COMPLAINTS AND CONCERNS
POLICY

DOCUMENT CONTROL

AUDIENCE	All staff and Public
POLICY TYPE	Governance
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DOCUMENT OWNER	Claire Newey | Head of Governance & Quality

VERSION CONTROL

NO.	DATE	DESCRIPTION OF CHANGE	REVIEW BY
1.0	17-11-2023	Complete rewrite. Replaces Complaints Policy v4.6. Requires full read	Head of Governance & Quality
1.1	18-03-2024	Correction to appendix 1	Head of Governance & Quality
1.2	26-07-2024	Removed procedures and transferred to SOP. Added reference to Complaints SOP.	Head of Governance & Quality

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1.0 WHY IS THIS POLICY NEEDED

1.1 PURPOSE

Mountain Healthcare strives to provide a high quality, safe and effective service for all our patients and their families; we understand however that at times we may not get things right. In these circumstances, it is important that patients and families can raise concerns to staff about their care, and that these are responded to in a timely and appropriate manner.

The aim of the policy is to ensure that all complaints are handled in a systematic and empathetic manner, that they are understood and investigated thoroughly, fairly and quickly. In liaison with the complainant a method of resolution is agreed that is proportionate to the issue being raised and in line with the complainant's desired outcome

The purpose of the complaints process is to establish the source of the complainant's dissatisfaction and through investigation address any service or care delivery problems which are found to improve the service quality.

A further purpose is to ensure trends are identified which enable lessons to be learned and for the quality of services to be improved.

We may also receive complaints from other agencies about their experience of our services or the care of others. It is important that these issues are identified and resolved quickly and professionally to ensure confidence in our services is maintained.

Handling complaints in an open, fair, and accessible way is an important part of our patient care process. It is important to ensuring that Mountain Healthcare as a provider, and our staff as individuals, can fulfil the duty of candour we have to our patients, their families, and the agencies we work with.

Mountain Healthcare values complaints, both formal and informal, and understands that they are opportunities to reflect and make improvements to our services. Identifying and acting upon organisational learning arising from complaints is an important aspect of our quality improvement processes across the organisation

1.2 REGULATIONS AND REFERENCES

- NHS Regulations 2009
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Good Practice Standards for NHS Complaints Handling
- NMC / GMC Guidance - Openness and Honesty When Things Go Wrong
- Mental Capacity Act 2005
- Data Protection Act 2018 and UK General Data Protection Regulation
- ISO15189:2022

1.3 DEFINITIONS AND ABBREVIATIONS

ITEM	MEANING
MH	Refers to Mountain Healthcare (the company)

ITEM	MEANING
THE PEAK	Mountain Healthcare's Intranet and location of the online Incident Form
CLINICAL QUALITY GOVERNANCE BOARD (CQGB)	The CQGB provides assurance to the Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice.
GILLICK COMPETENCE	Gillick competence is concerned with determining a child's capacity to consent. It was determined that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. There is no lower age limit for Gillick competence to be applied. That said, it would rarely be appropriate or safe for a child less than 13 years of age to consent to treatment without a parent's involvement.
PSS	Pathway Support Service. MH's contact centre support team. They can take details of complaints and submit on a patient's behalf.
COMPLAINT	A 'complaint' is defined as any expression of dissatisfaction, either verbal or in writing, about an act, omission, or decision, and whether justified or not, which requires a response. Comments, questions, concerns, general enquiries, or suggestions are not complaints, although the provision of timely and accurate information and advice is important.
CONCERN	A 'concern' is any issue causing concern to the patient, relative or carer relating to their care and treatment. Concerns are normally raised informally and are usually resolved at local level by front line Staff.

1.4 ROLES AND RESPONSIBILITIES

ROLE	RESPONSIBILITY FOR
ALL STAFF	• Familiarising themselves with this SOP and understanding the complaints process for patients and stakeholders. • Ensuring that all patients and their families are made aware of how they can complain, if they want to, and are supported to do so. • Addressing any concerns or complaints at the time they are raised where this is possible in a compassionate and professional manner. • Raising an incident form regarding any complaints they are involved with during patient care. • Treating complainants impartially and sensitively when managing a complaint • Escalating concerns to their line manager regarding complaints. • Ensuring that data protection and patient confidentiality are maintained when handling complaints.
MANAGERS	• Monitoring and reviewing complaints made within their service. • Identifying any improvements or organisational learning opportunities that arise from complaints.

ROLE	RESPONSIBILITY FOR
	• Investigating and responding to formal complaints within their service, where this is allocated. • Implementing any actions or improvements associated with investigation outcomes.
LEARNING RESPONSE LEAD	• Conducting a proportionate, fair, and open investigation into any complaints they are allocated. • Referring any findings related to staff conduct or capability to be managed within the appropriate HR processes. • Maintaining appropriate records of the investigation, including any interviews or fact finding. • Preparing the outcomes of the investigation to be shared with patients, or their representative.
GOVERNANCE & QUALITY	• Reviewing complaints received by MH • Advising on appropriate course of investigation, including suitable investigators. • Recording all formal complaints and their outcomes centrally. • Providing an update to the MH Board on the status and outcomes of all formal complaints
CQGB	• Monitoring the three-yearly review of this policy and associated procedure. • It will review any risks, incidents, and other issues that arise within the scope of this policy and process and update them accordingly. • It will monitor difficulties with pathways or processes escalated by local services and where required hold them on the organisational or divisional risk register.
BOARD	• Ensuring that MH follows the principles of sound governance. This includes development of systems of clinical governance and risk management and reviewing the effectiveness of internal controls. The Board, therefore, has a responsibility to ensure that it receives assurance that this policy is being implemented, that lessons are being learnt, and areas of vulnerability are improving.

2.0 HOW TO MAKE A COMPLAINT

A complaint can be made:

- by telephone 0330 223 0099 - we will seek to make the necessary reasonable adjustments to handle any complaint. For people whose first language is not English, we have access to an interpretation service.
- by email governance@mountainhealthcare.co.uk.
- verbally to any of our colleagues who will upload it via our Incident Form.
- if a complaint is about the Governance and Quality team, it should be sent via info@mountainhealthcare.co.uk. The complaint will be dealt with by an impartial third party and not anyone involved in the complaint.

Colleagues will ensure the complainant:

- will be taken seriously.
- will receive a compassionate response by a member of staff.
- that appropriate action will be taken.
- lessons will be learnt and disseminated to staff accordingly.
- there will be no adverse effects on their future care or that of their families.

Meetings can be arranged with colleagues and the person raising concerns where requested and appropriate to do so. Any feedback received can be provided either verbally or in writing.

3.0 WHO CAN COMPLAIN

3.1 THE PATIENT

A complaint may be made by a patient – a person who receives or has received services or a person who is affected, or likely to be affected, by the action, omission or decision which is the subject of the complaint.

If the patient has given consent to a third party acting on their behalf

We will require the following information:

- Name and address of the person making the complaint.
- Name and either date of birth or address of the person who is the subject of the complaint.
- A consent form signed by the person who is the subject of the complaint.
- Delegated authority to act on their behalf, for example in the form of a registered Power of Attorney which must cover health affairs.
- Is an MP, acting on behalf of and by instruction from a constituent

If the patient is a child:

- With children and young adults, a 'child' is anyone who has not yet reached the age of 18 years of age. With children, the representative making a complaint on their behalf must be a parent, guardian or other adult person who has parental responsibility for the child. Children under 16 years are not automatically presumed legally competent to make decisions about their health care, however, may give consent if they are Gillick competent. Our clinical staff will assess whether a child is Gillick competent. If a child Is not Gillick competent, then the consent of a person with parental responsibility or sometimes the courts is needed to proceed with treatment. We may ask to see proof of parental responsibility such as the child's birth certificate.
- Once a child reaches the age of 16 years, they are presumed in law to be competent to give consent. However, it is still considered good practice to encourage them to involve their family in decision making. Where the child is in the care of a local authority or a voluntary organisation, the representative making the complaint must have the appropriate authority to act.

If the patient has died, the complainant would usually be the personal representative of the deceased. To respond to the personal representative, we may request some formal documentation from this person such as copy of a will, to demonstrate their role as executor, or a lasting power of attorney relating to health care.

3.2 EXTERNAL AGENCIES

Can complain on behalf of patients, if they have been given consent to, or have the authority to act on behalf of a patient. It is important that clear documentation is maintained as part of the complaints process, written permission for another to act on behalf of a patient must be added to the complaint file to demonstrate compliance with information governance standards.

In addition, they can complain about our services or staff members where issues or concerns have been identified.

4.0 TIME PERIOD FOR MAKING A COMPLAINT

We encourage patients and professionals to raise any concerns at the time they occur, this will enable staff to respond quickly and sensitively to resolve any issues. We understand however that not all complaints may be raised or identified immediately, where this is the case, we encourage patients or professionals to contact us as soon as possible.

Complaints can be made up to 12 months after a patient has received care within our services, this is to help us best investigate and respond to any issues.

If a complaint is received after this timeframe, we will consider what led to the delay in the complaint being reported and whether this can still be investigated based on the circumstances. We ask that patients or professionals indicate what has led to the delay in reporting a complaint when contacting the service or complaints team.

5.0 EXCEPTIONS

5.1 CUSTODIAL HEALTHCARE COMPLAINTS

Where a complaint is made directly to MH by a patient who is still within the criminal justice process, the investigation will be completed on their behalf however, dependent on the outcome of the criminal proceedings it may not always be possible to provide a written outcome. All evidence will be saved in the appropriate SharePoint at the time of the complaint to ensure it is preserved.

Where patients wish to pursue their complaint within custody, must be advised to refer their complaint to the relevant police force for review.

Complaints made directly to police about medical care received will be managed as a joint investigation and will follow the same process as Formal Complaints.

5.2 STAFF

This policy does not include complaints made about by staff about their colleagues. Staff should refer to the Grievance Policy.

If a staff member wishes to make a complaint about a partner or external agency, they should discuss this with their line manager who can support them. Note the complaint will be conducted via the partner/external agency complaint's procedure not the MH Policy.

6.0 IF THE COMPLAINANT IS UNHAPPY WITH THE RESPONSE

Once a review has been completed, patients who are still unhappy with the outcomes of their complaint have the option to escalate their concerns further.

For NHS commissioned services, patients can refer their complaint to the Parliamentary and Health Service Ombudsmen.

Patients can contact 0345 015 4033 or visit https://www.ombudsman.org.uk/for more information.

Patients who have complained directly to police about their care in custody can request a review in line with the relevant force policy. Outside of the complaints process for each police force there are no further routes of escalation for patients who are unhappy with the outcome of their investigation.

The Independent Office for Police Conduct (IOPC) investigates serious and sensitive incidents and allegations involving the police. This includes persons who are seriously injured or die during detention in police custody, or upon the request of a police force to investigate conduct of officers.

More information can be found on the IOPC website https://www.policeconduct.gov.uk/complaints-reviews-and-appeals/make-complaint

7.0 PERSISTENT AND UNREASONABLE CONTACT

Persistent contact may be because of individuals having genuine issues and it is therefore important to ensure that this process is fair, and the person's interests have been taken into consideration.

This guidance covers all contacts, enquiries and complaints. It is intended for use as a last resort and after all reasonable measures have been taken to try to resolve an issue.

To assist the organisation to identify when a person is persistent or unreasonable, setting out the action to be taken.

7.1 DEFINITION

There is no one single feature of unreasonable behaviour. Examples of behaviour may include those who:

- persist in pursuing an issue when the procedures have been fully and properly implemented and exhausted.
- do not clearly identify the precise issues that they wish to be investigated, despite reasonable efforts by staff, and where appropriate, the relevant independent advocacy services could assist to help them specify their complaint.
- continually make unreasonable or excessive demands in terms of process and fail to accept that these may be unreasonable e.g. insist on responses to complaints being provided more urgently than is reasonable or is recognised practice.
- continue to focus on a 'trivial' matter to an extent that it is out of proportion to its significance. It is recognised that defining 'trivial' is subjective and careful judgment must be applied and recorded.
- change the substance of a complaint/concern or seek to prolong contact by continually raising further issues in relation to the original contact. Care must be taken not to discard new issues that

are significantly different from the original issue. Each issue of concern may need to be addressed separately.
- consume a disproportionate amount of time and resources.
- threaten or use actual physical violence towards staff.
- have harassed or been personally abusive or verbally aggressive on more than one occasion (this may include written abuse e.g. emails)
- repeatedly focus on conspiracy theories and/or will not accept documented evidence as being factual.
- make excessive telephone calls or send excessive numbers of emails or letters to staff.

7.2 ACTIONS PRIOR TO DESIGNATING A PERSON'S CONTACT AS PERSISTENT AND UNREASONABLE

It is important to ensure that the details of a complaint/concern are not lost because of its presentation. There are several points to bear in mind when considering imposing restrictions upon a person. These may include:

- ensuring the person's case is being, or has been dealt with appropriately, and that reasonable actions will follow, or have followed, the final response.
- confidence that the person has been kept up to date and that communication has been adequate with the complainant prior to them becoming unreasonable or persistent.
- checking that new or significant concerns are not being raised, that requires consideration as a separate case.
- applying criteria with care, fairness and due consideration for the person's circumstances – bearing in mind that physical or mental health conditions may explain difficult behaviour. This should include the impact of bereavement, loss or significant/sudden changes to the person's lifestyle, quality of life or life expectancy.
- considering the proportionality and appropriateness of the proposed restriction in comparison with the behaviour, and the impact upon staff
- ensuring that the person has been advised of the existence of the policy and has been warned about and given a chance to amend their behaviour.

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

- raising the issue with a senior manager with no previous involvement, to give an independent view.
- where there are multiple contact points, consider a strategy to agree a cross departmental approach.
- consider whether the assistance of an advocate may be helpful.

Consider how communication with the person could be managed, which may include:

- time limits on telephone conversations and contacts
- restricting the number of calls that will be taken or agreeing a timetable for contacting the service.
- requiring contact to be made with a named member of staff and agreeing when this should be.
- requiring contact via a third party e.g. advocate.
- limiting the person to one mode of contact.
- informing the person of a reasonable timescale to respond to correspondence.

- informing the person that future correspondence will be read and placed on file, but not acknowledged.
- advising that the organisation does not deal with calls or correspondence that are abusive, threatening, offensive or discriminatory.
- asking the person to enter into an agreement about their conduct.

7.3 MANAGING PERSISTENT AND UNREASONABLE CONTACT

Where a person's contact has been identified as persistent and/or unreasonable either the manager of the service will write to the person informing them that:

- their complaint/concern is being investigated and a response will be prepared and issued as soon as possible within the timescales agreed or
- their complaint/concern has been responded to as fully as possible and there is nothing to be added.

Additionally:

- that repeated contact regarding the complaint/concern in question is not acceptable and that further calls will be terminated and
- that any further correspondence will not be acknowledged.

All appropriate staff must be informed of the decision so that there is a consistent and co-ordinated approach across the organisation, ensuring that only information pertaining to the restriction is made available rather than information regarding the case.

If the person raises any new issues, then they must be dealt with in the usual way.

- a review of the status must take place at six monthly intervals. A virtual panel of the manager, Governance & Quality and the Caldicott Guardian will aim to meet prior to the end of the six-month interval to review any change in status. They may extend or remove any sanction.
- there may be rare occasions when the nature of the contact requires immediate and urgent action such as involving emergency services to safeguard either the person or staff member (or both). In these circumstances follow usual safeguarding processes and retrospectively apply the persistent and/or unreasonable as necessary.

7.4 RECORD KEEPING

Ensure that adequate records are kept of all contact with persistent and/or unreasonable contacts. Consideration should be given as to whether the MH must take further action, such as reporting the matter to the police, taking legal action, or using the risk management or health and safety procedures to follow up such an event in respect of the impact upon staff.

8.0 ADVOCACY

MH is not able to provide advocacy support for patients as part of our service but recognise the importance of patients understanding how to access services available to them.

When the complaints process is explained, patients should be made aware of their option to seek support from advocacy services if they would like to.

Advocacy services can be accessed through:

- Local council
- Healthwatch
- NHS complaints advocacy

9.0 CONFIDENTIALITY AND CONSENT

Mountain has a legal duty to maintain the confidentiality of personal information. We will not access or share information pertaining to complaints without following our procedure in relation to consent for complaints.

All personal data received is recorded and stored on a secure server with limited authorised access. Information is retained in accordance with NHS England's retention schedule.

10.0 EXTERNAL REPORTING AND INFORMING KEY STAKEHOLDERS

MH is regulated by several regulatory bodies and some incident types require reporting to an external agency or key stakeholder, for example, the Care Quality Commission, Forensic Science Regulator, United Kingdom Accreditation Service, the Health & Safety Executive, NHS Digital or the Information Commissioner's Office. Each has their own area of remit.

The Governance and Quality Team can provide advice on when and how to report and will submit the report on MH's behalf.

In addition, we may have a duty of care to notify our commissioners when a formal complaint has been received. They must be notified by the local manager at the earliest opportunity.

11.0 A JUST CULTURE

Mountain Healthcare adopts a just culture. A just culture:

- considers wider systemic issues where things go wrong, to enable colleagues to learn without fear of retribution
- does not punish for, freely admitted, inadvertent human error
- empowers investigators to attempt to understand why failings occurred, what led to them and how we support colleagues to implement improvements

Importantly, a just culture recognises the rare instances where issues of accountability are nevertheless appropriate to consider.

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A just culture holds people appropriately to account where there is evidence of gross negligence or deliberate acts

In the rare circumstances where someone's actions may have been inappropriate, it also supports a conversation about whether a staff member involved in an incident requires specific individual support or intervention to work safely.

12.0 SUPPORT FOR STAFF INVOLVED IN COMPLAINTS

MH support staff affected by incidents ensuring they are given time and are supported to participate in learning responses. We encourage staff to contact our Wellbeing Ambassadors and/or Mental Health First Aiders who can provide additional support and signpost to additional resources. In addition, MH has an employee assistance program which can provide external support.

All wellbeing resources can be found on The Peak Wellbeing Page.

13.0 HOW THIS POLICY WILL BE IMPLEMENTED

- This policy will be published on The Peak
- Line managers will disseminate this policy to MH staff through a line management briefing
- Staff must complete the Quality Document Declaration Form on reading and understanding this policy
- Training will be delivered using a range of approaches from formal teaching sessions where appropriate to colleagues working in clinical areas and local induction

14.0 HOW THE IMPLEMENTATION OF THIS POLICY WILL BE MONITORED

AUDITABLE STANDARD	FREQUENCY / METHOD	ACCOUNTABLE
All complaints are acknowledged within 2 working days	Monthly / Audit	Governance & Quality
Number and percentage of complaints completed within the agreed timescales	Monthly / Audit	Governance & Quality

15.0 MH SUPPORTING DOCUMENTATION

DOCUMENT NAME	MH REFERENCE NUMBER
Complaints SOP	MH-ORG-SOP-013
Incident Management Policy	MH-ORG-POL-003
Being Open & The Duty of Candour Policy	MH-ORG-POL-007

DOCUMENT NAME	MH REFERENCE NUMBER
Disciplinary Policy and Procedure	MH-ORG-POL-092
Grievance Policy	MH-ORG-POL-011
Disciplinary Policy	MH-ORG-POL-092
Speaking Up at Mountain Policy	MH-ORG-POL-022

EQUALITY IMPACT ASSESSMENT

Date of Assessment	26-07-2024
Completed by	Claire Newey | Head of Governance & Quality
Describe the benefit of implementing the policy	**Staff:** Ensure that all staff are aware of their roles, responsibilities, and limitations regarding complaints **Service users:** Manage the risks to ensure that service user complaints are managed effectively and responsively.

Are there concerns the policy could have an adverse impact because of

	Yes / No	Rationale if yes
Age	No	
Disability	No	
Sex (Gender)	No	
Race	No	
Sexual Orientation	No	
Religion / Belief	No	
Pregnancy / Maternity / Paternity	No	
Marriage / Civil Partnerships	No	
Caring responsibilities	No	
Socio-economic Backgrounds	No	
Other	No	

Action	Tick	Include any explanation / justification required
No barriers identified. You decide to **proceed with the implementation.**	✓	The policy ensures that there is a fair and consistent approach provided to all patients irrespective of age, race, colour, religion/belief, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status or gender reassignment.
You decide to **adapt the implementation** in a way which you think will eliminate the bias		
Barriers and impact identified, however having considered all available options carefully, there appear to be no other proportionate ways to achieve the aim of the change (e.g. in extreme cases or where positive action is taken). You decide to **proceed with caution** knowing that it may favour some people less than others, providing justification for this decision		