Leicestershire Partnership NHS Trust

Concerns and Complaints Policy

This document describes the process for reporting, investigating, and managing complaints.

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1.0 Quick Look Summary

This policy will provide you with answers to questions regarding how the Trust handles concerns and complaints, how these are triaged, why we ask for consent to share information and what to expect should you provide the Trust with any feedback regarding your experience. As a Trust, we welcome contact regarding concerns and complaints from patients, families, carers, or other interested parties and want to learn from your experience as well as use your feedback to make changes, where possible, to processes and services across the Trust.

1.1 Version Control and Summary of Changes

Version number	Date	Comments
Document v11	January 2016	The complaint form has been revised to support changes to the process. Changes are investigator contact with complainant to ensure understanding of complaint and agree timescale of investigation, investigation timescales to be variable depending on complexity of complaint, investigation of complaints whilst consent is sought to ensure no delay in individual or organisational learning opportunities, investigation of 'complaints assessed as High' severity will utilise an independent investigator, from within the directorate, delegated authority for 'sign off' of complaints that are assessed to be low or moderate severity after investigation.
Document v12	January 2017	Included that Trust is compliant with regulation 16 of the Care Quality Commission (CQC)
Document v13	September 2017	Included that complaints are reviewed with regards to application of Mental Health Act (MHA)/Code of Practice 2015 standards.
Document v14	January 2018	Revision of guidance for Section 5.2
Document v15	January 2019	Consultation to staff and external stakeholders for revision of current complaints policy.
Document v16	October 2019	Revision of the Trusts complaints process.
Document v17	October 2020	Revision of the Trust complaints process in line with NHFT.
Document V18	July 2023	Revision of the Trust complaints process in line with the New Parliamentary and Health Service Ombudsman Complaints Standards and following the internal PALS review.
Document V18	April 2026	Ext requested due awaiting new guidance and allow for the approval process
Document V18.1	July 2026	Ext due awaiting to allow for the approval process and checking from chief nurse
	October 2026	3 Month further Ext due awaiting to allow for the approval process and checking from chief nurse

1.2 Key individuals involved in developing and consulting on the document

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1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Complaints Review Group	Quality Forum/QSG

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

In carrying out its functions, LPT must have due regard for the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development and review.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy.

1.5 Definitions that apply to this Policy.

Comment	Patients, relatives, and carers may have valuable feedback good or bad relating to their experience and may wish to share this with the Trust.
Concern/Enquiry	A patient, relative or carer may be worried about an aspect of the care and need some advice or clarification. These issues can be resolved quickly and in the interest of the patient and can be recorded informally for the purpose of service improvement.
Complaint	A complaint is an expression of dissatisfaction, either in writing or verbally about the healthcare/treatment or services provided, which requires an investigation and formal response.
Complainant	A patient, relative, carer or representative expressing dissatisfaction about the healthcare/treatment or services provided.
ULYSSES	A database system to record comments, concerns, enquiries, and complaints.
Due Regard	Having due regard for advancing equality involves: Removing or minimising disadvantages suffered by people due to their protected characteristics. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.0. Purpose and Introduction

The purpose of the Concerns and Complaints Policy is to set out a clear framework for all staff on how the Trust will support the effective implementation of the NHS Complaints (England) Regulations 2009, as well as the Parliamentary and Health Service Ombudsman (PHSO) Complaint Standards, and the expectations when a complaint is handled by the Trust.

The Policy emphasises the importance of early local resolution of complaints where possible, and the need for frontline staff to be responsive and sympathetic to anyone that wishes to raise issues or subsequently, as part of a formal investigation.

Leicestershire Partnership NHS Trust recognises the importance and value of patient feedback, particularly concerns and complaints, and how the experience of our users can be used to improve the quality of service provided.

The Policy sets out the Trust procedure for managing and responding to complaints and concerns and provides staff with the confidence to effectively handle any that are received and to provide an approach which places the complainant at the heart off all decisions made.

The Trust actively promotes a culture that seeks and utilises feedback and recognises that complaints are an opportunity to obtain valuable information from our service users and to learn from their experience to improve the quality of our services. Complaints should be viewed as a positive way to improve services and avoid the risk of similar situations occurring again.

The Trust is committed to handling complaints in line with the NHS Complaints Regulations and adopting best practice principles from the Parliamentary and Health Service Ombudsman publications, including the updated Complaints Standards. The Policy promotes a service user led approach to handling complaints and provides the service user with confidence and support that their issues are important to us.

The procedure is available to all patients, their relatives, and careers irrespective of their characteristics and ensures that no individual is discriminated against on the grounds of their age, ethnicity, sex or sexual orientation or other characteristics.

3.0 Policy requirements

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (NHS Complaints Regulations)	New complaints will be acknowledged with 3 working days
Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (NHS Complaints Regulations)	Complaints will be responded to within 40 working days or timeframe agreed with complainant
CQC Regulation 16: Receiving and acting on complaints	Improvement action will be taken in response to any failure identified

4.0 Duties within the Organisation

4.1 Trust Board has the overall responsibility for ensuring compliance with all legal, statutory, best practice and quality improvement requirements and, will receive reports on complaints throughout the year to ensure this is undertaken.

4.2 The Quality Forum will receive complaints reports on a regular basis to seek assurance of the management of complaints in accordance with the standards set out in this policy that also meet statutory requirements.

4.3 The Complaints Review Group (CRG) will provide assurance and strategic oversight to the implementation of the Trust complaints procedure, complaints involvement plan and associated work streams, including how we learn from experience and feedback to make improvements to our services and the patient, carer, and family experience.

4.4 Chief Executive (CEO) holds overall accountability and fulfils the role of responsible person under the regulations. The Chief Executive is responsible for reviewing and signing each individual complaint. In their absence the role is delegated to an Executive Member as appropriate.

4.5 Director of Nursing, AHP's and Quality is the nominated board member with responsibility for compliance with the arrangements made under the complaints regulations and also has responsibility for ensuring that procedures are developed, agreed, and implemented throughout the Trust and monitored as appropriate.

4.6 Service Directors and Heads of Nursing are responsible for:

- The implementation of the Concerns and Complaints Policy within their directorate.
- To ensure every complaint they receive is reviewed.
- Ensuring an appropriate and robust investigation has been completed, which identifies lessons learned and any actions identified are appropriate and that the response provided addresses all concerns raised, in a caring and compassionate manner.
- The Head of Service shall form part of the approval and sign-off process, along with Head of Nursing, Associate Medical Director, and Clinical Directors, as appropriate and on a case-by-case basis.

4.7 Head of Service, Service Managers, Deputy Heads of Nursing, Team Managers (Investigation Leads) are responsible for:

- Ensuring the investigation of concerns and complaints are carried out in accordance with this policy.
- Investigating complaints, deciding if the complaint is upheld, partly upheld, or not upheld and for completing the Complaints Management Document (CMD) and preparing a response for complaints which relate to their service area.
- Implementation of learning from complaints and on-going improvement to services, as a result of feedback and developing action plans.
- Determining whether it is appropriate to reallocate the member(s) of staff providing ongoing care for the complainant if there is the potential that the position of staff or the complainant could be compromised as a result of a concern having been raised or a complaint being made.
- Notifying the PALS and Complaints Team when an action plan has been completed.
- The Head of Service or Clinical Director shall approve an investigation and response prior to completion by the Investigation Leads

4.8 The Complaints and PALS Manager is responsible for the overall management of complaints in accordance with the NHS Complaints Regulations, including ensuring compliance with policy and procedure and management of the Complaints Service function.

4.9 The Complaints and PALS Team will:

- Provide a single point of contact for patients, relatives, carers, and representatives wishing to complain and/or seek advice on the Trust complaints process.
- Ensure public and staff awareness of the complaints process and how to access it, providing any support as necessary.
- Develop and maintain systems which ensure that complaints are managed promptly and effectively with meaningful data held.
- Facilitate the complaints process ensuring the Trust is adhering to the policy. The Complaints Service will co-ordinate all complaints received including acknowledgement, seeking of consent, and response timeframe.
- Facilitate the approval process with Service Directors and sign off with the Chief Executive.
- Monitor the progress of investigations, the draft responses from investigating managers and any follow-up action that has been taken as a result of the complaint.

- Ensure any signposting to the Parliamentary and Health Service Ombudsman is undertaken for complaints that cannot be resolved locally.
- Produce the statutory return (Ko41a) to the Department of Health and an annual report for the Trust.

4.10 Patient Advice and Liaison Service (PALS) will work to resolve concerns and enquiries and be accessible for complainants and staff. Ensure all processes relating to the administration of concerns and enquiries are efficiently managed and continuously audit concerns to identify trends and themes.

4.11 All staff have a responsibility for listening and dealing with concerns and complaints in a sensitive and timely manner showing care and compassion. Staff must ensure that patients, their relatives, and carers are not treated differently or adversely affected in any way as a result of making a complaint. Staff should view complaints as a positive experience that provides an opportunity to resolve issues and make changes to improve the quality of services we provide. They should ensure concerns and complaints are managed in accordance with this policy. Staff should ensure that any correspondence relating to a complaint is kept separately from patient medical records.

5.0 Policy Details

5.1 Persons who may raise a concern or a complaint.

A complaint may be made by:

- Anyone who is receiving or has received care or treatment from the Trust.
- Anyone who is affected or likely to be affected by the action, omission, or decision of the Trust.
- A third party, for example an MP, relative, friend, carer, independent advocate on behalf of the patient.

A complaint made by a representative where that person:

- Has died.
- Is a child.
- Is unable by reason of physical or mental incapacity to make the complaint.
- Has requested the person to act on their behalf.

5.2 Time Limits for Making a Complaint

It is important that a complaint is made as soon as possible but generally a complaint should be made:

- Within 12 months of the date when the event being complained about occurred or,
- Within 12 months of becoming aware of the event/subject matter.

The Trust will consider complaints made outside of these time limits, the reasons for this and whether there is scope to investigate matters fairly and effectively. The Complaints and PALS Manager in cooperation with the Investigation Lead, will make a decision whether the Trust is in a position to investigate.

In the case that the Complaints and PALS Manager and Investigation Lead decide that it is not possible to fairly or effectively investigate the complaint due to the timeframe that has elapsed, the complainant will be informed of the decision in writing. The complainant can appeal in writing to the Trust.

5.3 Exclusions to the Complaints Procedure

Complaints that are excluded from the Trust's Complaints Procedure are:

- A complaint that has already been investigated under the complaint regulations.
- Complaints by a responsible body.
- Complaints regarding NHS Employment.
- A complaint that is or has been investigated by the Ombudsmen.
- Private healthcare unless this has been funded by the Trust.
- Complaints regarding requests under Freedom of Information.
- A complaint made orally, which has been resolved satisfactorily.

5.4 Consent and Capacity

Data protection is very important to the Trust as is the well-being of our patients. We have a duty to ensure that any information shared is for a legitimate purpose and only to those individuals who have the legal right to this information. It is important that any information shared is not likely to cause additional distress or upset. This is particularly relevant in cases where a complaint is made on behalf of a patient or where there are concerns around capacity.

If a complaint is made on behalf of a patient and the patient has capacity to consent to share information with the complainant and/or other agencies, this written consent will be facilitated by the Complaints and PALS Team as soon as possible. Where the patient lacks capacity, does not wish to give consent or consent is unable to be obtained for any other reason, the complaint will be shared with the service in question and an investigation completed. This process will allow the Trust to continue to learn and make tangible changes to the services we provide.

- If consent has been received before the complaint is finalised, a full and formal response will be provided by the Trust.
- Where consent is not received, a letter will be sent to the complainant acknowledging their concerns and providing any information which we are able to share.
- If consent is received after the complaint has been closed and a general response sent to the complainant, the Trust will provide a formal written response at a later date.

When a person lacks capacity and a Power of Attorney in place, the Trust must ask the attorney to provide written consent and provide supporting documentation in the form of the Power of Attorney for Health and Welfare. If these are not in place, a decision needs to be made on the appropriateness of sharing information with the person making the complaint. The Trust must consider the role and/or relationship of the individual making a complaint on their behalf and that they are acting in the best interests of the patient and that they have a legitimate reason to confidential information. The Trust will seek appropriateness to share with the clinical team/s caring for the patient. It may be that the Caldicott Guardian needs to be consulted to consider the Trust's position and decision making.

In circumstances where a patient is deemed to lack capacity to make a complaint or engage with the complaints process due to ill health, and commencing a complaint is likely to cause deterioration in the patient's health, the Complaints and PALS Team will liaise with the relevant clinical team/s caring for the patient to seek a best interest's decision on the appropriateness to commence the complaints process. If felt to be at the detriment to the patient's health, the complaint will be placed on hold until a time that the complainant is well enough to progress the complaint. The Complaints and PALS Team will liaise with the

Directorate to gain updates on the complainant's health and write to the complainant when they are deemed well enough to continue with the complaints process.

Where an adult with parental responsibility is complaining on behalf of child, consent will only be required where the child is over the age of 13 and has been deemed to have competence under the Gillick Competencies. Additionally, The Trust has a duty to gain a young person's involvement in the complaints process, if they are 16 years or over and where they have the capacity to do so. Further information and guidance can be obtained from the LPT Mental Capacity Act Policy. In the situation of a parent not having parental responsibility, advice will be sought from the Safeguarding Team.

In instances where the complaint is made on behalf of a person who has died, the Trust must ask the Executor or personal representative to provide written consent along with providing supporting documentation such as the Will or Grant of Probate. When these are not in place a decision must be made about the appropriateness of the person making the complaint and the right to confidential information. The Trust must consider the role and/or relationship of the individual making a complaint on their behalf and that they are acting in the best interests of the patient and that they have a legitimate reason to receive confidential information. The Trust will seek appropriateness to share with the clinical team/s caring for the patient. It may be that the Caldicott Guardian needs to be consulted to consider the Trust's position and decision making.

Where input is needed from another organisation in order to provide a coordinated response, consent will be sought from the patient, or in the event that the patient has died, the Executor or another legally entitled party in order to share the letter of complaint and to obtain the organisation comments and any patient records or documentation in support of their response.

Where a Member of Parliament has raised a complaint on behalf of a patient, the Trust must seek written consent from the patient before any information can be disclosed. To avoid any delays in the process, the Complaints and PALS Team will seek consent directly from the patient.

5.5 Confidentiality

Complaints will be handled in the strictest confidence in accordance with the relevant Trust policies. Care will be taken that information is only disclosed to those who have a demonstrable need to have access to it.

5.6 Equal Treatment

There are occasions where there is an irretrievable breakdown in the clinician/patient relationship, but it is important that the patient's care is not adversely affected due to making a complaint. Patients and their representatives need to be assured that they can raise concerns without fear or recrimination. They should be encouraged to raise concerns if they feel the patient is being treated differently or unfairly due to raising a complaint.

All complaints registered will be dealt with fairly and effectively and as promptly as possible. Access will only be limited where unreasonable behaviour has been noted as a concern.

5.7 Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service have an important role in supporting individuals who wish to make a comment, raise a concern, enquiry, or complaint. It is recognised that not all issues benefit from being escalated to a formal complaint (for example the decision does not

influence the clinical outcome or re-prioritise a patient) and there is often scope for PALS to seek to resolve matters, so they do not progress into a complaint.

PALS also have a valuable role to play in providing support and advice to anyone who wishes to pursue their concern via the NHS Complaints Procedure. This may be taking the details of the complaint verbally and recording these for them on the Complaint Form and explaining how the complaints process works.

5.8 Concerns

In the majority of cases, if a person is feeling dissatisfied, they may like the matter rectifying speedily as the Trust recognises that not all correspondence received will benefit from the NHS Complaints Procedure nor is it everyone's expectation when they write to the Trust.

All staff are encouraged to attempt to resolve any concerns as much as practically possible within their service area or at the point of service delivery. They must ensure that they:

- Take time to listen and consider the complainants' views.
- Reassure the service user, their relative, carer or representative that complaints are welcome, and they are entitled to raise concerns.
- Treat the complainant with empathy and fully consider their needs.
- Treat the issues with confidentiality, as far as practically possible and with sensitivity.

Where a member of staff or service are able to resolve matters locally a record of the discussion held, the outcome and actions agreed with the complainant should be recorded onto the customer service web on Ulysses. This should be done by a member of staff within the relevant Directorate. Further supporting documents can be found on the Staff Intranet or by contacting the Complaints and PALS Team directly.

A concern is often shared by way of feedback, or it can also be an enquiry made to clarify treatment and care. These are received by the Patient Advice and Liaison Service; the issues will be logged on Ulysses and the Directorates will be sent all the key information on the PALS Management Document. It may be that departmental staff, or the Patient Advice and Liaison Service can resolve matters quickly without the need for a formal route. This process should take no longer than 10 working days. However, a date agreed with the complainant can also be negotiated should additional information imperative to the investigation be required and there are issues with speaking to staff or accessing documentation.

Concerns or complaints which are dealt with to the complainant's satisfaction within one working day of the concern being made, or if the concern/complaint raised is dealt with by staff to the complainant's satisfaction, will be classified as an informal concern/complaint.

If a meeting is arranged or a letter written by the Directorate staff to try and resolve the concern, it will remain open on Ulysses until a fully completed PALS Management Document (PMD) is received with the outcome of the meeting or a copy of the letter written by the directorate provided.

A record of the outcome of concern or complaint should be recorded on the PALS Management Document and sent back to PALS. They will close the concern on Ulysses.

Where the complainant remains unhappy with the outcome and informal resolution is not possible, staff should give assistance to the complainant to allow them to raise their complaint formally. Staff should provide ease of access to the complaints process and make it as simple as possible.

Staff should provide details and documentation in the way of this policy and our complaint leaflet (see appendix 4) on how to make a complaint or direct the complainant to our website or Complaints and PALS Team for further information.

5.9 Local Resolution

This is the process by which the Trust makes every effort and all appropriate steps to try and resolve the complaint. The Trust should observe the Parliamentary and Health Service Ombudsman's Principles of remedy, good complaint handling and, My Expectations to Raising Concerns and Complaints – a user led vision. See appendix 5 for the general principles and the link for the full report. (https://www.ombudsman.org.uk/publications/my-expectations-raising-concerns-and- complaints).

The Trust will aim to ensure all complaints that are not subject to Patient Safety Reviews are responded to within 40 working days or a date agreed with the complainant. If the investigation cannot be completed within the timeframe, the complainant will be kept fully informed and will be contacted to discuss a possible extension. Should a local resolution meeting be agreed between the Trust and the complainant, it may be the case that the complaint is placed on pause to allow this to happen and a new shorter timeframe re-set once the meeting has taken place. The aim is to resolve the issues raised in a timely and fair manner for all parties concerned.

Good communication is key to resolving complaints and this should be effective first and foremost with the complainant offering a point of contact. Internally there should be good communication between staff and departments involved in the care. There should also be close links with external organisations involved, to ensure a collaborative approach to responding to the complaint.

5.10 Complaint Handling – Investigation – Outcome

Complaints can be made either in writing, by email or letter, or verbally to any member of staff within the service or directly to the Patient Advice and Liaison Service (PALS) and Complaints Team. Any complaint that is received verbally should be recorded using the Complaint Form (Appendix 7 and 8).

Any complaint verbally or in writing received within the service should be forwarded electronically to the Complaints and PALS Team within 1 working day of receipt.

Receipt and triage

Following receipt of any complaint, the Complaints Team will triage the complaint to assess

the content, specifically if consent is required, and whether the issues are eligible to be investigated under the NHS Complaints Regulations or should be directed to a more appropriate pathway.

Should the issues not be eligible to be investigated under the complaints process due to being out of time, a letter from the Chief Executive will be sent explaining the reasons why this approach has been taken. This should be done, where practically possible, within 3 working days of receipt of the complaint. The letter is recorded on Ulysses as an enquiry should the complainant get back in touch to appeal against the decision. Should the issues not be eligible to be investigated under the complaints process due to falling under the remit of the Patient Safety Team, the Complaints and PALS Team will contact the complainant to confirm this verbally, where possible and will provide confirmation of the process in writing within 3 working days.

Acknowledgement and seeking consent.

Where a complaint has been made on behalf of another person and consent is required, the Complaints and PALS Team will write to the complainant to seek assistance with the appropriate consent form and supporting documents, where relevant. The complaint will be logged onto Ulysses as pending and details of the complaint will be shared with the directorate. Should there be any Patient Safety or Safeguarding Concerns that need intervention whilst consent is obtained, this should be done within 3 working days of receiving the complaint. The timeframe for investigation will not begin until consent and/or the appropriate supporting documents are received by the Complaints and PALS Team.

If appropriate to formally register the complaint, the Complaints and PALS Team will record the details on Ulysses and issue the complaint and all relevant documents to support the investigation to the relevant Complaints Governance Lead. This will be the process followed on receipt of consent.

Initial contact

Following receipt of the complaint and documents, the Directorate should allocate an Investigation Lead. The Investigation Lead is responsible for reviewing the complaint and contacting the complainant to establish further context to the issues raised, agree who will receive the response, the preferred way the complainant would like to receive their response and if there are any special requirements that need to be considered as part of the investigation and response process. Importantly the complainant should also be provided with the name of the Investigation Lead and contact details should they wish to contact the investigator at any stage of the investigation.

If the contact with the complainant has been unsuccessful and every reasonable attempt has been made on more than one occasion or, they have indicated that they do not wish to be contacted by telephone, the Investigation Lead should email or write to the complainant to outline:

- Their name, role and contact details should they wish to get in touch at any point during the investigation.
- Their understanding of the issues of the complaint.
- How the issues will be investigated.
- Who they will liaise with and any resources that may be needed to investigate.
- What documents, policies, or procedures they will potentially refer to.

Should the complainant wish for the investigation to be in writing and for no contact to be made once the initial complaint has been received, the Investigation Lead will endeavour to

investigate the complaint based on the information they have within the records and by speaking with the staff involved. The Investigation Lead will then produce a formal response, with the caveat that if the complainant is unhappy or has additional issues to raise upon receipt of the response, that these are investigated further.

If it is identified at this point that input is required from another organisation, the Complaints and PALS Team will progress this by seeking the appropriate consent from the complainant considering sections 5.16.

Where any issues relating to Patient Safety, litigation, Safeguarding are identified, the Investigation Lead should ensure the appropriate action or department is contacted to progress the issues. The Complaints and PALS Team, where appropriate, should be made aware of the action taken.

The Investigation Lead should also highlight any concerns relating to the application of the Mental Health Act (MHA)/Code of Practice 2015 standards. Where concerns are identified, these shall be shared with the Regulation and Assurance Lead for the Trust, supported by the Senior MHA Administrator for their review and advice on any further action to be taken, where required.

The Investigation Lead should complete an initial risk assessment of the complaint. Please refer to section entitled level of risk and use of the Severity Grading Tool within the Management Document (Appendix 8).

The Investigation Lead should ensure contact is made and that a record of the contact with the complainant, details of any incident, Duty of Candour and response method agreed with the complainant are completed on the Complaint Management Document (CMD) and sent to the Complaints and PALS Team, where possible, within 5 working days of receiving the complaint. The Complaints and PALS Team will update all the details within the management document onto Ulysses.

The response

The Trust recognises the importance and value of providing a response to all complaints which is fair, open, honest, and transparent and is considerate to the circumstances and individual needs of each complainant. A full response must be made within 40 working days of receipt of the complaint, or a date agreed with the complainant, if different.

If, in exceptional circumstances, it is necessary to request an extension this must be discussed with the Complaints and PALS Team and/or the Director of Nursing and then agreed with the complainant. The Complaints and PALS Team will contact the complainant to discuss the extension, the reasons for this and agree a new date and will update the Investigation Lead and service, as well as Ulysses accordingly.

The complainant may be unwilling to grant an extension and in these circumstances the Investigation Lead in cooperation with the Complaints Team should do everything possible to meet the original timeframe. If the timeframe will elapse, the Complaints and PALS Team will contact the complainant to advise of the reasons why and when the complainant is likely to receive their response.

When looking to provide a response, this should be flexible to the preferred response method of the complainant and can be either via a letter, email, local resolution meeting or telephone call.

Where a complainant or their representative wishes to have a meeting to discuss the

complaint, the Investigation Lead should encourage this as part of the resolution process, as the benefits of meeting face to face can be significant in understanding the issues fully and allow for a positive discussion on the findings of the investigation and what actions the Trust intend to implement. A local resolution meeting can take place at any point in the complaint process, and it is important for all staff in attendance to have undertaken preparation.

The complainant should be engaged in the process of arranging a date, but should it not be possible to arrange a date within the 40 working day timeframe, it will be confirmed to the complainant either in writing or verbally the reasons why and advising that a response will be provided within 25 working days of the meeting date, or a date agreed with the complainant. This will also be confirmed with the complainant at the meeting.

Where a response has been provided by a local resolution meeting or telephone call, a summary of the issues discussed, and any actions and learning should be provided in the response to complainant section of the management document and sent to the Complaints and PALS Team. The Complaints and PALS Team will draft a covering letter that will be sent to the complainant, along with a copy of the notes, which will be signed off by the Chief Executive.

When concluding the investigation, the Investigation Lead shall ensure that the investigation is evidence based, clear and supports the response. In drafting the response to complainant, the Investigation Lead should consider:

- All points raised in the initial letter and contact with the complainant are addressed.
- A clear chronology of events detailing times and dates and a description of what took place is provided.
- The response is clear, jargon free, easy to understand and is not defensive and spelling and grammar is checked.
- The response is written sympathetically and considering the circumstances of the complaint and complainant.
- An apology is provided, where appropriate, and any learning and actions the service will undertake.
- Medical issues are checked by the appropriate clinicians/medics for factual accuracy.
- The Trust complaint response or covering letter should offer the opportunity for the complainant to approach us again either to obtain a further written response or offer a meeting.
- The details of the Parliamentary and Health Service Ombudsman are provided.

Along with the draft response or summary of the meeting, the Investigation Lead will also complete:

- The investigation process section of the management document, ensuring a detailed account of their investigation to each point raised, making use of the discussion template for any statements taken from staff involved in the complaint.
- The Complaint outcome section of the management document detailing the outcome as (upheld, partly upheld or not upheld) to each point raised.
- The overall outcome is provided (upheld, partly upheld or not upheld)
- Any lessons learnt are detailed along with a fully completed action plan that has emails/evidence from relevant staff acknowledging their responsibility for completing the actions.
- The final risk grading.
- The details of the Head of Service, that has approved the management document and the date this took place.

Along with the management document any statements, interviews, email exchange or

telephone conversations with staff as part of the investigation should be provided to the Complaints and PALS Team. In addition, any relevant health records, policies, procedures, or journal articles referred to within the investigation should be provided to the Complaints and PALS Team, where appropriate.

The written response or covering letter to accompany any summary of a telephone or meeting discussion will be composed by the Complaints and PALS Team and should be appropriately processed through the Trust quality assurance process with the Chief Executive or their nominated deputy ultimately signing this off.

A signed copy of the final response will be shared with the Directorate Governance Team, so that this can be disseminated to the relevant staff involved in the complaint investigation and service for noting and learning, where relevant. If the complaint relates to a medical practitioner, a copy of the signed final response will be emailed to the Medical Director copying in their PA by the service.

5.11 Learning from complaints, remedial action, and compensation

All complaints offer the opportunity for the Trust to learn and improve the quality of service provided. It is important that all complaints, even those that are considered not upheld, are shared and we learn from those with foundation.

Any learning and actions identified following the investigation will be included in the Complaints Management Document and an action plan devised, where appropriate. All actions identified will be recorded onto Ulysses under the relevant complaint reference.

Each Investigation Lead will be required to provide the relevant information relating to action onto the action plan and provide evidence in the form of a signature or email from the action lead stating their involvement in formulating and agreeing to the responsibility of the actions. The Directorate will then be required to evidence that the actions and learning have been implemented. Bi- monthly reports will be produced by the Complaints and PALS Team to monitor the progress of each action and will remain outstanding on Ulysses until satisfactory evidence has been provided.

Learning from Complaints should be discussed anonymously on Wards, at Departmental meetings, Directorate Governance meetings and the Complaints Review Group. The Complaints and PALS Team will also provide quarterly and annual reports for the Complaints Review Group and highlight reports which will feed into the Quality Forum, Lessons Learnt Group and Quality Assurance Committee to ensure ward to board feedback. Monthly and quarterly reports will also be provided to each directorate.

Not all complaints require financial remedy and complainants often seek an apology when things have gone wrong. The Trust should consider all forms of remedy, such as acknowledging if a mistake or error has been made, an explanation of events, action taken as a result and, where appropriate, financial reimbursement. Ex-gratia payments in respect of expenses incurred by patients should also be considered where the Trust is found to be at fault, in accordance with the Trust's Losses and Special Payments Policy.

The PHSO may also recommend redress for the complainant in instances where they partly uphold or uphold a complaint following their review.

Complainants seeking compensation for non-quantifiable loss, for example negligence and distress should be advised to seek legal advice and information on how to make a claim should be provided by the service or the Complaints and PALS Team in writing to the complainant.

5.12 Further Local Resolution (Reopened Complaints)

Although the aim of following the above process is that the complainant will be satisfied with the outcome and the complaint will be resolved, the Trust recognises that complainants may remain dissatisfied with the explanation and remedial action suggested. It is acknowledged that the information provided in our response may lead to further concerns being raised.

It is important in the first instance that the Trust receives from the complainant the issues that they remain unhappy with in order to fully investigate these or, if a meeting is indicated, ensure the correct staff are in attendance.

If the further letter contains new issues, these should be recorded as a new complaint on Ulysses and the issues investigated as the above process.

Once the Trust is in receipt of the further issues, the Complaints and PALS Team will provide a written acknowledgement. Where possible a response should be provided within 40 working days, or a date agreed with the complainant.

The response should include a reminder of the complainant's right to approach the Parliamentary and Health Service Ombudsman.

5.13 The Parliamentary and Health Service Ombudsman (PHSO)

If a complainant remains dissatisfied with the handling of their complaint and all avenues to help resolve matters have been exhausted, they can approach the Parliamentary and Health Service Ombudsman. The PHSO is independent of the Trust and may be able to undertake an independent review of the complaint.

The Complaints and PALS Team will handle any requests from the PHSO and liaise with the relevant directorate or services. In the interest of resolving the complaint, the Trust needs to fully cooperate with any requests by the PHSO.

Any initial contact from the PHSO should be logged onto Ulysses and raised with the Complaints and PALS Manager to consider their request.

In the event the PHSO requests the patient medical records and complaints file, the Complaints and PALS Team will coordinate these documents with the Data Privacy Team, ensuring they are sent within the stipulated timeframe along with any accompanying comments.

If the PHSO decide to investigate the complaint and subsequently provide a report on their findings to the Chief Executive, the Chief Executive will delegate the responsibility of dealing with any recommendations made to the relevant Directorate or service. The Complaints and PALS Team will assist the Directorate to collate and send any relevant comments and evidence to the Ombudsman.

5.14 Supporting staff involved in a complaint.

The Trust recognises our duty to staff rights to anonymity in written complaint responses where there is no demonstrable need for an individual to be personally named. However, it is admissible to identify an individual by their post or title, where such detail is necessary within the context of the response for purposes of clarity.

A demonstrable need to personally identify staff members may arise where:

- An individual bears overall responsibility for the service user's healthcare (e.g., a Consultant).
- An individual has been identified by the complainant and the issues concerning the individual require a direct response.

Where a demonstrable need arises on the part of one staff member, this does not automatically give rise to the need to name other staff members in the same response. Each disclosure of an individual's name must be determined on its own merits.

Wherever staff members are identified and whenever statements prepared by staff members are used in whole or in part in response letters, the staff members shall be made aware of this by the Investigation Lead and provided with a copy of the response letter.

5.15 Complaints that involve more than one directorate and service.

Where a complaint is received which spans more than one service or directorate, the Complaints and PALS Team will in the first instance identify the primary or most serious issue within the complaint and register the complaint on Ulysses against the directorate this issue relates to. The subsequent issues will be identified and recorded on Ulysses under the relevant service and directorate.

The complaint will be issued to the lead Directorate, who will be required to contact the complainant to complete the relevant sections of the management document, including the issues for the other Directorates. This is to ensure that all issues are fully understood and that they are not contacted by more than one member of staff.

The lead directorate, with support from the Complaints and PALS Team, will be responsible for coordinating a joint response between the different services/directorates and providing a collaborated response and management document.

5.16 Complaints involving more than one organisation.

When a complaint is received that requires involvement from more than one organisation, the recommendation is that a coordinated response should be provided.

In the first instance, the Complaints and PALS Team will seek consent from the complainant or patient if the complaint is being made on their behalf. Following receipt of the appropriate consent, the Complaints and PALS Team will share the letter with the relevant organisation and establish who should be the lead organisation and communicate with the complainant from that point forward. The investigation will not commence, nor will any information be shared with the other organisations until the appropriate consent is received.

Due to the varying timeframes across organisations, it may not be possible to produce a coordinated response and the Trust on occasion may need to respond in isolation. In these instances. The Complaints and PALS Team will seek permission from the complainant in advance of any complaint response being provided.

5.17 Complaints received which fall wholly within the remit of another organisation.

On occasion a complaint will be received which relates entirely to another organisation. This may be due to a lack of understanding about which organisation is responsible for the care or service. The Complaints and PALS Team will acknowledge receipt of the complaint and seek consent either verbally or in writing to share the complaint with the relevant organisation.

5.18 Independent Complaint Advocacy Services (ICAS)

ICAS are independent organisations where their primary function is to support those making a formal complaint about the NHS. The Trust should make the complainant aware of this service and encourage the use of their services. All staff have a responsibility to actively promote the use of ICAS and to provide details which can be located in the Trust complaints leaflet, on the website or directly from the Complaints and PALS Team.

5.19 Level of Risk

The Investigation Lead is required to undertake an assessment of the risk associated with the complaint after the investigation has been completed. This is undertaken using the severity grading tool and matrix.

5.20 Patient Safety Incidents

Complaints may be received regarding a patient safety incident. It may be that on review of a new complaint, it becomes evident the situation:

- Is or has been subject to a patient safety investigation.
- A person affected by a patient safety incident may raise a complaint about the handling of the investigation or may choose to raise a complaint about the situation despite the incident being under investigation.

Each situation will be reviewed and managed as required.

If a complaint is received and there are implications that it is part of an existing patient safety investigation or that it will be escalated to a patient safety investigation, the complaint should be sent to the CPST via email at lpt.patientsafety@nhs.net and it will be reviewed at the Trust's Incident Review Meeting, which occurs once a week every Friday morning.

The complaint will be acknowledged and recorded in our normal process, however; the complainant will subsequently be contacted by the Investigation Lead and advised that the complaint will form part of the patient safety investigation. The complaint will subsequently be re-defined as "escalated to a patient safety investigation" and feedback achieved through the Patient Safety Incident investigation process.

The Complaints and PALS Team will follow up in writing to keep the complainant fully informed of the decisions made. It is important that the CPST are fully briefed with regards to the content of the complaint to ensure that the Patient Safety Investigator includes the concerns raised and also acknowledges this with the patient/family, as appropriate. A copy of the complaint should be made available to the CPST for addition to the patient safety investigation file.

5.21 Duty of Candour

It is a requirement of the Trust to be open, honest, and transparent with people who use the services when a patient comes to harm that is considered to be moderate or above which may also lead to a notifiable patient safety investigation.

Duty of Candour is part of all NHS organisations Care Quality Commission (CQC) registration requirement. Duty of Candour applies to all incidents where moderate or severe harm or death has occurred as a result of an incident.

To give clarity to this policy there are currently five categories of harm that allows organisations and teams to determine the level or degree of harm as a result of a patient safety incident:

- **No harm** – a situation where no harm occurred: either a prevented patient safety incident or a no harm incident
- **Low harm** – any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.
- **Moderate harm** – any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.
- **Severe harm** – any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.
- **Death** – any unexpected or unintended event that caused the death of one or more persons.

A Duty of Candour monitoring section is included as part of the complaints management document, which should be completed and returned to the Complaints and PALS Team on completion of the investigation.

The Trust must 'be open and honest' in its communication and service provision for its patients and must ensure staff know their responsibilities, as described in the Trusts 'Being Open and Culture of Candour Policy' and Procedures that are linked to it.

Any complaint relating to the death of a patient should be escalated into the Directorate Learning from Death Process and copied to lpt.patientsafety@nhs.net. The Complaints and PALS Team in cooperation with the Patient Safety Team will write to the complainant to make them aware. The Complaint will be placed on hold whilst this process is undertaken, and a response subsequently provided by the directorate once the learning from death process is complete.

5.22 Coroner's Cases

The fact that a death has been referred to the Coroner or a death has been reviewed by the Coroner does not mean that the complaint needs to be suspended but the complaint investigation should take into account any reports to the Coroner and may need to be used to assist with the investigation and response to the complaint issues.

5.23 Litigation

If litigation is indicated or commenced, the Trust will need to ensure that the complaints process will not prejudice any legal or judicial proceedings. It is unusual for complaints and legal action to run concurrently but if there are no reasons for this not to take place, the complaints investigation will commence alongside litigation or judicial proceedings. If there are reasons for the investigation not to proceed, the complaint will be placed on hold and the complainant made aware of this in writing by the Complaints and PALS Team

5.24 Criminal investigations or allegations of serious misconduct

Where a complaint alleges issues of criminal proceedings and the matter has been referred to the Police, the Investigation Lead may defer matters relating to that part of the complaint. This is only done after taking advice from the Trust Solicitors, the Crown Prosecution Service, and the Police, as appropriate. It is important that care is taken to ensure that any Trust investigation does not compromise the Police inquiry.

The Complainant must be kept informed of the action taken and, if the complaints procedure has commenced, it must be concluded at the appropriate time.

In cases where serious misconduct has been alleged, the relevant Service Director/Head of Nursing should be notified immediately to enable decisions on the most appropriate way forward as the complaint process may no longer remain relevant. In these cases, it may be that the concerns would be more appropriately managed through the Human Resources policies and these issues are not registered as part of the complaints process. In this case, the complainant will be advised by writing that the complaints process is not relevant, and the issues are being taken forward with the most appropriate people, but the Trust will not disclose any specific details in the interests of protecting staff confidentiality.

Additionally, if it is identified that the concern or complaint represents an allegation against an employee/bank worker, that they may be harming a child, young person or an adult at risk, Policy and Procedure should be followed and the allegation recorded as an incident on Ulysses (E-IRF).

5.25 Staff Complaints

Staff can complain about their own care and treatment or in the role of carer to a relative who is a service user. However, issues that relate to management issues, grievances or concerns over health and social care practice, should be addressed under the appropriate established policy and cannot be investigated under the complaints procedure.

5.26 Disciplinary Action

Staff should be supported in any complaint received but it is recognised that some complaints may lead to disciplinary and conduct procedures being instigated separately. It is not the Trusts policy to share this action and any outcome with the complainant.

5.27 Complaints of fraud and corruptions

Any complaints concerning or alleging fraud or corruption should be passed immediately to the Director of Finance and the Trust Counter Fraud, Bribery and Corruption Policy should be considered prior to commencing any investigation.

5.28 Record Keeping and retention of concerns and complaint documentation.

Staff must ensure that their record keeping is clear and accurate and that all sections of the concerns or complaint management document are fully completed. Staff must keep all information collated during the management of a concern or a complaint including emails, statements, notes of meetings or telephone calls and information relied upon to respond or formulate the concern or complaint response.

In relation to concern, this detail should be forwarded to the PALS Team and a complaint should be forwarded to the Complaints Team; this includes the patient records or a reference to the records used. Registered electronic complaint files will be kept for 10 years in the archive storage area. Further information about this and how we use your data can be found under our Data Privacy Notice.

Staff should abide by the NHS Constitution and not place any details or reference to a complaint on the electronic patient records.

5.29 Publicity

Information about this complaint policy is available to the public on the Trust website, where key features of the complaint process can be observed along with electronic copies of our complaints leaflet.

5.30 Unreasonable and persistent behaviour

The Trust is committed to dealing and responding to complainants fairly and sympathetically. There may be occasions where a complainant's behaviour may become unreasonable or persistent, which can place undue strain on time and resources and cause unacceptable stress on NHS staff and service with little hope of resolution.

The Trust recognises and should remember that there may be substance to the complaint, and this should be dealt with in line with the regulations. We do not, however, accept staff should not have to endure difficult situations or behaviour which is abusive, insulting, or frequent in nature and may need to consider the way we communicate with the complainant and restrict how someone can contact us.

The Trust should ensure an equitable approach and provide an open and honest response to matters. This procedure should only be used as a last resort and after all reasonable measures have been exhausted.

The definition and options for handling any complainant who is deemed to be unreasonable and persistent in their behaviour can be found in Appendix 9.

Consent

• *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.*
• *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:*

- *Understand information about the decision.*
- *Remember that information.*
- *Use the information to make the decision.*
- *Communicate the decision.*

5.0 Monitoring Compliance and Effectiveness

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
Whole document	The organisation listens and responds to concerns and complaints from patients, their	Complaints reports	Complaints and PALS Manager	Complaint reports to the Complaints Review Group and highlight reports to

Page/Section	Minimum Requirements to monitor	Process for Monitoring	Responsible Individual /Group	Frequency of monitoring
	relatives, and carers.			Quality Forum & QAC
Page 7	The organisation will make sure that, patients, their relatives, and carers are not treated differently as a result of raising a concern or complaint.	Included in Complainant satisfaction surveys, undertaken by the Complaints Process.	Complaints and PALS Manager	Ongoing – Quarterly basis to all complainant upon closure of their complaint
Pages 5,7,7-19	The organisation makes improvements as a result of a complaint.	This is reported in quarterly reports as part of the Quality Schedule. Complaint reports to the Complaints Review Group and highlight reports to Quality Forum & QAC.	Complaints and PALS Manager	Quarterly
Pages 5, 7	Survey of complainants to receive feedback	Complainant satisfaction surveys undertaken by the Complaints Process	Complaints and PALS Manager	Quarterly basis to all complainant upon closure of their complaint
Pages14	Review of lessons learned and action plans to demonstrate improvements, made as a direct result of complaints.	Complaint reports to the Complaint Review Group and highlight reports to Quality Forum & QAC.	Complaints and PALS Manager	Quarterly
Pages 4, 32	Annual monitoring captured against the protected characteristics	Annual Report	Equality & Human Rights Team	Annual

6.0 References and Bibliography

References and Bibliography

Policy was drafted with reference to the following:

- The Local Authority Social Services and National Health Service Complaints
- (England) Regulations 2009
- Department of Health 'Listening, Responding, Improving: A guide to better customer care' (February 2009)
- The Francis Recommendations from the Mid Staffordshire NHS Foundation Trust
- Public Enquiry (February 2013) - Chapter 3 Complaints: Process and Support
- The Clwyd / Hart Report 'Putting Patients Back in the Picture – A Review of NHS
- Hospitals Complaint Handling' October 2013
- The Patient Association 'Complaints Management Standards'
- The Parliamentary and Health Service Ombudsman (PHSO) Principles of remedy
- The Parliamentary and Health Service Ombudsman (PHSO) – My expectations to concerns and complaints.
- The Parliamentary and Health Service Ombudsman (PHSO) NHS Complaints Standards.
- LPT Record Keeping and Care Planning Policy
- NHS Constitution
- NHS Serious Incident Framework: Supporting Learning to Prevent Recurrence
- LPT 'Being Open/Duty of Candour Policy 2020
- The LPT Data Protection and Information Sharing Policy
- LPT Mental Capacity Act Policy
- LPT Consent Policy

7.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery, and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

- Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.
- Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.
    - If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Flowchart(s)

Feedback into Action

NHS
Leicestershire Partnership
NHS Trust

Appendix 2 Training Requirements

Training Needs Analysis

Training topic:	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development
Directorate to which the training is applicable:	☐ Adult Mental Health ☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children / Learning Disability/ Autism Services ☐ Hosted Services
Staff groups who require the training:	
Regularity of Update requirement:	
Who is responsible for delivery of this training?	
Have resources been identified?	
Has a training plan been agreed?	
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)
How is this training going to be monitored?	

Appendix 3 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families, and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance	☐

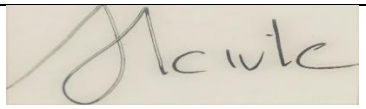
Appendix 4 Due Regard Screening Template

Section 1	
Name of activity/proposal	Complaints Policy
Date Screening commenced	
Directorate / Service carrying out the assessment	Enabling/Corporate
Name and role of person undertaking this Due Regard (Equality Analysis)	Mary Mahon (Complaints and PALS Manager)
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: LPT recognises and encourages feedback from diverse communities as being a valuable tool for improving the quality of services it provides. It also helps to identify possible equality, diversity and human rights issues that may adversely impact on service delivery across the organisation. The principal aim is to resolve complaints as fairly and as quickly as possible, and to identify lessons learnt, to prioritise service improvements and to continually improve the quality-of-service delivery.	
OBJECTIVES: The purpose of this policy is to ensure that complaints, concerns, enquiries, comments, and compliments received about the services LPT provides to service users and the general public are managed consistently and meet the requirements of the NHS Complaints Regulations.	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	This policy has been screened to eliminate any unlawful discrimination and as such this policy has no specific impact on any protected characteristic or equality group.
Disability	As above
Gender reassignment	As above
Marriage & Civil Partnership	As above
Pregnancy & Maternity	As above
Race	As above
Religion and Belief	As above
Sex	As above
Sexual Orientation	As above
Other equality groups?	As above

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No (X)
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4
If this proposal is low risk, please give evidence or justification for how you reached this decision:
All staff implementing the policy will have received appropriate training including equality, diversity, and human rights awareness, together with support from the Equality, Diversity, and Inclusion Team. Information is provided in an appropriate format to reduce any adverse impact such as large print, braille, and alternative language on request. In addition, equality monitoring of all relevant protected characteristics to whom the policy applies will be undertaken. This will help identify any specific adverse or positive trends in respect of any relevant equality group and contribute to providing lessons learnt outcomes to improve service delivery and achieve the overall purpose of this policy.

This policy will be continually reviewed to ensure any inequality of opportunity for service users, patients, carers, and staff is eliminated.			
Signed by reviewer/assessor	Mary Mahon	Date	24.07.2023
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	09.08.2023

Appendix 5 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	LPT Complaints Policy	
Completed by:	Alison Kirk	
Job title	Head of Patient Experience and Involvement	**Date** 09.08.2023

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	Yes	Complainants tend to disclose additional information and not just the complaint issue, although we only record the essential information to log the complaint.
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	Yes	When discussing the cause and details of the complaint.
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	Yes	When these occasions arise, consent is sought from the complainant. Where no consent is given then we do not share any information
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	Yes	To investigate the complaint – may require review of electronic patient records.
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records, or other	Yes	Electronic records can sometimes need to be reviewed as part of the

information that people would consider to be particularly private.		complaint or concern investigation.
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
If the answer to any of these questions is 'Yes', please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.		
Data Privacy approval name:	S Ratcliffe	
Date of approval	18/08/2023	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 6: A User-Led vision for raising complaints and concerns.

Appendix 7 Telephone Complaint Form

Complaint Form

You, or a staff member on your behalf, may use this form to raise a complaint about the services provided by Leicestershire Partnership NHS Trust. However, if you would like further advice or help in completing this form, please ask a member of staff, or contact our Complaints Team on 0116 295 0831.

If you would like to seek independent advice and assistance about making a complaint, please contact POhWER on 0300 456 2370.

Please be assured that your care and treatment will not be affected in any way by raising your concerns. If, at any point in the process, you feel that your care has been adversely affected as a result of you making a complaint, please contact the Patient Advice and Liaison Service (PALS) on 0116 295 0830 or via email on lpt.pals@nhs.net.

Summary of complaint: What happened, what went wrong, and the reason for your complaint – please provide any other information you feel is relevant to help us understand your complaint.

Are there any specific questions you would like to be addressed?

Please state what you would like to see happen as a result of your complaint?

About you Please provide as many details as possible	
Your name:	
Date of birth:	
NHS number (if known):	
Address (including postcode):	
Email address:	
Telephone number:	
Preferred method of contact:	

If you are making a complaint on behalf of another person, please provide their details: We will usually need the patient's consent before we can release our investigation findings, however, we will contact you to discuss this.	
Name of patient:	

Date of birth:	
NHS number:	
Address (including postcode):	
Telephone number of patient:	

Please provide the details of the team/service/person you are complaining about?	
Name of service:	
Address (if known):	
Staff members involved:	

Thank you for completing this form.

Please forward the completed form to Complaints Team, Leicestershire

Partnership NHS Trust, Swithland House, 352 London Road, Leicester, LE2 2PL or share this via email to lpt.complaints@nhs.net

Appendix 8 Complaints Management Document (CMD)

Complaints Management Document (CMD)

Ulysses Ref:	
Date received:	
Complaint Type	

1. Complaint Details

Patient Name	
NHS Number	
Postal Address	
Patient deceased	Choose an item.

Complainant Name/Relationship to Patient	
Postal Address	

Contact number/email	
How received?	Choose an item.
Special requirements?	Choose an item.
Response Type Required	Choose an item.

Complaint Documents	

2. Triage by Complaints Team

Date of contact with Complainant	
Adult Consent required?	Choose an item.
Gillick Principle applies?	Choose an item.
Young person aware of complaint?	Choose an item.
Consent received- Date	
Agreed timescales for investigation	Choose an item.
Patient Safety/Safeguarding contacted?	Choose an item.
Additional Actions, if applicable	
Multi-Agency Complaint	Choose an item.
Which organisations involved?	

Directorate	Choose an item.
Ward/Department (s)	
Initial Category (s) (to be reviewed upon completion of investigation	
Specific Team	

3. Initial Complaint Review by Investigator

Please fill out this section and send email to Choose an item. to confirm you have contacted the complainant within 5 working days from the date of this case being allocated to you.

Name of Investigator	

Have you raised an incident?	Choose an item.
If yes, Incident Reference Number	
Have you completed Duty of Candour?	Choose an item.
Date of contact with Complainant	
Summary of conversation with Complainant following contact	

Please fill out the following attached form regarding the patient's equality and diversity information.	Equality Monitoring Form 22

Preferred method of communication for patient/family/carer	Choose an item.

As the investigator I can confirm that I have no conflicts of interest in relation to this case or the individuals involved. Please sign below:

Investigator	

4. Complaint Investigation

Please provide supporting evidence of the records/systems you have reviewed, who you have spoken to and when and what policies/procedures you have looked at in order to come to your overall outcome. Template for telephone calls with complainants and staff discussion statement template embedded for your use.

Meeting-Telephone Summary Template.d	Discussion Template.docx	Complaint Response Template updated Apı

5. Complaint Outcome

Please detail each issue raised and the outcome

1)
2)
3)

Complaint Outcome	Choose an item.
If complaint resolved on the phone, is cover letter required?	Choose an item.
If yes, is a copy of the call/meeting notes attached?	Choose an item.

6. Changes/Improvement

Please detail any learning identified and action being taken to improve the service as a result of the complaint.

Issue identified	Action to be taken	Target date	Evidence	Responsible Person

7. Final Risk Grading

Seriousness	Likelihood	Severity
	Severity Grading Tool.docx	
Choose an item.	Choose an item.	Choose an item.

8. Final Review of Categories and Department

To be completed by Lead Investigator or Clinical Governance Team following investigation. Please review the department and category that the case was initially logged under (Dark Blue Section above) and confirm whether this reflects the investigation.

Directorate	Choose an item.
Ward/Department (s)	
Category (s)	

9. Sign off process/QA

Member of staff	Name	Date
Medic Oversight		
Clinical Governance		
HOS/HON (required as a minimum for Directorate)		
Complaints Team Quality Assurance		
Satisfaction to be sent with response	Choose an item.	N/A
Director		
Director of Nursing		
SG/PT Safety/Legal		
CEO		

Appendix 9 Managing unreasonable and persistent behaviour.

When determining arrangements for managing and dealing with unreasonable and/or persistent behaviour staff should ensure that the complaints procedure has been correctly implemented as far as practically possible. It is important that staff appreciate the behaviour of the complainant may be challenging, but that does not mean that there is no substance to their complaint, and we should explore the issues appropriately.

Definition of unreasonable or persistent behaviour

Complainants and/or anyone that is acting on their behalf may be deemed to be unreasonable or persistent where current or previous contact with them shows that they have met one or more of the following criteria. The list is not exhaustive and other factors may be considered when determining if an individual is to be considered under these procedures.

Where a complainant or the person acting on their behalf:

- Persists in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted or where implementation of the NHS complaints procedure is inappropriate for the issues raised (for example – where an investigation is 'out of time' and cannot be investigated fairly or effectively, or where the issues of concern arise from care as a private patient) or,

- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints) or,

- Are unwilling to accept documented evidence of treatment as being factual (e.g., drug records, medical or nursing records) or,

- Deny receipt of an adequate response in spite of correspondence specifically answering their questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed or,

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

- Repeated focus on specific issues which have been appropriately and fully considered and responded to or,

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

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

- Display unreasonable demands or patient/complainant expectations and fail to accept that these may be unreasonable (e.g., insist on responses to enquiries being provided more urgently than is set out in the national guidance on complaints handling).

The context and history of the complaint should be reviewed when considering the questions above.

Considerations prior to taking action.

You must make sure that the details of a complaint are not lost because of the presentation of that complaint. There are a number of things to bear in mind when considering the imposition of restrictions on a complainant.

These may include:

- Ensuring that the complaint case is being, or has been, dealt with appropriately, and that reasonable actions will follow, or have followed the final response.

- Confidence that the complainant has been kept up to date and that communication has been adequate with the complainant prior to their behaviour becoming unreasonable or persistent.

- Checking that the complainant is not raising any new or significant concerns that need to be considered that will affect the organisation's view on the existing case.

- Applying criteria with care, fairness, and due consideration for the complainant's circumstances – bearing in mind any known physical or mental health conditions that may explain the reason for their difficult behaviour. This should also include consideration of the impact of any bereavement, loss or significant/sudden changes to the complainant's lifestyle, quality of life or life expectancy.

- Considering the proportionality and appropriateness of the proposed restriction in comparison with the level of unreasonableness of the behaviour and impact on staff.

- Ensuring that the complainant has been advised of the existence and purpose of the policy and has been warned about and given a chance to amend their behaviour or actions.

- Consider whether there are further actions to take before designating the complaint as fixated or unreasonable.

Actions prior to designating a complainant as unreasonable or persistent.

Consideration should be given as to whether any further action can be taken prior to designating the complainant as 'unreasonable' or 'persistent'. This might include:

- Where no meeting with staff has been held, consider offering this as a means to dispel misunderstandings and move matters forward – this option will only be appropriate where risks have been assessed, and a suitably senior member of staff can be present.

- Where multiple departments are being contacted by the complainant, consider setting up a strategy meeting to agree a cross-departmental approach.

- Issue a warning letter explaining that if the complainant's actions continue, the organisation may decide to treat them as an unreasonable or persistent complainant and explain why.

- Consider if providing a copy of records, or setting up a meeting to talk through records may help to dispel misunderstandings or misconceptions – this option will only be appropriate where staff are unaware of any circumstances where this would not be advisable, and consent is appropriately obtained.

Options for dealing with unreasonable or persistent complainants.

Where complaints have been identified as unreasonable or persistent in accordance with the above criteria, the Chief Executive (or appropriate Deputy in their absence) will determine what action to take.

The Chief Executive (or Deputy) will implement such action and will notify complainants in writing of the reason why they have been classified as unreasonable or persistent complainants and the action to be taken, and how long the restrictions will remain in place. The complainant should be provided with a copy of this Policy.

This notification may be copied for the information of others already involved in the complaint, e.g., clinicians, Advocacy support, Members of Parliament. A record must be kept for future reference of the reasons why a complaint has been classified as unreasonable or persistent.

The Chief Executive may decide to deal with complainants in one or more of the following ways:

- Place time limits on telephone conversations and personal contacts.

- Decline contact with the complainants either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained, (if staff members are to withdraw from telephone conversations with a complainant, it may be helpful for them to have an agreed statement available to be used should the complainant persist in ringing).

- Restrict contact liaison through a third party (such as an advocate).

- Refuse to register and/or process further concerns or complaints about the same matter - notify the complainant in writing that the Trust has responded fully to the points raised and has tried to resolve the complaint but has nothing more to add and continuing contact on the matter will serve no benefit. The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged

but not answered. Complainants should be reminded of their right to pursue their complaint via the Parliamentary and Health Service Ombudsman (PHSO).

- State that the organisation does not deal with correspondence that is abusive or contains allegations that lack substantive evidence, request that a revised version of the correspondence be provided.

- Inform the complainant that any personal contact will take place in the presence of a witness.

- Drawing up a signed agreement" with the complainant which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened, consideration would then be given to implementing other actions, as indicated in this section.

- Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or persistent complaints to its solicitors.

- Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice, or guidance from the Parliamentary and Health Service Ombudsman.

- Consider invoking the Violence Prevention and Reduction Policy.

Reviewing and Withdrawing 'Complainant' Status.

Once complainants have been determined as unreasonable or persistent, there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach, or if they submit a further complaint for which normal complaints procedures would appear appropriate.

Staff should have used discretion in recommending the initial unreasonable or persistent status and discretion should similarly be used in recommending that the status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Chief Executive (or nominated Deputy). Subject to their approval, normal contact with the complainants and application of NHS Complaints Procedures will then be resumed.

Record Keeping.

Ensure that adequate and accurate records are kept of all contact with unreasonable or persistent complainants. This should include circumstances when:-

- The decision to use this policy is invoked.

- Where a Deputy is used to make the decision, the reason for the non-availability of the Chief Executive should be recorded on the file.

- A decision is taken not to apply the policy when a member of staff asks for this to be done or make exception to the policy once it has been applied.

- The context and history of the complaint should be reviewed when considering the questions above.