POLICY TITLE:	**Complaints**
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Author:	Dave Parkes, Group Complaints Manager
Ratified by:	Dave Parkes, Group Complaints Manager
Responsible signatory:	David Watts, Director of Safety
Outcome:	This policy: • aims to ensure that all service users have access to an effective complaints process. • gives details on how to deal with a complaint. • sets out our responsibilities on dealing with complaints and provides information on the third party organisations which service users can contact to pursue complaints further. • includes Priory Group's Duty of Candour.
Cross Reference:	ES53 Safeguarding Children Policy (Education Services) H105 Practising Privileges for Independent Doctors H105.1 Practising Privileges for Therapists and other Health Professionals HR04.3 Grievance OP02 Data Protection OP04 Incident Management, Reporting and Investigation OP05 Mental Capacity OP05.2 MCA Deprivation of Liberty Safeguards (England and Wales) OP06 Safeguarding Children (Anyone under the age of 18) OP08 Safeguarding Adults (Anyone aged 18 or over) OP17 Advocacy OP21 Confidential Reporting (Whistleblowing) OP29 Service User and Carer Involvement Priory Group Employee Handbook

EQUALITY AND DIVERSITY STATEMENT

Priory Group is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, e-mail SQCHelpdesk@priorygroup.com.

COMPLAINTS

1 INTRODUCTION

1.1 This policy applies to all complaints received by any division within Priory Group and establishes a clear procedure for effective and efficient complaint management.

1.2 However, it does not prejudice the right of a complainant to take legal action and furthermore allows, in certain circumstances, for the making of a gesture of goodwill payment without acceptance of liability, if considered appropriate.

N.B. No statement accepting responsibility or admitting liability should be made by any member of staff without prior consultation with the Group Risk Manager or divisional CEO.

1.3 Complaint ownership remains with the Hospital Director, School Principal, Registered Home Manager or Service Manager throughout the process. Complaints should be addressed and resolved at service level whenever possible.

1.4 Local resolution is actively encouraged in all services.

1.5 Staff will be provided with the necessary basic training and updates in communications and complaints handling in order to ensure that complaints are communicated and dealt with sensitively and courteously at all levels via a Foundations for Growth module; with Hospital Directors, School Principals, Registered Home Managers, Service Managers and senior Priory managers invited to attend internally provided Complaint Handling for Managers training.

2 OBJECTIVES

The objectives of this policy, processes and forms are:
(a) To provide ease of access for service users to the complaints process;
(b) To instil service user confidence in the way in which complaints are managed;
(c) To provide service users with information on how to make a complaint;

(d) To have an honest, open and thorough approach to all investigations;
(e) To address all legitimate concerns raised by the complainant or the authorised representative;
(f) To adopt a fair and consistent approach to the investigation of all complainants;
(g) To separate complaints from disciplinary/grievance procedures, where appropriate;
(h) To effectively record, audit and cross-reference complaint data to other quality and risk management processes;
(i) To extract lessons learned from complaints so as to continually improve the quality of services provided and reduce incidents and risk to the business;
(j) To identify any shortfalls and/or failings in personal or professional conduct;
(k) To initiate a corporate drive towards excellence in complaint management;
(l) To signpost complainants, wherever appropriate, to other organisations that may provide assistance and support in their pursuance of a complaint.

3 DEFINITIONS

3.1 A complaint is defined as 'an expression of dissatisfaction about a service that requires a response'. Any complaint, whether it is of minor concern to the service user or staff and can be dealt with immediately, or it is of more major concern to several parties, is an expression of dissatisfaction that requires a satisfactory and efficient resolution.

3.2 A service user, relative, visitor, funder, clinician, local authority, NHS authority, regulatory body or any other interested party or stakeholder acting with the authority of a service user may raise a complaint.

3.3 Complaints may relate to any aspect of care, treatment, professional competencies or to any of the administrative or support services and may be made by telephone, in person, in writing or by email to any member of Priory Group personnel.

3.4 A complaint by a service user's representative will only be accepted in the following circumstances:

(a) Where the service user has consented, either verbally or in writing
OR
(b) Where the service user cannot complain unaided and cannot give consent because they lack capacity within the meaning of the Mental Capacity Act 2005
AND
(c) The representative is acting in the service user's best interests i.e. where the matter complained about, if found to be true, would be detrimental to the service user. This may also require the service user's lawful representative being informed and asked to approve the proposed further action.

4 KEY PRINCIPLES

4.1 **Accessibility and Simplicity -** The complaints process is well publicised, easily accessible and clearly understood by service users, staff and the public. Complaint Notices, explaining how a service user is able to access the complaints process and register comments and compliments are prominently displayed in the reception area of all services. Service users should also be directed to this notice board for details about local advocacy services. (See OP17 Advocacy).

4.1.2 The Complaints Policy is available on the Priory website – www.priorygroup.com. The Priory Group website provides an online email link for registering comments, compliments and complaints regarding services provided – complaints@priorygroup.com together with contact telephone numbers should service users wish to discuss their concerns directly with a member of the Safety (Complaint) Team.

4.1.3 Where care and treatment are provided to children, young and older people or those with enduring mental health or learning disabilities, staff should be aware of the difficulties that such a service user faces in expressing a concern or a complaint and must provide them with

assistance in order to help them to make their individual views known. Supplementary and service user friendly complaint literature will also be made available within these services (e.g. **OP Form: 18** (Easy Read) Making a Complaint booklets and the Priory 'Making a Complaint' booklet).

4.1.4 Information on how to make a complaint can be made available upon request in other languages and in other formats e.g. braille transcriptions, large print and voice recordings by SQCHelpdesk@Priorygroup.com.

4.1.5 A copy of OP03 Complaints is distributed to Commissioners with all contracts for care.

4.1.6 Priory Group provides a separate process to enable employees to communicate any concerns that they may have about any practice or procedure. See HR04.3 Grievance Policy and OP21 Confidential Reporting (Whistleblowing).

4.2 **Communication** - There is early direct contact with the complainant and this continues throughout the complaints process. Effective communication is required within the organisation and with the complainant and all other interested parties, recognising and addressing, as a priority, any perceived difficulty that may be posed by barriers such as language, culture or disability.

4.3 **Record Keeping** - There is an effective complaint recording and feedback system that will enable continual service improvements to be made. All complaints will be recorded on the Priory eCompliance Complaint Reporting system within 48 hours of receipt and actioned in accordance with the process flowchart outlined in **Appendix 1**. Any action taken in dealing with a service users' complaint must be recorded in the appropriate complaint records (but this must **not** form part of a service users' personal Health, Care or Education record).

4.4 **Credibility** - The complaint process is closely managed and regularly reviewed in order to ensure that improvements and changes are identified and implemented for the benefit of all service users and there is an effective quality assurance system in place to ensure that the complaints system and continual learning from it have a high profile across the Group.

4.5 **Accountability** - Complaint information is provided in a clear, concise and open way and is properly managed with regular follow-up to complaint investigation and resolution in order to ensure decisions are properly and promptly implemented. There is regular monitoring of the complaint process to ensure that timescales and service user expectations are met. The complaint process is periodically reviewed, updated and any changes communicated to service users, Priory Group staff and all interested parties.

4.6 **Timeliness** - Clear timeframes are set and effectively communicated to all interested parties in relation to all aspects of the complaint investigation process.

4.7 **Fairness and Impartiality** - Roles and responsibilities are clearly defined. All complaints are dealt with in an open-minded and impartial way, with responses being proportionate to the concerns because 'one size' does not fit all.

4.8 **Confidentiality** - Service user confidentiality will be maintained at all times.

4.9 **Improvement in quality** – Complaints provide an opportunity to closely review our services, care and clinical practices and to ensure promotion of a culture of continual quality improvement and risk reduction. The outcome of complaint investigations enables improvement opportunities to be identified and changes implemented across the service line or group through lessons learnt. Though not used to apportion blame, investigations may uncover information about serious matters that may indicate a need for disciplinary action.

4.10 **Consent** – Across Priory Group, service users' personal information is protected in line with the requirements of the Data Protection Act and Caldicott principles. The service user to whom a

complaint relates must give their consent before any information relating to their own care and/or treatment is shared with a third party and whilst this should be in a written form (by completion of **OP Form: 18D** Statement of Authority to Access Service User Records), verbal consent is permitted so long as it is recorded and logged. The complainant and/or service user are entitled to a full explanation as to why consent is being sought. If the complaint is not being made by the service user, **OP Form: 18C** Statement of Authority to take up a Complaint on behalf of a Service User must be completed by the service user prior to the disclosure of any service user confidential information.

4.10.1 Consent may not be needed in situations where the service user is unable to consent, for example if they are too young (assuming the complainant has parental responsibility), too ill or have died. In the case of any service user who has capacity at times and not at others (fluctuating capacity), no confidential information will be given to a third party unless deemed to be in the 'best interest' of the service user at the time and fully documented using **OP Form: 65** Mental Capacity Assessment and **OP Form: 65A** Best Interests Decision.

4.11 In addition, refer to **Appendix 3 –** Duty of Candour.

5 COMPLAINT PROCESS

5.1 The Priory Group process for resolution of all complaints consists of 3 stages:
(a) **Stage 1** – Local resolution at service/site level
(b) **Stage 2** – Internal Review via the Group Complaints Manager
(c) **Stage 3** – External Review by the Ombudsman, Parliamentary Health Service Ombudsman (PHSO) or Adjudication by the Independent Sector Complaints Adjudication Service (ISCAS) for privately funded Healthcare service users or by the Independent Complaint Panel convened in respect of the Education Division.

5.2 The three stages of resolution are described further in sections 6 – 10 respectively.

6 STAGE 1 - LOCAL RESOLUTION AT SERVICE/SITE LEVEL

6.1 Some complaints represent a minor concern for the complainant and these may include general comments, suggestions or criticisms about a service. Complaints falling into this category will normally be made verbally to 'front line staff' and will be seen as issues that can be 'fixed' either immediately or relatively quickly. Staff receiving such complaints, should note the details on **OP Form: 18G** Complaint Record and whilst ensuring that the service user's immediate health and care needs are being met attempt to address and resolve the concern.

6.2 If the employee to whom the complaint is made is unable to resolve the problem immediately or feels unable to give the assurances that the complainant is looking for, then the Hospital Director, School Principal, Registered Home Manager or Service Manager (or their deputy) will take responsibility to resolve the complaint, by the next working day, in an informal and conciliatory manner ('next working day' excludes weekends and bank holidays).

6.3 Should a Hospital Director, School Principal, Registered Home Manager or Service Manager be unable to resolve the matter quickly and to the complainants' satisfaction, they must advise the complainant that their concerns will require further time to investigate fully prior to responding to the issues raised.

6.4 In such circumstances, staff should assist the complainant in putting their concerns in writing, if previously verbal, and advise them further on the complaint process. It should be noted, however, that failure to put a verbal complaint in writing, will not prevent a complaint from being investigated.

6.5 In those cases in which staff are able to satisfactorily address and resolve a minor concern by the next working day, the complainant should receive a full and positive response with the aim of assuring them that their concerns have been addressed and this should include an expression of regret and/or explanation for the earlier problem. The Hospital Director, School Principal,

Registered Home Manager or Service Manager will then 'sign off' the complaint, record brief details on the eCompliance Complaint Reporting system (including details of resolution and any lessons learnt). If an **OP Form: 18G** Complaint Record was completed, this should be signed by the complainant and retained as part of the complaint record in order to confirm that they are satisfied with the way in which the complaint was addressed and resolved. A copy of the completed form may be provided to the service user if requested.

6.6 Some concerns, be they verbal or written, will be viewed as more serious or complex and it will not be possible to address and resolve these by the next working day.

6.7 Staff receiving such a complaint either verbally or in writing (including email) must ensure that the date of receipt by the site/service is recorded and that it is passed **immediately** to the Hospital Director, School Principal, Registered Home Manager or Service Manager for recording and investigation purposes.

6.8 Once the Hospital Director, School Principal, Registered Home Manager or Service Manager is assured that the complaint can be investigated i.e. it is not deemed 'out of time' (refer to section 6.20), full details of the complaint must be recorded on eCompliance Complaint Reporting system and a note made of the system generated Complaint Reference Number which will be unique to that service/site complaint. An investigating officer must also be assigned.

6.9 Any complaints from MP's and Officers of the Crown, complaints that may result in litigation, involve accidents and injury or that may involve a gesture of goodwill payment being made must be emailed to the Group Complaints Manager and Group Risk Manager **immediately.**

6.10 Letters from solicitors should be faxed to the Group Risk Manager, on the day of receipt, who will then liaise with the company loss adjusters regarding the response.

6.11 A case file should be created in which copies of all complaint investigation related documentation will be held throughout the investigation. **OP Form: 18A -** Complaints Process Checklist is designed to assist in this matter.

6.12 A letter of acknowledgment **MUST** be sent to the complainant, by the Hospital Director, School Principal, Registered Home Manager, Service Manager or delegated member of staff **within 2 working days** of the date on which the complaint was received. A copy of the **signed** letter must be kept in the case file. **OP Letter: 18A** – Complaint Acknowledgement Letter Template, published on the Intranet, is to be completed and used for this purpose. This letter **MUST** offer the complainant the opportunity to meet with the Investigating Officer to clarify their specific concerns and will state that we aim to respond fully to all complaints within 20 working days of the date of receipt.

6.13 Any meeting with the complainant should clarify the purpose and the desired outcome, be fully minuted and a copy of the minutes provided to the complainant as an accurate record of the discussions and making clear the agreed areas for investigation.

6.14 Should a complainant make subsequent contact (including via email or by telephone) following receipt of their original complaint, the Hospital Director, School Principal, Registered Home Manager, Service Manager or delegated member of staff **MUST** acknowledge this contact in writing **within 2 working days** of receipt. This will provide an assurance that we have received and noted any additional comments made or the issues raised and that these will be fully taken into account as part of the ongoing investigation.

6.15 If at working day 15, it is clear that the investigation and response will not be complete within the agreed 20 working day timeframe a further letter will be issued informing the complainant of the reason for the delay and advising on a revised timeframe. **OP Letter: 18B** Holding Letter Template, published on the Intranet, is completed and used for this purpose.

6.16 The complaint investigation should be assigned to the investigating officer for their action, which requires production of an investigation report and subsequent preparation of a draft response to the complainant. **OP Form: 18B** Complaint Investigation Log is available to assist in recording details of the investigation.

6.17 All investigation documentation should be placed in the complaint case file and copies uploaded to the eCompliance system when updating the case record.

6.18 A formal and detailed response should be sent to the complainant within the agreed timescale. **OP Letter: 18C** Complaint Final Response/Decision Letter Template and Guidance, published on the Intranet, is to be completed and used for this purpose. This letter **must** issue from the Hospital Director, School Principal, Registered Home Manager or Service Manager (but may be signed in their absence) and signpost the complainant as to the course of action available to them should they remain dissatisfied with the outcome of the Stage 1 investigation.

6.19 In the event that a complainant remains dissatisfied with the outcome of the Stage 1 investigation, they have the right to request that their case be considered at Stage 2 – Internal Review by the Group Complaints Manager. It should be noted, however, that an expression of dissatisfaction will in itself not automatically warrant a review at Stage 2, since it may be more appropriate for the Hospital Director, School Principal, Registered Home Manager or Service Manager to offer a further opportunity for a discussion/meeting in order to attempt to reach satisfactory resolution.

6.20 We do take all complaints very seriously and will always thoroughly investigate any service users' concerns in those circumstances in which it remains right and possible to do so despite the lapse of a period of time. However, it is generally felt that a complaint should be made as soon as possible after the matter that a service user is complaining about happened; with the time limit usually being:

(a) Six months from the date something happened, or
(b) Six months from the date that a service user first becomes aware of it.

6.20.1 We can and do extend the time limit in circumstances where it would be unreasonable to expect a service user to have complained within time so long as it remains possible for us to investigate the service users' concerns. **OP Letter: 18** Out of Time Complaint Template, published on the Intranet, is to be completed and used for the purpose of responding to those concerns deemed out of time.

7 STAGE 2 - INTERNAL REVIEW

7.1 If a complainant remains dissatisfied after **all** attempts to resolve a complaint locally have failed, then they may, within 6 months of the date of the Stage 1 formal response, request that their case be reviewed at Stage 2 of the Priory process. The request must be in writing and forwarded to:

Group Complaints Manager
Priory Northern Office
Middleton St George
Darlington
Co. Durham DL2 1TS

7.2 The Group Complaints Manager if satisfied that there is **NO** further potential for the complaint to be resolved at Stage 1 will, within 2 working days, formally acknowledge the complainants' request to refer the case to Stage 2 and will advise them of the review process. **N.B. See section 7.8 for special arrangements in relation to Stage 2 requests that involve the Education Division.**

7.3 Upon receipt of copies of all Stage 1 investigation documentation and access to Health/Care records (subject to appropriate consent being provided for access to records), the Group

Complaints Manager will undertake a detailed review of the Stage 1 investigation and make a decision as to whether or not there are grounds for a re-investigation of the earlier complaint.

7.4 If a re-investigation is warranted, an Independent Complaints Manager, assigned by the Group Complaints Manager, will be asked to consider those aspects of the earlier complaint that are deemed to require further consideration.

7.5 The Group Risk Manager will if necessary be consulted if there are areas of concern that relate to risk and potential litigation.

7.6 Based upon the outcome of the initial review or following advice from the Independent Complaint Manager, if re-investigation was warranted, the Group Complaints Manager will formally respond to the complainant, within **20 working days** of the original receipt of the Stage 2 request (or further extended period if agreed), by either confirming the findings and actions as taken by the Hospital Director, School Principal, Registered Home Manager or Service Manager at Stage 1 or, alternatively, by advising on a revised outcome.

7.7 Should a complainant remain dissatisfied with the Stage 2 decision, they will be advised in the formal response regarding recourse to Stage 3 of the Priory Complaints process; referral to the Ombudsman, PHSO, ISCAS (if relating to privately funded healthcare) or Independent Complaint Panel (for Education Division complaints).

7.8 Requests for a Stage 2 review in relation to the Education Division will likewise be received, acknowledged and managed by the Group Complaints Manager however the review will be undertaken by an Executive Director who has had no direct involvement in the handling of the complaint at Stage 1 of the complaint investigation process. The Executive Director will liaise with the Group Complaints Manager on the review findings and both will jointly agree the terms of response; this process fulfilling the requirements of The Education (Independent School Standards) Regulations 2014 (S.I. 2014/3283) – with regards to the manner in which complaints are handled.

8 STAGE 3 - OMBUDSMAN

8.1 If a complainant remains dissatisfied with the outcome following a Stage 2 complaint investigation, they may refer their complaint to either the Ombudsman or Parliamentary Health Service Ombudsman (PHSO) and request that their case be reviewed.

8.1.1 The Ombudsman provides a free and independent service, available to those service users who self fund their care, have arranged it themselves with a personalised budget, as well as to those funded through a local authority.

8.1.2 The PHSO provides a similarly free and independent service for those receiving NHS continuing healthcare - the name given to a package of care that is arranged and funded solely by the NHS for those individuals whom, whilst not in hospital, nonetheless have complex ongoing healthcare needs.

8.2 Before investigating any complaint, the Ombudsman will ensure that the care provider knows about the complaint and has had a reasonable opportunity to investigate and respond to it. If the Ombudsman's investigator believes that this has not happened, they will refer the complaint back to Priory Group to complete our own investigation.

8.3 If the complainant still remains dissatisfied after all avenues of complaint resolution have been followed and exhausted, the Ombudsman may undertake their own independent review of the case and may request copies of all Priory Group investigation documentation and may also visit the site to interview staff involved in the case before reaching a decision as to whether or not there are grounds for further action.

8.4 Priory Group sites will afford the Ombudsman full and courteous co-operation with any

investigation. Hospital Directors, Registered Home Managers and Service Managers will immediately inform the Group Complaints Manager when any correspondence is received from the Ombudsman.

9 STAGE 3 – INDEPENDENT SECTOR COMPLAINTS ADJUDICATION SERVICE (ISCAS)

9.1 As Priory Group are members of the Independent Sector Complaints Adjudication Service (ISCAS) we have a responsibility to provide access to an independent external adjudication of complaints in respect of privately funded healthcare service users.

9.2 The Independent Sector Complaints Adjudication Service (ISCAS) process is available for use by complainants who are not satisfied with the results of the Stage 1 investigation and Stage 2 review but only once the internal process has been thoroughly exhausted.

9.3 A complainant's request for external adjudication must be initiated by the complainant in writing and be sent to the Independent Sector Complaints Adjudication Service (ISCAS) **within 6 months of the date of the Stage 2 Review decision letter.**

9.4 The request must contain adequate details of the complaint and must be accompanied by copies of any documents the complainant wishes to rely on. (See the ISCAS Code of Practice for the Management of Complaints 2013 (available on the Intranet) for further details).

9.5 To initiate Stage 3, the complainant must write to ISCAS at the address below within 6 months of the Stage 2 decision letter:

The Independent Sector Complaints Adjudication Service
1 King Street
London
EC2V 8AU
Tel No: 020 3713 1746
Email: info@iscas.org.uk www.iscas.org.uk

9.6 ISCAS will formally notify the Group Complaints Manager of a complainant's request and its own intention to consider adjudication in the case. The Hospital Director and Group Complaints Manager will then be asked to provide ISCAS, within 10 working days, with a full set of medical records and a detailed investigation timeline together with copies of all documentation relating to all stages of its earlier investigation. The process will be closely managed by the Group Complaints Manager, in consultation with the Group Risk Manager, by liaising with the Hospital Director in arranging the submission of ISCAS requested documentation.

9.7 ISCAS will acknowledge the complainant's request for independent external adjudication within 2 working days of receipt and upon establishing that the hospital's processes for local resolution and Stage 2 review have been exhausted, will ask the complainant to clarify in writing those aspects of their complaint that they wish to refer for adjudication and to provide consent to the ISCAS process and the release of relevant case records from the hospital.

9.7.1 An Independent Adjudicator will be appointed to consider the complaint, being entirely independent of Priory Group and will ensure that the complainant fully understands the binding nature of the independent external adjudication and that in proceeding, the complainant accepts:

(a) The finality of the decision by the Independent External Adjudicator;

(b) That any decision and/or goodwill payment awarded by the Independent External Adjudicator brings the complaint process to a close;

(c) That the Independent Adjudicator's decision is binding on Priory Group, as an ISCAS member, however, for the avoidance of any doubt any award of a goodwill payment recommended by the adjudicator does not preclude a complainant from seeking any additional legal remedy; monetary or otherwise.

9.7.2 The complainant will be reminded of their right to seek independent legal advice where any aspects of their complaint might give rise to a clinical negligence claim. Even if independent legal advice is being sought about clinical negligence or might be sought in the future pending the outcome of the adjudication process, the ISCAS Code recommends that the complaint can be considered under the complaints procedure and ultimately Stage 3 adjudication.

9.8 A full adjudication decision will be provided within 20 working days or a letter will be issued explaining the reason for the delay to the complainant, at a minimum of every 20 working days.

9.9 If the Adjudicator rejects or upholds a complaint, they will also consider what further remedy (if any) is appropriate including asking Priory Group:

(a) To provide an explanation and apology, where appropriate
(b) To take action to put things right
(c) To share details of how the organisation has learnt from the complaint and any changes made as a result
(d) To offer a goodwill payment in recognition of shortfalls in the complaint handling, inconvenience, distress, or any combination of these, up to a limit of £5,000. Any goodwill payment awarded by the Independent External Adjudicator should take account of any claim that Priory Group has against the complainant (e.g. for unpaid hospital fees); with acceptance of the goodwill payment by the complainant bringing all matters that are subject to the complaint to a close.

10 STAGE 3 – INDEPENDENT COMPLAINT PANEL (EDUCATION)

10.1 Should a parent, carer or funding authority be dissatisfied with the outcome of the investigation at Stage 1 by the School Principal and at Stage 2 following review at Executive Director level, the complainant can make a written request for the complaint to be heard by a panel; thereby fulfilling the requirements of Schedule 1 (Part 7) of The Education (Independent School Standards) Regulations 2014 (S.I. 2014/3283) – with regards to the arrangements made in the event that a parent, carer or funding authority remains dissatisfied with the outcome of the school's earlier investigation and Executive Director review.

10.2 The Panel membership will comprise the following independent experts, all of whom are wholly independent of the management of the school:

(a) Head of Quality (Education)
(b) Director of Safety or other nominated specialist
(c) Operations Director/Regional Manager (out of area)
(d) Group Complaints Manager
(e) A suitably qualified and experienced Independent Person

10.3 Arrangements will be made for the Panel to meet at a place, time and date that is mutually convenient to both the complainant and Panel members, with details being communicated in writing and with the parents/carers being invited to attend with a representative should they wish.

10.4 The Panel will make findings and recommendations, with copies of the findings being sent or given to the complainant and, where relevant, the person complained about and will also be made available for inspection on the school premises by a representative of Priory Group as Proprietor.

11 CLAIMS ARISING FROM COMPLAINTS

11.1 Any claim arising from a complaint will be co-ordinated by the Group Risk Manager in consultation with Priory Group's loss adjustors and Insurers. The Group Risk Manager will be responsible for collating information already available, co-ordinating further investigation, if required, and for liaising with the company lawyer.

12 COMPLAINTS RECEIVED OTHER THAN BY SERVICE/SITE

12.1 As complaints are regularly received in the complaints@priorygroup.com mailbox or via Priory Registered Office, these are initially addressed by the Group Complaints Manager who will arrange for details of the complaint to be added to a central complaint register.

12.2 If it is clear that the complaint requires investigation at Stage 1, the correspondence will be immediately passed to the relevant Hospital Director, School Principal, Registered Home Manager or Service Manager (or in complex or more serious cases, to the Regional Manager/Operations Director) requesting that:

(a) Details to be added to the Priory e-Compliance Complaint Reporting system;
(b) An acknowledgement letter be issued within 2 working days of receipt;
(c) A meeting be offered with the complainant;
(d) A full investigation be undertaken;
(e) A formal response be issued.

12.3 The Hospital Director, School Principal, Registered Home Manager or Service Manager are advised to seek the approval of the RM/OD prior to issuing a response and may also, if required, forward the investigation findings report and draft response to the Group Complaints Manager for final consideration prior to issue. If doing so, they must allow **AT LEAST 5 working days** for consideration and a holding letter (**OP Letter: 18B**) must be issued if the timeframe for response is in any danger of being missed due to referral.

12.3.1 The Hospital Director, School Principal, Registered Home Manager or Service Manager should also consider whether the case might benefit from discussion at the Group Complaint Manager's weekly Complaint Surgery held every Wednesday - perhaps facilitating a speedier decision/response.

12.3.2 Upon completion of **ALL** cases, a scanned copy of the signed letter of response must be forwarded to the Group Complaints Manager for recording purposes.

13 HANDLING OF PERSISTENT OR VEXATIOUS COMPLAINANTS

13.1 Services will, from time to time, come into contact with a small number of complainants who absorb a disproportionate amount of staff resource in dealing with their complaints. It is important to identify those situations in which a complainant might be considered to be persistent and to suggest ways of responding to those situations which are fair to both staff and complainant.

13.2 Handling persistent complainants places a great strain on time and resources and causes undue stress for the service user and staff who may need extra support. A persistent complainant should be provided with a response to all their genuine grievances and be given details of independent advocacy.

13.3 Although staff are trained to respond with patience and empathy to the needs of all complainants, there can be times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

13.4 In determining arrangements for handling such complainants, staff are presented with the following key considerations:

(a) To ensure that the complaints process has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
(b) To appreciate that habitual complainants believe they have grievances which contain some genuine substance;
(c) To ensure a fair, reasonable and unbiased approach;
(d) To be able to identify the stage at which a complainant has become habitual;
(e) To give very early consideration to implementing a management care plan for the handling of the service users' concerns thereby affording the service user the opportunity to discuss

their concerns in an agreed forum and at predetermined times; with staff better able to manage and address/resolve the issues without the associated problems posed by, for example, numerous emails/letters and with the service user being suitably and further reassured that we are taking their concerns seriously.

13.5 Ensure that a complainant meets the minimum criteria to be classified as a habitual complainant. Complainants (or anyone acting on their behalf) may be deemed to be persistent or habitual where previous or current contact with them shows that they meet at least **TWO** of the following criteria. Where complainants:

(a) Persist in pursuing a complaint where the complaints process has been fully and properly implemented and exhausted;
(b) Seek to prolong contact by changing the substance of a complaint or continually raising new issues and questions whilst the complaint is being addressed. (Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints);
(c) Are unwilling to accept documented evidence of treatment given as being factual e.g. drug records, medical records, nursing notes;
(d) Deny receipt of an adequate response despite evidence of correspondence specifically answering their questions;
(e) Do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed;
(f) Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts by staff or independent advocacy, to help them specify their concerns, or where the concerns identified are not within the remit of the service to investigate;
(g) Focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. (Determining what a 'trivial' matter is can be subjective and careful judgement must be used in applying this criteria);
(h) Have, in the course of addressing a registered complaint, had an excessive number of contacts with the service placing unreasonable demands on staff. (A contact may be in person or by telephone, letter, e-mail or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section using judgement based on the specific circumstances of each individual case);
(i) Are known to have recorded meetings or face to face/telephone conversations without the prior knowledge and consent of the other parties involved;
(j) Display unreasonable demands or expectations and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice);
(k) Have threatened or used actual physical violence towards staff or their families or associates at any time - this will in itself cause personal contact with the complainant or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication;
(l) Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this).

13.6 **Where a complaint investigation is ongoing -** The nominated Hospital Director, School Principal, Registered Home Manager, Service Manager or Regional Manager/Operations Director should firstly consider writing to the complainant setting parameters for a code of behaviour and the lines of communication. If these terms are contravened, consideration may then be given to implementing other action.

13.7 **Where a complaint investigation is complete -** At an appropriate stage, the Hospital Director, School Principal, Registered Home Manager, Service Manager or Regional Manager/Operations Director should write a letter informing the complainant that:

(a) They have responded fully to the points raised;
(b) Have tried to resolve the complaint;
(c) There is nothing more that can be added and therefore, the correspondence is now at an

end;

(d) (optional) state that future letters will be acknowledged but not answered.

13.8 In extreme cases, the Hospital Director, School Principal, Registered Home Manager, Service Manager or Regional Manager/Operations Director should reserve the right to take legal action against the complainant; liaising in the first instance with the Group Complaints Manager and Group Risk Manager for advice and guidance.

13.9 **Withdrawing 'Persistent' Status -** Once complainants have been determined as persistent or habitual there needs to be a mechanism for withdrawing this status at a later date if, for example, a complainant subsequently demonstrates a more reasonable approach or if they submit a further complaint for which the normal complaints process would appear appropriate.

13.10 As staff used discretion in recommending persistent or habitual status, discretion should similarly be used when recommending that this status be withdrawn.

14 ADDITIONAL INFORMATION FOR EDUCATION DIVISION

14.1 All students will receive information advising them how to raise a concern in a format that they can easily understand.

14.2 If a student feels unable to speak to any member of staff, due perhaps to the nature of the complaint etc, he/she has the opportunity to register the complaint with parents/carers, the funding authority or an independent visitor, either by telephone or by requesting a visit.

14.3 A register of complaints will be kept readily available for inspection as required. The Priory Group Complaints Log is available for this purpose from the On-line Print shop.

14.4 The School Principal will review the register on a quarterly basis and sign and date the register to confirm that this has been done.

14.5 The School Principal will immediately notify the appropriate registration and inspection authority of any allegations or complaints involving police investigations or any allegations of service user abuse.

14.6 If the complainant continues to hold the view that Priory Education Services has not satisfactorily resolved the problem, the option is for the complainant to contact the registration and inspection authority.

15 ADDITIONAL REQUIREMENTS FOR HEALTHCARE DIVISION

15.1 Hospital Clinical Governance Committees will review all complaints and advise on practice issues arising and improvements to be made. These will be recorded in the minutes at local Clinical Governance meetings. Dissemination of lessons learnt needs to be clearly articulated in the minutes.

15.2 **Complaints Involving Independent Practitioners -** Many practising clinicians are independent practitioners and are not Priory group employees. Their practising privileges are conditional on participation in and adherence to the Priory Group Complaint policy. If a clinician fails to adhere to the policy, practising privileges may ultimately be suspended or withdrawn. The Hospital Director shall not withdraw the practising privileges of any clinician without first consulting the Medical Director. Complainants should be informed of their right to complain direct to the professional body.

15.3 The Hospital Director must always inform a clinician of a serious or clinical complaint made by a service user for whom the clinician is responsible.

15.4 The clinician will likewise always inform the Hospital Director of any complaints received by him

or her, in the first instance. If the complaint relates to clinical care, the Hospital and clinician may both be involved in investigating the complaint at Stage 1. The scope of the service user's consent as to the release of information and his/her preferences as to the manner in which the complaint is dealt with will be respected in this process.

15.5 Any response sent out by a Hospital Director or independent practitioner must be factually accurate. It is good practice for all complaint responses to be checked for factual accuracy by both parties prior to issue, particularly where observations on the conduct or performance of one professional are made by another.

15.6 Cases involving serious clinical complaints or allegations of professional incompetence must be brought to the attention of the Group Medical Director and passed to the Hospital Director for acknowledgment; liaising as appropriate with the GMC as professional body.

15.7 **General Medical Council (GMC) Complaints and Complaints against Doctors –** All Consultants and Doctors are requested to notify the Hospital Director if there are any complaints made against them. If the complaint has been made directly to the GMC, the Group Medical Director must be informed immediately with appropriate details.

16 ADDITIONAL REQUIREMENTS FOR OLDER PEOPLE SERVICES

16.1 **Complaints Notices –** Residents are to be advised on how to register a complaint with Priory Group's older people's services. The appropriate Complaint Procedure Notice must be prominently displayed in the Care Home Reception area.

16.2 Notices for display for Older People Services are available from the Intranet. Use **OP Form: 18E** for Northern Ireland and **OP Form: 18F** for England, Wales and Scotland.

17 ADDITIONAL REQUIREMENTS FOR CRAEGMOOR DIVISION

17.1 There are no special requirements for handling complaints in Craegmoor Services. They should be dealt with in line with this policy in accordance with the particular regulatory body for the individual service.

18 REFERENCES AND USEFUL GUIDANCE DOCUMENTS

18.1 Care Standards Act 2000
Care Act 2014
Children Act 2004
Children's Homes Regulations 2015
Data Protection Act 1998
Freedom of Information Act 2000
Education (Independent School Standards) Regulations 2014 (S.I. 2014/3283)
Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011
Independent Health Care (Wales) Regulations 2011
Independent Health Care Regulations (Northern Ireland) 2005
Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
CQC (2015) Specialist Mental Health Services: Provider handbook
CQC (2015) Residential Adult Social Care Services: Provider handbook
CQC (2015) Community Adult Social Care Services: Provider handbook
DfE (2014) Guide to the Children's Homes Regulations including Quality Standards
DfE (2015) Residential Special Schools: National minimum standards
DHSSPSNI –
Care Standards for Nursing Homes (2015)
Residential Care Homes Minimum Standards (2011)
Scottish Executive –

National Care Standards, Care Homes for Children and Young People (2005)
National Care Standards, School Care Accommodation Services (2005)
National Care Standards, Care Homes for Older People (2007)
National Care Standards, Care Homes for People with Learning Disabilities (2007)
National Care Standards, Care Homes for People with Mental Health Problems (2007)
Welsh Assembly Government –
National Minimum Standards for Children's Homes (2002)
National Minimum Standards for Residential Special Schools (2003)
National Minimum Standards for Care Homes for Older People (2004)
National Minimum Standards for Care Homes for Younger Adults (2004)
National Minimum Standards for Private and Voluntary Healthcare Services (2006)
Parliamentary Health Service Ombudsman (2009) Principles of Good Complaint Handling
ISCAS (2013) A Code of Practice for the Management of Complaints in the Independent Healthcare Sector - for Subscribing Members of the Independent Sector Complaints Adjudication Service (ISCAS)
NHS Litigation Authority guidance

Appendix 1 - Complaints Process Flowchart
Appendix 2 – Other Organisations that Service Users may wish to Contact
Appendix 3 – Duty of Candour

Associated Forms:

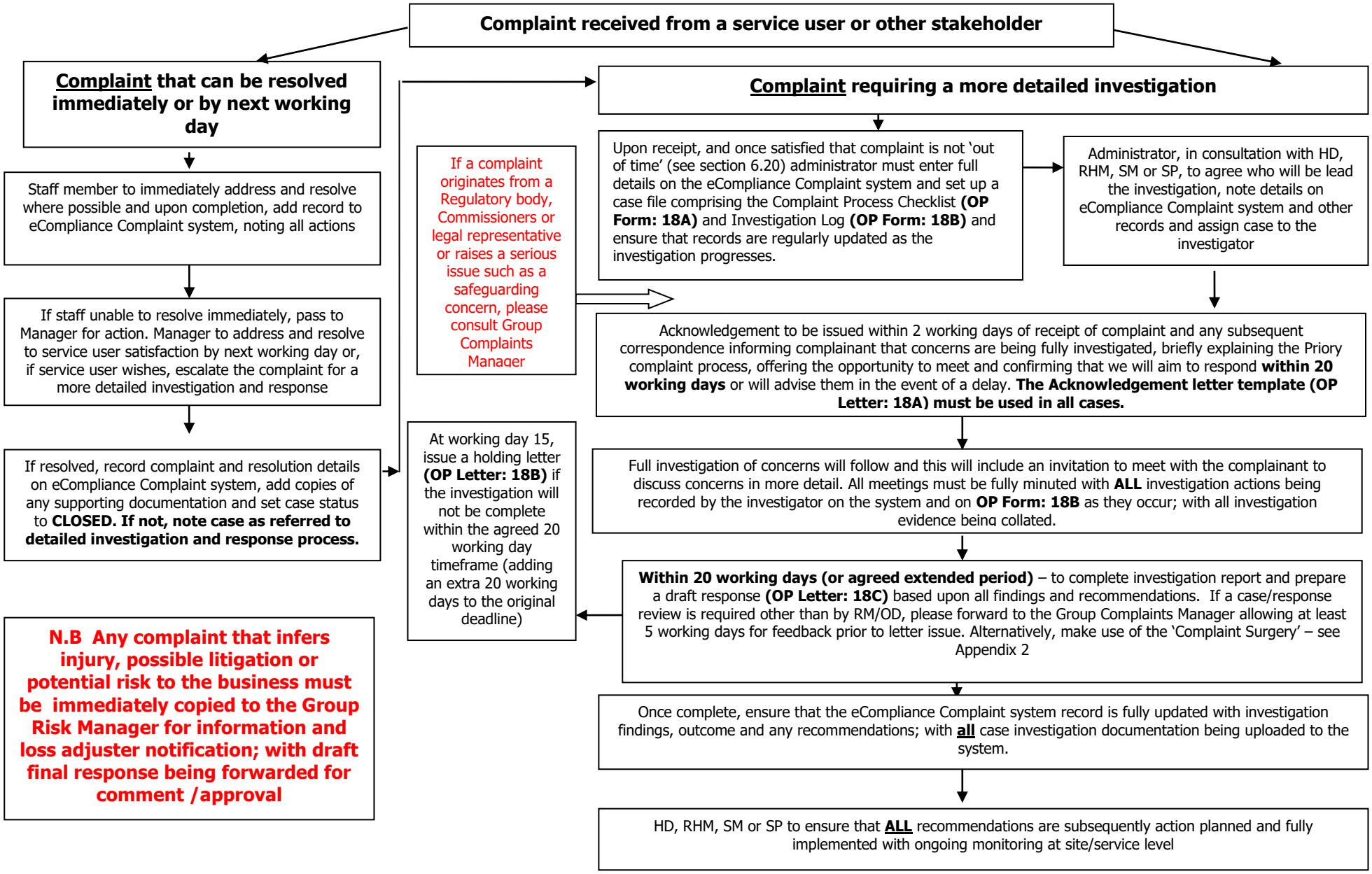
PRINTED DOCUMENTS: (available from the On-line Print Shop)
Making a Complaint (PG00979) - Priory hospitals, clinics, care homes and schools booklet
Mumbles and Grumbles (PG00985) - Adolescent Complaint Booklet
Complaints Log (PG04006) - for Education Division

FORMS: (Printable from the Intranet)
OP Form: 18 (Easy Read) – Making a Complaint (England)
OP Form: 18A - Complaint Process Checklist
OP Form: 18B - Complaint Investigation Log
OP Form: 18C - Statement of Authority to take up a Complaint on behalf of a Service User
OP Form: 18D - Statement of Authority to access Service User Records
OP Form: 18E - Complaint Procedure Notice (Older People) – Northern Ireland
OP Form: 18F - Complaint Procedure Notice (Older People) – Eng, Scot, Wales
OP Form: 18G - Complaint Record
OP Form: 18H (Easy Read) - Making a Complaint (Northern Ireland)
OP Form: 18J (Easy Read) - Making a Complaint (Scotland)
OP Form: 18K (Easy Read) - Making a Complaint (Wales)

LETTERS: (Templates copied from the Intranet, to be printed on headed paper)

OP Letter 18 - Out of Time Complaint Letter Template
OP Letter 18A - Complaint Acknowledgement Letter Template
OP Letter 18B - Complaint Holding Letter Template
OP Letter 18C - Complaint Final Response/Decision Letter Template and Guidance
OP Letter 18D - Gesture of Goodwill Letter Template and Guidance

Appendix 1 – COMPLAINT PROCESS FLOWCHART – STAGE 1



Complaints to complaints@priorygroup.com mailbox and those received by Priory "Central" Office

Group Complaints Manager to arrange for noting on Central complaint register and assign for investigation at Stage 1 by appropriate HD, SP or RHM/SM or for an independent investigation by an RM/OD if appropriate.

N.B Any complaint that infers injury, possible litigation or potential risk to the business must be immediately copied to the Group Risk Manager for information and loss adjuster notification; with draft final response being forwarded for comment /approval

Acknowledgement **(OP Letter: 18A)** to be issued by HD, SP or RHM/SM within 2 working days of complaint receipt, informing the complainant that their concerns are being investigated, offering an invitation to meet with the complainant to discuss concerns in more detail, explaining the complaint process and confirming that Priory will aim to respond **within 20 working days** or advise them in the event of a delay. Full details of complaint to be added to the eCompliance Complaint System; with investigation progress being monitored centrally.

Within 20 working days (or agreed extended period) – HD, SP, RHM/SM or RM/OD to complete investigation report and draft response **(OP Letter: 18C)** based upon findings ready for issue. If required, forward to Group Complaints Manager for case/response approval prior to issue (allowing at least 5 working days for feedback prior to letter issue) .

At working day 15, issue a holding letter **(OP Letter: 18B)** if the investigation and response will not be complete within the agreed 20 working day timeframe (adding an extra 20 working days maximum)

PLEASE REFER TO THE PRIORY COMPLAINTS POLICY OP03 FOR A MORE DETAILED EXPLANATION OF THE COMPLAINTS PROCESS

Upon letter issue by HD, SP, RHM/SM or RM/OD update resolution details on e-Compliance Complaint system and ensure that all case documentation is uploaded to e-Compliance.

Ensure that all recommendations are action planned and fully implemented; with ongoing monitoring at site/service level

APPENDIX 2

COMPLAINT SURGERY

The Complaint Surgery is offered every Wednesday from 10:00 – 16:00 and is facilitated by the Group Complaints Manager.

The initiative is aimed at providing an advice and guidance service to all Hospital Directors, School Principals, Registered Home Managers, Service Managers or other delegated members of staff who may wish to discuss the handling of particular complaint investigations whether they be complex in nature or simply require a different approach to that normally followed.

It is hoped that the Surgery will amongst other things:

(a) Reduce the need for often lengthy exchanges of emails with the team when seeking advice/guidance on a case

(b) Provide an improved turnaround time on earlier requests for advice and guidance

(c) Lead to continuing improvement in the handling of Priory complaint policy and process

(d) Facilitate the effective and improved sharing of experience and the transfer of knowledge across the service

(e) Lead to better reporting and awareness on complaint trends and help identify any education/training needs.

Colleagues are asked to contact the Group Complaints Manager on **07920 041525** should they wish to arrange an 'appointment' or to simply request further information.

Appendix 3

OTHER ORGANISATIONS THAT SERVICE USERS MAY WISH TO CONTACT

ENGLAND		
The Parliamentary Health Service Ombudsman (PHSO) Millbank Tower, Millbank, London SW1P 4QP		Tel: 0345 015 4033 www.ombudsman.org.uk
Local Government Ombudsman (LGO) PO Box 4771, Coventry CV4 0EH		Tel: 03000 610 614 www.lgo.org.uk
NORTHERN IRELAND		
The Ombudsman FREEPOST RTKS-BAJU-ALEZ Belfast, BT1 6BR		Tel: 0800 343 424 or 0289 023 3821 Email: ombudsman@ni-ombudsman.org.uk www.ni-ombudsman.org.uk
The Regulation and Quality Improvement Authority (RQIA) 9th Floor Riverside Tower 5 Lanyon Place, Belfast, BT1 3BT		Tel: 028 9051 7500 Email: info@rqia.org.uk www.rqia.org.uk
Patient and Client Council (PCC) FREEPOST 1st Floor, Ormeau Baths 18 Ormeau Avenue, Belfast, BT2 8HS		Tel: 0800 917 0222 Email: info.pcc@hscni.net www.patientclientcouncil.hscni.net
SCOTLAND		
Social Care and Social Work Improvement Scotland (SCSWIS) Compass House 11 Riverside Drive, Dundee, DD1 4NY		Tel: 0845 600 9527 Email: enquiries@careinspectorate.com www.scswis.com
Scottish Public Services Ombudsman (SPSO) FREEPOST EH641 Edinburgh, EH3 0BR		Tel: 0800 377 7330 www.spso.org.uk
Healthcare Improvement Scotland (HIS) Gyle Square 1 South Gyle Crescent, Edinburgh, EH12 9EB		Tel: 0131 623 4300 Email: comments.his@nhs.net www.healthcareimprovementscotland.org
WALES		
Healthcare Inspectorate Wales (HIW) Welsh Government Rhydycar Business Park Merthyr Tydfil, CF48 1UZ		Tel: 0300 062 8163 Email: hiw@wales.gsi.gov.uk www.hiw.org.uk
Public Services Ombudsman for Wales (PSOW) 1 Ffordd yr Hen Gae Pencoed, CF35 5LJ		Tel: 0300 790 0203 www.ombudsman-wales.org.uk
Care and Social Services Inspectorate CSSIW national Office Welsh Government Office Rhydycar Business Park, Methyr Tydfil, CF48 1UZ		Tel: 0300 7900 126 Email: cssiw@wales.gsi.gov.uk www.cssiw.org.uk
If a complaint involves a serious allegation of professional misconduct, a complainant may wish to contact the following regulatory authorities:		
Nursing & Midwifery Council (NMC) 23 Portland Place London W1B 1PZ		Fitness to Practice Tel: 0207 462 5800 / 5801 Email: fitness.to.practise@nmc-uk.org www.nmc-uk.org General Enquiries Tel: 0207 637 7181
General Medical Council (GMC) Fitness to Practice Directorate 3 Hardman Street Manchester, M3 3AW		Tel: 0161 923 6602 Email: gmc@gmc-uk.org www.gmc-uk.org
Health & Care Professions Council (HCPC) Park House 184 Kennington Park Road,		Tel: 0845 300 6184 www.hcpc-uk.org.uk

London, SE11 4BU		
If the complainant is or has been a patient detained under the Mental Health Act and their complaint relates to the performance of a duty, they may approach the Care Quality Commission at:		
Care Quality Commission National Customer Service Centre Citygate, Gallowgate Newcastle upon Tyne, NE1 4PA		Tel: 03000 61 61 61 Email: enquiries@cqc.org.uk www.cqc.org.uk
OTHER ORGANISATIONS		
Ofsted (England and Wales) Piccadilly Gate Store Street Manchester, M1 2WD		Tel: 0300 123 1231 www.gov.uk/government/organisations/ofsted
POhWER Independent Complaints Advocacy Services PO Box 14043 Birmingham, B6 9BL		Tel: 0300 456 2370 Email: pohwer@pohwer.net www.pohwer.net
Consumer Futures Victoria House Southampton Row London, WC1B 4AD		Tel: 020 7799 7900 Email: contact@consumerfutures.org.uk www.consumerfutures.org.uk
Action Against Medical Accidents (AvMA) Freedman House Christopher Wren Yard 117 High Street Croydon, CR0 1QG		Tel: 0845 123 2352 www.avma.org.uk
Citizens Advice Bureau (CAB) Post Point 24 Town Hall Walliscote Grove Road Weston super Mare North Somerset, BS23 1UJ		Tel: 03454 04 05 06 or check your local bureau's contact details www.citizensadvice.org.uk
The Patients' Association PO Box 935 Harrow Middlesex, HA1 3YJ		Tel: 0845 608 4455 Email: helpline@patients-association.com www.patients-association.org.uk
Age UK Tavis House 1-6 Tavistock Square London, WC1H 9NA		Tel: 0800 169 6565 www.ageuk.org.uk
Independent Age 18 Avonmore Road London, W14 8RR		Tel: 020 7605 4200 Email: charity@independentage.org www.independentage.org

Appendix 4

DUTY OF CANDOUR

(This appendix is associated with OP03 Complaints and OP04 Incident Management, Reporting and Investigation)

Introduction - Service user safety incidents, particularly those causing significant harm, or having the potential to do so, can have devastating consequences for service users and their families, and can be distressing for the professionals involved. Being open about what happened and discussing incidents promptly and compassionately can help with the impact of this. (Incidents referred to in this policy are those that do or have the potential to a medium or high level of harm or death).

Openness and honesty can not only reassure the service user, their families or staff that the incident has been recognised and their concerns acknowledged, but also helps to prevent such events becoming formal complaints and litigation claims that can only add to the upset and distress to all involved.

Being open involves:
(a) Acknowledging, apologising and explaining when things go wrong
(b) Conducting a thorough investigation into the incident
(c) Learning from the incident and putting measures in place to stop any reoccurrence
(d) Providing support for those involved with the physical and emotional consequences of the incident.

Principles - Priory Group is committed to embracing the following principles based on those set out by The National Patient Safety Agency to assist with the creation and embedding of a culture of being open:
(a) Acknowledgement
(b) Truthfulness, timeliness and clarity of communication
(c) Apology
(d) Recognising service user and carer expectations
(e) Professional support
(f) Risk management and improvement in working practices and processes
(g) Multidisciplinary responsibility
(h) Effective Corporate Governance
(i) Confidentiality

Priory Groups duty of candour (being open and honest) applies to all Priory staff including senior management up to Board level.

Committing to being open and honest will create an environment where service users, their families and carers and staff can be assured that, in the event of an incident, they will:
(a) Receive the information that they need to understand what happened
(b) Receive the reassurance that everything possible will be done to ensure that a similar type of incident does not recur
(c) Feel supported when things go wrong

Staff should understand that saying sorry is not an admission of liability; it is part of acknowledging that something untoward has happened. Service users and staff have a right to expect recognition and support.

An open culture recognises that competent people make mistakes, but has no tolerance for reckless, dangerous or negligent behaviour.

Guidance from regulatory bodies - Guidance from the regulatory bodies (CQC, RQIA, Care Inspectorate, HIS, CCSIW, HIW, Ofsted) includes a requirement for organisations to:

(a) Analyse incidents that could have caused harm
(b) Involve service users in making decisions about their care
(c) Have an effective complaints procedure
(d) Notify the regulatory bodies of a range of incidents resulting in harm or having the potential to cause harm to a service user
(e) To reflect published research evidence and guidance issued by appropriate professional and expert bodies as to good practice in relation to care, treatment and support of service users.

Expectations - An apology should be made as soon as possible after an incident to the service user. This is not an admission of liability, but a sincere expression of sorrow or regret for what has occurred. The service user and their families can expect to be given a step by step explanation of what happened, based on the facts known at the time and as soon as practicable after the incident.

Written and face to face explanations and apologies will be given, unless the service user and their families explicitly decline an offer of a meeting. This must be clearly recorded in the service user's records.

Full documentation of any meetings must be kept, but filed separately from the service user's records. Copies should be made available to service users and their families on request. A staff debriefing will also take place, and support will be given to staff involved if required. The staff supervision system can be utilised for this process.

Service users and staff can expect to be kept updated if further investigation reveals more information than has been initially provided. Managers should ensure the provision of timely and accurate information.

Senior managers on site should also give consideration to discussing those incidents that caused no harm (near misses) but had the potential to cause serious harm, with service users, but need to make a local decision as to whether such a discussion should take place depending on local circumstances and what is in the best interests of the service user.

In future, under the terms and conditions of contracts with the NHS there may be financial consequences and penalties for a provider organisation that break their commitment to a culture of being open and honest.

Communications - The terms of reference for serious incident investigations will be set and agreed by the Senior managers involved but there will be scope for the service user and or their advocate to contribute to those terms of reference if they wish to. Only appropriate contributions relevant to the incident will be considered and any issues raised outside of the reasonable scope of the investigation will be addressed separately. The findings of the investigation will be shared with those involved in a planned and systematic way. It is not automatic that a copy of the whole investigation report will be provided. As part of this process there will be a sharing of the lessons learned and processes put in place to avoid a similar incident happening again.

The most appropriate person to communicate with the service user or their family/advocate will usually be the most senior person responsible for the service user's treatment, care or support, or someone who has expertise in the type of incident that has occurred. However, where serious incidents have occurred a discussion needs to take place as to who is the most appropriate person(s) to be involved and lead on any communication with the service user, their family/advocate. Please note that if there is a request for a legal advocate to be present at any meeting, this needs to be discussed with the central legal team.

The person communicating with the Service User or the family/advocate will :

(a) Ideally be known to and trusted by the service user
(b) Have good knowledge of the facts relevant to the incident either by direct involvement or having been as fully appraised of the facts at that particular time.
(c) Be senior enough to have sufficient experience in relation to the type of incident and be credible to service users, their families and carers and staff
(d) Have excellent interpersonal skills, including being able to communicate with service users in a way they can understand, especially if the service user communicates non-verbally
(e) Be willing and able to offer a meaningful apology, reassurance and feedback to the service user or

member of staff

(f) Be able to maintain a medium to long term relationship with the service user and their family where possible to provide continued support and information

(g) Be culturally aware and informed about the specific needs of the service user and their family.

A Staff debriefing will be held by the most appropriate person and this may be a line manager, senior manager of the site, supervisor or other person who has expertise in the type of incident that has occurred and the skills to debrief and understand the psychological processes that staff may be experiencing especially after a traumatic incident.

It is extremely important that information is also provided to the service user and their family to confirm the arrangements that have been put in place to prevent a similar incident happening again.

If an incident has resulted in the death of a service user, it is appropriate to send condolences to the family on behalf of the unit and Priory Group. This will be discussed between the Head of Quality and the Director of Safety prior to sending as to who is the most appropriate person to send.

Careful consideration will need to be given regarding the emotional state of the family when deciding when would be the most appropriate time to discuss what happened. There may be an initial meeting with the Service User and their family/advocate immediately following an incident and then a further meeting to go through the findings of the investigation. This will usually be before any Coroner's inquest, but it may be decided to wait until after the inquest to maximise on the information available. However, this decision should be taken in communication with the deceased's family and the Divisional Managing Director

Lessons learnt from the incident and from subsequent discussions with the service user and family will be shared with the staff to ensure that they are fully aware of the service users and family views regarding what happened.

Where an incident involves a child with 'Gillick' competency, the child will be involved as appropriate in the discussions. The opportunity for the parents to also be involved will be provided, unless the child expresses a wish for them not to be involved. Where a child does not have 'Gillick' competency, consideration needs to be given to whether the meeting is with the parents (or the person with parental responsibility) alone, or for the child to also be present. In these instances the views of the parents should be sought.

The only circumstances in which it would be appropriate to withhold information from a service user with mental health issues or from their family is when advised to do so by the responsible clinician (usually the consultant psychiatrist) who feels it would cause adverse harm to the service user or others.

In the case of an adult service user, it is not appropriate to discuss information about an incident with a carer or relative without the express permission of the service user. Where a service user has learning difficulties, which may include difficulty in expressing their opinion verbally, an advocate, agreed in consultation with the service user, should be appointed who may be a relative or carer. The advocate should be focussed on making sure that the opinions of the service user are considered during the discussions. (See also OP17 Advocacy).

Where the service user uses a language other than English or a non-verbal language, an interpreter or translator will be used so that the opinions and wishes of the service can be expressed.

If service users or their families, advocates or carers wish to have copies of Priory policies or procedures, the information should be provided, and they should also be given support to understand the contents if they require it. Copies of policies will be printed from the Intranet to ensure that they are the current version, but if previous versions are required because of the date of the incident, assistance should be sought from the Safety Quality and Compliance Helpdesk - SQCHelpdesk@priorygroup.com. Copies of local procedures that were current at the time of the incident may also be provided on request.

Support For Staff - Staff may need emotional support and advice following a service user safety incident. As soon as possible after an incident a staff debrief should be held and an offer of support and advice given

To support staff involved in service user safety incidents managers will:

(a) Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame.
(b) Ensure that staff understand that apologising to a service user for what happened is not an admission of liability
(c) Provide opportunities for staff to discuss their involvement or the circumstances leading up to a service user safety incident within the working schedule.
(d) Ensure that staff are aware of the Helpline number for staff support
(e) Encourage staff to discuss issues around service user safety incidents at supervision sessions, including any support needs they may have.

Record Keeping - Written records of discussions and meetings should be kept, but not as part of the service user's record.

Records will include:

(a) The time, date and place of any discussions/meetings, including the names and positions of all those present
(b) The exact content of the discussion
(c) The plan for providing further information
(d) Offers of assistance made
(e) Questions raised and answers given
(f) Plans for follow-up meetings
(g) Action points
(h) Copies of any letters sent including any minutes.

The Incident Reporting system will be kept updated at all times.