NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Document name:	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
Document type:	Policy and Procedure
What does this policy replace?	Update of previous policy
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How to access:	Intranet and internet
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Approved by:	Executive Management Group on 20 May 2021 Trust Board on 29 June 2021 Extended to March 2023 by EMT on 22 September 2022. Further extended to August 2023 approved at EMT on 20 April 2023.
Developed by:	Reviewed by Associate Director of Nursing & Quality
Director leads:	Director of Nursing & Quality
Contact for advice:	Customer Services

With all of us in mind.

1. Introduction

South West Yorkshire Partnership NHS Foundation Trust endeavours to provide the best service it can to its patients. Sometimes patients' carers, families and/or their representatives may have concerns about services provided and it is important that there should be a clear and effective Customer Service Policy and Procedure for such matters. The service operates as a single gateway for raising issues and enquiries. This policy primarily covers feedback about Trust services and the management of complaints, concerns and compliments.

To enable the Trust to provide a responsive, quality public service it is essential to actively seek the views of those people who use our services and to respond appropriately when things go wrong. Complaints handling is a good proxy for an open, transparent and learning culture – which must be evident in a well-led organisation.

The Customer Services policy incorporates the obligations in the NHS Constitution and the Health and Social Care Act. It has been devised with reference to and also takes account of national reports, in particular:

- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – which sets out evidence commissioners should be seeking as part of their regular quality assurance processes with providers (updated September 2018)
- The NHS Constitution (Rights and Responsibilities of NHS staff and patients)
- Patients Association, Good Practice Standards for NHS Complaints Handling (2013)
- NHS Resolution Risk Management Standards (2020)
- Lessons learnt following the inquiry into the care provided by Mid Staffordshire NHS Foundation Trust (Francis report 2013)
- Health Service Ombudsman guidance, including:- - Ombudsman Principles - Improving complaint handling across the NHS and Social care and My Expectations (2014) - 'Breaking down the barriers' (2015)
- Healthwatch (2013)
- Independent Advocacy Services
- Human Rights Act (1998)
- Duty of Candour obligations (2013)
- Care Quality Commission – Complaints Matter (2014)

Making the process of feedback easy is essential; the Trust recognises that complaints might only arise as a culmination of a number of experiences, so actively encouraging feedback and apologising for negative experience is important.

Dealing with feedback in a transparent and responsive way demonstrates a commitment to improving people's experience of services and to ensuring they get the best possible support. This is built on the duty of candour, mutual respect, effective engagement, excellent customer service and a necessary and proportionate response to issues.

Complaints matter because every concern or complaint is an opportunity to improve and well-handled complaints will improve the quality of care for other people. Failure to deal with complaints appropriately presents a risk to the organisation – a missed

opportunity to improve services as a consequence of feedback and could have an adverse effect on the Trust's public reputation.

2. Purpose and Scope

People who use Trust services have a right to have their views heard and acted upon. The Trust has given a commitment through its mission and values to put the person first and centre and to be honest, open and transparent in all its dealings.

NHS complaints legislation requires a single approach for the handling of complaints across health and social care. The Trust has adopted a person centred approach to ensure that issues are dealt with in a way that people are empowered and able to make choices about how their concerns are dealt with. This approach has been further strengthened through the adoption of the framework which sets out best practice in five steps which is reflected in this policy:

- Considering a complaint – ensuring people are given information about how to complain, that they will be supported to do so and care will not be compromised.
- Making a complaint – ensuring all staff can help, and that making a complaint is easy and convenient.
- Staying informed – keeping people up to date and making the response personal.
- Receiving outcomes – resolving complaints and achieving the appropriate outcome.
- Reflecting on the experience – ensuing complaints are handled fairly and consistently and people understand how their feedback has helped to improve services.

Every member of staff is responsible for supporting people who wish to provide feedback or raise concerns and helping to resolve issues at service level wherever possible. Staff are alerted to customer services processes through promotional activity with services and teams, supported by publicity material and intranet based information. All staff should be able to advise service users, carers, relatives and visitors to the Trust on how to access customer services, including how to make a complaint. Staff assigned to investigate complaints should be supported to take action as appropriate in accordance with Trust policy and procedures and in highlighting necessary learning.

The commitment to learning from people's experience includes:

- Staff empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible.
- The use of insight gained from complaints, concerns and compliments, and other forms of feedback to improve the care provided to service users and carers.
- Thorough and timely investigation of complaints and concerns, and an open and conciliatory response.
- Fair treatment for people who make complaints, and assurance that care will not be compromised in any way.
- Feedback used as essential element of the Trust's approach to Governance.

3. Definitions

For the purposes of this policy, feedback is defined across three categories:

3.1 Compliments

Positive feedback received regarding care received by service users, their relatives and carers.

3.2 Comments (Service Issues)

A comment is a matter that is not about an individuals care and treatment. It is something that is a cause for concern to the complainant, eg. they may be unhappy with parking arrangements at the service, or someone is leaving lights on when a building is empty which serives will respond to an provide the relevant information on a monitoring form to the customer service team.

3.3 Concerns

A concern is a matter which an individual wishes to be considered on an informal basis. It is expected that the majority of concerns raised will be dealt with by the complaints process. All staff are expected, on a routine and daily basis, to deal with patient's concerns as presented to them. Wherever possible, staff are encouraged to achieve speedy resolution of the concern by either resolving it personally or establishing a dialogue between the complainant and the relevant personnel within operational areas. The objective will be speedy, informal resolution of the concern without recourse to correspondence/formal procedure.

3.4 Complaints

The NHS complaints regulations define a complaint as an expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action by the Trust or someone working for the Trust has detrimentally affected the experience of the service user or carer
- The complainant believes that a mistake or error occurred and that this has detrimentally affected them
- The complainant brings to the attention of the Trust an issue about a Trust service which could detrimentally affect them or someone else which they expect the Trust to put right.

4. Other forms of feedback

A range of approaches are in place across the Trust to obtain feedback from people who use our services, which, taken together, provide a framework for gathering insight into service user experience.

The framework includes real time feedback, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Care Quality Commission

4.1 Who can give feedback?

Any individual can give feedback to any Trust employee, including Customer Services. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carers, relatives, MPs, councillors, advocates and Healthwatch.

There is a Customer Service Information Leaflet available on the Trust Internet and Intranet (and also an easy read version) that can be provided to support people to give feedback on the services they have received.

4.2 Receiving feedback

The Trust encourages and expects staff to seek feedback and to know how to signpost to Customer Services if that is the person's preference. Customer Services leaflets and posters will be displayed in all service areas.

The Customer Services team can be contacted by telephone, email, via web link, text, in writing or by referral from a member of staff. Corporate social media accounts and external websites (NHS Choices, Patient opinion, Healthwatch) are also monitored to ensure feedback is captured and responded to if possible.

4.3 Acting on Feedback

A key objective of the Trust is to listen, learn, change and improve in response to concerns and complaints. The lessons learnt and trends identified as a result of concerns and complaints play a key role in continuously improving the quality of care received by patients and are a priority for the Trust.

4.3.1 Compliments

- Compliments can be provided to any member of staff by any member of the public, other members of staff or partner organisations. If a compliment is provided in writing to the relevant ward/department, the manager will respond to acknowledge the compliment.
- Each BDU is responsible for ensuring all compliments are logged.

4.3.2 Concerns and Complaints

4.3.2a Informal

- Services should invite and welcome feedback.
- Response to concerns and complaints should be *on the spot* wherever possible and a monitoring form completed.
- If it is not possible to resolve the concern or complaint straight away, assistance should be sought from the service line management. If the concern or complaint is raised verbally, and can be resolved within one working day, the response does not need to be in writing. The issue should be documented using the monitoring form.
- Concerns that are addressed at service level will be agreed on an individual basis as to whether the complainant prefers a response in writing or is happy with verbal feedback (verbal feedback should be recorded on the monitoring form).

4.3.2b Formal

- Concerns and complaints received in writing, by email or via telephone that cannot be resolved quickly (by the service) will be reviewed by the Customer Services manager and allocated to a case handler.

- Customer services staff will agree a handling plan with the person raising the issue.
- Formal complaints will always require a formal investigation and written response and the person raising the complaint will receive a written response from the Responsible Officer for Complaints Management

The procedure for complaints handling is detailed in **Appendix A**.

There is also guidance on dealing with persisitant and unreasonable contact in **Appendix B.**

4.4 NHS Complaint Regulations (2009)

The NHS Complaints Procedure covers the following:

- A person who is in receipt of, or who has received, services from the Trust.
- A person who is affected, or likely to be affected, by an action, omission or decision of the Trust.
- A person who is acting on behalf of a person who has died, is a child, is unable to make the complaint themselves because of physical incapacity, or lack of mental capacity (Mental Capacity Act), or has been requested to act as a service user's representative
- The Regulations require that a complaint must be made within 12 months of:
  - (i) The date on which the matter which is the subject of the complaint occurred; or
  - (ii) If later, the date on which the complainant become aware of the matter which is the subject of the complaint.

  Complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

  Where a complaint is made outside this time limit the Customer Services Manager in discussion with the Assistant Director of Nursing & Quality may exercise discretion to admit the complaint to the Procedure if they are satisfied that:
  (i) The complainant had good reason for not making the complaint within the time limit; and
  (ii) Notwithstanding the delay it is still possible to investigate the complaint effectively and fairly.

  If it is not possible to waive the time limit and the complaint is not accepted into the Customer Services Procedure, an explanation of this will be provided to the complainant in writing.
- Complaints can also be made by a person acting on a patient's behalf for any services connected with the Trust, as long as consent is provided by the patient or the person has the legal authority to do so.
- All complainants will be informed about the right to access independent complaints advocacy.

- All complainants have the option to apply to the Parliamentary and Health Service Ombudsman, to ask for independent review of their complaint, should they remain dissatisfied following the Trust's management of their complaint.

In line with the NHS regulations, the following are **not** covered by the Trust's Customer Services policy:

- Requests for access to records or an amendment to the clinical record (refer to Access to Records procedure).
- Requests for a change to care plan or medication (refer to clinical team).
- Challenges to policy decisions by the Trust Board (refer to Trust Board chair).
- Complaints made by a member of staff about their employment or about another member of staff. (refer to HR policies).
- Complaints made about volunteer activity (refer to Equality & Engagement eam).
- Complaints about involvement activity (refer to Equality & Engagement Team).
- Commissioning decisions (refer to appropriate Clinical Commissioning Group).
- Complaints about services delivered by an independent provider, on behalf of the Trust, are not covered by the NHS Complaints regulations. However, the Trust must satisfy itself about the quality of service and that the independent provider has its own robust complaints procedure.
- Complaints about superannuation (refer to payroll/HR department).
- Staff who wish to voice concerns or grievances should be raised through appropriate line management processes in line with Human Resources policy, or through the Freedom to Speak up Guardians where appropriate.
- Complaints which have already been investigated and concluded using the NHS procedure (refer to the section of this policy covering Parliamentary and Health Service Ombudsman).

4.5 Complaints to other bodies, including the Care Quality Commission (CQC)

People who are, or who have been, detained under the Mental Health Act have the right to complain to the Care Quality Commission (CQC) about use of the Mental Health Act. The CQC will usually ask that the complaint is initially submitted to the hospital managers.

The Mental Health Act Code of Practice (2015) requires information on how to complain to the CQC to be readily available on all wards that are registered to support people detained under the Act. The Trust will ensure CQC policy material providing the relevant information is available on its wards. Due consideration will be given to the Accessible Information Standard in sharing this information.

5. Duties

The customer services process is supported by:-

5.1 The Chief Executive

The Chief Executive (or nominated deputy) has overall responsibility for ensuring the Trust Customer Service Policy meets statutory requirements as set out in the NHS Complaints Regulations (2009). Will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

5.2 The Trust Board
Trust Board is responsible for approving the policy for the approval, dissemination and implementation of policies and procedures as outlined in this document. The Clinical Governance And Clinical Safety Committee will receive quarterly reports from the Customer Service Team

5.3 The Executive Management Team (EMT)
The Executive Management Team will monitor key performance indicators (KPIs) in relation to complaints through monthly business intelligence dashboard reporting. The Executive Management Team will also review any action plans arising from complaints upheld or partially upheld by the Parliamentary and Health Service Ombudsman.

5.4 Directors
The Director of Nursing & Quality is the lead director for customer services, including complaints management. The Director of Nursing & Quality will ensure appropriate arrangements are in place to respond to issues raised, in ways that support people to live well in their communities, and that maintain and enhance the Trust's reputation for putting people who use services at the heart of service delivery. The Director of Nursing & Quality will ensure that Customer Services information is reported appropriately to BDUs, in integrated performance reports and in quarterly and annual reports to the Clinical Governance & Clinical Safety Committee. The Director of Nursing & Quality will review and sign all final responses to complainants, having received assurances from the relevant director that the response addresses all points raised in the complaint management plan.

Deputy Directors and Clinical Leads will ensure appropriate systems are in place to:
- Respond to feedback, investigate concerns and complaints
- Review complaint responses to ensure:
    - Ownership of the response by the service
    - Quality assurance of the response in terms of addressing the root causes
    - Actions are consistently learned and applied across services and in the system.
- Monitor delivery of complaint action plans through BDUs governance processes.
- Provide updates to Customer Services to incorporate in quarterly reports to Trust Board.

5.5 Customer Service Team
The team will ensure processes that support complaints investigation and resolution, for example the complaints toolkit, remain fit for purpose, support staff to resolve issues, and service users in an effective complaints management process.

When concerns or complaints are received, the Customer Services Team will:

- Ensure that the complainant is contacted by an allocated team member to explain the process and discuss the handling of the concern/complaint.
- Ensure the complainant is at the centre of the process, and that a complaint management plan is developed, taking account of the complainant's expectations for resolution and negotiated timescale for investigation.
- Alert directors as appropriate to concerns / complaints that suggest quality of care is compromised or other risk assessment is required.

- Ensure written acknowledgement is sent to the complainant within 3 working days.
- Ensure the assigned team member liaises with the relevant clinical lead, manager, or other organisations, to facilitate a response within the agreed timescale.
- Ensure the complaint investigator keeps Customer Services updated with the progression of the complaint at all times and at least weekly.
- Receive information from the complaint investigator to enable a response to be produced for director review prior to sign of by the Responsible Officer for Complaints Management.

Where more than one organisation (health or social care) is involved, the Customer Services Manager or Assistant Director of Nursing & Quality will ensure appropriate consent is obtained, and that a lead person is appointed to co-ordinate the investigation and response.

Where complaints received by the Trust relate to another organisation the complaint will be referred on as appropriate, without delay, following receipt of consent from the complainant.

5.6 Clinical leads / General Managers / Practice Governance Coaches/ Quality & Governance Leads/Matrons

Working with Customer Services as appropriate:

- Ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues in person or by appointing a suitably skilled member of staff to conduct the investigation.
- Ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit.
- Meet agreed timescales in relations to complaints investigation and management.
- Advise the deputy director about complaints, and support review of issues and learning through BDU governance processes.
- Ensure any learning for the wider Trust is shared.

5.7 Complaint Investigators

Complaint investigators will have completed relevant training. They will co-ordinate the response, collaborating with relevant colleagues as required. The complaint investigator is responsible for:

- ensuring the response for each element of the investigation is of a high quality, prior to amalgamating for inclusion in the final response;
- ensuring that the investigation is completed within the expected timeframes and escalating this if the agreed response date will not be met to the customer service team;
- ensuring an appropriate investigation has been completed;
- planning the investigation, timescale expected and keeping the customer service team informed.

5.8 All Staff

All staff need to be aware of policies and how they impact on their practice. All new policies approved by Trust Board, its committees and / or EMT are communicated through the staff briefing and via the intranet. Staff have an individual responsibility to

seek out this information. All staff will assist and cooperate in the complaints process. Wherever possible they will try to deal with issues of concern before it becomes a formal complaint.

5.9 Reporting Feedback

The Customer Services Team will provide regular reports to BDUs, advising open and closed complaints in the period and progress on complaints investigation.

The Customer Services Team will provide quarterly reports to the Clinical Governance & Clinical Safety Committee and to BDUs, covering the number of issues raised, a breakdown of complaints, concerns, comments and compliments, identification of themes and evidence to demonstrate that lessons have been learned as a result of service user feedback. Reports will also include issues referred to the Parliamentary and Health Service Ombudsman, including any financial redress. The quarterly report will be shared with the Mental Health Act Committee to alert to complaints relating to application of the Mental Health Act, and with the Members' Council Quality Group for review and information.

The Report will also be shared externally with CCGs through contracting and quality monitoring processes and with Healthwatch across Trust geography.

An annual report will be produced for consideration by the Clinical Governance & Clinical Safety Committee. The the Clinical Governance & Clinical Safety Committee is responsible for approving Trust policy in relation to complaints handling, for ensuring compliance with national and local targets in relation to complaints, and that robust systems are in place to enable feedback about services and that lessons learned lead to an improved service user experience.

6.Process for learning and improving as a result of comments, concerns and complaints

Many complaints arise from misunderstandings and may be resolved through appropriate explanation and discussion. Other complaints, however, will reveal ways in which Trust services may be improved. The Trust recognises the pledge in the NHS Constitution to learn lessons from complaints and use these lessons to improve its services.

A complaints action tracker will be held by the Customer Serivces team and progress will be required to be reported to the dedicated Customer Services Officer by the complaint investigator for each complaint. This will track whether actions are "open" or "closed".

Where the complaint raises any performance issues of particular concern, these should be reported by the relevant Deputy Director to the relevant General/Service Manager, Clinical Lead, the Medical Director or Director of Nursing & Quality, as appropriate.

Where it is clear that improvements to services can be made, these should be explained to the complainant in the response to the complaint.

Whilst responsibility for managing the Customer Service Policy rests with the Customer Service Department, it remains the responsibility of staff within individual Service to identify whether they may learn from the complaints received by the Trust and create an action plan.

Responsibility for ensuring that all appropriate actions have been implemented will rest with the Service through their established governance arrangements.

Analysis of lessons learnt from complaints will be undertaken by the Customer Service team with recommendations for wider improvements in response to identified trends considered by the Clinical Governacne & Clinical Safety Committee.

7.Process for monitoring compliance with this policy

The Assistant Director of Nursing & Quality is responsible for monitoring compliance with this policy. This will be achieved through:

- The ongoing monitoring role of the Customer Services team.
- The Customer Services team make data and reports available within the Trust as described above.
- Routine contact with services and investigators regarding the ongoing process for complaints investigation.
- Feedback from Commissioners.
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsmen, the CQC, the Information Commissioner and NHSI.

Relevant concerns will be reported to the Executive Management Team, with action by the appropriate director.

8. Associated documentation

Supporting procedural documents include:

- Investigating and analysing incidents, complaints and claims to learn from experience Policy and Procedures.
- Being Open policy – including duty of candour.
- Claims Management Policy and Procedure.
- Safeguarding Children procedures.
- Safeguarding adults procedures.
- Health and Safety policies, procedures and processes.
- Human Resources and related policies and procedural and related documents.
- Information Governance (and Caldicott Guardian) related policies and procedural documents.
- Freedom of Information Policy
- Accessible Information Policy
- Communications, Engagement and Involvement Strategy
- Preventing Violence and Agression Policy

9.Equality Impact Assessment

This policy promotes equality of access to the Trust's Customer Services function. See **Appendix C** for equality impact assessment.

The potential for people to have difficulty in accessing this procedure is mitigated by ensuring support is available through Customer Services, the availability of information in different formats on request, and promoting access to advocacy and interpreting services.

10 Dissemination and implementation

This policy will be promoted through 'The Headlines' weekly staff bulletin and accessible via the Trust intranet and internet. Leaflets and posters publicising the ways to offer feedback will be available in all Trust clinical and public areas.

Implementation of the policy will be the responsibility of staff at all levels, and supported by all managers and directors.

Managers are required to monitor compliance with this policy and to ensure a systematic approach to responding to feedback from people who use services and their families / carers.

Managers are required to ensure appropriate support is in place for staff impacted by complaints.

BDUs are required to ensure staff who undertake complaints investigation are skilled and supported to do so, to develop action plans to address areas for improvement, and to monitor delivery of same through governance processes.

11 Review and Revision arrangements

This policy and procedure will be subject to annual review by the Trust Board, with review instigated in the event of policy change. **Appendix D**

12 Document control and archiving

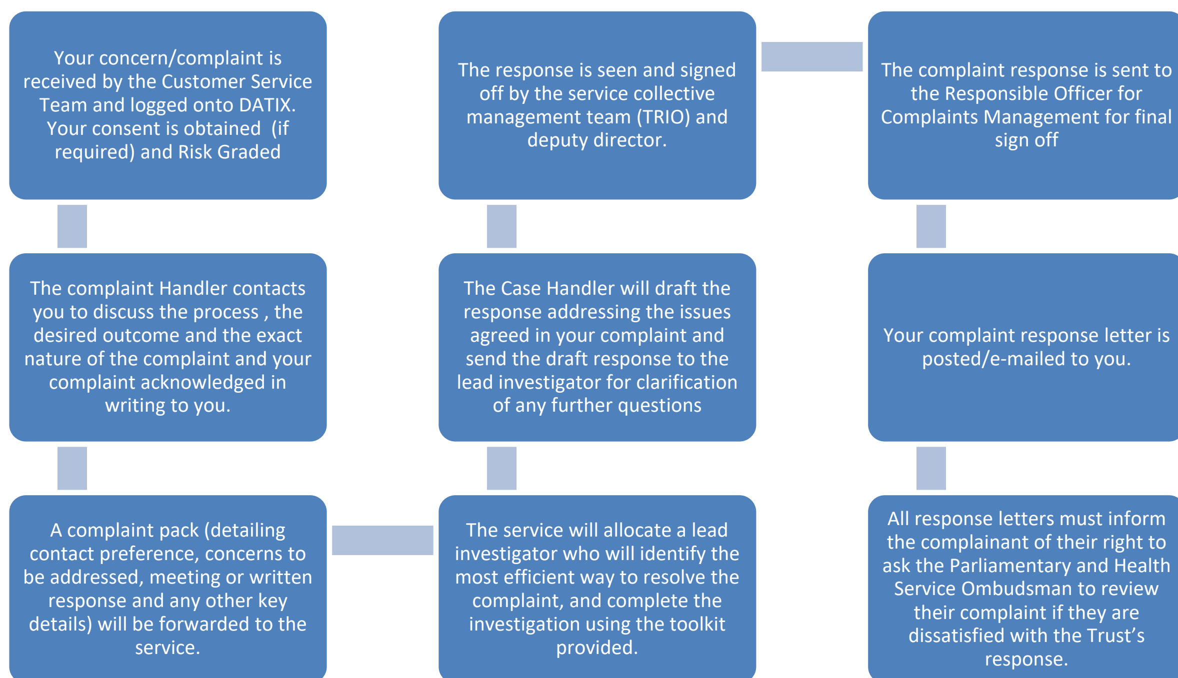
This policy will be accessible via the Trust's intranet and website in read only format and managed in accordance with the requirements for retention of non-clinical records. **Appendix E**

APPENDIX A

Complaints Procedure (Local Resolution)

All complaint investigations should follow the pathway for comapliant management as set out below.

Every effort must be made to support people who wish to make a complaint. This could include language support, support in dicumentingthe issues/concerns, signposting to advocacy services or providing mediation.



All records relating to complaints investigation are confidential and must be be kept by the Trust in a secure environment for 10 years. No other files relating to complaints should be held by the organisation and complaints correspondence should not be part of the clinical record. Clinical staff must be appraised of actions taken to resolve complaints to promote learning.

- Consideration must be given to the following:

    - All complaints are risk screened on receipt.
    - If a complaint involves clinical issues that require urgent attention or raises issues that could potentially compromise public or service user safety, the appropriate deputy director must be informed immediately.
    - Complaints that could fall into the Serious Incident category must be referred for advice to the Patient Safety Support Team. Every effort must be made to minimise distress or confusion to the complainant.
    - Where a complainant indicates they intend to take legal action, the matter must also be referred to the Assistant Director of Legal Services. The Trust will take legal advice and in some, but not all, circumstances it may be appropriate to cease action under the complaints procedure. This is consistent with national guidance.
    - Complaints / concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate.
    - Complaints about members of staff that involve accusation of misconduct must be referred to Human Resources. Staff have the right to be dealt with fairly in such cases, and complainants do not have the right to information about specific action taken against staff members.
    - Issues that could potentially attract media attention must be referred to the Communications Team.
    - Issues relating to child protection must be referred to the Trust's Named Nurse for Child Protection, and dealt with under joint agency protocols for child protection.
    - Issues relating to Vulnerable Adults must be referred to the Trust's Vulnerable Adults Specialist Advisor, and dealt with under joint agency protocols for vulnerable adults.
    - Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police, and will be supported to do so. If the complainant chooses not to report a serious matter which may be criminal, the Trust may choose to notify the police. Advice should be sought from the Caldicott Guardian where such action might be in breach of a person's confidentiality.
    - Investigators should always alert the Customer Service team at an early stage if a complaint is proving particularly complex or difficult to resolve. Revising the approach may prevent a complaint escalating to Ombudsman Review.

APPENDIX B

Guidance for dealing with persistant and unreasonable contact

Most complaints are entirely reasonable; however a few are not. Some may, for example, abuse or threaten members of staff or continue to raise the same concerns when these have already been addressed. The following are examples of behaviour which might be regarded as unreasonable:

- Refusing to specify the grounds of a complaint, despite offers of assistance with this from the authority's staff.
- Refusing to co-operate with the complaints investigation process while still wishing their complaint to be resolved.
- Refusing to accept that issues are not within the remit of a complaints procedure despite having been provided with information about the procedure's scope.
- Insisting on the complaint being dealt with in ways which are incompatible with the adopted complaints procedure or with good practice.
- Making what appear to be groundless complaints about the staff dealing with the complaints, and seeking to have them replaced.
- Changing the basis of the complaint as the investigation proceeds and/or denying statements he or she made at an earlier stage.
- Introducing trivial or irrelevant new information which the complainant expects to be taken into account and commented on, or raising large numbers of detailed but unimportant questions and insisting they are fully answered.
- Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved.
- Adopting a 'scattergun' approach: pursuing a complaint or complaints with the authority and, at the same time, with a Member of Parliament/a Councillor/the authority's independent auditor/the Standard Board/local Police/Solicitors/the Ombudsman.
- Making unnecessarily excessive demands on the time and recourses of staff whilst a complaint is being looked into, by for example excessive telephoning or sending emails to numerous hospital staff, writing lengthy complex letters every few days and expecting immediate responses.
- Submitting repeat complaints, after complaints processes have been completed, essentially about the same issues, with additions/variations which the complainant insists make these 'new' complaints which should be put through the full complaints procedure.
- Refusing to accept the decision – repeatedly arguing the point and complaining about the decision.
- Combination or some or all of these.

Trust staff should acknowledge that, at times, people might find it difficult to express their frustration and might behave in a way that makes resolution difficult. Staff should support people to raise their issues in a constructive manner, manage expectations, and work towards a satisfactory outcome. However, the Trust has a responsibility to protect its staff from people who behave in an abusive or malicious manner, and to

avoid inappropriate use of resources through dealing with persistent or unreasonable complaints.

If an investigation lead or customer services co-ordinator becomes concerned that a complainant is becoming unreasonable, they must seek assistance from the Customer Services Manager. It is vital that any restrictions placed on a complainant should be as a result of a fair and consistent process. Any request to cease or limit an investigation about a complaint that is considered unreasonable or persistent, needs to be considered in consultation with the Director of Operations and the Chief Executive (or nominated deputy).

It may be necessary to request that the complainant only makes contact with a named individual, by one contact method only, for example either by telephone, email or in writing. Where a named individual is assigned they should ensure a comprehensive record of all contact is maintained.

The complainant must be advised that issues already responded to will not be re-opened or re-investigated. If appropriate, the complainant should be informed that abusive correspondence, or threatening behaviour, will not be responded to. The complainant should be offered information regarding independent advocacy support.

Letters or telephone calls received during the formal investigation stage will be acknowledged and any new issues included in the overall investigation. A meeting may be offered to clarify the issues to be investigated and confirm the process. The complainant should be advised if new issues are likely to affect the timescale for providing a final response to the complaint.

The precise nature of the action the Trust decides to take in relation to an unreasonable persistent complainant should be appropriate and proportionate to the nature and frequency of the complainant's contacts with the Trust at that time.

The following list is a 'menu' of possible options for managing a complainant's involvement with the Trust from which one or more might be chosen and applied, if warranted. It is not exhaustive and often local factors will be relevant in deciding what might be appropriate action.

- Placing time limits on telephone conversations and personal contacts.
- Restricting the number of telephone calls that will be taken (for example, one call on one specified morning/afternoon in any week.
- Limiting the complainant to one medium of contact (telephone, letter, email etc) and/or requiring the complainant to communicate only with one named member of staff.
- Requiring any personal contacts take place in the presence of a witness.
- Refusing to register and process further complaints about the same matter. Where a decision on the complaint has been made, providing the complainant with acknowledgements only of letters, faxes, or emails or ultimately, informing the complainant that future correspondence will be read and placed on the file but not actioned. A designated officer should be identified who will read future correspondence.

- When a caller has been officially declared a habitual or repetitive caller, the Chief Executive, or in her/his absence by another of the Trust's Executive Directors, may decide that no further telephone communication will be accepted.
- Where there is on-going correspondence or investigation the Complaints Manager will write to the caller setting the parameters for a code of behaviour and the lines of communication. These will be communicated to all relevant staff to ensure consistency of approach within the Trust.
- When an investigation or correspondence is completed, the Complaints Manager will, at an appropriate stage, write to the caller informing him/her that the Trust has responded fully to the points raised and that there is nothing further that can be added, therefore correspondence is at an end. The Trust will state that further correspondence will be acknowledged, but not answered.

The final decision regarding ceasing all contact with a complainant lies with the Chief Executive.

Notification of the Decision.
Once a decision has been made to take action in relation to a service user/complainant under this policy, the relevant Deputy Director, in conjunction with the Customer Service Manager will write to them to explain the following:

- The decision that has been taken.
- The reasons why that decision has been taken.
- That any restrictions will remain in force until notified otherwise in writing.
- How a request can be made to have the decision reviewed and the time limit within which to make a request. The Customer Services will be responsible for ensuring that key staff are aware of the decision and any restrictions in place, including any changes to those decisions/restrictions (see paragraph below).

A central record of decisions/restrictions will be held in the Customer ServiceTeam. Where a valid request has been made to review a decision within the appropriate time limit, the review will be carried out by a Deputy Director. The review will be conducted as the Deputy Director sees fit, including considering any relevant documents that informed the original decision, the decision letter and the information provided in the request for a review. The Deputy Director has the discretion to uphold the original decision/restriction(s), uphold the original decision and amend the restriction(s), or quash the original decision in its entirety. The service user/complainant will be notified of the decision by letter or their preferred method of communication e.g. email.

Review of Restrictions
Where a decision was taken to impose restrictions on a service user/complainant, that restriction will be reviewed by the relevant service area at appropriate intervals not exceeding 12 months and the decision will either be re-imposed, amended or removed. In the event that they are amended or removed, the service user/complainant must be notified by letter or their preferred method of communication.

New Complaints from Persons who are designated as unreasonable/unreasonably Persistent

The Trust will not operate a blanket policy of refusing to deal with any genuinely new complaints. If a new complaint is received, from a person who has previously been identified as unreasonable/an unreasonably persistent complainant under this policy, the new complaint will be dealt with on its merits.

Failure to Adhere to Restrictions

Should a service user/complainant continue to behave unreasonably and/or fail to comply with restrictions previously imposed under this policy, then the Trust may take further action as it deems reasonable and proportionate, including legal action and reporting the matter to the police where their behaviour may amount to a criminal offence.

APPENDIX C

Equality Impact Assessment Template to be completed for all Policies, Procedures and Strategies

Date of Assessment: 12.05.2021

	Equality Impact Assessment Questions:		**Evidence based Answers & Actions:**
1	**Name of the document that you are Equality Impact Assessing**		Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		To provide a framework for ensuring feedback is valued and responded to appropriately. To support effective complaints management processes, consistently applied across all services. People who use services, carers, staff
3	**Who is the overall lead for this assessment?**		Assistant Director of Nursing & Quality
4	**Who else was involved in conducting this assessment?**		Customer Services Team
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		Customer services processes and procedures are subject to constant evaluation with service users and carers (following their contact with the team) and with staff following involvement in complaints handling or report review. Information used to inform policy
6	**What equality data have you used to inform this equality impact assessment?**		Protected characteristics data collected via the function.
7	**What does this data say?**		From the figures shown in the data there is more work to do to ensure that our services reach and obtain feedback from our diverse population to reflect and represent the population we serve. This work with be completed as part of an engagement plan.
8	**Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:**	**No**	It is not anticipated that this Policy will have any negative impact on any of the equality groups. The potential for people having difficulty giving feedback or raising complaints and concerns is mitigated by promoting an allocated caseworker to provide individual support, access to advocacy and / or interpreting services and taking account of information requirements (which will be further

			enhanced through compliance with the Accessible Information Standard. The policy will have a positive impact on all groups and will drive service improvements to ensure the voice of these groups is gathered, recorded, reflected, and considered in the decisions we make as a Trust regarding customer feedback.
8.1	**Race**	**No**	The Trust needs to consider why there is so little feedback from certain groups (or people are not identifying their ethnicity) in our diverse population and identify strategies to obtain feedback going forward.

Race equality

	White	Asian	Black	Mixed	Chinese & Other
England % av.	85.5	5.1	3.4	2.2	1.7
Kirklees					
% average	79.1	15.7	1.9	2.3	0.7
Barnsley					
% average	97.9	0.7	0.5	0.7	0.2
Calderdale					
% average	89.6	7	0.9	1.3	0.6
Wakefield					
% average	95.4	2.6	0.77	0.9	0.29

Taken from Census 2011 for each area

Ethnicity	Total	%
White British	28320	82.93%
Pakistani	1175	3.44%
Not Stated	1156	3.39%
Any Other White background	997	2.92%
Not Recorded	691	2.02%
Any other Ethnic group	293	0.86%
Indian	265	0.78%
White and Black Caribbean	201	0.59%
Any other Asian background	176	0.52%
Black Caribbean	170	0.50%
Any Other mixed background	165	0.48%
White Irish	128	0.37%
Black African	124	0.36%
White and Asian	102	0.30%
Any other black background	96	0.28%

			White and Black African	50	0.15%
			Chinese	21	0.06%

Trustwide Information May 2021 data

ethnicity		%
White British	146	56
Prefers not to say	6	2
Pakistani	3	1
bangladeshi	1	1
black caribbean	3	1
black african	1	1
Unknown	97	37
Any other white background	3	1
Customer Service data 2019/2021	**260**	**100**

8.2	**Disability**	**No**	Across all communities the Trust will ensure that services remain fully accessible due to a higher than national average proportion of people whose day to day activities are limited 'a lot' by their disability. We will use the services EIA's to ensure we fully understand the nature of the disability so we can adjust and adapt our services according to need and feedback, remaining person centred throughout.

Disability groups

	Day to day activities limited by disability		
	Not at all	A little	A lot
England % av.	47.2	13.2	4.2
Kirklees			
% average	45.5	12.5	13.7
Barnsley			
% average	76.1	11.3	12.6
Calderdale			
% average	56.5	12.2	13.8
Wakefield			
% average	77.93	9.33	8.31

Taken from Census 2011 for each area

Disability	**Total**	**%**
Not Recorded	24980	73.15%
Not disabled	5937	17.39%
Disability NOS	1275	3.73%
Registered disabled	1121	3.28%
	836	2.45%

Disability status not given - patient refused			
Total Patients	**34149**		

Trustwide Information May 2021 data

Disability		%
Mental Health Condition	40	15
Does not have a Disability	28	11
Autism	3	1
Physical Impairment	5	2
Prefers not to say	15	6
Alzheimers	1	1
Learning difficulties	12	5
Long standing illnes	12	5
Cognitive impairment	3	1
Unknown	141	53
	260	**100**

Customer Service data 2019/2021

8.3	**Gender**	**No**	Gender equality is reported as part of our workforce approach and services continue to ensure environments and workplaces remain gender sensitive and appropriate.

	Male	**Female**
England % av.	49.2	50.8
Kirklees		
% average	49.4	50.6
Barnsley		
% average	49.1	50.9
Calderdale		
% average	48.9	51.1
Wakefield		
% average	49	51

Taken from Census 2011 data

Gender	**Total**	**%**
F	18158	53.17 %
M	15987	46.82 %
I	2	0.01%
U	2	0.01%
Total Patients	**34149**	

Trustwide Information May 2021 data

Gender		%
female	113	43
male	72	28
Prefers not to say	1	1
Transgender	1	1
Unknown	73	27

Customer Service data 2019/2021

	260	**100**

8.4	**Age**	**No**	The Trust provides services to children and young people through to older age adults. The table reflects the population age of the communities the Trust serve and there is increasing evidence that Barnsley represent a higher than average older population and Calderdale a higher than average age range of 0-15 age range. The Trust will ensure that feedback is encouraged across all the age ranges and support to give feedback is provided for those who need it.

	0-15	**16-29**	**30-44**	**45-64**	**65+**
England % av.	18.9	18.6	20.3	22.4	16.9
Kirklees					
% average	15.8	18.5	20.3	22.2	15.8
Barnsley (2011 data)		16-24	25-44	45-59	60+
% average	18.5	10.8	26	20.9	23.8
Calderdale					
% average	19.6	16.4	20.1	24.2	16.6
Wakefield					
% average	18.4	17.2	19.6	24.2	17.6

Taken from Census 2011 data

Age Band	**Total**	**%**
18-29	5447	15.95 %
Under 16	5405	15.83 %
30-39	4680	13.70 %
50-59	3981	11.66 %
40-49	3849	11.27 %
70-79	3104	9.09%
80-89	2823	8.27%
60-69	2590	7.58%
16-17	1625	4.76%
90-99	635	1.86%
100 and over	10	0.03%

			Total Patients 34149

Trustwide Information May 2021 data

Age		%
18-25	14	5
26-55	159	61
56-64	35	13
65-74	14	5
75 and over	9	4
Under 18	8	4
Unknown	21	8
Customer Service data 2019/2021	**260**	**100**

8.5	Sexual Orientation	No	The Trust will improve on the recording of sexual orientation in line with the 'Sexual Orientation Monitoring standard' so the Trust can ensure that services and workforce adequately represent the population they serve. The 2020/21 census may contain further baseline information which can be used to support the Trust understanding further as this is an area that remains mainly unknown.

Sexual orientation	Total	%
Not Recorded	18182	53.24%
Heterosexual	14345	42.01%
Sexual orientation unknown	961	2.81%
Sexual orientation not given - patient refused	281	0.82%
Bisexual	208	0.61%
Female homosexual	97	0.28%
Male homosexual	75	0.22%
Total Patients	**34149**	

Trustwide Information May 2021 data

Sexual Orientation		%
heterosexual	119	46
Prefers not to say	15	6
Bisexual	4	2
Gay	1	1
Unknown	118	44
Lesbian	3	1

			Customer Service data 2019/2021
			260 | **100**
8.6	**Religion or Belief**	**No**	Faith and spiritual care and support in an important component of person-centred care provided. The Trust have a spirit in mind service who play a central role in engaging faith and spiritual leaders in the communities we serve and involving them in the work of the Trust. Understanding religion and belief plays an important role in service delivery however there is a lack of information when it comes to providing feedback and there is little or no inomfration to draw upon therefore customer services will ensure information is gathered to understand further if the Trust can make improvements around relgion or belief.

	Christian	**Buddhist**	**Hindu**	**Jewish**	**Sikh**	**Muslim**	**Other**	**No religion**
England % av.	71.8	0.3	1	0.5	0.7	10.1	0.2	15.1
Kirklees								
% average	67.2	0.2	0.3	0.1	0.7	10.1	0.2	14
Barnsley								
% average	59.4	0.5	1.5	0.5	0.8	5	0.4	24.7
Calderdale								
% average	60.6	0.3	0.3	0.1	0.2	7.8	0.4	30.2
Wakefield								
% average	66.4	0.16	0.25	0.04	0.12	2.0	0.3	24.4

Taken from 2011 Census data

Religion	Total	%
Not Recorded	12117	35.48%
Not religious	4147	12.14%
Church of England, follower of religion	3979	11.65%
Religion NOS	3258	9.54%
Patient religion unknown	2390	7.00%
Christian	1683	4.93%
Religion not given - patient refused	1661	4.86%
Church of England	1121	3.28%
Muslim	964	2.82%
Roman Catholic	901	2.64%
Christian religion	296	0.87%
Atheist	288	0.84%

			Methodist	274	0.80%
			Agnostic	184	0.54%
			Religion (Other)	136	0.40%
			Declines to disclose religious beliefs	125	0.37%
			Religious affiliation	69	0.20%
			Mormon	64	0.19%
			Spiritualist	58	0.17%
			Protestant	50	0.15%
			Pagan	43	0.13%
			Baptist	36	0.11%
			Sikh	34	0.10%
			Buddhist	30	0.09%
			Hindu	30	0.09%
			Anglican	27	0.08%
			Pentecostalist	19	0.06%
			Catholic: non Roman Catholic	18	0.05%
			Nonconformist	17	0.05%
			Church of Scotland, follower of religion	14	0.04%
			Church Of God	8	0.02%
			Orthodox Christian	8	0.02%
			Rastafarian	8	0.02%
			Quaker	7	0.02%
			Patient religion could not be communicated	6	0.02%
			Wesleyan Methodist	5	0.01%
			Sunni muslim	5	0.01%
			Church of Ireland, follower of religion	5	0.01%
			Apostolic Pentecostalist	5	0.01%
			Eastern Catholic	5	0.01%
			Seventh Day Adventist	4	0.01%
			Ismaili Muslim	4	0.01%
			Evangelical Christian	3	0.01%
			Coptic Orthodox	3	0.01%
			Presbyterian	3	0.01%
			Russian Orthodox	3	0.01%

Follower of United Reformed Church	3	0.01%
Christadelphian	2	0.01%
Unitarian	2	0.01%
Orthodox Jew	2	0.01%
Independent Methodist	2	0.01%
Greek Orthodox	2	0.01%
Salvation Army member	2	0.01%
Greek Catholic	2	0.01%
Serbian Orthodox	2	0.01%
Shiite muslim	2	0.01%
Old Catholic	1	0.00%
Heathen	1	0.00%
Congregationalist	1	0.00%
Jain	1	0.00%
British Israelite	1	0.00%
Celtic Christian	1	0.00%
Uniate Catholic	1	0.00%
Christian Spiritualist	1	0.00%
Jewish	1	0.00%
Wiccan	1	0.00%
Church in Wales, follower of religion	1	0.00%
Romanian Orthodox	1	0.00%
Reformed Christian	1	0.00%
Total Patients	**34149**	

Trustwide Information May 2021 data

No information available as this is not collected by Customer Services

8.7	**Transgender**	**No**	The customer service policy and agenda for transgender people will remain a focus and data collection will need to be improved to support improvements to disclosure and recording. The 2020/21 Census report may provide further baseline data.

Gender reassignment	**Total**	**%**
No	34119	99.91%
Gender reassignment patient	30	0.09%
Total Patients	**34149**	

Trustwide Information May 2021 data

For Customer Service information please see figures included in sexual orientation section.

8.8	**Maternity & Pregnancy**	**No**	

Pregnancy (last 9 months)	**Total**	**%**
No	33627	98.47%
Patient currently pregnant	522	1.53%
Total Patients	**34149**	

Trustwide Information May 2021 data

No information available as this is not collected by Customer Services

8.9	**Marriage & Civil partnerships**	**No**	

	Married	Single	In a [registered] civil	Divorced	Widowed	Separated
England % av.	46.6	34.6	0.2	9.0	6.9	2.7
Kirklees						
% average	48.4	32.4	0.2	9.3	6.8	2.8
Barnsley						
% average	46.6	34.6	0.2	9	6.9	2.7
Calderdale						
% average	46.7	32.1	0.3	10.5	7.3	3.0
Wakefield						
% average	48.2	30.9	0.18	10.5	7.5	2.6

Source unknown

Marital Status	**Total**	**%**
Single person	16072	47.06%
Marital state unknown	5047	14.78%
Married	3207	9.39%
Married/civil partner	2848	8.34%
Widowed	1326	3.88%
Not Recorded	921	2.70%
Divorced/person whose civil partnership has been dissolved	702	2.06%
Single - living with family	698	2.04%
Marital/civil state not disclosed	635	1.86%

			Divorced 518 1.52% Separated 494 1.45% Widowed/surviving civil partner 492 1.44% Cohabiting 381 1.12% Single - living alone 323 0.95% Common law partnership 259 0.76% Widower 103 0.30% Engaged to be married 43 0.13% Broken with partner 17 0.05% Separated from cohabitee 14 0.04% Husband left home 14 0.04% Wife left home 13 0.04% Monogamous 8 0.02% Remarried 6 0.02% Number of previous marriages 3 0.01% Cohabitee left home 2 0.01% Eloped 1 0.00% Spouse left home 1 0.00% Polygamous 1 0.00% Total Patients **34149** *Trustwide Information May 2021 data* No information available as this is not collected by Customer Services
8.10	**Carers*** **Our Trust requirement***	**No**	It is not anticipated there will be any negative impact on service users or their carers, feedback is captured through service evaluation.
9	**What monitoring arrangements are you implementing or already have in**		The Policy is subject to annual review.

Relationship to service user		%
Parent	51	20
Service user	158	61
Sibling	4	1
Son/Daughter	11	4
Spouse/Partner	18	7
Other	15	6
Unknown	3	1
Customer Service data 2019/2021	**260**	**100**

	place to ensure that this policy/procedure/strategy:-	
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**	The policy promotes equality of opportunity as it provides for a supportive, fair and non-discriminatory approach to customer services and complaints management
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**	The Trust is committed to eliminating discrimination in all its forms, including those with protected characteristics
9c	**Promotes good relations between different equality groups;**	The Trust's approach to equality promotes good relations including with those from different equality groups.
9d	**Public Sector Equality Duty – "Due Regard"**	EIAs are completed at service level as part of the introduction of new/revised policies. These documents are used in the planning, implementation, and development of services. A short form EIA and process supports decisions a that are required urgently. The voice of people who use our services is captured using feedback, involvement and learning lessons from experiences across the Trust. Regular monthly audit provides the opportunity to identify if there are any issues/trends related to protected characteristics, relationships between different groups and 'due regard'.
10	**Have you developed an Action Plan arising from this assessment?**	No but an engagement plan will be developed for the next update of the policy when further changes from the PHSO come in 2022
11	**Assessment/Action Plan approved by (Director Lead)**	**Sign:** **Title:**
12		**Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Engagement Development Managers:** Aboobaker.bhana@swyt.nhs.uk Zahida.mallard@swyt.nhs.uk **Please note that the EIA is a public document and will be published on the web. Failing to**

		complete an EIA could expose the Trust to future legal challenge.

APPENDIX D

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	YES	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	N/A	
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

APPENDIX E

Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	Dec 2013	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with Francis Report, Patient's Association Report on Complaints and the Rt Hon Ann Clwyd review of NHS Complaints Management.
2	Dec 2014	Head of Communications and Customer Services	Final	Approved by Trust Board Included updates in line with the Francis Report, The Government's response, 'Hard Truths' and the Duty of Candour.
3	January 2016	Deputy Director of Corporate Development	Final	Approved by Trust Board Included updates in line with CQC Essential Standards and PHSO report 'My Expectations'
4	January 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes update in line with: • CQC inspection 2016 • CSE Accreditation 2016 • PHSO report 'My Expectations' • NHSE Assurance of Good Complaints Handling • CQC report 'Complaints Matter'
5	June 2017	Deputy Director of Corporate Development	Final	Approved by Trust Board Includes updates in line with CQC action plan to include reference to people's right to complain to the CQC about detention under the Mental Health Act – in line with the Mental Health code of practice.
6	May 2021	Accociate Director of Nursing & Quality		