The Tavistock and Portman
NHS Foundation Trust

Complaints Management Policy

Key points
This policy relates to the management of complaints in accordance with the relevant Health and Social Care Legislation.

Type	Policy
Version:	6.0
Key changes since last version:	Replacing Complaints Procedure v5.0 Revision/Introduction of timelines and definitions for formal and informal complaints
Bodies consulted:	Service User Experience Group August 2022
Approved by:	Chief Nursing Officer
Date approved:	16th October 2024
Lead manager:	Complaints & Enquiries Manager
Responsible director:	Chief Nursing Officer
Ratified by:	Policy Approval Group
Date Ratified:	20/12/2024
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Public website	Yes

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Complaints Management Policy

1. Introduction

1.1. The Tavistock and Portman NHS Foundation Trust is committed to ensuring that those who use its services are readily able to access information about how to make a complaint and that the issues raised are dealt with promptly and fairly.

1.2. Complaints are just one of the many ways in which the organisation receives feedback and must be used to inform, learn and improve services. Patients often see the service from a different perspective to those who work in it; their views provide a valuable insight in an organisation committed to continuous quality improvement.

1.3. The policy makes clear what people should expect when they complain and supports a culture of openness, honesty and transparency. Trust practice is informed by the Parliamentary and Health Services Ombudsman (PHSO) good complaint handling guidance.

1.4. In most circumstances the quickest and most effective way of resolving a concern or complaint is to deal with the issues when they arise or as soon as possible after via local resolution. Usually this is best undertaken as close to the point of care / service delivery as possible. In circumstances where early local resolution is not possible, this policy and procedure describes the processes in place to ensure concerns and complaints are handled efficiently and investigated thoroughly.

1.5. The policy clarifies the roles and responsibilities of Trust staff in assessing, acknowledging, and investigating concerns or complaints and ensures that the complainant is listened to, is involved in decisions about how their concern or complaint is handled and receives an open, honest and proportionate response to their complaint.

1.6. The policy promotes the use of people's experience of care to improve quality. By listening to people about their experience of healthcare, the Trust can resolve mistakes faster, learn new ways to improve the quality and safety of services and prevent the same problem from happening in the future.

1.7. The policy will outline in a clear and concise manner for patients, relatives, carers and staff on the process of handling complaints regarding Trust services, buildings or the environment. Concerns and complaints may be received from patients; patient relatives, carers, visitors and other service users (noting that consent may apply).

1.8. The policy applies to all sites, departments and areas within the organisation and applies to all permanent and temporary staff working within the Trust. (DET Students wishing to raise a complaint should use the Student Complaints Procedure at the following link: Student complaints procedure – Tavistock Training)

2. Purpose

2.1. The purpose of this policy is to set out the processes for dealing with formal and informal complaints in accordance with revised National Health Service (Complaints) Regulations 2009 no 309 and the NHS Complaints Standards 2022

2.2. This policy aims to satisfy complainants by providing a compassionate, positive and detailed response to matters of concern. A complaint handled well will often restore public confidence in services. At no time will the patient's care or treatment be compromised as a result of them raising their concerns. All information given to patients and the public about raising concerns makes it clear that people will not to be treated any differently as a result of doing so.

2.3. The Trust's aim is to use a personalised approach to handling complaints by incorporating a focus on listening, responding and improving services.

2.4. The policy and procedure will, as far as reasonably practicable, be easy to understand, accessible, publicised in ways that will reach all service users and include information about support and advocacy services. It explains how the Trust will:

- Listen, acknowledge mistakes, explain what went wrong where applicable and to consider prompt, appropriate and proportionate remedies to put things right.
- Provide a consistent approach to the timely and efficient handling of all concerns and complaints, establishing an agreed complaints investigation plan with the complainant, with an emphasis on early resolution.
- Ensure organisational openness and an approach that is conciliatory and fair to people both using and delivering services.
- Respect the individual's right to confidentiality and treats all users of this policy with respect and courtesy.
- Learn from concerns and complaints and use them to improve the quality of services and to prevent mistakes happening again.
- Ensure that service users and carers can raise a concern or complaint without their care, treatment or relationship with staff being compromised.
- Ensure all formal complaints will be acknowledged within 3 working days of receipt. This can be done in writing or verbally. Where possible the complaint issues will be clarified, investigation timescale agreed with the complainant, and the best way to reach a satisfactory outcome discussed.
- Investigations will be fair, thorough, honest, responsive, compassionate and appropriate to the seriousness of the complaint, conducted within the timescales agreed with the complainant.

- The format of the response to the concern/complaint will be agreed with the complainant. This may be verbal (by phone or at a meeting), by email or written letter. Often, a concern can be satisfied with a verbal response. Formal complaints will require a written response, although some complainants prefer to receive this via email. The response will detail the complaint investigation apologising where appropriate, explain the outcome of the investigation, what actions have been / will be taken and what the next steps are for the complainant if they remain dissatisfied.

- The Trust will strive to resolve all complaints locally, whilst reminding complainants of their right to take the matter to the Parliamentary Health Service Ombudsman (PHSO) if they are not satisfied.

- Within Divisions, local leadership and accountability will facilitate early resolution and ensure concerns and complaints are responded to promptly and used to initiate actions for service improvement / opportunities for staff improvement.

- Divisional clinical and corporate governance structures will be used to ensure organisational learning from complaints and the sharing of best practice.

3. Scope

3. This policy relates to the management of complaints in accordance with the relevant Health and Social Care Legislation and is not for the purpose of complaint handling for personal/HR/organisational related complaints.

4. Definitions

4.1. A complaint can be defined as any expression of dissatisfaction, a perceived grievance or injustice or where a concern has not been locally resolved by the relevant department or Patient Advice and Liaison Service (PALS) team. Although it is sometimes difficult to clearly differentiate between a concern and complaint, for the purpose of this policy the following definitions will apply:

Complaint – A verbal or written contact that meets any **ONE** of the following criteria:

- The contact represents an expression of dissatisfaction that requires both an investigation and a written response.
- There is a specific statement of intent on the part of the person making the contact that they wish their concerns to be dealt with as a complaint under this procedure. Staff must be aware of any alternative language that the person making the contact may use to describe their intent in this respect, such as a stated wish to pursue the complaint “formally”.
- The problem or issue relating to the contact has previously been dealt with as a concern without resolution and the person making the contact remains dissatisfied

and seeks further action from the Trust.

Complaints are considered under the following categories/levels:

- **Issues and concerns:** minor concerns occurring in the day-to-day running of a service which can be resolved relatively quickly (within 48 hours), including ideas and suggestions, comments and feedback, and general criticisms.

- **Informal complaint / Local Resolution:** The first stage of the NHS Complaints Procedure which gives the Trust the opportunity to resolve issues of discontent or dissatisfaction no matter how they are raised. A complaint relating to the immediate service, which can be locally resolved with the attention of the Service Manager within 10 working days. This resolution will be followed up in writing to the complainant.

- **Formal complaint:** A complaint requiring in-depth, formal investigation and response due to complexity or nature of content, by a person's independent to the immediate service within 40 working days

The level of investigation required is informed by the nature and complexity of complaint, and the degree of response required. The method of raising a complaint, either orally or in writing, does not necessitate the investigation route.

Further definitions relative to this policy include;

- **Compliment** – A verbal or written contact where providing positive feedback is the primary aim of the contact. Care must be taken to assess such contacts to ensure that these do not also include concerns or complaints.

- **Consent** -The verbal or written agreement of a patient to allow the Trust to release confidential information about their care to a complainant acting on their behalf.

- **Feedback** - A verbal or written contact detailing a person's experiences or views of Trust services and where no further response from the Trust is anticipated or wanted by the person making the contact.

- **Independent Review –** This is the final stage of the complaints process and is managed by the Parliamentary Health Service Ombudsman (PHSO). Their role is to provide an independent review function for complainants who consider that the Trust has not resolved their complaint to their satisfaction. The PHSO is independent of the NHS and government and derives power from the Health Service Commissioners Act 1993 [the 1993 Act]. The PHSO judges NHS performance against the standards for good administration and complaint handling set out in full in the Ombudsman's Principles which is available at www.ombudsman.org.uk. The PHSO will not be able to investigate complaints until the NHS complaints procedure has been exhausted, unless in the circumstances of a particular case they judge that these conditions would be unreasonable.

- **Query** – A verbal or written contact where a request for information is the primary aim

of the contact.

- **Radar** - Is the product name of the complaint database and incident reporting software the Trust uses to support the management of healthcare risk and adverse event reporting. Radar is the only system on which complaints data should be entered.

- **Responsible body** – A Local Authority, NHS body or independent provider.

- **Working Day** – Any day except Saturday, Sunday or a Bank Holiday.

5. Duties and responsibilities

5.1 **The Chief Executive** is the named officer with responsibility for ensuring that the Trust complies with the statutory obligation to ensure that patients, relatives and carers views are heard, acted upon and that complaints are dealt with in compliance with the Department of Health directives.

5.2 **Chief Nursing Officer** has overall responsibility, delegated from the Chief Executive, for ensuring that effective systems and processes are in place to deal with complaints, concerns, comments and compliment feedback and ensure this is shared and acted upon to continually improve the quality of care provided.

5.3 **The Chief Medical Officer and Chief Nursing Officer** are responsible for providing expert clinical (for medics) and nursing (for nursing and all other therapies/professions) advice/guidance where appropriate and for ensuring action is taken following the outcome of independent reviews by the PHSO. Issues of clinical concern will be escalated to these roles as appropriate.

5.4 **Associate Director of Nursing & Patient Experience** is responsible for ensuring that all complaints activity is reported to the relevant Committees and Groups and overseeing the implementation and monitoring of this policy. They are also responsible for ensuring that the Trust is compliant with all statutory requirements and that the Trust Complaints Management Policy is robust and responsive to the needs of its service users.

5.5 **Complaints and Patient Enquiries Manager** is responsible for the co-ordination of all formal complaints and PALS working closely with the Associate Director of Nursing and Patient Experience to oversee the complaints management process from start to finish. The Complaints and Patient Enquiries Manager will assume responsibility for the initial grading of each complaint, ensure consistency in the approach to complaints handling across the organisation and ensure lessons learnt, or changes in action are communicated to the Trust Board as well as to the Divisional teams. The Complaints and Patient Enquiries Manager is responsible for coordinating investigations required by the PHSO.

5.6 **The Complaints & Enquiries Team** works closely with the Complaints and Patient Enquiries Manager to ensure the smooth centralised administration of the complaints and enquiries

process. They are the first point of contact for patients or their families wanting to raise a concern or complaint. They are also responsible for the grading and entering of all complaints onto the system in a timely manner. This will ensure a consistent and qualitative approach is maintained. The team will be responsible for ensuring that the investigating lead (IL) will receive automated milestone reminders via Radar in conjunction with a weekly reminder report which will include all outstanding complaints assigned to them. The team is also responsible for managing the Trust's patient enquiries (Patient Advice Liaison Service (PALS), providing support and help to patients, relatives, carers and visitors and to liaise with staff to facilitate prompt solutions.

5.7 The **Legal Services Manager** is responsible for the management of all clinical negligence, personal injury and property claims, and deals with/advises on any legal or potential legal matters relating to the Trust.

5.8 The **Information Governance team** is responsible for the management and processing of patient requests for their personal information and medical records under the Subject Access Request (SAR) process.

5.9 **The Investigating Lead (IL)** is responsible for leading on the investigation of formal complaints, meeting with complainants where appropriate seeking comments from additional services mentioned in the complaint and drafting the investigation report to complaints. It is the responsibility of the IL to ensure that the draft response is completed within the identified timeframe, includes comments from additional services (where appropriate) which have been approved ahead of being forwarded to their service lead for divisional sign–off as part of the quality assurance process. They must also ensure that any delays or updates are communicated to the Complaints and Patient Enquiries Manager. The IL will be supported by the Complaints and Patient Enquiries Manager to ensure consistency in the Trust's approach to managing complaints.

5.10 **The Clinical Service Leads** are responsible for ensuring that their own units are compliant with the Trust policy, with regards to the management of timescales and breaches. Also, for identifying those who will assume responsibility for undertaking investigation of formal complaints. They will also be responsible for ensuring that any actions or recommendations made following independent review by the PHSO are completed. The Service Clinical Leads are responsible for ensuring that complaint responses are monitored through Clinical Governance meetings and that themes and learning are presented and progressed against actions and are monitored via Radar. will be responsible for ensuring that the process for complaints management is adhered to. Once a complaint is allocated, it is the responsibility of the unit to ensure that in the absence of an appointed IL, contingency plans are in place for the management and monitoring of outstanding complaints.

5.11 **The Director of Therapies and Clinical Governance** is responsible for quality checking and signing off all complaints for the clinical division before being finalised by the executive lead.

5.12 Where the patient complains directly to **NHS England or an Integrated Care Board**, the receiving team will acknowledge receipt and coordinate the complaint on behalf of the patient. The Directorate will still undertake the complaint investigation in the same way as they would normally locally and will notify the Complaints and Patient Enquiries Manager so

that it can be recorded on Radar. Once quality assured, the final response will be sent to the patient by NHS England.

6. Procedures

6.1 See Appendix A for further detailed information on the complaints & enquiries procedures.

6.2 **Time limits for raising a complaint**
A complaint should ideally be made within twelve months of the date of the incident. Should a complaint be made after this time, the Complaints & Enquiries Manager may decide to investigate if it is accepted that the complainant had good reasons for not making the complaint within that period. The complainant must be advised that the passage of time may affect the investigation.

6.3 **Raising a complaint**
Complaints can be made to any member of the Trust's staff either verbally, or in writing, by email, letter, phone or via the online form on the Trust's website. It should be noted that the method of raising a complaint, either orally or in writing, does not necessitate the investigation route or determine degree of seriousness.

6.4 **Consent & Capacity**
Consent to access personal information for the purpose of investigating a complaint is implied when the complaint is raised by the patient.

Where a complaint is received from someone acting on behalf of a patient, the Trust will only instigate a full investigation once written consent is received from the patient. If consent is not received within 10 days, it will be presumed that consent has been refused.

Where a complaint is made by a carer or relative about issues that affect them in their role as carer or relative, consent is not required, although detailed clinical information may not be shared.

Where a service user lacks capacity and someone with Lasting Power of Attorney (LPoA) has been appointed to act on their behalf, then the LPoA should be consulted – as long as the LPoA specifically states that they have the authority to consent on behalf of the patient.

Where a service user lacks capacity and has no-one to support them then a referral should be made to the relevant Independent Mental Capacity Advocacy Service (IMCA).

If the patient is deceased the Personal Representatives, Executors or Next of Kin or Administrator of the deceased's estate can raise a complaint on production of documentation to confirm their status.

6.5 **Processing the complaint**

The Complaints & Enquiries team will process all contacts as outlined in Appendix 1. This includes acknowledgement and assignment of the complaint within three working days of receipt. The team will also advise and support the investigating lead in resolving the complaint in the following ways;

Informal Complaint

Definition: A complaint relating to the immediate service, which can be locally resolved with the attention of the Service Manager within 10 working days.

Where the complainant is not satisfied with the outcome of an issue/concern, or where the matter immediately necessitates input from senior colleagues, then the matter should be immediately brought to the attention of the service management team by the Complaints & Enquiries team.

In those cases in which colleagues are able to satisfactorily address and resolve the concern within 10 working days, the complainant should receive a full and positive written response with the aim of assuring them that their concerns have been addressed and this should include an expression of regret and/or explanation for the earlier problem.

A copy of the written response should be forward to the Complaints & Enquiries Team, who will upload and close the Radar file. If the service is unable to locally resolve the situation then staff should refer the individual to the Complaints & Enquiries Team for further discussion on how the matter will be dealt with.

Formal Investigation

Definition: A complaint requiring in-depth, formal investigation and response due to complexity or nature of content, by a persons independent to the immediate service.

Where the complainant is not satisfied with the outcome of an informal complaint, or where the matter immediately necessitates formal investigation then the staff member should immediately inform the Complaints & Enquiries team.

An investigation report template will be used to guide the formal investigation process. The Investigation Lead is responsible for determining the outcome of a complaint which is substantiated by information gained as part of the investigation process. They are also responsible for identifying any lessons learned as part of the investigation process and for ensuring action plans are implemented and monitored through Directorate governance meetings.

Formal complaints must be responded to within 40 working days.

Where the complaint includes third parties or is particularly complex the IL should consider and where appropriate negotiate an extended timeframe with the complaint at the earliest opportunity.

If it becomes apparent that this timeline will not be achieved, the complainant must be immediately informed and advised of the new timeline for response.

Appendix 1 further outlines the timed stages of formal complaints.

6.6 Vexatious Complaints

From time to time the Trust may come into contact with a small amount of complainants who require a disproportionate amount of time and resource in managing their complaints. It is important to identify those situations in which a complainant's behaviour might be considered to be unacceptable and to suggest ways of responding to those situations which are fair to both colleagues and complainant.

Complainants (and/or any third party acting on their behalf) may be deemed to be vexatious where contact with them shows that they meet two or more of the following criteria, (or are in serious breach of one):

- Have harassed, threatened, or used actual physical violence, been personally abusive or verbally aggressive, racist or homophobic towards staff dealing with their complaint or their families or associates. Personal contact with the complainant and/or their representatives may be discontinued and the complaint will, thereafter only be pursued through written communication. Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They must document all incidents of harassment using the Trust's incident reporting system.
- Have, in the course of addressing or raising a complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. A contact may be in person or by telephone, letter 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.
- Persist in pursuing a complaint when the Trust's complaints procedure has been fully and properly implemented and exhausted or is not within the Trust's remit to investigate.
- 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 should be addressed as separate complaints).
- Are unwilling to accept documented evidence of treatment given as being factual. e.g. drug records, manual or computer records, nursing records
- Deny receipt of an adequate response in spite of correspondence specifically answering their questions.
- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of Trust staff and, where appropriate, the aid of advocacy services to help them specify their concerns. Or the concerns identified are not within the remit of the Trust to investigate but they continue to be raised.
- Focus on a trivial matter to an extent that is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a "trivial" matter can be subjective and careful judgement must be used in applying this

criteria). Whilst staff must endeavour to respond to all complainants with patience and sympathy there are times when unreasonable behaviour is extreme or persistent and there is nothing further which can be reasonably done to assist the complainant or to rectify a real or perceived problem.

When considering management of complainants considered vexatious, staff must ensure;

- That the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint has been overlooked (even habitual or vexatious complaints may have aspects which contain some genuine substance, to ensure that an equitable approach has been followed)
- That the complaint response has been communicated in a manner which is understood by the complainant, and all reasonable and practicable steps have been taken to ensure understanding
- That a fair and reasonable response has been provided to the complainant
- There is clear documented evidence of behaviour which is considered unacceptable and staff are able to identify the stage in which the complainant became vexatious
- That the complainant has been afforded opportunity to discuss the matter in an agreed and pre-arranged forum with a colleague best suited to address their concerns
- Where appropriate, the complainant has been encouraged to contact an independent Advocate for support and advice, or a referral has been made.

Where complainants meet the criteria as stipulated above, the service must refer the case to the Associate Director of Nursing & Patient Experience who will review the case and determine whether there is enough evidence to implement a vexatious complainant management plan. The Associate Director of Nursing & Patient Experience and the Chief Nursing Officer have discretion on how they may decide to manage vexatious complaints. Consideration this may include, but is not limited to, directing the following;

- Try to resolve matters by drawing up a signed “agreement” with the complainant (and if appropriate involving the relevant clinician in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action
- Decline contact with the complainant (and/or the third party acting on their behalf) either in person, by telephone, by fax, by letter or any combination of these, provided that one form of contact is maintained.
- Restrict communication through a third party (e.g. advocate) by negotiation
- Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered
- Inform the complainant that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust’s solicitors

- Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from the Strategic Health Authority or other relevant agencies
- Time limit the declaration or make it subject to its review for reconsideration. An agreed Management Plan will be devised by the Complaints & Enquiries Manager and approved by the Associate Director of Nursing & Patient Experience. The Management Plan will be circulated to all relevant staff to ensure consistent delivery and implementation.

6.7 **Complaints from third party agencies**

Any complaints from MPs and Officers of the Crown, CQC enquiries or complaints that may result in litigation must be emailed to the Patient Experience Team immediately to log on Radar and as per Appendix 1 or via the Legal Claims Team as appropriate.

7. Training requirements

7. The Complaints & Enquiries Team will provide training on national guidance and local process and ensure that they are supporting staff in investigating and handling complaints.

7.1. The Complaints & Enquiries Team will deliver training on the Trust induction to all new staff outlining the complaints process.

7.2. Further supportive training for individual members of staff, teams and all Trust staff may be identified and sourced as part of a training needs analysis.

7.3. The Service Manager will ensure that all service users have access to materials detailing their right to complain and fair access to the complaints process

8. Process for monitoring compliance with this policy

8.1. The Complaints and Patient Enquiries Manager will provide a quarterly report detailing the complaints received in the quarter. This will be used to inform individual services, clinical governance structures and meetings and sub-groups of the Trust Board and the Quality & Safety Committee.

8.2. Details of service lines, numbers of complaints and whether they were upheld, partially upheld or not upheld should be included. The corporate and clinical governance structures will report assurance of compliance with the procedure to the Quality & Safety Committee and refer any matters arising from complaints to the Executive Leadership Team for action if required.

8.3. Monitoring of changes agreed as a result of feedback from complaints will be monitored by the agreed corporate and clinical governance structures and the Complaints & Enquiries Manager.

9. References

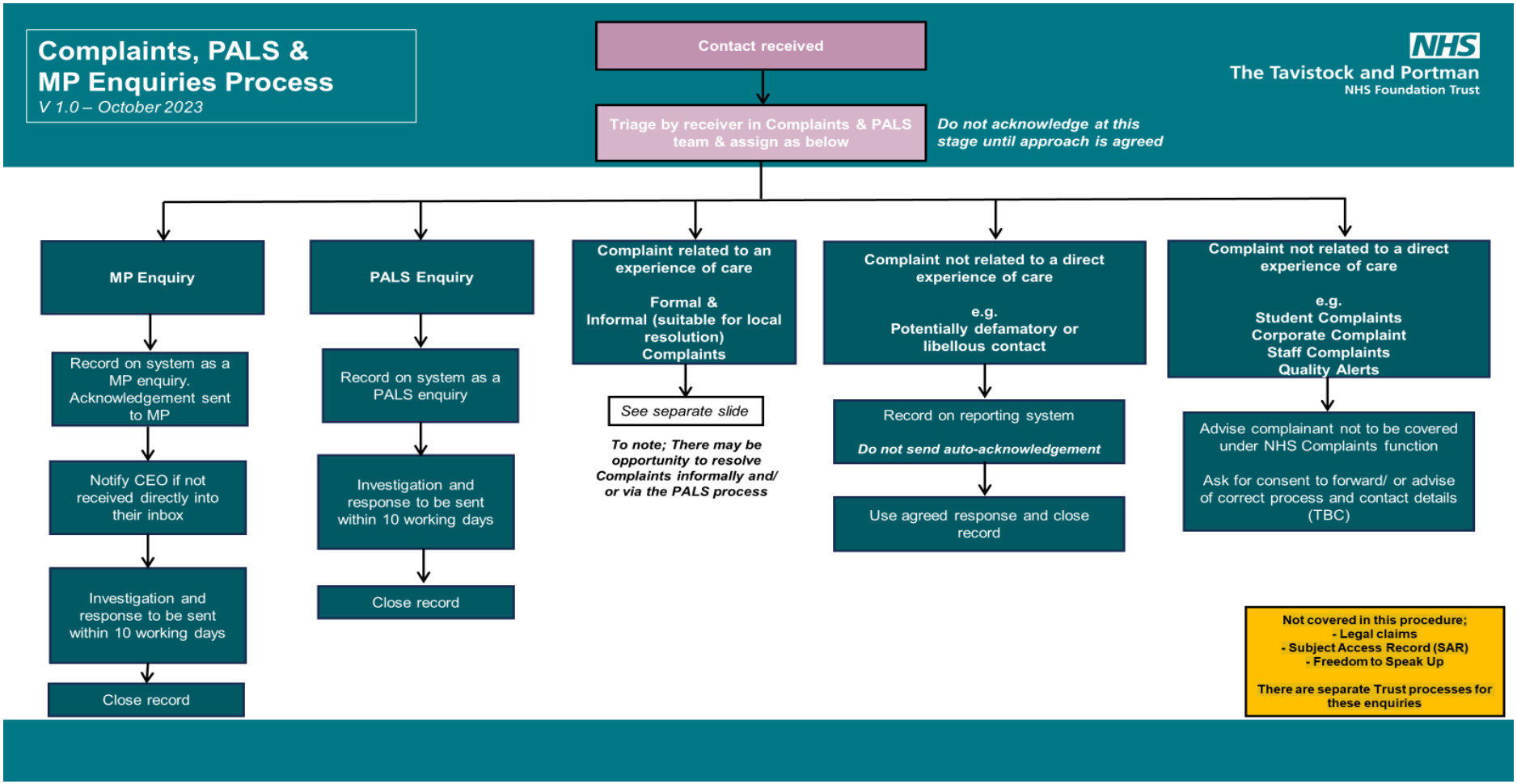
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- The Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman, 2008)
- Patient Safety Incident Response Framework (PSIRF) and supporting guidance 2022
- Care Quality Commission Fundamental Standards Regulation 16 Receiving and Acting on Complaints
- NHS Constitution (DH, 2009)
- NHS Litigation Authority guidance about complaints

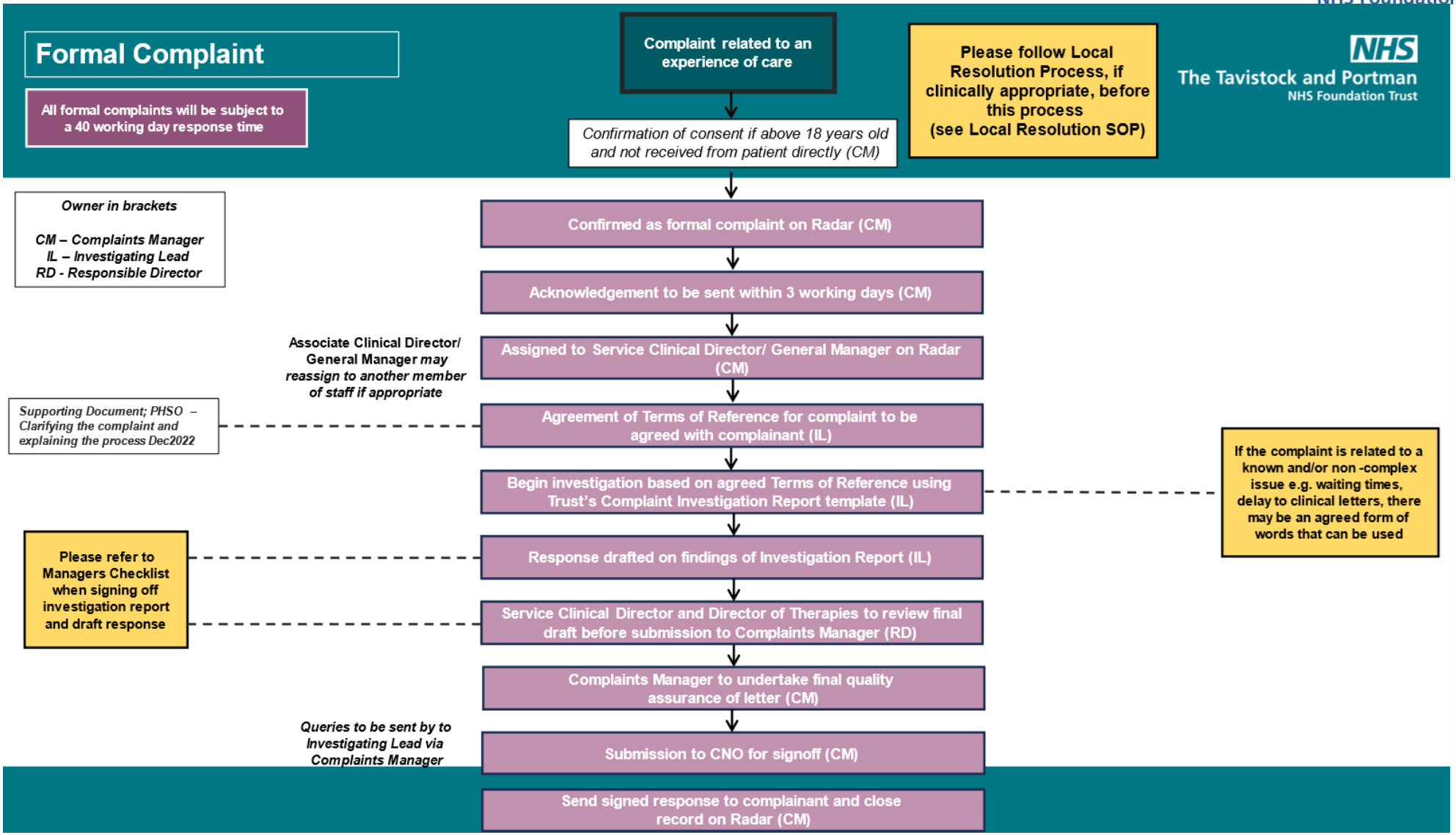
10. Associated documents

10.1. This policy should be read in conjunction with the following Trust policies and procedures:

- PALS Standard Operational Procedure
- Incident Reporting Policy
- Risk Management Procedure
- Claims Management Procedure
- human resources policies into employment concerns
- Information Governance policies
- Safeguarding policies
- Patient Safety Incident Response Framework Policy & Plan

Appendix A – Complaints, PALS & MP Enquiries Process V 1.1 – May 2023




Formal Complaint
All formal complaints will be subject to a 40 working day response time
Complaint related to an experience of care
Confirmation of consent if above 18 years old and not received from patient directly (CM)
Please follow Local Resolution Process, if clinically appropriate, before this process (see Local Resolution SOP)
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Owner in brackets
CM – Complaints Manager
IL – Investigating Lead
RD - Responsible Director
Confirmed as formal complaint on Radar (CM)
Acknowledgement to be sent within 3 working days (CM)
Associate Clinical Director/ General Manager may reassign to another member of staff if appropriate
Assigned to Service Clinical Director/ General Manager on Radar (CM)
Supporting Document; PHSO – Clarifying the complaint and explaining the process Dec2022
Agreement of Terms of Reference for complaint to be agreed with complainant (IL)
Begin investigation based on agreed Terms of Reference using Trust's Complaint Investigation Report template (IL)
If the complaint is related to a known and/or non -complex issue e.g. waiting times, delay to clinical letters, there may be an agreed form of words that can be used
Please refer to Managers Checklist when signing off investigation report and draft response
Response drafted on findings of Investigation Report (IL)
Service Clinical Director and Director of Therapies to review final draft before submission to Complaints Manager (RD)
Complaints Manager to undertake final quality assurance of letter (CM)
Queries to be sent by to Investigating Lead via Complaints Manager
Submission to CNO for signoff (CM)
Send signed response to complainant and close record on Radar (CM)

Formal Complaint – Timed process

All formal complaints will be subject to a 40 working day response time

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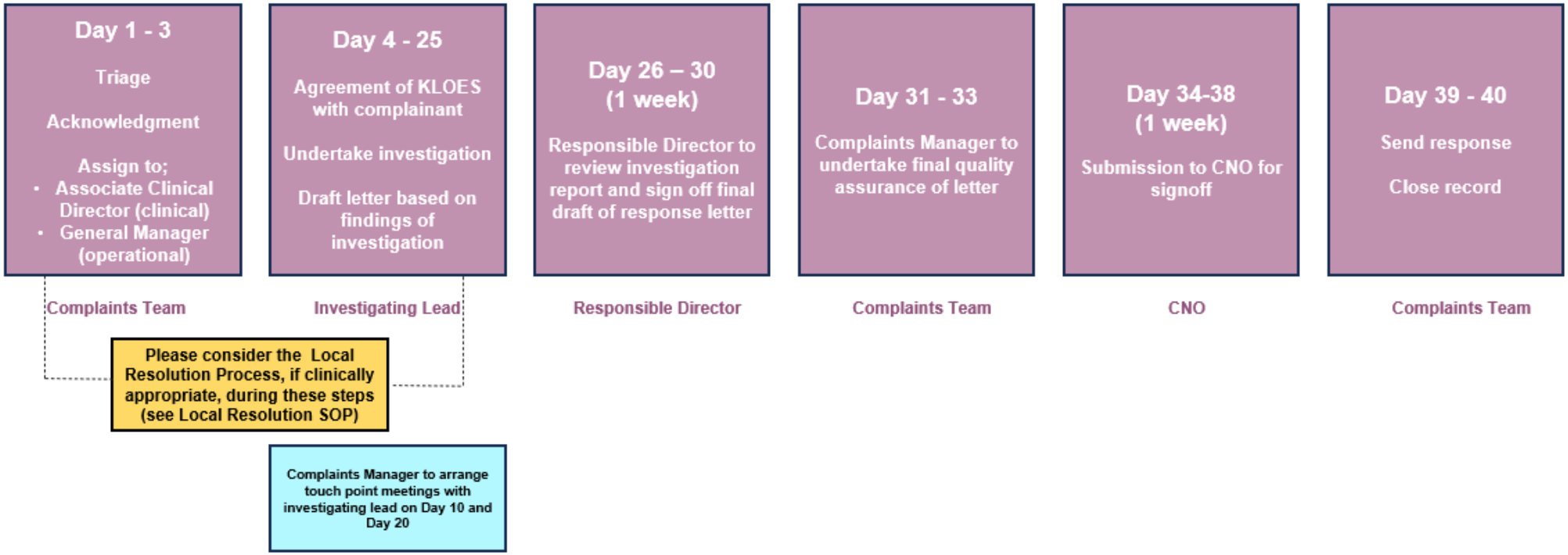

Formal Complaint – Escalation points

All formal complaints will be subject to a 40 working day response time

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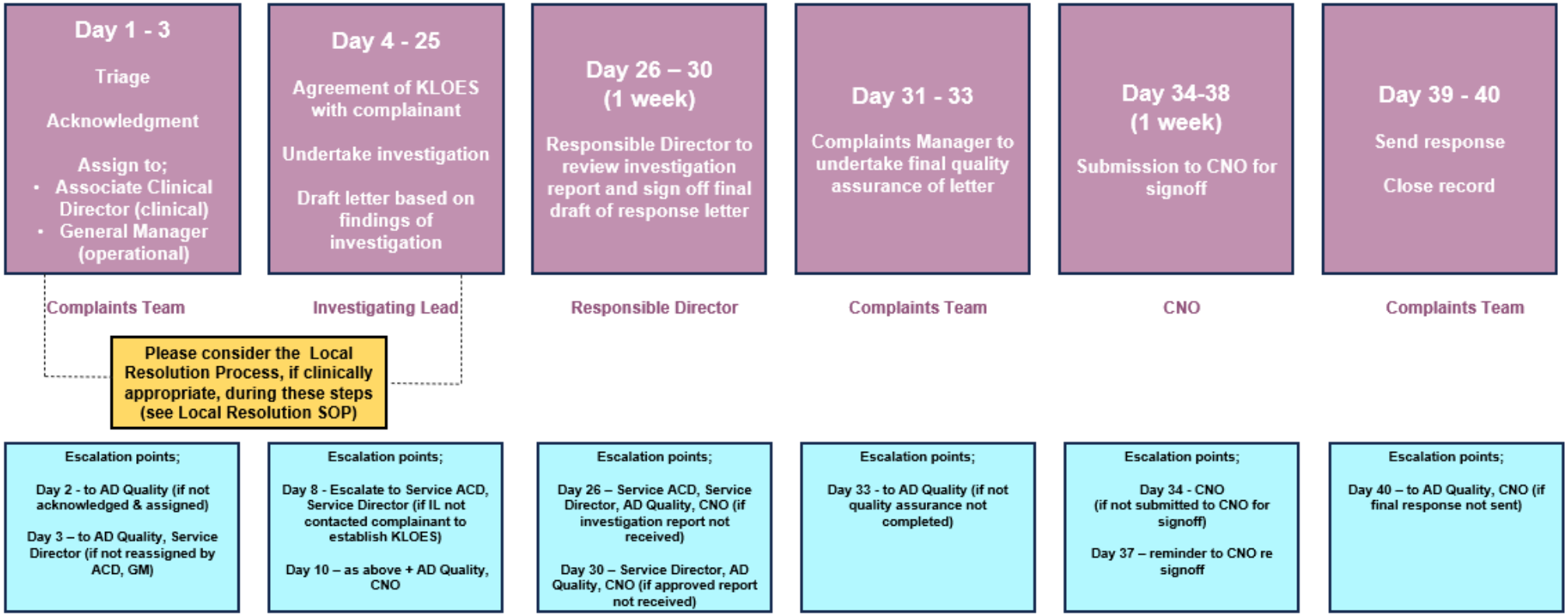

11. Equality impact analysis

Equality Impact Assessments are a tool used to assess all organisational activity including policy, strategies, plans, service delivery and practice or a decision.

The general equality duty set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- eliminate any form of unlawful discrimination (including direct or indirect discrimination, harassment, victimisation, and any other conduct prohibited under the Act)
- advance equality of opportunity between people who share a relevant characteristic and people who do not, and
- foster good relations between people who share a protected characteristic and people who do not.

Please refer to guidance notes if you need any further information (Appendix 1).

1	**Name and Job Title of person completing the Equality Impact Assessment**	Fay Shorter, Complaints and Enquiries Manager
2	**Title of what you are proposing**	Approval of V6 of Complaints Management Policy
3	**What are the main objectives or aims of what you are proposing?**	Updated process for effective management of formal complaints within the Trust.
4	**Date you are completing this form**	13th November 2024
5	**Summary overview** (What changes have you made following completion of the EIA)	No changes made after EIA review

Stage 1: Initial Screening			
6	**What evidence is available to suggest what you are proposing will have an adverse or positive impact on People from the protected characteristics or vulnerable groups?** Please state N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note: These groups may also experience health inequalities.		
Protected characteristics		**Impact** *No impact* *Low* *Medium* *High*	**Evidence** List below for each protected group the evidence you have used in your decision making, demographic data and other statistics including census findings, results of consultation or engagement, findings research, surveys (internal & external), complaints and complements, incidents reports, recommendations of external investigations or audit reports (see appendix). Are there any key gaps in the evidence? Published or consultation findings.
Age (Older people; middle years; early years; children and young people.)		**N/A**	
Disability (Physical, sensory, and learning impairment; mental health condition, long-term conditions)		**N/A**	
Gender Reassignment Inc. people who identify as Transgender		**N/A**	

Marriage and civil partnership (People married or in a civil partnership.)	**N/A**	
Pregnancy/maternity (Women before and after childbirth and who are breastfeeding.)	**N/A**	
Race and ethnicity	**N/A**	
Religion/belief (People with different religions /faiths or beliefs, or none.)		
Sex (Women, men)	**N/A**	
Sexual Orientation (inc Lesbian; Gay; Bisexual; Heterosexual)	**N/A**	
Vulnerable groups including but not limited to: Carers or carers of patients (unpaid, family members), Homeless (living on streets, sofa hoping with friend/family, hostels or B&Bs), Looked after children and young people. Asylum seekers and refugees (modern day slavery). People involved in the criminal justice system (offenders/ex offenders, probation, in-prison. Unemployed or low-income people or families, Sex workers, Prisoners and Probationers, Domestic Abuse/Drugs and Alcohol, Mental health, neurodiversity, poor literacy, or health literacy. Depravity (people living in deprived areas or remote/rural locations). Other groups experiencing health inequalities (please describe).	**N/A**	

6. **Human Rights (1998)** Are there any Human Rights considerations, if so, please identify which aspects (see guidance)

Yes (please explain)	
No	X
Don't know	

(a) If what you are proposing is assessed as **not having impact** - Go to Section 12
(b) If what you are proposing is assessed as **having impact** - Continue to Stage 2

	Stage 2: Full Equality Impact Assessment Procedure		
8	**Is there service user, public or staff concerns that what you are proposing may be discriminatory, or have an adverse or positive impact on people from the protected characteristics?** Please tick as appropriate		
8.1	Service Users		If yes, please identify and explain in section 9
8.2	Staff (including contractors)		If Yes, please identify and explain in section 9
9	**Can the adverse impact be justified?** Please provide details		
10	**What arrangements will you put in place to monitor the impact of the proposed action or change?** Please provide details		
11	What actions will you take to address any unjustified impact and promote equality of outcome for individuals from protected characteristics.		

	Review date:	

	Equality & Diversity Lead Approved?	Yes ☐ No ☐
	Equality & Diversity Lead Name:	
	Approval Date:	

Please send EIAs for review to the central mailbox:
eia@tavi-port.nhs.net

12. DECLARATION: I am satisfied that an equality impact assessed has been completed.

Date: 13/11/2024

Author: Fay Shorter

Title: Complaints and Enquiries Manager