NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Developed by:	Reviewed by Associate Director of Nursing, Quality and Professions
Director leads:	Chief Nurse and Director of Quality and Professions
Contact for advice:	Customer Services

With **all of us** in mind.

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1. Introduction

The Trust is committed to the provision of high-quality care. To enable delivery of high-quality care it is essential to receive feedback and where necessary use this to make positive changes.

On occasion service users carers, families and/or their representatives may have concerns about the service, care or treatment they receive. The customer services function operates as a single gateway for raising issues and enquiries.

The Customer Services policy provides a framework for how complaints, compliments and feedback received are handled, processed and responded to.

2. Purpose and scope of the policy

People who use Trust services have a right to have their views heard and acted upon.
The Trust has made a commitment through its mission and values to put the person first and in the centre and to be honest, open and transparent. This policy sets out a framework for the management of complaints and feedback received into the Trust. It defines roles and responsibilities and the processes which are followed when feedback is received.

The Customer Services policy incorporates the obligations set out in the NHS Constitution and the Health and Social Care Act. The NHS Complaint Standards (December 2022) align with all the legal requirements arising from the NHS Complaint Regulations and other regulations which relate to complaint handling. This includes:

- NHS England's Assurance of Good Complaints Handing for Acute and Community Care – A toolkit for commissioners (updated September 2018)
- The NHS Constitution (updated January 2021)
- Patients Association, Good Practice Standards for NHS Complaints Handling (2013)
- NHS Resolution Risk Management Standards (2020)
- Report of the Mid Staffordshire NHS Foundation Trust public inquiry (2013)
- Parliamentary and Health Service Ombudsman guidance
- Healthwatch
- Independent Advocacy Services
- Human Rights Act (1998)
- Being open when things go wrong (duty of candour) policy (updated February 2022)
- Care Quality Commission – Complaints Matter (updated 2022)

3. Definitions

For the purposes of this policy, feedback is defined across four categories, compliments, comments, concerns and complaints. These are based on definitions outlined in the NHS Complaint Standards:

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

3.2. Compliment: Positive feedback received regarding care, generally from service users, their relatives and/or carers. Compliments are also sometimes received from other health care professionals, services or external partners.

3.3. Comments (service issues): A comment is a matter that is not about an individual's care and treatment. It is something that is a cause for concern to the complainant, e.g., they may be unhappy with parking arrangements at the service, or someone is leaving lights on when a building is empty. The relevant service provides information to the customer services team on a monitoring form to allow for feedback to be provided.

3.4. Concerns: A concern is a matter which an individual wishes to be considered on an informal basis. This can be done by the complainant directly with the service and should be resolved to the individual's satisfaction within two working days. All staff are expected, on a routine and daily basis, to deal with patient 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/clinical areas, allowing for timely and informal resolution of the concern.

3.5. Complaints: An expression of dissatisfaction with care, services or facilities provided by the Trust, where any of the following apply:

- Action or activity 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.

3.6. 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, friends and family test, surveys, focus groups, workshops and events, and participation in National Patient Surveys as prescribed by the Care Quality Commission. These are not considered as part of this policy.

4. Principles

The NHS Complaint Standards (December 2022) outline that an effective complaint handling system promotes a learning culture across organisations. The Trust welcomes complaints positively and acts thoroughly and fairly when complaints are investigated. The responses we provide aim to be fair, accountable and offer apology.
The Trust adopts the following principles in the management of concerns and complaints:

- Identifies complaints as an opportunity to learn and improve services
- Approaches complaints in an open and non-defensive manner
- Shares learning from complaints and helps people to understand how this learning has been used to improve services
- Supports and trains colleagues to deliver best practice in handling complaints
- Provides a timely response, considering the complexity of the issues

- Ensure that service users and colleagues are able to have their say and are kept up to date
- Sets out what happened and whether mistakes were made or standards met in responses and fairly reflects the experiences of those involved
- Outlines organisational accountability
- Take action to make sure learning is identified and used to improve services

Failure to deal with complaints appropriately presents a risk to the organisation – a missed opportunity to improve services because of feedback and could have an adverse effect on the Trust's public reputation as well as to future service user and carer experience.

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 which ensures that issues are dealt with in a way that empowers people and allows them 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 are reflected in this policy:

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

4.1. Who can give feedback?

Any individual can give feedback to any Trust employee, including the customer services team. Feedback is most commonly received from service users, those affected by service provision, those acting as a representative of a service user, carer, relative, member of parliament, councillors, independent advocates and Healthwatch.
A customer service information leaflet is available on the Trust internet and intranet page, this includes an easy read version. This leaflet 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 the customer services team if required. Customer service leaflets and posters are 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. Details of which can be found on our website/in our leaflets and displayed within ward and service environments.

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 service users and remains a priority for the Trust.
Feedback is received through everyday conversations with the people who use our services. This can be to raise an issue, make a request, ask a questions or highlight a worry. In many instances staff can help to deal with feedback immediately. This policy supports and encourages staff to:

- Feel empowered to support service users, their relatives and carers in giving feedback and to resolve issues promptly and locally wherever possible
- Encourage people to discuss any issues they have as they may be able to sort out the issue to their satisfaction quickly and without the need for them to make a formal complaint

4.4. Concerns and Complaints

a. Informal concerns

Responses to concerns should be immediate wherever possible and a monitoring form should be completed and shared with the customer services team to ensure these are logged to support any future contacts from the service user or their representative.

If it is not possible to resolve the concern straight away, assistance should be sought from the service line management team. If the concern is raised verbally, and can be resolved within two working days, the response does not need to be in writing or managed under the complaint regulations. The issue should be recorded using the monitoring form along with details of the feedback provided).

b. Formal complaints

It is recognised that issues cannot always be resolved as they arise and that sometimes people will want to make a formal complaint. A complaint can be about:

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

If it is considered that a complaint (or any part) does not fall under this policy, the reasons for this will be explained. This will be done in writing and any relevant information, including signposting will be provided.

Complaints are received in the following ways:

- in person
- by telephone
- in writing
- by email
- through accessing the Trust internet site

All accessibility and reasonable adjustments will be made for anyone who wishes to make a complaint in an alternative way. This will be documented.

Concerns and complaints received in writing, by email or via telephone that cannot be resolved quickly by the service (within two working days) will be managed in accordance with complaint

regulations. Complaints are reviewed by the customer services manager and allocated to a named case handler.

The allocated case handler will always contact the complainant to understand the specific concerns/issues they want the Trust to investigate and respond to. The complainant will receive an action letter for their records in line with complaint regulations.

Complaints will be acknowledged within three working days of receipt and recorded on DATIX (incident management reporting system), with a complaint reference number allocated.

Formal complaints will always require a formal investigation and written response. The complainant will receive a written response from the Responsible Officer for Complaints Management (the Trust's Chief Executive).

The target response time for formal complaints is within six months from the date of receipt. This is a statutory timeframe as outlines in NHS complaint regulations. This is monitored on a monthly basis and reported through the integrated performance report.
The procedure for complaints handling is detailed in appendix a.

Guidance for managing persistent and unreasonable contact is detailed in appendix b.

4.4.1. Who can make a complaint

In line with the NHS Complaint Standards (2009) the following apply:

- 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 2005), or has been requested to act as a service user's representative
- 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 service user or the person has the legal authority to do so

All complainants will be informed about the right to access independent complaints advocacy. This is done verbally and in writing during the initial acknowledgement.

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 receipt of the Trust's formal response to their complaint or the Trust's handling of their complaint. This response completes stage one of the complaint process (local resolution).

4.4.2. Timescale for making a complaint

Complaints must be made within 12 months of the date of the incident being complained about occurred or the date the person raising the complaint found out about the incident, whichever is the later date.

If a complaint is made after that 12-month time limit, it will be considered if:

- It is believed there are good reasons for not making the complaint earlier, and
- It is still possible to properly consider the complaint

If a good reason is not identified, or it is thought it is not possible to properly consider the complaint (or any part of it), the complainant will be notified in writing.

4.4.3. What is not covered within this policy

In line with the NHS complaint regulations, the following are **not** covered by this 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 team)
- Complaints about involvement activity (refer to Equality & Engagement Team)
- Commissioning decisions (refer to appropriate Integrated Care Board (ICB))
- 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)

4.4.4. Complaints involving multiple organisations

If the Trust receives a complaint that involves other organisations (including cases that cover health and social care issues) the complaint will be investigated in collaboration with the other organisations. It will be agreed who will be the ‘lead’ organisation, responsible for overseeing and coordinating the complaint.

Handling of the complaint, such as making sure the complainant is kept involved and updated throughout and ensuring the individual receives a single, joint response will be delivered by the lead organisation.

4.4.5. 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 that information on how to complain to the CQC is readily available on all wards that are registered to support people detained under the Act. The Trust has a duty to ensure this information is available and displayed on its wards, with consideration given to the accessible information standard in how this information is shared.

4.4.6. Management of unreasonable and persistent behaviour

The Trust is committed to dealing with all concerns and complaints fairly and impartially and to providing a high-quality service. As part of this approach the Trust would rarely limit people from making contact.

There are a small number of people where the frequency of their contact with the Trust, or their individual behaviour, hinders consideration of their own and/or other people's complaints. Examples of unreasonable and persistent behaviours are detailed in appendix B.

The Trust recognises the need to distinguish between people who make a number of genuine complaints and those whose persistence goes far beyond what is reasonable and/or which may have significant resource implications for the Trust.

The Trust will ensure it meets the requirements of the Equality Act 2010 and the Public Sector Duty Act and ensure we consider reasonable adjustments for disabled individuals. Some individuals may have difficulty expressing themselves or communicating clearly or appropriately. Where there is indication that this is the case, the needs and circumstances of the individual will be considered, including applying any reasonable adjustments. This does not mean that we will tolerate abusive language, shouting or unacceptable behaviour/actions.

When a person's behaviour is considered to be unacceptable, or they are being unreasonably persistent in their requests, they will be advised of the need to address this. This will be determined through a review of the person's contact, frequency and supported utilising the examples in appendix B. Communication of behaviour which is considered unacceptable will initially be shared verbally and will then be followed up in writing should there be no changes to the contact. During this verbal communication with the complainant, it will be explored if there are barriers to the communication and if the person needs support with the complaints process. The person will be reminded of advocacy support that is available to them. If this is unsuccessful, action may be taken to limit their contact with the Trust.

Any decision to limit access or place restrictions on contact with the Trust will be taken by the deputy director of nursing, quality and professions, in liaison with the relevant service director and clinical lead. Limiting access will follow a decision-making process, utilising available evidence and details of this will be held on the Datix system alongside the restrictions in place. Any restrictions imposed will be appropriate and proportionate with a regular timeframe for review. Options for consideration are detailed in Appendix B, alongside the timescale for review of any restrictions.

Where behaviour becomes so extreme that it threatens the immediate safety and welfare of others additional options will be considered. These will include reporting the matter to the police or taking legal action. In such cases a complainant may not be given prior warning of that action.

Appendix B outlines the procedure which identifies situations where a complainant may be considered habitual/unreasonably persistent and possible courses of action.

4.4.7. Learning from feedback

Themes from complaints and feedback are gathered by the customer services team and reported annually through reporting to Quality and Safety Committee (formally clinical governance and clinical safety committee).

Care Group quality and governance groups are responsible for aligning themes and learning from complaints within their own quality improvement and service improvement programmes. This learning should be triangulated with other forms of feedback on care and service delivery so that improvements are made to services.

Themes and learning from complaints are shared through the Patient Experience group, where other forms of patient experience are reviewed and triangulated. This is then shared through clinical governance group.

4.5. Data and complaints information

All records relating to complaints investigation are confidential and must 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.

4.6. 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 Care Group is responsible for ensuring all compliments are logged with the customer services team so timely feedback can be given to the staff or team being complimented and compliment numbers per service can be monitored.

Compliment numbers and themes are shared within the Patient Experience annual report and used to demonstrate the positive work of staff and services.

5. Duties

The customer services process is supported by: -

5.1. The Chief Executive

The Chief Executive (or nominated deputy), as the nominated responsible person, has overall responsibility for ensuring the Trust Customer Service Policy meets statutory requirements as set out in the NHS Complaints Regulations (2009). The Chief Executive 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 approval of this policy. Quality and Safety Committee (formally clinical governance and clinical safety committee) will receive quarterly reports from the Customer Service Team and be responsible for receipt of the patient experience annual report.

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. Executive Directors

The Chief Nurse and Director of Quality and Professions is the director with overall responsibility for the customer services team, including the management of complaints. Alongside the Chief Operating Officer and Chief Medical Officer (the executive trio) they have the following responsibilities:

- To 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
- To ensure that, through agreed processes, customer services information is reported appropriately to Care Groups; reported into integrated performance reports (IPR) and through quarterly and annual reporting to Quality and Safety Committee
- To review all final responses to complainants, having received assurances from the customer services team that the response addresses all points raised in the complaint management plan

5.5. Service Directors and Clinical Leads

The Service Directors and Clinical leads will ensure appropriate systems are in place within Care Groups and services to:

- Respond to feedback, investigate concerns and complaints
- Ensure that staff who deal with complaints are properly supported and trained
- Make sure that people who use Trust services know how to complain and where to get support
- Have oversight of open complaints being investigated within their own Care Group
- Review complaint responses to:
    - Ensure the response addresses the concerns raised
    - Have oversight of the quality and tone of the response
    - Ensure that any learning has been identified and is detailed within the response, as appropriate
- Monitor delivery of complaint action plans through Care Group governance processes
- Provide updates to the customer services team to support reporting into Board and Quality and Safety Committee.

5.6. Customer Services Manager

The customer services manager is responsible for managing delivery against this policy and related procedures and for overseeing the handling and considerations of any complaints and feedback received into the Trust.

5.7. The Customer Services Team

The customer services team will ensure processes that support effective complaints investigation and resolution, for example the complaint toolkit, remain fit for purpose, support staff to resolve issues, and support service users in receiving effective complaint resolution.

The role of the customer services team is as follows:

- On receipt of a formal complaint, acknowledge receipt of the complaint verbally with written formal acknowledgement which explains the process and discusses the handling of the complaint and the need to receive consent from the service user to be able to proceed. The written acknowledgement is sent within three working days, in line with the statutory target
- Share informal concerns with the relevant service to facilitate a quick resolution/discussion with the complainant where possible within two working days as set out in the complaints regulations
- Ensure the complainant is at the centre of the process and that a complaint management plan is developed
- A named complaint handler is allocated to agree the scope of a formal complaint with the complainant, including expectations for resolutions and a timescale for the investigation and response. The complainant will receive an action letter which provides a written copy of the agreed scope of their complaint in line with the complaint regulations. The complainant must agree the scope of their complaint before a complaint investigation can proceed
- To liaise with the relevant general manager to facilitate the allocation of a lead investigator from within the Care Group/service to formally investigate the complaint and provide their written findings by returning the toolkit which details the agreed concerns from the action letter
- Provide advice, support and guidance to the lead investigator and receive timely updates on the progress of the investigation so these can be communicated to the complainant to manage their expectations about how their complaint is progressing.
- On receipt of the completed toolkit from the lead investigator, customer services will draft a written response to the complaint which then enters the Trust's internal quality assurance process with senior managers before final sign off from the Chief Executive

The customer services team are also responsible for alerting service directors to any concerns or complaints which highlight that quality of care may be compromised, where there is a safeguarding concern or immediate scoping/intervention may be required.

5.8. Clinical Leads / General Managers / Quality & Governance Leads

These roles, or people with delegated responsibility have the following responsibilities:

- To receive new toolkits for investigations and allocate a lead investigator, within two working days. Service directors should be included in any initial email correspondence for awareness and oversight
- To ensure objective and thorough investigations in accordance with the procedure, either by investigating the issues personally or by appointing a suitably skilled member of staff to conduct the investigation
- Provide support to the lead investigator and ensure wellbeing is maximised at all times
- To ensure all relevant information to respond to a complaint is collated and provided to the lead investigator, who will complete the complaints toolkit (Appendix D)
- Understand and comply with agreed timescales and key performance indicators (KPIs) in relation to complaints investigation and management (outlined in Appendix C)
- Advise the service director of open complaints within the service or Care Group, and support review of issues and learning through Care Group governance processes

- Ensure any learning for the wider Trust is shared through Care Group governance groups and into Clinical Governance Group or Operational Management Group as appropriate

5.9. Complaint Investigators

Complaint investigators will have completed relevant training, such as root cause analysis training. They will be responsible for coordinating the response and collaborating with relevant colleagues as required. The complaint investigator is responsible for:

- Undertaking a thorough investigation, which includes, where relevant, discussion with the individuals involved in the complaint
- Seeking specialist advice from clinical specialists as required, e.g., medical colleagues, specialist advisors
- Liaising with the customer services team on a weekly basis to provide an update on the progress of the complaint investigation
- Ensuring the response for each element of the investigation is of a high quality and addresses the concerns and questions asked
- Ensuring that the investigation is completed within the expected timeframes (see appendix 2 for KPIs). Any delays should be highlighted to the customer services team as early as possible and shared with their general manager
- Completing the toolkit with detail found during the investigation and including any learning identified. The toolkit should be returned to the customer services team for formulating into a formal response

5.10. All Staff

All staff need to be aware of Trust 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.

6. Reporting Feedback

The customer services team will provide regular reports to Care Groups, advising of open and closed complaints during the reporting period and provide an update on where open complaints are in the complaints process, i.e. under investigation. The general managers have the responsibility for oversight of complaints open in their respective areas. This includes a breakdown of the complaints and concerns, themes identified and any lessons learnt.

The customer services team review and report on the following information:

Internal:

- Patient experience annual report, in collaboration with patient experience lead, equality and inclusion team and freedom to speak up guardian
- Monthly report analysis, looking at the numbers of complaints closed in the relevant period, how many of these were responded to within the six-month statutory timeframe and identifying delays within the process

- Quarterly report and review of numbers of persistent and unreasonable complaints with restrictions in place
- Monthly data to the IPR including key performance indicator data as outlined in Appendix C
- Quarterly report into the mental health act committee to highlight complaints which relate to the application of the mental health act

External:

- KO41a Hospital and Community Health Services complaints collection annually. This is submitted to NHS Digital and monitors written complaints received by the NHS. The data submitted includes:
    - Organisational detail
    - summary of complaint numbers
    - age or patient
    - status of complaint
    - service area
    - subject area of complaint
- Complaints related to mental health act are reported monthly to the CQC MHA team

The Quality and Safety Committee is responsible for approving Trust policy for 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.

7. Learning and improving as a result of feedback

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.

Themes from complaints and other feedback are collated by the customer services team.

Complaints which suggest a performance, conduct or particular concern or where a risk is identified within a service will be reported to the Service Director, clinical lead and the Chief Medical Officer and Chief Nurse and Director of Quality and Professions, as appropriate.

Individual care Groups are responsible for monitoring and identifying areas for learning which arise from complaints. It is expected that each Care Group will have their own system in place for monitoring themes from complaints and for ensuring learning is disseminated into practice.

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 Governance Group and Quality and Safety Committee (formerly clinical governance and clinical safety committee).

8. Equality Impact Assessment

The Trust aims to ensure its policies and procedures promote equality both as a provider of services and as an employer.

An equality impact has been completed for this policy and this can be found in **Appendix D.**

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. Monitoring of complaints received from people with protected characterises is completed as part of annual reporting. Further work is needed to enable more regular monitoring of access to complaints.

9. Dissemination and implementation arrangements

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

General managers within Care Groups 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.

10. Process for monitoring compliance and effectiveness

The Associate Director of Nursing, Quality and Professions is responsible for monitoring compliance with this policy. This will be achieved through:

- Monitoring and reporting on complaints and feedback as outlined above
- Data analysis and reporting to ensure compliance with the principles outlined within this policy
- Supporting Care Groups to ensure staff are aware of this policy and appropriately trained in its use and in what to do when feedback is received
- Monitoring of action plans through Care Group governance as outlined above
- Receiving feedback from Care Groups on the effectiveness and usefulness of this policy
- Gathering feedback from service users and complainants about their experience of being supported through making a complaint
- Contact, as appropriate, with partner organisations, the Parliamentary and Health Service Ombudsman, the CQC, the Information Commissioner and NHSI.

11. Review and revision arrangements

This policy is subjected to a full review every 3 years but may be amended or reviewed sooner to ensure it is in line with statutory requirements for the management of complaints and feedback.

12. Associated documentation

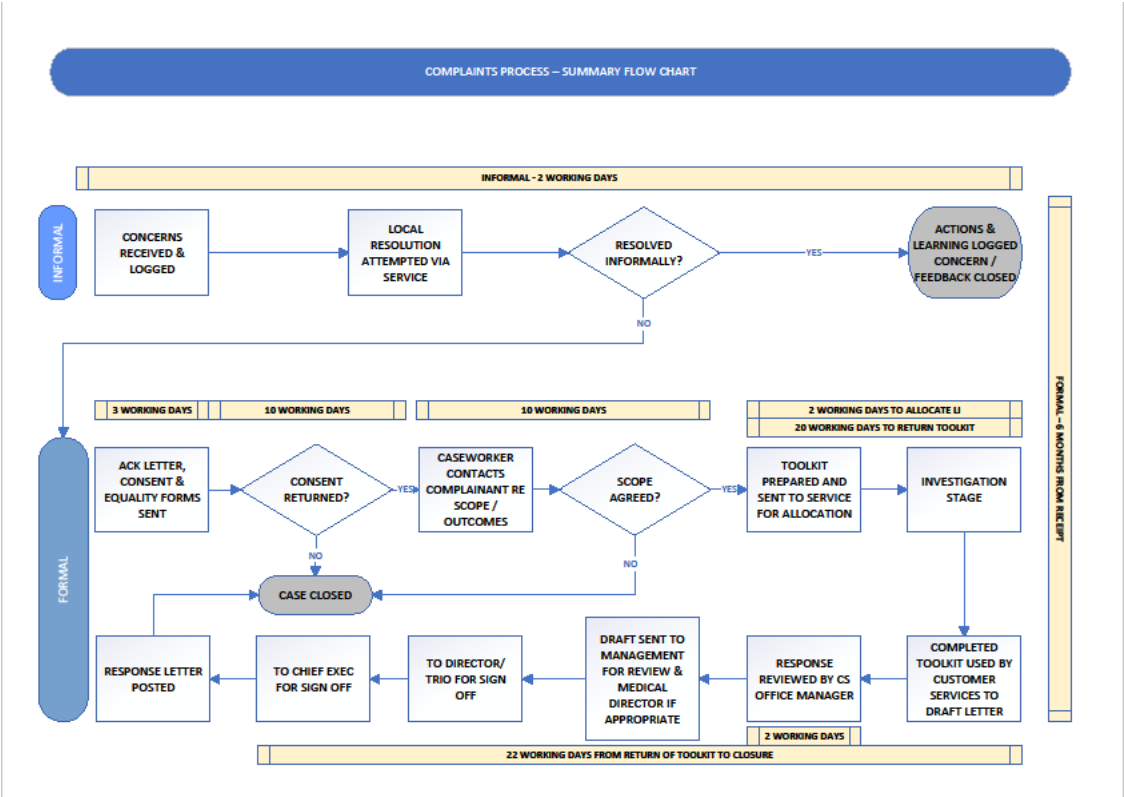
Supporting procedural documents include:

- 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 Aggression Policy

Appendix A

Complaints Procedure (Local Resolution)

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



Throughout the complaints process consideration must be given to the following:

- All complaints must be risk screened on receipt. This enables any rated as ‘red’ to be escalated early and for any other risks to be identified early
- If a complaint involves clinical or patient safety issues that require urgent attention the appropriate Service Director must be informed immediately
- Complaints that may have a learning response underway under the Patient Safety Incident Response Framework must be referred for advice to the patient safety support team and escalated to clinical risk panel
- 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 complaint’s procedure. This is consistent with national guidance
- Complaints or concerns highlighting professional practice issues must be referred to the medical or nursing directorate as appropriate
- Complaints about members of staff that involve an accusation of misconduct must be referred to the Peoples Directorate. 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 through a HR process
- Issues that could potentially attract media attention must be referred to the Communications Team
- Issues relating to child protection or vulnerable adults must be referred to the Trust safeguarding team
- Where a complaint alleges a criminal offence, the complainant will be advised of their right to report the matter to the police. If the complainant chooses not to report a possible criminal matter 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 by providing support timely to reach a satisfactory resolution

APPENDIX B

Guidance for dealing with persistent and unreasonable contact

a. Definitions

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or unreasonably persistent where current or previous contact with them shows that they have met at least two of the following criteria listed below. However, once it is clear that a complainant meets any one of the criteria, it would be appropriate to inform them verbally initially and follow up in writing if there is no change in behaviour that they are at risk of being classified as habitual/ unreasonably persistent, allowing them the opportunity to modify their behaviour. They should be advised of what the outcome might be if they continue to behaviour in an unacceptable way. This can include:

- Aggressive/abusive behaviour
- Unacceptable demands
- Unacceptable levels of contact
- Refusal to cooperate

More detailed examples of unacceptable or persistent behaviour are outlined below.

- Insufficient, or no grounds for their complaint and are making it for reasons that they do not admit or make obvious
- Refusal to co-operate with the Trust's established complaint investigation process, whilst still wishing their complaint to be resolved.
- Insists on their complaint being dealt with in ways that are incompatible with NHS complaints regulations or good practice or are disproportionate to the complaint.
- Adopts an excessively 'scattergun' approach, for instance, in pursuing a complaint with multiple organisations, departments or individuals.
- Makes the same complaint repeatedly, perhaps with minor differences, after the complaint has been investigated. This would include where people insist that the minor differences constitute new complaints that require further investigation
- Persists in pursuing a complaint where the Trusts Customer Services policy has been fully and properly implemented
- Seeks to prolong contact by changing the substance of a complaint or by continually raising new issues and/or questions whilst the complaint is being addressed (care must be taken to recognise new issues which have not previously been considered)
- Is unwilling to accept evidence of treatment given as being factual (e.g. clinical records)
- Does not accept that facts can be difficult to verify when a prolonged period of time has elapsed
- Does not identify clearly the precise issues they want investigated, despite reasonable efforts by staff to help them to do so and/or the independent advocacy service
- Electronically recording meetings and conversations without the prior knowledge and consent of the other persons involved
- Uses physical violence or threats towards staff or their families/carers at any time. This will in itself cause personal/individual contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented and reported via the Trust DATIX system and to the police after consultation with the appropriate senior management staff

- In the course of pursuing a complaint, has made an excessive number of contacts (or made multiple complaints) with the Trust, placing unreasonable demands on staff and resources. Such contacts may be in person, by telephone, letter, or electronically. Discretion must be exercised in deciding how many contacts are required to qualify as excessive, using judgement based on each case
- Has harassed or been abusive or verbally aggressive towards staff dealing with their complaint – directly or indirectly. If the nature of the harassment or aggressive behaviour is sufficiently serious, this could in itself be sufficient reason for classifying the complainant's behaviour as unreasonable. It must be recognised that complainants may sometimes act out of character at times of stress, anxiety, bereavement or distress and reasonable allowances should be made for this
- Displays unreasonable demands or expectations and fails to accept that these may be unreasonable after a clear explanation has been provided about what constitutes an unreasonable demand. For example, insisting on responses to complaints or enquiries being provided more urgently than is reasonable or recognised practice

b. Implementation

Where people identified as exhibiting 'habitual or unreasonable' behaviour in accordance with the above criteria this should be raised with the Customer Services Manager in the first instance.

Prior to any action is should first be considered and confirmed that:

- The Customer Services Policy and procedure for the management of complaints has been implemented correctly and if any material element has been overlooked or inadequately addressed
- The stage at which the complainant became or is developing into a persistent complainant. There should be evidence to demonstrate the habitual and persistent nature of the complaint. This will support any restrictions to be as the result of a fair and consistent process

Any action taken must be proportionate and appropriate to the nature and frequency of the complainant contact with the Trust.

Consideration must be given as to whether there are any relevant equality considerations that may be linked to the persistency of the complaints. It is the responsibility of the manager reviewing each individual case to recognise that some complainants (for example, individuals with speech/hearing impairment, learning disability or other permanent or temporary cognitive impairment or service users for whom English is not their first language) may need the Trust to implement relevant adjustments to the process for the handling of their complaint (s) to minimise communication issues and barriers.

The management of perceived unacceptable or persistent behaviour should be undertaken in two stages.

Stage one:
Once a complainant has been identified as being persistent or unreasonable in their contact the customer services manager will review the case and can consider the following:

- Offer a face-to-face meeting or telephone call to attempt to resolve outstanding issues

- The complaints should be informed verbally that their behaviour is unacceptable/persistent. This should be followed up in writing if a verbal request to change behaviour does not support a change in behaviour
- Notify the complainant in writing that the Trust 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 complainant should also be notified that the correspondence is at an end and that further letters received might be acknowledged but not responded to
- Ensure that the complainant is aware of how to contact an advocate to support them in the complaints process if they are having difficulty

Stage two:

Should the above not support the complaint to modify their behaviour then the matter should be escalated to the deputy director of nursing, quality and professions, the relevant service director and clinical lead to consider next steps. The trio will consider all available evidence, review any actions taken to support the complainant through the complaint process and recommendations from the customer services manager.

Below is a list of possible options for consideration. One or more might be chosen and applied if warranted. The list 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, it may be decided that no further telephone communication will be accepted.

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

c. 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 Service Director in liaison with the Deputy Director of nursing, Quality and Professions 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 they are notified otherwise and that the restriction will be reviewed at appropriate intervals (to be agreed and defined during the decision to take action)
- How a request can be made to have the decision reviewed and the time limit within which to make a request. The customer services manager 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)

Should a request for any imposed restrictions to be reviewed be received this will be escalated to the Trust Chief Executive for oversight.

A central record of decisions/restrictions will be held in the customer services team. This will include name of complainant, restrictions imposed, decision made by, date imposed, review date, reason for restrictions. This will also be recorded on the DATIX system.

Where a valid request has been made to review a decision within the appropriate time limit, the review will be carried out by the Customer Services Manager in collaboration with the Associate Director of Nursing, Quality and Professions and a recommendation made to the deputy director of nursing, quality and professions. Any review will consider any relevant documents that informed the original decision, the decision letter and the information provided in the request for a review. The associate director has the discretion to make a recommendation to the deputy director 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.

d. Review of Restrictions

Once a complainant has been deemed as habitual or unreasonably persistent a mechanism to review or withdraw that status (if appropriate) needs to be agreed.

The status should be reviewed by the customer services manager and associate director of nursing, quality and professions every quarter. This will be done through the Complex Complaints Panel, with attendance from the deputy director, service director and clinical lead (or nominated representative). Any recommended changes will be agreed and put into place with written notification sent to the complainant. This can be reviewed earlier if it becomes apparent that the complainant has adopted a more reasonable approach.

Any changes or review to restrictions must be communicated to the complainant in writing.

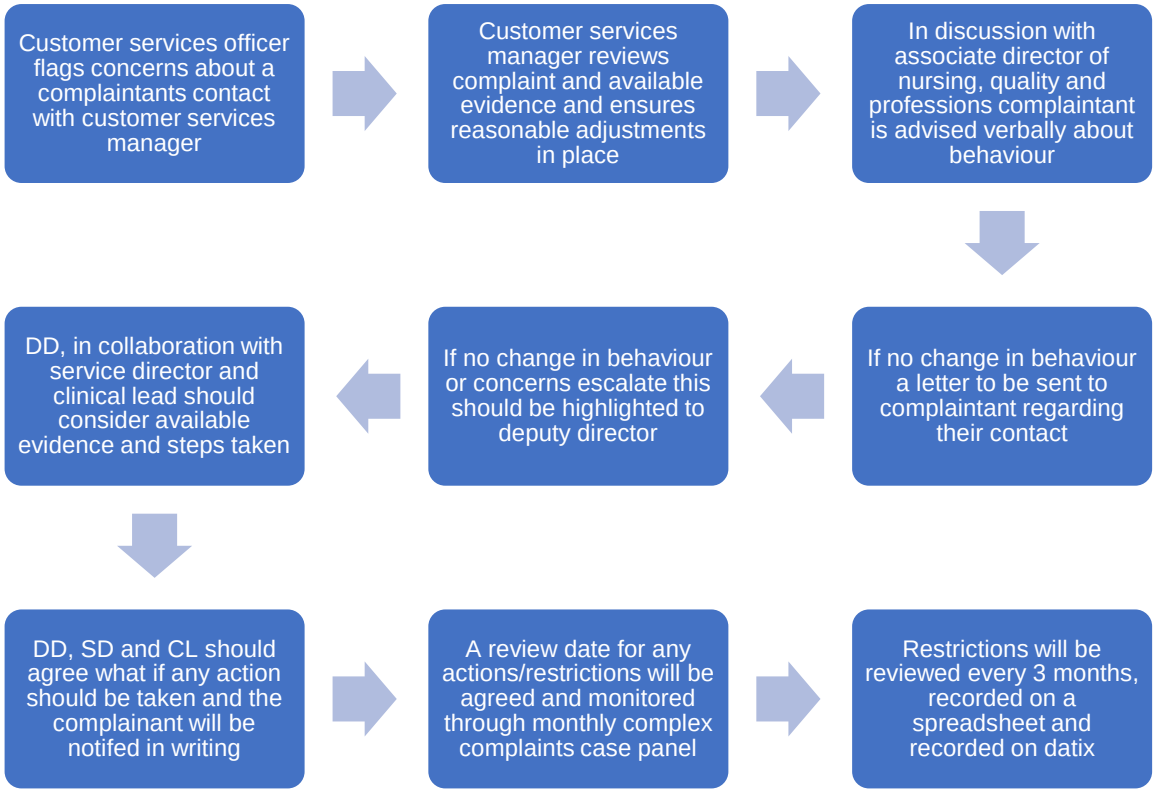
e. New Complaints

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 persistent or unreasonable in their contact under this policy, the new complaint will be considered.

f. 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.

Flowchart for the management of unacceptable and persistent behaviour



APPENDIX C

Complaint Investigation Toolkit

Date:

Reference: CS

Case Handler:

Your investigation is due back on:

BDU	
Service/Ward identified in complaint	
Names of staff identified in complaint	
Lead Investigator	TBC
Background	**Complainant –** **Service user –**
What the complainant is requesting as an outcome?	Apology if appropriate Full investigation Service improvement

Issue 1 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

Issue 2 of

What should have happened? What did happen?	Evidence Provided to support findings
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	Mandatory field

Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

Issue 3 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

Issue 4 of

What should have happened? What did happen?	**Evidence Provided to support findings**
• Do not use abbreviations or language that may not be accessible to all readers. • Provide the full names of members of staff and their full job title. • Include relevant dates of key events and episodes of care • Please include time and date of calls, meetings referred to.	**For example**: • RiO/SystmOne notes • Witness statements • Policies

Lessons Learned	**Mandatory field**		
Actions to implement learning	**Mandatory field**		
Standards of care	Standards not met – urgent action required – see learning	Standards partially met, requires some improvement	Standards met
Good Practice identified			

APPENDIX D

Equality Impact Assessment

Date of EIA: **September 2023** **Review Date:** **September 2026**

Completed By: Sandra Montisci

	QUESTIONS	ANSWERS AND ACTIONS
1	**What is being assessed?** Prompt: what is the function of this document (new or revised)	Customer Services Policy: supporting the management of complaints, concerns, comments and compliments
2	**Description of the document** Prompt: What is the aim of this document	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, partner organisations
3	**Lead contact person for the Equality Impact Assessment**	Sarah Whiterod, Associate Director of Nursing, Quality and Professions
4	**Who else is involved in undertaking this Equality Impact Assessment**	Customer Services team
5	**Sources of information used to identify barriers etc** Prompts: service delivery equality data – refer to equality dashboards (BI Reporting - Home (sharepoint.com) satisfaction surveys, complaints, local demographics, national or local research & statistics, anecdotal. Contact InvolvingPeople@swyt.nhs.uk for insight **What does your research tell you about the impact your proposal will have on the following equality groups?**	Equalities data – BI equalities reporting Staff Surveys National and local data sets
5a	**Disability Groups:** Prompt: Learning Disabilities or Difficulties, Physical, Visual, Hearing disabilities and people with long term conditions such Diabetes, Cancer, Stroke, Heart Disease etc. Accessible information standard	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 clinical services and Care group data and 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. The policy support the provision of accessible information and support to disability groups to effectively submit their complaint and be part of the complaint process. This includes where a complainant might be identified as persistent or habitual and ensuring that all appropriate actions have been taken to support.

Disability groups

	Not Disabled	Disabled
England % av.	47.2	13.2
Kirklees		
% average	82.6	17.4
Barnsley		
% average	78	22
Calderdale		
% average	81.7	18.3
Wakefield		
% average	79.9	20.1

Taken from Census 2021 for each area

Disability	Total	%
Not Recorded	63032	54.17
Not disabled	37268	32.03
Disability NOS	5670	4.87
Registered disabled	7313	6.29
Disability status not given - patient refused	3067	2.64
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Disability		%
Mental Health Condition	35	28
Does not have a Disability	13	10
Hearing impairment	1	1
Epilepsy	2	2
Prefers not to say	48	39
Aspergers	1	1
Learning Difficulties	8	6
Cognitive Impairment	3	2
Unknown	11	9
Sensory Impairment	1	1
Dyslexic	1	1
	124	**100%**

Customer Service data 2021/2022

	QUESTIONS	ANSWERS AND ACTIONS
5b	**Gender:** Prompt: Female & Male issues should be considered	Gender equality is reported as part of our workforce approach and services continue to ensure environments and workplaces remain gender sensitive and appropriate. There is no impact from this policy on gender, although further work is needed to understand data around complaints submitted to the Trust which relate to gender.

	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 2021 data

Gender	Total	%
F	63629	54.68
M	52666	45.26
I	39	0.03
U	16	0.01
Total Patients	**116350**	

Trustwide Information 2021/2022 data

Gender		%
Female	87	70
Male	35	28
Prefers not to say	2	2
	124	**100**

Customer Service data 2021/2022

5c **Age:**

Prompt: Older people & Young People issues should be considered

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.

The customer services policy outlines how the complaints process should be adapted to support the needs of older individuals where hearing impairment or cognitive impairment (which may arise from dementia) and to ensure they can be supported through the complaint process.

There is further work to do to understand complaints which relate to age.

	4yrs & under	5-9	10-15	16-19	20-24	25-34	35-49	5
Barnsley	13463	14366	16953	9653	12448	32951	44859	5
%	5.5%	5.9%	6.9%	3.9%	5.1%	13.5%	18.3%	2
Calderdale	11317	12803	15877	9038	10125	24920	39471	4
%	5.5%	6.2%	7.7%	4.4%	4.9%	12.1%	19.1%	2
Kirklees	25144	27647	34153	21328	25844	54869	83410	8
%	5.8%	6.4%	7.9%	4.9%	6.0%	12.7%	19.3%	1
Wakefield	20074	20994	24764	13933	18001	48974	67143	7
%	5.7%	5.9%	7.1%	3.9%	5.1%	13.9%	19.0%	2

	50-64	65-74	75-84	85+

Barnsley	52285	26462	15765	5371
%	21.4%	10.8%	6.4%	2.2%
Calderdale	43769	21958	12688	4661
%	21.2%	10.6%	6.1%	2.3%
Kirklees	84012	42461	25146	9208
%	19.4%	9.8%	5.8%	2.1%
Wakefield	72882	36927	22110	7573
%	20.6%	10.4%	6.3%	2.1%

Taken from Census 2021 data

Age Band	Total	%
18-29	20134	17.3
Under 16	19244	16.5
30-39	16393	14.15
50-59	12450	10.7
40-49	12351	10.62
70-79	10512	9.0
80-89	9610	8.26
60-69	8512	7.32
16-17	4873	4.2
90-99	2271	1.95
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Age		%
18-25	8	6
26-55	88	72
56-64	13	10
65-74	7	6
75 and over	3	2
Unknown	5	4

Customer Service data 2021/2022	**124**	**100**

5d **Sexual Orientation:**

Prompt: Heterosexual, Bisexual, Gay, Lesbian groups are included in this Category

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.

There is no impact from the customer services policy on sexual orientation.

	Straight/ Heterosexual	Gay/ Lesbian	Bisexual	Pansexual
Barnsley	182948	2990	1817	290
%	91.6%	1.5%	0.9%	0.1&

Calderdale	149815	2811	1968	395
%	89.9%	1.7%	1.2%	0.2%
Kirklees	311501	4340	3697	504
%	90.0%	1.3%	1.1%	0.2%
Wakefield	261615	4321	2968	504
%	91%	1.5%	1.0%	0.2%

	Asexual	Queer	Other	Not Given
Barnsley	69	14	23	11638
%	0%	0%	0%	6.9%
Calderdale	71	62	22	11488
%	0%	0%	0%	6.9%
Kirklees	147	58	61	25742
%	0%	0%	0%	7.4%
Wakefield	126	29	30	17945
%	0%	0%	0%	6.2%

Taken from Census 2021 data

Sexual orientation	Total	%
Not Recorded	53576	46.04
Heterosexual	57001	48.99
Sexual orientation unknown	2614	2.24
Sexual orientation not given - patient refused	821	0.71
Bisexual	1082	0.94
Female homosexual	739	0.64
Male homosexual	517	0.44
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

Sexual Orientation		%
heterosexual	73	59
Prefers not to say	42	34
Bisexual	4	3
Lesbian	4	3
Gay	1	1
	124	**100**

Customer Service data 2021/2022

5e	**Religion & Belief:** Prompt: Main faith groups and people with no belief or philosophical belief issues should be considered	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 and as such the analysis of complaints which relate to religion and belief are reviewed and shared with Care Groups and services. There is further work to do to ensure this analysis support all people and enables learning from complaints.

There is no impact from the policy on religion 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	38437	33
Not religious	20517	17.6
Church of England, follower of religion	6686	5.7
Religion NOS	7180	6.18
Patient religion unknown	4591	3.9
Christian	15395	13.2
Religion not given - patient refused	3269	2.8
Church of England	1999	1.7
Muslim	3209	2.8
Roman Catholic	1662	1.4
Christian religion	629	0.5
Atheist	669	0.5
Methodist	447	0.4
Agnostic	335	0.3
Religion (Other)	1495	1.3
Declines to disclose religious beliefs	4321	3.7
Religious affiliation	136	0.1
Mormon	114	0.1
Spiritualist	91	0
Protestant	85	0
Pagan	163	0.1
Baptist	36	0
Sikh	120	0.1
Buddhist	101	0

		Hindu	58	0	
		Anglican	41	0	
		Pentecostalist	25	0	
		Catholic: non Roman Catholic	65	0	
		Nonconformist	55	0	
		Church of Scotland, follower of religion	19	0	
		Church Of God	8	0	
		Orthodox Christian	12	0	
		Rastafarian	13	0	
		Quaker	9	0	
		Patient religion could not be communicated	12	0	
		Wesleyan Methodist	6	0	
		Sunni Muslim	15	0	
		Church of Ireland, follower of religion	7	0	
		Apostolic Pentecostalist	7	0	
		Eastern Catholic	10	0	
		Seventh Day Adventist	4	0	
		Ismaili Muslim	9	0	
		Evangelical Christian	7	0	
		Coptic Orthodox	3	0	
		Presbyterian	8	0	
		Russian Orthodox	16	0	
		Follower of United Reformed Church	5	0	
		Christadelphian	3	0	
		Unitarian	2	0	
		Orthodox Jew	10	0	
		Independent Methodist	3	0	
		Greek Orthodox	6	0	
		Salvation Army member	4	0	
		Greek Catholic	2	0	
		Serbian Orthodox	2	0	
		Shiite Muslim	2	0	
		Old Catholic	1	0	
		Heathen		0	
		Congregationalist	7	0	
		Jain	2	0	
		British Israelite		0	

		Celtic Christian 2 0 Uniate Catholic 1 0 Christian Spiritualist 2 0 Jewish 20 0 Wiccan 5 0 Church in Wales, follower of religion 2 0 Romanian Orthodox 4 0 Reformed Christian 2 0 Total Patients *Trustwide Information 2021/2022 data* No information available as this is not collected by Customer Services
5f	**Marriage and Civil Partnership** Prompt: Single, Married, Co-habiting, Widowed, Civil Partnership status are included in this category	There is no impact on marriage or civil partnership from this policy. **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 62828 54.0 Married 21158 18.2 Widowed 8063 6.9 Not Recorded 18209 15.6 Divorced 4240 3.6 Separated 1852 1.9 Total Patients **116350** 100%
5g	**Pregnancy and Maternity** Prompt: Currently pregnant or have been pregnant in the last 12 months should be considered	No information available as this is not collected by the Trust or Customer Services
5h	**Gender Re-assignment** Prompt: Transgender issues should be considered	The customer service policy and agenda for gender re-assignment 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	116143	99.8
Gender reassignment patient	207	0.2
Total Patients	**116350**	100%

Trustwide Information 2021/2022 data

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

5l **Carers**

Prompt: Caring responsibilities paid or unpaid, hours this is done should be considered

It is not anticipated there will be any negative impact on service users or their carers from this policy.

A number of people who contact the customer services team are carers/family members for service users and are supported to raise a concern on behalf of a service user who might be unable to do so themselves.

Relationship to service user		%
Parent	37	30
Service User	70	56
Sibling	4	3
Son/Daughter	5	4
Spouse/Partner	6	5
Other	2	2
Customer Service data 2021/2022	**124**	**100**

5j **Race**

Prompt: Indigenous population and BME Groups such as Black African and Caribbean, Mixed Heritage, South Asian, Chinese, Irish, new Migrant, Asylum & Refugee, Gypsy & Travelling communities.)

Work has developed within the customer services team to understand who is in contact with the team and providing feedback/raising concerns/complaints. There is further work to do to examine this data and understand why there is a disproportionate amount of people who are white British providing feedback and how to encourage feedback from other ethnic groups.
The policy supports the sharing of information in different languages and formats and the team are able to access language line for support if needed.

Race equality

	White	Asian	Black	Mixed	Chinese & Other
England % av.	81%	9.6%	4.2%	3%	2.2%
Kirklees					
% average	73.6%	19.4%	2.3%	3.1%	1.5%
Barnsley					
% average	96.9%	0.9%	0.7%	0.9%	0.5%
Calderdale					
% average	86.1%	10.5%	0.7%	1.9%	0.8%
Wakefield					
% average	93%	3.6%	1.3%	1.4%	0.7%

Taken from Census 2021 for each area

Ethnicity	Sum of All Patients	
Any other Asian background	496	0.30%

Any other black background	302	0.26%
Any other Ethnic group	815	0.7%
Any other mixed background	575	0.49%
Any Other White background	2591	2.22%
Bangladeshi	87	0.075%
Black African	554	0.48%
Black Caribbean	426	0.36%
Chinese	82	0.07%
Indian	975	0.58%
Not Recorded	1543	1.32%
Not Stated	2070	1.78%
Pakistani	3513	3.01%
White and Asian	340	0.29%
White and Black African	177	0.15%
White and Black Caribbean	624	0.53%
White British	100730	86.57%
White Irish	450	0.38%
Total Number of Patients	116350	100%

Trustwide Information May 2021/2022 data

Of people who made a complaint to the Trust their Race/Ethnicity is recorded below (124 received in total)

ethnicity		%
White British	89	72
Prefers not to say	13	10
Pakistani	4	3
Any other Black	1	1
Any other Ethnicity	1	1
Any other White	3	2
Black African	1	1
Indian	1	1
Unknown	6	5
White & black Caribbean	3	2
White Asian	2	2
Customer Service data 2021/2022	**124**	**100%**

Action Plan

When thinking about actions look at the impacts you have identified and add **1-3 annual actions** that will mitigate against impacts and ensure service improvement.

Potential themes for actions could cover anything from geographical location, built environment, timing access to a service, make up of workforce, stereotypes and assumptions, improved equality monitoring, community relations/cohesion, ward environments and care, or any other specific issues/barriers you would like to address. Complete one action for each form below and RAG rate your progress.

Who will benefit from this action? (tick all that apply)		Action 1: This is what we are going to do	Lead/s	By when	Update	RAG
Age		Further data analysis required to understand complaints which relate to protected characteristic to identify where learning and changes are needed to services.	Ruth Foxcroft	August 2024		
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						
Carers						

Who will benefit from this action? (tick all that apply)		Action 2: This is what we are going to do	Lead/s	By when	Update	RAG
Age		Work to gather feedback from complainants who have a protected characteristic to understand their experience of providing feedback to the Trust	Ruth Foxcroft	August 2024		
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						

Carers						

Who will benefit from this action? (tick all that apply)		**Action 3: This is what we are going to do**	**Lead/s**	**By when**	**Update**	**RAG**
Age						
Disability						
Gender reassignment						
Marriage and civil partnership						
Race						
Religion or belief						
Sex						
Sexual Orientation						
Pregnancy maternity						
Carers						

Involvement & insight:

- Have you reviewed existing insight i.e. patient experience, complaints, previous surveys to support EIA completion?
- Have you gathered the views of people to support EIA completion?

If yes, please add any reports or evidence in the box below

The Customer Services team captures data on most protected characteristics to support the development of Trust services for people. This information has been utilised to complete this EIA, however, as outlined in the actions section there is further work to do on this captured information and to understand what impact this policy and the customer services process has on people with protected characteristics.

7 Methods of Monitoring progress on Actions

Progress and completion of the actions will be monitored through the customer services team meetings, through clinical governance group and reported through the Customer Services Annual report where these have also been identified as areas for action over the coming year.

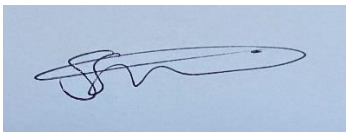
8 Publishing the Equality Impact Assessment

The EIA will be published as part of the customer services policy. The policy is available both internally and publicly on the Trust website.

- This EIA will be shared with InvolvingPeople@swyt.nhs.uk who will publish as they see fit.
- This EIA will be saved within the shared drive of for the team to have access to.
- This EIA will be saved within the Team Managers folder for others to have access to.

The EIA has been graded as **Developing** by Aboo Bhana Equality and Involvement Manager

9 Signing off Equality Impact Assessment:



Sarah Whiterod
Associate Director of Nursing, Quality and Professions

Once approved, you must forward a copy of this Assessment/Action Plan by email to:
InvolvingPeople@swyt.nhs.uk

Appendix E

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**		
	Is the type of evidence to support the document identified explicitly?	YES	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	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**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Is it clear who will be responsible implementation and review of the document?	YES	

APPENDIX F
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	Associate Director of Nursing & Quality		
7	August 2023	Associate Director of Nursing, Quality and Professions	Final	Full update of policy and alignment with NHS Complaint regulations. Section on managing persistent and

				unreasonable contact expanded and updated.