009 Regulations allow us to delegate any complaint handling function to relevant staff where appropriate.

Role	Responsibility
Group Chief Executive	Has overall responsibility for making sure we: • Comply with the 2009 and 2014 Regulations. • Comply with the NHS Complaint Standards and this procedure. • Take any necessary remedial action. • Report annually on how we learn from complaints. Also responsible for: • Signing the final written response to the complaint (unless delegated to an authorised person(s)).

Divisional / Directorate Team of Three (TOT)	Are responsible for: • Overseeing complaints and the way we learn from them. • Overseeing the implementation of actions required because of a complaint, to prevent failings happening again. • Contributing to complaint investigations. • Deputising for the Responsible Person, if authorised. They retain ownership and accountability for the management and reporting of complaints. They are responsible for preparing, quality assuring or signing the final written response. They should be satisfied that the investigation has been carried out in accordance with this procedure and guidance, and that the response addresses all aspects of the complaint. They review the information gathered from complaints regularly (at least quarterly) and use this to consider how services could be improved, or how internal policies and procedures could be updated. They report on the outcomes of these reviews via the organisation's governance structure. They are also responsible for making sure complaints are central to the overall governance of the organisation. They make sure staff are supported both when handling complaints and when they are the subject of a complaint.
Associate Director – Patient Relations Head/Deputy Head of Patient Relations	Is responsible for overall day-to-day management and oversight of procedures for handling complaints. Working with senior manager(s) or partner(s), they will be involved in a review of quarterly reports. They will review this information to identify areas of concern, agree remedial action and improve services. They may also be responsible for the management and oversight of a complaints team and may also act as a complaint handler/investigator or complaint lead.

Complaint Handler, Investigator or staff member dealing with the complaint	Assigned to oversee and co-ordinate the investigation of the complaint and the response to the complaint. If needed, they seek out support and input of others. They make sure the information and responses they receive from the person making the complaint, and from staff being complained about, clearly addresses all the issues raised. They are trained in investigative techniques. Where possible they are also trained in advanced dispute resolution skills. This enables them to seek a mediated resolution to the concern or complaint at any time during the investigation of the issues. They may also act as a Complaint Lead and they may delegate their responsibilities as set out in this procedure to the Complaint Lead.
Complaint Lead	As appropriate and when required, the Complaint Handler will call for the input of a designated Complaint Lead(s) with knowledge of the care or services complained about. The Complaint Lead will carry out an investigation, as set out in this procedure, and provide the Complaint Handler with: • An objective account of what happened. • An explanation if something has gone wrong. • Details of any action already taken or planned to resolve the matter.
All staff	We expect all staff to proactively respond to service users and their representatives and support them to deal with any complaints raised at the 'first point of contact'. We will provide training so they can do this. We expect all our staff who have contact with patients, service users, or those that support them, to deal with complaints in a sensitive and empathetic way. This includes making sure people are aware of our local independent advocacy provider and/or national sources of support and advice. We expect all staff to listen, provide an answer to the issues quickly, and capture and act on any learning identified.

Annex 2

Unreasonable Behaviour Guidance

- 13.1** We are committed to dealing with all people fairly and impartially and to providing a high-quality service. In order to do this it is important that we are able to communicate with someone bringing a complaint to us so we can make sure we fully understand it. We therefore do not limit the contact that people have with us.

- 13.2** We do not expect our staff to tolerate any form of behaviour that could be considered abusive, offensive or threatening, or that becomes so frequent it makes it more difficult for us to complete our work or help other people. We will take action under this guidance to manage this type of behaviour, and this applies to all contact with us including the use of social media.
- 13.3** We will make reasonable adjustments to ensure our service is accessible to everyone. It is important to us though, that we provide a safe environment for our staff to work in, which may mean we decide to restrict how someone can contact us.
- 13.4** If we consider a person's behaviour is unreasonable, we will tell them why and will ask them to change it. If this behaviour continues, we will take action including deciding whether to restrict the persons contact with us. This decision will usually be taken by the **Chief Nursing Officer, Associate Director – Patient Relations**, the **Head/Deputy Head of Patient Relations** and may involve a discussion with other colleagues and the **Local Security Management Specialist (LSMS)**.
- 13.5** We will usually only take action to restrict someone's contact with us after we have considered whether there are any other adjustments we could make to prevent unreasonable behaviour from occurring. Any restrictions imposed will be appropriate and proportionate. The options we are most likely to consider are:
- Asking for contact in a particular form (for example, email only).
 - Only allowing contact with a specific member of staff or at specific times
 - Asking the person to enter into an agreement about their future behaviour; and/or actions designed to specifically meet the needs of the person
- 13.6** In all cases we will write to tell the person why we believe their behaviour is unreasonable, what action we are taking and how long that action will last. We will also tell them how they can challenge the decision if they disagree with it.
- 13.7** If, despite any adjustments we have made, a person continues to behave in a way which is unreasonable, we may decide to end contact with that person.
- 13.8** There may be occasions, one would hope rarely, where we decide that a person's behaviour is so extreme that it threatens the immediate safety and welfare of our staff or others. In these instances we will consider stopping all contact immediately, reporting what has happened to the Police or taking legal action. In such cases, we may not warn the person before we do this.

What is unreasonable behaviour?

- 13.9** Unreasonable behaviour is difficult to define and will usually depend on the situation of the individual concerned. It can occur in a variety of circumstances including in person, on the telephone, in written correspondence or on social media.
- 13.10** Any behaviour that makes someone feel uneasy, uncomfortable, distressed, anxious or unsafe is likely to be considered unreasonable and action can be considered under the policy in these instances. Examples include behaviour that a staff member considers abusive, offensive or threatening in nature.
- 13.11** We should also consider taking action under the guidance where a high frequency of contact causes a disruption to the service we provide. For example, a series of disruptive calls which contain no abusive content may be suitable for action to be taken under this guidance as much as a single call which contains a specific threat.
- 13.12** If at any stage we consider a person's behaviour poses an immediate threat to the health, welfare or safety of staff then we should decide whether more immediate action is required.

Considering equality issues in deciding whether to take action under the policy

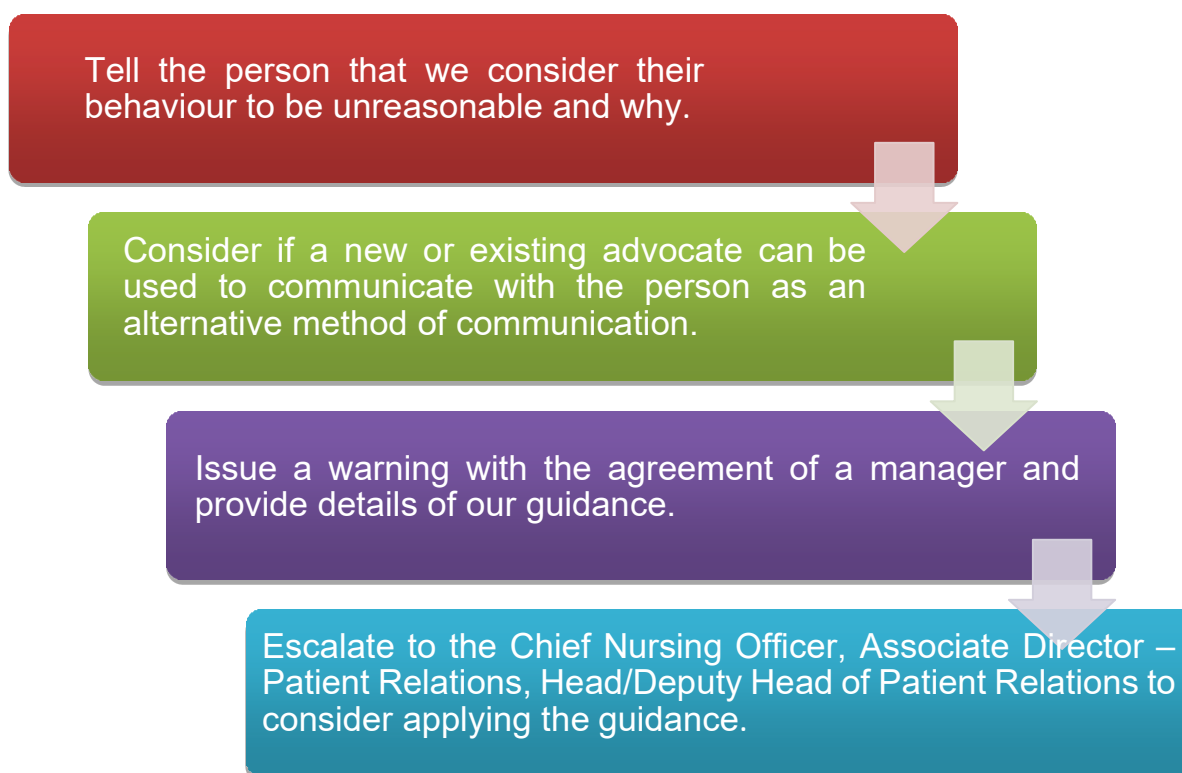
- 13.13** The staff member must take into account any equality issues that may affect a person's behaviour before deciding whether to take action under the guidance. This should include reviewing any adjustments currently in place and deciding whether any further steps could be taken to manage the person's behaviour. Any changes should be recorded on the Trust complaint management database.
- 13.14** If the staff member considers further adjustments cannot be made to support the person, or their request for adjustment is unreasonable, then the reasons for this decision must be recorded on the Trust complaint management database. If the staff member has any concern about deciding that a requested adjustment is not reasonable, they must consult their line manager and discuss with the Trust Legal team if appropriate via the **Associate Director – Patient Relations**.
- 13.15** A staff member can still take action under this guidance even if a relevant equality or diversity issue is identified. They must take account of any reasonable adjustments agreed in deciding what action to take. For example, a dyslexic complainant may only want telephone contact. We may therefore decide to limit their contact to one person, rather than restrict all telephone calls to us.

Recording unreasonable behaviour

- 13.16** The staff member should log full details of any behaviour they consider unreasonable on the Trust Incident Management System. This should include details of why they consider the behaviour is unreasonable and details of, for example, and offensive terms used.
- 13.17** The staff member should record the exact language used in the contact and give us as much information as possible about how and when it was used. This should not only include what someone said or did but also the way they spoke and how they acted. They should also create a new record for each telephone call to capture the frequency of contact.

The process

- 13.18** Staff members should complete each stage of the process below before moving to the next stage and should only take further action if the person's behaviour continues to be unreasonable.



Tell the person that we consider their behaviour to be unreasonable and why

- 13.19** The staff member who has experienced the unreasonable behaviour should usually be the one to challenge it. This is because they are in the best position to explain why the person's behaviour is unreasonable.

- 13.20** The staff member should tell the person involved that they consider their behaviour unreasonable, explain why, and give them opportunity to stop. (This explanation can, if necessary, be given at the same time as a warning about the potential application of this guidance). They should ask the person at this time if there is a way we can adjust our service to help them.
- 13.21** If for any reason the staff member feels uncomfortable in challenging the person's behaviour at the time or is concerned for their personal safety they should record any details of the person's behaviour and discuss what happened with their manager as soon as possible. The staff member can still contact the complainant to discuss their behaviour after the telephone call if appropriate.

Examples of when and how to challenge unreasonable behaviour

- 13.22** If a person uses offensive language during a telephone call the staff member involved should explain to the person that their language is unreasonable and ask them to stop. If the person refuses to comply with that request the staff member should politely end the call. A record should be made on the Trust Incident Management System of what has happened and the telephone call should be discussed with a manager.
- 13.23** If offensive language is used in letters or emails, the staff member should explain in their next written response to the person that the language they have used is unreasonable and ask them not to repeat this in future correspondence.
- 13.24** If a person persistently makes repeated telephone calls without legitimate purpose (for example, to ask about progress on their case when they have recently been given that information) the staff member should explain to them that their behaviour is disruptive and is preventing work on their case and others. They should also ask the person to stop doing this. If the person refuses to comply with the request, then in the short term further calls can be terminated politely after a brief explanation (for example, that we have nothing further to add to the last update given on the case). If the behaviour continues the staff member must take action under the guidance and should not continue to just terminate calls.
- 13.25** If a person sends repeated emails or letters without legitimate purpose (for example, if they send on letter each day that does not add anything to the evidence in support of their case) the staff member should ask, in their next contact with the person, that they limit the amount of correspondence sent to us.

Consider if a new or existing advocate can be used to communicate with the person

- 13.26** If a person displaying unreasonable behaviour has an advocate, the staff member should approach them as soon as possible to ask for assistance in understanding and managing the person's behaviour.

13.27 If the person does not have an advocate, the staff member should, if appropriate, suggest they get one and provide details of a suitable provider. This may be particularly suitable in cases where there are equality considerations.

Issue a warning with the agreement of a manager and provide details of our policy

13.28 A warning will normally be given before the policy is applied. This is different to telling the person their behaviour is unreasonable. The staff member will usually have already told the complainant why their behaviour was unreasonable and given them the opportunity to change.

13.29 The staff member should consider the most appropriate way of giving the warning, whether this be by telephone, email or by post. The staff member should also record the warning on the Trust Incident Management System. This must include a summary of the reasons for the warning, and the manager it was discussed with.

13.30 If the warning is communicated over the telephone the staff member should also send the person concerned either a copy or a link to the guidance via email or writing. This should be accompanied by a brief letter reiterating the warning and, if appropriate, a statement of our willingness to discuss a reasonable adjustment if helpful.

13.31 The staff member involved should usually deliver the warning as they are best placed to explain why the complainant's behaviour was unreasonable. Another staff member can do this though if appropriate. The warning should explain what the behaviour was, why we consider it to be unreasonable and the likely consequences of any conclusion.

13.32 The staff member should usually discuss the decision to issue a warning in advance with a manager. There will be occasions when a person's behaviour requires a staff member to issue a warning without being able to discuss the case with a manager first. In these instances, the staff member should inform their manager as soon as possible after the event.

13.33 If a Member of Parliament and/or representative have been involved in the case, the staff member should tell the person that, if the unreasonable behaviour continues and we decide to apply our guidance, that we will tell the MP and/or representative.

13.34 If the staff member considers the person's behaviour is particularly serious (for example, a specific and immediate threat is made) a decision may be taken by an **Executive Director, Associate Director – Patient Relations** or the **Head/Deputy Head of Patient Relations** to apply restrictions without prior warning. In that event, the staff member who authorises the restriction should contact the person immediately explaining the reasons for doing this.

13.35 The staff member should also consider whether the Security Officer should be informed. This will mainly be relevant when the staff member feels threatened by the person's actions, for example, a threat is made to come to our offices.

Recording a warning on the Trust Incident Management System

13.36 The staff member should record the warning on the Trust Incident Management System. Staff should enter details of the warning and the manager who agreed it. Restrictions applied will only normally apply to an individual and therefore to their contact in any cases that they have with us. The staff member will therefore need to specify if the restrictions only apply to one case.

Escalate to consider application of a restriction

13.37 If the person continues to behave in a way that is unreasonable, a request to apply the restriction should be referred to an Executive Director, Associate Director of Patient Relations or the Head/Deputy Head of Patient Relations. The staff member should ensure the request provides detail. For example: steps taken so far, nature and frequency of the behaviour, information about the complainant's needs and circumstances (if known), and the type and duration of any proposed requirements or conditions.

13.38 In deciding whether to apply the restriction, the relevant manager should consider and record the following on the Trust Incident Management System.



13.39 The staff member should record the outcome of the referral on the Trust Incident Management System and detail the possible reasons why it has been agreed or not agreed that the policy should be applied. This should include whether restrictions need to apply to any other existing enquiries, reviews, investigations, or information requests that the person has with us.

13.40 If it is decided that the restriction should not be applied then the manager who considers the request should decide how to manage contact from the person in the future and record this on the Trust Incident Management System.

13.41 If it is decided the restriction should apply, the manager considering the request should agree how to restrict the person's contact with us. In doing this, they should balance the interests of that person with the duty to protect the health, safety and welfare of staff.

13.42 Possible actions include:

- Requesting contact in a particular form (for example, emails only)
- Requiring contact to take place with a named officer
- Restricting telephone calls to specified days and times
- Asking the person to enter into an agreement about their conduct
- Actions designed specifically to meet the needs of the person

13.43 When applying a restriction then the manager considering the request should set a date when it will be reviewed. This date should be recorded on the Trust Incident Management System. This will not be more than 6 months after the restrictions are imposed.

13.44 The manager applying the restrictions should contact the person and explain:

- The reasons for the decision.
- The requirements/conditions the person must follow and any adjustments that can be made to assist with this.
- The date set for review.
- How the person can challenge the decision.
- A warning that continued unreasonable behaviour may lead to the case being closed.
- And, where relevant, that the MP/representative has been told of the action.

13.45 The manager should preferably make this contact by telephone. If they are aware that the person has a preferred method of communication then contact should be made this way instead. This contact must be followed up in writing.

Recording the application of the restriction on the Trust Incident Management System

- 13.46** The staff member should record that the restriction has been applied as part of the complaint file on the Trust Incident Management System. They should also include details of the manager who approved the decision and the date the restrictions should be reviewed. The staff member will need to specify if only applying the policy to only one of multiple incidents.
- 13.47** The staff member should set up a task to alert them when the policy is due for review. If they are no longer the staff member dealing with the person on this date then they should contact the staff member currently dealing with the person to inform them a review is due.
- 13.48** The staff member who is currently dealing with the person (or their case) is responsible for keeping the case record updated about the application of the restriction. This includes where restrictions on the contact are altered, varied, or removed.

What if the contact restrictions that have been applied are not complied with?

- 13.49** If a staff member receives a telephone call from a person who has been informed, they cannot contact us this way, they should explain the restriction to the complainant. They should politely ask the person to contact us using an alternative method or via an advocate. The call can then be terminated.
- 13.50** If a staff member receives a letter or email from a person who has been informed they cannot contact us this way, then they should explain this restriction to the complainant (this can be done in writing if appropriate). They should then ask the person to contact us using an alternative method or via an advocate.

What if the unreasonable behaviour continues after the policy is applied?

- 13.51** If the person continues to behave unreasonably after the policy has been applied, then the manager of the staff member currently dealing with the person should decide whether further restrictions are required. They should ensure that any changes made are recorded on the Trust Incident Management System as soon as possible.
- 13.52** An Executive Director can decide to terminate contact with a person completely if appropriate (which would also have the effect of closing or discontinuing any assessment, investigation, or review consideration currently ongoing). The intention of this guidance though is to manage challenging behaviour so we can continue to work on cases. This should therefore only be considered in rare circumstances. If the decision is made to do this, then this should be recorded on the Trust Incident Management System.

- 13.53** If the decision is made to terminate contact completely, then the manager of the staff member currently dealing with the person should decide whether to acknowledge or consider any further contact. This should be considered on a case by case basis and any action taken must be recorded on the Trust Incident Management System.

Complaints about decisions to apply the restriction

- 13.54** The Patient Relations Team can consider complaints about whether the policy has been applied in line with this guidance. If the process has not been followed correctly, the Patient Relations Team should pass the case back to the manager who applied the restriction and ask for it to be reconsidered. The outcome should be recorded on the Trust Incident Management System.
- 13.55** If the complaint concerns our decision to apply the restriction, the complaint should be forwarded to the manager of the manager who agreed the restrictions to review. The member of staff carrying out that review must issue a written decision to explain the outcome and record the decision on the Trust Incident Management System.

Behaviour that poses an immediate risk

- 13.56** There will be exceptional cases where we consider a person's behaviour poses an immediate threat to the health, welfare or safety of staff members. In these cases, an **Executive Director, Associate Director – Patient Relations, Head/Deputy Head of Patient Relations** may decide to act without prior warning, including terminating all contact. They may also consider other suitable actions such as police involvement.
- 13.57** The staff member taking this action must clearly record what action has been taken on the Trust Incident Management System and their manager and the Trust LSMS must be notified.

Modification of behaviour

- 13.58** If a staff member considers the person has modified their behaviour before the review date, to the extent that existing restrictions should not apply, a proposal to remove or modify the restrictions can be agreed by an **Executive Director, Associate Director – Patient Relations, Head/Deputy Head of Patient Relations**.
- 13.59** If restrictions are removed on a person's contact with us before the review date set, the staff member should contact the person to explain this. At this time, they should also make it clear to the person that if their previous behaviour resumes this could lead to restrictions being imposed again or further restrictions imposed.

Decided whether to continue applying the restriction at the review date

- 13.60** The staff member who currently holds the case has the responsibility for ensuring a review is conducted (including cases that are held by the Patient Relations Team). This is because they are best placed to comment on whether the person's behaviour has changed and restrictions should be lifted.
- 13.61** Before the review date, the staff member should discuss the case with their manager and pass it to an **Executive Director, Associate Director – Patient Relations, Head/Deputy Head of Patient Relations** to review.
- 13.62** The person reviewing the case should take into account the evidence and reasons for making the original decision, and any evidence of the person's subsequent behaviour. They should also seek comments from appropriate staff, including those affected by the behaviour, and consider the effectiveness of any adjustment already made.
- 13.63** If the person reviewing the case decides not to extend the original restrictions for a further period, the conditions imposed will lapse. This decision should be recorded on the Trust Incident Management System
- 13.64** If there is a continuing contact with the person, the person reviewing the case should write to them explaining the decision. If the person is not in regular contact then contact does not need to be re-established to tell them about the decision. The decision should then be shared if and when they make contact again.
- 13.65** If the person reviewing the case does not extend the original decision and the unreasonable behaviour occurs again at a later point, they can decide to enforce the previous restrictions without going through the warning stage.
- 13.66** If the person reviewing the case decides to extend the original decision, they should set a further period during which restriction should apply up to a maximum of 12 months. When this expires, a further review should be conducted.
- 13.67** The review of the application of this policy should be recorded fully on the Trust Incident Management System by (or on behalf of) the person carrying out the review.

Social media

- 13.68** We generally consider unreasonable behaviour on social media (for example, Facebook or Twitter) to be when a person is abusive, makes personal threats, or repeatedly references an individual member of staff. We should not usually take action under this part of the policy if the comment is a general criticism of our organisation or service.

- 13.69** If a person displays unreasonable behaviour on social media then this policy can be used to try and manage it. In these circumstances, the staff member responsible for responding to the person should not continue to respond online in order to prevent personal or confidential information (either about a case or about a member of staff) being disclosed in a public manner.
- 13.70** If a social media post about a specific member of staff is found online, then this should be referred to by the relevant staff member's manager, Human Resources, and the Communications Team. The manager should inform the staff member and take responsibility for agreeing what action to take, working with the Communications Team and, if appropriate, the Legal Team.

The following options can be considered:

- Support for the employee
- Asking the person who made the post to remove it (discuss this with the Head of Communications first)
- Asking the Communications Team to report the person to the social media platform (if the behaviour persists)
- Seeking advice from the Legal Team

Contact received on staff member's personal social media

- 13.71** Most comments we receive on social media will be made to our corporate accounts. Action can be taken under this policy though in relation to contact received from a person that is sent directly to a member of staff's personal social media account.
- 13.72** If a staff member received contact through social media from a person who is currently, or has previously, used our service then they should raise this with their manager. The staff member should not respond to the contact or acknowledge the person has a case with us, as this may be considered a breach of data protection.
- 13.73** If this contact is threatening or abusive, the staff member should report it to their manager as soon as possible. The manager should then consider whether action is required under this policy.

Further complaints and information requests

- 13.74** Restrictions under this policy should usually be applied to an individual. We can still decide to apply restrictions on a case-specific basis if appropriate. This should be considered on the individual circumstances of the case.
- 13.75** If a person who has had restrictions applied under this policy seeks to make a fresh complaint, the staff member should consult an Executive Director,

the Head of Patient Relations, or the Patient Relations Lead for a decision on how to respond to that further contact.

- 13.76** If a person who has had restrictions applied under this policy makes a Freedom of Information request or Data Protection Act subject access request then an **Executive Director, Associate Director – Patient Relations, Head/Deputy Head of Patient Relations** should be consulted for advice as well as the Head of FOI/DPO.

Variation of these procedures

- 13.77** The procedures associated with this guidance may be varied in individual circumstances or on a specific issue by agreement with a member of staff at Head of Service or Director Level.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

7.0 Maintenance

This policy will be maintained by the Head of Patient Relations and the Deputy Head of Patient Relations on behalf of the Associate Director – Patient Relations. Any changes / amendments required will be monitored and agreed via the Patient Experience Group.

8.0 Communication and Training

The Associate Director – Patient Relations will be responsible for ensuring this policy is adhered to. The Patient Relations Team will provide consistent advice and support as

necessary in the application of this policy. The Patient Relations Team have also developed a series of Complaint Investigation E-Learning modules which are available to all staff via MyAcademy.

9.0 Audit Process

The purpose of this policy is to ensure complaint and concerns are investigated in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, and the Parliamentary & Health Service Ombudsman Complaint Standards 2021. This policy outlines the process staff must follow to promote a clear, fair and accessible complaint process for patients and service users when raising concerns regarding the care or services we provide. In line with this guidance, our complaint process focuses on service user involvement, encouraging clear and continual communication with the complainant, ensuring they are involved in the process and any service improvements identified.

All formal complaints are validated by the Divisional / Directorate TOT, with final approval from the Chief Executive. A random selection of complaints is also shared with our Complaint Review Panel, which is a subgroup of the Trust's Patient Involvement Partners (PIPS). Feedback from staff is also sought from staff across the Trust, with Complaint Handlers and staff involved in complaints having access to an anonymous feedback survey, whereby they can provide feedback on the complaint process.

A random selection of complaints is audited on a quarterly basis, including a review how the complaint process was followed, taking into account the language and terminology used, and any learning identified. The Complaint Review Panel are provided with a Complaint Review Matrix to complete, along with an anonymised copy of the complaint file. Following their review, the completed Complaint Review Matrix is shared with the Complaint Handler and the most appropriate Divisional / Directorate TOT for educational purposes.

In the event the Complaint Review Panel is unable to take place, an internal peer review will take place, conducted by staff not involved in the complaints identified for review. The Complaint Review Matrix will be utilised and the feedback process will continue as outlined above.

Criterion	Lead	Monitoring method	Frequency	Committee
All complaints should be acknowledged within 3 working days and a response provided within an agreed timeframe.	Head of Patient Relations Deputy Head of Patient Relations	Random audit of closed complaints.	Quarterly	Patient Experience Group

10.0 References - Legal, professional or national guidelines

- Local Authority, Social Services and National Health Service Complaint Regulations 2009.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Equality Act 2010.
- Parliamentary & Health Service Ombudsman Complaint Standards 2023.

Evidence for Best Practice

Parliamentary & Health Service Ombudsman Complaint Standards.

Appendices

Appendix 1 - Formal Complaint Investigation Toolkit

Appendix 2 – Complaint Review Panel Terms of Reference

Appendix 3 – Complaint review Panel Quality Assurance Matrix



Patient Relations Team

Formal Complaint Investigation Toolkit



Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust



Care Colleagues
Collaboration Communities

Contents

1. Timeframe for complaint response
2. Complaint Handler Plan
3. Complainant/Family Plan
4. Letter to complainant – template for information
5. Quality Assurance Checklist
6. Trust Statement Template
7. Verbal Action Form – concerns

1. Timeframe for responding to a formal complaint

At the start of the investigation process, the complaint handler must contact the complainant to agree a response timeframe specific to their case. Guidelines listed below.

Level of seriousness	Descriptor	Timeframe
Simple	Single issue – low impact	Downgrade to informal / 10 working days
Moderate	Several issues – medium impact	20 - 30 working days
Complex	Several issues – high impact	45 working days

If you feel the complaint can be resolved informally then please contact the complainant and have that discussion with them. If they agree, contact the Patient Relations Team and we will downgrade the case.

2. Complaint Coordinators Plan

The key to achieving the completion deadline is to have a plan to work to. The checklist below will help, along with the plan for your contact with the complainant. Ensure you obtain as much help from your secretary/admin with regards to obtaining health records, requesting statements etc.

Any issues in these areas please escalate to your Line Manager/Patient Relations Team who will be able to support. (A few examples are included to help as a guide)

Please note – 2-3 working days will already have been taken up with the complaint handler nomination process. At the point of acknowledging receipt of a complaint, the Patient Relations Team will set a provisional timeframe of 30 working days for a response to be provided.

In line with the Parliamentary & Health Service Ombudsman (PHSO) complaint standards, complaint handlers are asked to contact the complainant at the beginning of their investigation to agree a timeframe for a response.

Stages once received by the Complaint Handler	Timeframe (working days)	Comments	Completed/Received
Read through the complaint, request the patient's health records (if required) and rate the severity/harm of the complaint. (If you think harm has been caused as a result of the care provided please raise a clinical incident)	As soon as the complaint is received	Examples – Health Records request Severity/Harm Complete – Clinical Incident Moderate Harm raised	12.6.25 received 10.6.25 10.6.25 raised
Review the concerns raised from a safeguard perspective.	As soon as the complaint is received	Have any concerns been identified? i.e. Signs of alleged abuse or neglect including: • Unexplained bruising. • Developed pressure ulcers. • Had a fall on the ward • Unexplained weight loss, unwashed and unkempt in appearance. • Refuses to eat/drink/wash/take prescribed medication/engage in treatment. • Does the person lack capacity to make decisions relevant to their own safety and wellbeing • Evidence of refusing treatment • Patient appears worried/distressed about being discharged home? If any of the above answers are “Yes” make a referral to the Adult Safeguarding Team.	

Stages once received by the Complaint Handler	Timeframe (working days)	Comments	Completed/Received
Contact the complainant/ family direct to introduce yourself as complaint handler. Follow process outlined in complaint plan and agree a timeframe for response.	By the 3rd day	Tried contacting on 10.6.25 – no answer	
Seek statements from staff, giving a clear 7 day deadline and ensuring they are prepared on the Trust template (included). Also consider hosting a reflective shoes session with the staff involved.	By the 5th day	CSW A Ssr B Consultant A Consultant B	Received Chased 14.6.25 Received On leave until 18.6.25
Liaise with partner agencies, other organisations if necessary Identify other information that may be required	By the 5th day		
Seek an independent opinion in complex matters.	By the 5th day		
Collate statements/ interviews and evidence such as staffing rotas/vital pac/policies/guidelines start putting the final response together ensuring issues are answered.	By the 12th day		
Request any additional information which may be missing from statements. Consider meeting with staff involved.	By the 15th day		
Pull response together by answering all the questions and using the guidance within the toolkit.	By the 18th day		

Stages once received by the Complaint Handler	Timeframe (working days)	Comments	Completed/Received
Update Reflective Shoes action plan notifying those who are required to complete the actions (this can be an ongoing process throughout the investigation).	By the 18th day		
Forward to the appropriate person for Divisional validation.	By the 20th day		

It is important that staff who have provided statements to aid with the investigation have sight of the proposed final response letter. It is advised that 48 hours is allocated for the staff involved to review your draft response and provide comments prior to the response being submitted to the divisional team for validation.

The remaining 7-10 working days will allow for validation by the Division which should be completed within 48 hours – any queries should be sent back to the complaint handler within that timescale and returned to the Division for validation within 48 hours or request for further information.

NB - Staff absence is not a reason for delaying a response. If the statement of a particular staff member is crucial, then ensure the rest of the complaint is answered within the required timescale and give the complainant a timescale when you will respond with the missing information. If advice is required, then be sure to seek it promptly.

If there are any issues around timescales please contact the Patient Relations Team.

3. Complainant/Patient/Relatives plan

(To be completed with the complainant – phone or face to face)

Complaint reference number:	
Complainants Name and Address:	
Telephone:	
Mobile:	
Preferred method of contact and time:	
Patients name and details (if different from above):	
Name of staff member who contacted complainant:	
Brief Summary of discussion:	
It was agreed the following issues would be investigated:	
Outcome the complainant is seeking (i.e explanation, apology, compensation) and has a meeting been offered?	
Agreed timescale for response (provisional agreement 30 working days):	
Is there a safeguarding issue relating to this complaint? If yes, detail how this has been reported/actioned:	

4. Initial conversation with the complainant

Making early contact with the complainant is essential to ensuring they feel listened to, and are reassured their concerns are being taken seriously. It also helps with getting a timely response out to the complainant and you can be confident that the response letter addresses all of their concerns.

Saying sorry to a patient, or their relatives, is not an admission of liability. If you are the complaint handler, you can say sorry that they have had cause to write in to complain and inform them that you are appointed to lead on the investigation. It may be that there is a clinical incident raised at the same time and this conversation will also fulfil the Duty Of Candour process if undertaken in accordance with the Duty Of Candour timescales.

It is important to note that if the individual is already taking part in another process (i.e. litigation) they are still entitled to an investigation via the complaint process.

If a Patient Safety Incident Investigation (PSII) is raised or ongoing on receipt of a complaint and is related to the same episode of care, the Trust will carry out a single investigation and provide a response covering both the incident and the concerns raised. (This should be confirmed with the Assurance Team on receipt).

Tips for having the conversation

- Make some time for yourself and clear your desk/office for 15 mins, make others aware you are making a potentially difficult phone call so you do not get interrupted. Use the complainant (page 5) to make your notes.
- Familiarise yourself with the complaint first so you are focused on that patient and their issues.

Write down a list of points you need to mention such as:

Introduction – Sounds obvious but introduce who you are, where you are calling from and what your role is.

Condolences – If the patient has passed away then always give condolences.

Reason for calling – Start with “I’m contacting you following receipt of your formal complaint. I have been appointed as the complaint handler for your complaint and I have read through your letter and I understand that your concerns are around I am very sorry that this happened.

How are you? – Ask how the patient or relative are doing now or how their treatment is progressing if relevant.

Process – Let them know what happens now i.e. an investigation takes place which may include gathering statements, meeting with staff and reviewing records.

There will be actions which need to be implemented to minimise the risk of this happening again. We will let you know the findings and actions in your final response letter.

Timescales – Let them know how long it might be before they receive the final response and agree this timeframe with them. If the final response date is coming up and it is looking as though it may go over the agreed timescale then contact the complainant to let them know. Most complainants are happy for any updates.

Any questions? – Once you have let them know about the investigation always ask if they have any questions – it may be that they need time to digest the information and will come back at a later date to talk to you and they should be given your details and assurance that it is ok to contact you with any further queries – these can be included in the investigation and will be responded to in any report or letter.

5. Guidance for a Response Letter

This guidance has been written to assist staff when you produce responses to complaints.

Value of Complaints

It is always helpful to think of the positive value of complaints:

- They are a measure of quality.
- They are a catalyst for change.
- They aid future planning.
- They reflect opinions and views of users.
- They project the image of the organisation.
- They can be an early warning system.

Steps to a good response

- Read the complaint and understand the key issues.
- Address each issue as identified by the complainant.
- Think of the complainant and respect their strength of feeling.
- Give explanations.
- Avoid using technical language or being too wordy.
- Apologise appropriately.
- Outline action taken to prevent the event occurring again.
- Write as much as possible in active not passive tenses e.g. 'I will send a report to your doctor.' rather than 'a report will be sent to your doctor.'
- Leave the complainant feeling that they have been taken seriously and their concerns have been listened to and acknowledged.
- Avoid being patronising or defensive.
- Ensure that all facts are correct.
- If there is a reason why a specific issue cannot be addressed, this should be stated.
- Be open and honest.

Getting the tone of the response right

Take the time to do a personal check where you step out of your role and put yourself in the shoes of the complainant to see if you have satisfactorily answered the complaint. Look at the situation from their point of view - **would you be satisfied with the response?**

Ask a colleague to read your response to double check that it is balanced and fair and demonstrates that the organisation welcomes complaints as a mechanism for learning.

Useful phrases to include in complaint responses

The following phrases may prove helpful in writing complaint responses, though it is important to ensure that the content of the letter sounds personal and not “a standard response”.

- ✓ I was sorry to hear that you were unhappy with.....
- ✓ I regret that you found [xx] to be upsetting as this was not the intention.
- ✓ The normal practice is [xx]. I apologise that in this instance this did not occur. ✓ I apologise for any additional anxiety this caused.
- ✓ As a result of your letter we will.....
- ✓ I trust that my letter has answered the issues you raised and I sincerely regret that this situation arose.
- ✓ It is always our intention to provide excellent and responsive care for patients and I very much regret that this was not the case on this occasion
- ✓ Your experience of our services falls short of the standards we set for patient care and I would like to apologise, as would all staff concerned, for the stress and anxiety this experience has caused you.
- ✓ [X] would like to apologise that the [staff member] appeared rude at any time during the conversation with you. [He/She] would like assure you that this was not [his/her] intention.
- ✓ I will be happy to write to you with further details, discuss your concerns or arrange a meeting with relevant staff.
- ✓ Finally, I would like to take this opportunity to thank you for bringing this to my attention. The opinions of those who use our services give us valuable insight into the care/services that we provide and areas where improvements are required.

Remember, the response will be signed by the Chief Executive and should be written as a personal letter from him/her.

Be mindful of confidentiality constraints – if the patient involved has not given consent to the sharing of information, take care to ensure that the complaint does not breach confidentiality, but does not hide behind confidentiality either.

6. Response to Complainant letter template

Please proof read once you have completed the final response - maybe get a colleague to do this for you?

REFERENCE (Surname/Case ref) DATE

IN CONFIDENCE

Dear *(insert name here)*

I am writing in response to your letter dated, in which you raised concerns about *(if over agreed timeframe insert Our investigation took longer than expected and I am very sorry for our delay in writing to you.)*

I am sorry to learn of your poor experience and I would like to apologise for the distress this matter has caused you.

The investigation has been undertaken on my behalf by and included the gathering of statements from hospital staff, and a review of your/Mr/Mrs health records. I do hope you find the following response helpful.

Brief Story/Background

RESPONSE – pick out issues/questions direct (Bullet point issue raised not in italic but in bold. A full explanation should be given ensuring that all questions raised by the complainant have been answered)

- i.e Delay in carrying out procedure

Closing paragraph

Summary and further apology. *(Please note that an apology is not an admission of liability)*

I would like to thank you for taking the time to raise these matters with the Trust and reiterate my sincere apologies for

As a result of your complaint the Trust will make the following improvements:-

1. There will be a review of
2. The member of staff concerned will undergo additional training.....

3. Your complaint will be anonymised and shared with.....

We should always agree an action as part of our final response letter, even if the care provided was in line with expected standards. For example this could be sharing the complaint with an individual/team for training. It is important to take into account the unintended impact of the service we have provided, even if the service was provided correctly.

I hope that you are reassured that your complaint has been investigated thoroughly and that the action which is being taken will prevent anything similar happening in future. If you would like to be kept up to date in relation to our agreed actions, please inform the Patient Relations Team who will note this on your complaint file.

Finally, if you would like to share your experience as part of our Patient Story programme, please contact the Patient Relations Team on the contact details noted above. This process allows us to share your experience with staff in your own words, either via video or audio recording, with the aim of further improving the service we provide for our service users.

We would also like to invite you to join our Patient Involvement Partner (PIP) programme. As a PIP, you will be invited to meet with staff on a quarterly basis to discuss ongoing and upcoming initiatives in the Trust, as well as having the opportunity to become involved in helping us shape these workstreams. The PIP program aims to ensure a collaborative approach to improving the overall service we provide as a Trust. If this is something you would like to be involved in, please contact the Patient Experience Team on 01922 721 172 ext. 6903.

This letter is our final response letter, however, if you would like to discuss the situation further please contact the Patient Relations Team at:

Patient Relations Team, Address or via telephone on Contact Number.

If you are not happy with our final response to your complaint and would like to take the matter further, you can contact the Parliamentary and Health Service Ombudsman. The Ombudsman makes final decisions on complaints that have not been resolved by the NHS, government departments and some other public organisations. The service is free for everyone. To take a complaint to the Ombudsman, go to **www.ombudsman.org.uk/making-complaint** or call 0345 015 4033. It is important that you make the complaint as soon as you receive our final response as there are time limits for the Ombudsman to look into complaints.

As noted above, we are always seeking to improve services and this applies to the Patient Relations Service as well as our clinical services. I would therefore be most grateful if you could access our satisfaction survey via the QR code below to provide some feedback on our Formal Complaints process.

If you would prefer a form to be sent out in the post please contact the Patient Relations Team direct who will be happy to assist with this.

Yours sincerely

Joe Chadwick-Bell

Group Chief Executive

7. Statement Template

Ref:

Patient Relations Team
Address

Date:

Tel: Contact number

Statement for: Complaint ref:
Dear (Complaint Handler’s name)

Patient’s Name:
Patient’s Address:

Name of staff member providing statement:
Designation:

A statement should be factual, and you should avoid providing an opinion.

.....

.....

.....

.....

.....

.....

.....

.....

.....

[illegible]

SIGNATURE

DATE _____

Tips for writing a statement

- Insert 'Statement of Truth' – i.e. this statement is true to the best of my knowledge and belief.
- If appropriate please set out details of your role on the ward/team, e.g. do you have primary nurse responsibility, are you a manager, do you participate in multidisciplinary team planning and so on. If you were under supervision you should say by whom.
- As part of your statement, please set out details of your earliest contact with the patient. Ensure you refer to the medical records – if this is not possible you should state this. If you use an abbreviation, this should be explained fully and a translation provided in Layman's terms. Please format dates and times in full using the 24 hour clock, e.g. 13:00hrs on 27.6.11 – Not 1 on 27/6.
- Please set out the history in chronological order, and in first person (I did this...). Say what your involvement was, what you did, what you heard, what you saw (other witnesses can explain their own involvement), include details of our subsequent contact with the patient, your interaction with them, and/or relevant others. If you made a decision jointly, set this out e.g. "..... and I agreed that I should do this"
- When referring to others use their name and job title. If protocols or standard procedures are relevant, you can refer to these in your statement – and attach a copy if you have one. Any attachments should be marked as an exhibit (e.g. with your initials and a number) and referred to in the statement.
- As far as possible be clear when you have witnessed events, or if you have been given information, and set out the source of it.
- If you refer to specific information in the records and/or a report of some kind then please identify this by date. Sometimes it is helpful to have a transcript of those notes incorporated into your statement. Sometimes a diagram/illustration will help you explain – these can also be incorporated into your statement.

If you do require support with writing a statement, or in relation to the content of the complaint, please contact your line manager or a member of the Patient Relations Team.

Please note - all statements are disclosable upon request from external sources including the complainant, the Parliamentary & Health Service Ombudsman and Trust Solicitors.

8. Complaint Management Breach Report

Complaint Reference Number (Datix)	Complainants Name
Name of Complaint Handler	Division / Directorate

Complaint Investigation Performance Summary				
Date Complaint Received	Original Response Due Date	Extension Agreed		
		Date	Yes	No
Evidence of Early Contact				
Revised Response Date 1				
Revised Response Date 2				

*Please note, a maximum of 2 extensions can be applied. The extended timeframe must not exceed 4 weeks in total.

Details of Reasons for Response Timeframe Breach

Complaint Handler Signature	
-----------------------------	--

Divisional Director / Directorate Manager Comments**Divisional Director / Directorate
Manager Signature**

The purpose of the complaint handler completing this document in the event of a timescale breach is to provide a clear explanation for the delay, to assess any impact on the complainant, and to ensure accountability and transparency within the formal complaint process.

This helps us to identify any systemic issues or areas for improvement, supports compliance with our Trust standards and promotes timely resolution in future cases.

9. Quality Assurance Checklist

Formal complaint

Quality Assurance Checklist

Complaint Reference	
Final Severity Rating	
Complaint Handler	
Response Due Date	
Date actually completed – if not completed within the agreed response timeframe please explain why.	

Is this response fit for purpose:	Outcome:
- Written in plain English. - Response on letter headed paper. - Medical or technical terms explained. - If acronyms are used – explanation is provided related to meaning.	Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA

Are the steps taken to investigate and the evidence that has been taken into account explained? Including:	Outcome:
- The complainants account of events. - The account of events by the person(s) complained about (if relevant). - Relevant documentation, including medical records (if applicable). - Relevant law, policy, guidance, or procedures. - Any independent clinical or professional advice (if relevant).	Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA

Have the concerns raised:	Outcome:
- Been considered in line with the incident reporting policy. If an incident has been raised please provide the case number. - Been reviewed in line with the safeguarding triggers as outlined in the formal complaint investigation toolkit. - Has this incident been discussed with the safeguarding adults team? - Has a safeguarding referral been submitted?	Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA

Does the response:	Outcome:
• Give a thorough explanation of what you think happened, and if different explain what you think should have happened? • State the conclusions based on evidence? • Address any conflicting evidence or lack of evidence? • Is the decision regarding the outcome of the investigation clear? • Does the response include an apology for anything that has gone wrong?	Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA Yes/No/NA
• Include details of lessons learnt or actions taken as a result of the investigation (training, change to process, staffing)? • If so, who will monitor this and when will the actions be completed? • Does the response consider any other remedy including financial redress (if relevant)?	Yes/No/NA Yes/No/NA Yes/No/NA

10. Parliamentary & Health Service Ombudsman (PHSO) Guidance



The PHSO make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations. The PHSO aim to do this fairly and without taking sides.

The PHSO complaint standards were introduced in April 2023 and set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. The complaint standards aim to ensure that the complaints process is fair, transparent and accessible for everyone.

In line with the PHSO complaint standards, the PHSO have provided NHS organisations with a number of guidance resources which offer support and guidance on various aspects of the complaint process. These include:

- Promoting a just and learning culture.
- Making sure people know how to complain.
- Identifying a complaint.
- Who can make a complaint.
- Independent NHS complaints advocacy and other specialty advice.
- Early resolution.
- Clarifying the complaint and explaining the process.
- Carrying out the investigation.
- Writing and communicating your final response.
- Providing a remedy.
- Referring people to the Ombudsman.
- Complaints and other procedures.
- Complaints involving multiple organisations.

The above guidance modules are available on the Patient Relations Team page on the Trust intranet.



11. Reflective Shoes action plan



Reflective Shoes

The Reflective Shoes process gives us the opportunity to view the concerns raised from the complainant's perspective. This can help us to identify the unintended impact of our actions and to highlight shared learning to improve the service provided to patients and their relatives.

Case Ref	
Complaint Handler	
Date	
Staff Present members for Discussion	
What is the patient's / complainant's current situation? (e.g. have they been discharged, are they in distress?).	
What are their thoughts? (e.g. unsure what happens next).	
What are their feelings? (e.g. disappointed, scared, anxious).	

How did it feel hearing / reading the complaint? (This is an opportunity to share your feelings and offer your perspective on the feedback received).	
What learning can be taken from the complaint? (Think about what you or your team could do to prevent this occurring in future).	
How will you reflect on this practice? (Think about what went well, what didn't go so well and what you would do differently next time).	
Do you require any additional support? (This could be in the form of peer support, support from your manager or additional training)	

Please document any action agreed and the action plan template provided on the next page. Please also ensure a copy of this document is shared with the Patient Relations Team upon completion.

To be completed by complaint handler

RESPONSE TO COMPLAINT - ACTION PLAN

Please complete this plan to identify actions to be taken to resolve each of the issues raised in the complaint.

Complaint Ref	Action Required	Action completed	Responsibility	Deadline date	Actual completion

COMPLAINT AND ACTION PLAN SIGN OFF

For completion when all actions have been implemented

Complaint Handler's name	Signature	Date of completion

EVIDENCE TABLE

Please include any evidence of changes made and where available

Evidence	Where can this be located?

[illegible]



Appendix 2

Complaint Review Panel Terms of Reference

Background

The Francis Report (2013) highlighted that complaints often signal problems within a hospital and noted that individuals faced barriers and unresponsive staff, leading to reluctance in lodging complaints. Responding to these and other concerns in the Francis Report, the government initiated a comprehensive review of the complaint system. The final report, "Putting Patients Back in the Picture" (2015), recommended addressing causes of dissatisfaction and improving access and responsiveness to the complaints system. The review also emphasised the importance of raising concerns. Consequently, the Complaint Review Panel has been established to enhance the complaints system by evaluating the handling of cases at the local level.

Aim, Purpose and Responsibilities of the Group

- Address causes of dissatisfaction - Examine cases where complainants believe they have faced injustice, hardship, or feel their concerns have been ignored.
- Impartial review - Objectively assess statements from patients, relatives, and staff to determine if the Trust acted properly and fairly or if poor service was experienced
- Effective Communication and Confidentiality - Engage with patients, relatives, carers, representatives, managers, clinical staff, and other organizations to foster stronger relationships and ensure public confidence in the healthcare system and Trust.
- Listening and Learning Culture - Ensure the complaints handling process aligns with the new Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards, emphasising fairness, transparency, and responsiveness.

Membership and Accountability

The Group will meet on a quarterly basis

Chair – A member of the Trust Patient Involvement Partners appointed by the team

Members – At least 2 members drawn from the Patient Involvement Partners
Patient Relations Manager or representative

The meeting will be quorate when 2 or members are present. The Group will be responsible to the Patient Relations Team and through them will also report to the Trust Patient Experience Group.

In the event the Complaint review Panel are unable to meet, an internal peer review will take place, conducted by staff not involved in the complaints identified for review. The Complaint Review Matrix will be utilised, and the feedback process will continue as outlined in this document.

Working Procedures

Case selection

Cases will be selected randomly, ensuring at least one case per division / directorate is reviewed. Specific departmental focuses can be requested by divisional / directorate teams, applying relevant filters to the complaint search.

Confidentiality

All materials and documents will be anonymised and treated with confidentiality.

Feedback and Recommendations

- If the Group identifies errors by the Trust, they may suggest apologies, explanations, and/or service improvement recommendations.
- If the Group finds insufficient resolution by the Trust, they may recommend seeking an external review.
- If the Group determines the Trust has done everything possible to rectify issues, this feedback will be provided to the Divisional / Directorate Team.

Reporting

The Chair will generate a report on the outcomes, suggestions, and/or recommendations of the review, which will form part of the Trust Quarterly Patient Voice Report.

References

- Putting Patients Back in the Picture RT Hon Anne Clwyd MP and Professor Tricia Hart (October 2013).
- The Francis Report on Failings at Mid Staffordshire NHS Trust (2012).
- Parliamentary & Health Service Ombudsman (PHSO) Complaint Standards.

Appendix 3

Patient Involvement Partners / Maternity Voices Partnership Complaint Monitoring Panel Quality Assurance Matrix

Date of review:	
Complaint reference:	
Division / Directorate:	
Complaint Reviewed by:	Names
Evidence of Complaint handler contact with complainant	Y/N
Response completed within timescale	Y/N

Checklist:	Yes/No	Additional comments
The response is written in plain English.		
Medical or technical terms have been explained.		
If acronyms have been used, an explanation of what this represents has been provided.		
The response gives a thorough explanation of what happened.		
The response was empathetic toward the complainants' feelings.		
The decision regarding the outcome of the investigation clear.		
Does the response include an apology for anything that has gone wrong?		
The response considers any other remedy including financial redress (if relevant)?		
The actions outlined are proportionate to the concerns raised.		

Group RWT/WHT GOP04 / Version 1.0 / TPG & TPMCG Approved: 13 October 2025

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Summary:

Part A - Document Control

Policy number and Policy version: GOP04 V1	Policy Title NHS Model Complaints Handling Procedure	Status: FINAL		Author: Alison Dowling – Associate Director – Patient Voice - Relations Chief Officer Sponsor: Lisa Carroll – Chief Nursing Officer WHT Deborah Hickman – Chief Nursing Officer RWT
Version / Amendment History	Version	Date	Author	Reason
	1.0	Oct. 2025	Associate Director – Patient Voice - Relations	Implementation
Intended Recipients: All staff working within Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust.				
Consultation Group / Role Titles and Date: WHT – shared 21 July 2025 Christine Steen (CS) - PA to Community Directorate Team Vicky Wood (VW)- Team Leader/ Personal Assistant to Division of Medicine Daya Athwal (DA)- Divisional PA and Team Leader Division of Surgery Misbah Habib (MH) - Divisional PA - Women’s, Children’s and Clinical Support Services RWT – shared 22 July 2025				
Division 1				
Deputy COO		Lewis Grant (LG)		
Associate Deputy COO		Charlotte Hathaway (CH)		
Divisional Medical Directors		Mr (Steve) John Billing (JB)		
		Mr John Murphy (JM)		
Head of Nursing		Doreen Black (DB)		
Deputy Head of Nursing		Karen Wooding (KW)		
Director of Midwifery		Tracy Palmer (TP)		
Head of Nursing and Midwifery		Kate Cheshire (KC)		
Deputy Head of Nursing and Midwifery		Stacey Thacker (ST)		

Group RWT/WHT GOP04 / Version 1.0 / TPG & TPMCG Approved: 13 October 2025

Working in partnership

The Royal Wolverhampton NHS Trust
 Walsall Healthcare NHS Trust

Healthcare Governance Manager	Joanne Colgan (JC)
Division 2	
Deputy COO	Kate Shaw (KS)
Divisional Medical Directors	Dr Phil Dainty (PD) Dr Rajeev Raghavan (RR)
Head of Nursing	Beverley Morgan (BM)
Healthcare Governance Manager	Kelly Emmerson (KE)
Division 3	
Deputy COO	Rachael Brown (Interim) (RB)
Divisional Medical Directors	Dr Cathy Higgins (CH) Dr R McCathie (RMcC)
Head of Nursing	Jodie Winfield (JW)
Healthcare Governance Manager	Joanne Hughes (JH)
Name and date of Trust level group where reviewed	RWT - Trust Policy Group – 13/10/25 Trust Policy Management Core Group - 13/10/25
Name and date of final approval committee	RWT - Trust Policy Group – 13/10/25 WHT – Trust Policy Management Core Group - 13/10/25
Date of Policy issue	October 2025
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated).	October 2028 – 3 Yearly
Training and Dissemination: This policy and associated process will be shared via the Trust weekly dose including targeted emails to all staff groups and presentations to staff forums. The policy will also be linked to the Patient Voice dashboard available on the staff intranet. The policy will is also referenced in the Trust Formal Complaint Investigation E-Learning Modules, available on MyAcademy.	
Publishing Requirements: Can this document be published on the Trust's public page: Yes If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.	
To be read in conjunction with: Duty of Candour Policy Claims Policy Information Security & Incident Management Policy Root Cause Analysis Policy Security (MOVA) Policy	

Group RWT/WHT GOP04 / Version 1.0 / TPG & TPMCG Approved: 13 October 2025

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Initial Equality Impact Assessment (all policies): Completed Yes Full Equality Impact assessment (as required): Completed NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator	
Monitoring arrangements and Committee	Patient Experience Group
Document summary/key issues covered. This policy is to ensure that all staff are aware of the policy and procedures in the management of complaints, concerns and compliments in line with the Parliamentary & Health Service Ombudsman (PHSO) complaint standards.	
Key words for intranet searching purposes	Complaint PALS Patient Relations
High Risk Policy? Definition: - Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. - References to individually identifiable cases. - References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	Yes / No (delete as appropriate) No No No