NHS
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Ambulance Service
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Complaints, Concerns, Compliments and Comments Policy

Document Author: Patient Relations Manager

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Staff Summary

Yorkshire Ambulance Service (YAS) welcomes all feedback about the quality of our services.
YAS will actively promote the channels via which patients and the public can make their views known about the services we provide and will ensure that the process is inclusive and accessible.
YAS approach to handling feedback is outcomes focused and seeks to resolve problems as early and as speedily as possible in the first instance.
All staff, including volunteers and subcontracted service providers, have a part to play in the resolution of problems for patients and members of the public and are empowered to do so.
YAS is committed to learning from compliments, comments, concerns and complaints to improve the quality of its services and to contribute to continuous improvement of patient safety, clinical effectiveness and patient experience. Feedback from patients via the 4Cs is reviewed alongside feedback obtained through other Patient Experience mechanisms.
YAS is committed to recognising and rewarding excellent service provided by staff. Positive feedback from patients and members of the public will be shared with staff.
Complaints and concerns will be handled in a way that is open, fair and proportionate.
Appropriate and proportionate remedies will be made in line with Parliamentary and Health Service Ombudsman Principles.
All complaints, concerns, comments and compliments are recorded on the Datix data management system. The Datix record is an end-to-end record of the issue raised, local investigation, learning, action plan and response.
Staff and managers must contribute openly, honestly and fully with investigations into complaints and concerns. They can be assured that the aim of complaints resolution is not to apportion blame but to determine what happened, with subsequent actions being taken to improve future service delivery.

1.0 Introduction

1.1 Welcoming and listening to feedback from patients, their families and members of the public is an essential part of YAS quality and safety governance policies. The effective management of that feedback is necessary to ensure that patients are confident their feedback is acted upon in a consistent, fair and timely manner, that it leads to positive changes in our service delivery, and that we recognise the effect the quality of our services have had upon them and aim to remedy any hardship we may have caused.

1.2 YAS must comply with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and associated guidance 'Listening, Responding, Improving' issued by the Department of Health in February 2009. YAS must meet the Care Quality Commission registration requirements as specified in Regulation 19. A number of recommendations regarding complaint handling are contained within national reports and reviews and relevant content has been incorporated into the complaint handling processes within the Trust, as necessary. YAS needs to have regard to these recommendations and YAS must also comply with the Principles of the Parliamentary and Health Service Ombudsman (PHSO).

2.0 Purpose/Scope

2.1 The purpose of this document is to:

2.1.1 Set out the principles by which YAS and its subcontractors handles compliments, comments, concerns and complaints;

2.1.2 Define the roles and responsibilities for handling compliments, comments, concerns and complaints within the Trust and across organisational boundaries;

2.1.3 Set out the standards, structure and systems via which serious incidents and risks identified through patient feedback are managed and acted upon;

2.2 This Policy covers compliments, comments, concerns and complaints relating to any aspect of the services provided by Yorkshire Ambulance Service NHS Trust (A&E Operations, Emergency Operations Centre, Patient Transport Service, Integrated Urgent Care, YAS support services, volunteers and Non-Executive Directors). This includes feedback relating to all organisations acting as a subcontractor to Yorkshire Ambulance Service;

2.3 Feedback about staff members which does not relate to their duties for YAS is excluded from this Policy. Feedback from or on behalf of existing staff about the recruitment process is also excluded. These matters are handled by the HR department. This Policy is not intended for use by staff who may have complaints or concerns relating to their employment (further details in section 3.15.7);

2.4 Concerns which YAS wishes to raise about partner organisations are not covered by this Policy. These concerns are to be brought to the attention of the Quality and Safety team who will raise as Quality Alert cases with the relevant organisation.

2.5 This Policy is designed to reduce the risk of repeated failures by ensuring that necessary improvements are appropriately identified and acted upon as a result of feedback by providing a robust governance framework; and to reduce the risk of escalated dissatisfaction through effective, early resolution wherever possible.

2.6 All references to Patient Relations and the Patient Relations Manager throughout the Policy are to be read as IUC Clinical Governance and Quality team and NHS 111 Head of Nursing and Quality Assurance, IUC respectively where the feedback concerned relates to the NHS 111 service. This is with the exception of Appendix B where roles are explicitly laid out. This is also with the exception of sections 3.17, 3.18 and Appendix J in which the role of Patient Relations Manager is a Trust wide role for all services.

3.0 Process

3.1 Accessibility of Process

3.1.1 People are able to give their feedback in a variety of ways. This includes by telephone, email, in writing to our postal address, via the Trust external public website or using a paper feedback form. YAS has a contract for real-time translation services where callers wish to give their feedback in another language. Type-talk is available to people who are deaf or have a hearing impairment. SMS texting is also available. Where face to face British Sign Language (BSL) interpreters or language interpreters for people whose first language is not English are required, attempts will be made to arrange this service through the existing contract arrangement. People may also give their feedback to a member of staff or volunteer face to face who will ensure it is handled in accordance with the person's wishes. If a person wishes to give feedback verbally, they can expect a member of staff to make a written record and to receive a copy of the written record of their feedback should they so wish. All attempts will be made to meet specific communication needs of individuals on a case by case basis.

3.1.2 Information about how to give feedback is made widely available via posters in our vehicles and patient reception centres and on the Trust external public and internal websites. Paper feedback forms are made available on request. This information is presented in clear, plain English and using a layout and format which is accessible to all, including for people with learning disabilities or moderate visual impairment. Large print, audio, Braille and other language versions are also available upon request. Responses to feedback may also be requested in any of these formats or additional formats which are requested if reasonable and essential.

3.1.3 All responses to feedback will be made in plain language and will not contain specialist terminology without clear explanation of its meaning. All communication throughout the 4Cs process has regard to the requirements of the Accessible Information Standard.

3.1.4 Any person wishing to communicate by email regarding their feedback will be alerted to the insecure nature of the internet for personal and confidential information.

3.1.5 YAS is adhering to standards outlined within the Accessible Information Standard. The specific communication needs of all using the 4Cs process are discussed and recorded at first point of contact.

3.2 Compliments

3.2.1 A compliment is the expression of satisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff.

3.2.2 Compliments can be made to any member of staff or volunteer and will be acknowledged by the person receiving them in the format in which they were received (i.e. verbally, by email, etc.) with the exception of compliment letters. All written compliment letters will receive a written response from the Chief Executive arranged by Patient Relations.

3.2.3 Compliments received by members of staff or volunteers in the operational services are to be passed to Patient Relations along with details of the acknowledgement made. Patient Relations will record all compliments on the Datix system in accordance with Appendix H.

3.2.4 Patient Relations will identify the team and individual staff members (if possible) to whom the compliment relates and will provide the Head of Service with the details of the compliment through the Datix system. The Head of Service (or delegate) will provide the individual staff members with a letter of commendation. The Head of Service will complete the Datix record with copies of the letters to staff.

3.3 Comments

3.3.1 A comment is feedback from a patient, their family member or a member of the public giving a view of a general nature of a YAS service, which has not been proactively sought or solicited, and to which they do not require a response, as stated by the individual making the comment. Comments do not relate to specific patient care episodes.

3.3.2 Comments can be made to any member of staff or volunteer and will be acknowledged by the person receiving them in the format in which they were received (i.e. verbally, by email, by letter etc.)

3.3.3 All comments should be considered by the Head of the Service (or delegate) to which they relate. The Head of Service will be responsible for making any service changes deemed appropriate.

3.3.4 All comments graded 3 received centrally by Patient Relations will be recorded on the Datix system, in accordance with Appendix H and passed to the relevant Head of Service for their information and consideration. No feedback to the person making the comment is required in line with their request.

3.3.5 All comments graded 1 or 2 will be allocated to a Patient Relations Coordinator for investigation.

3.4 Patient Advice and Liaison Enquiries

3.4.1 The Patient Relations Team receives other forms of contact from patients, their families and members of the public. These are not always compliments, comments, concerns or complaints. These other types of contact are dealt with immediately if possible and recorded as Patient Advice and Liaison (PALs) enquiries on the Datix system.

3.4.2 These enquiries can be very varied in nature and often include requests for advice and information about YAS services, assistance to locate lost property, etc. There is no set process for handling such enquiries and the Patient Relations Team may be able to handle the enquiry themselves or may need to hand over the enquiry to the service to which it relates.

3.4.3 All members of staff and volunteers who receive similar enquiries are expected to assist the person if they are able to do so or to hand over the enquiry to the relevant service. It is not required that all such enquiries are passed to Patient Relations by members of staff unless the staff member is unable to identify who may be able to help.

3.4.4 The PALs service provided by the Patient Relations team is there to assist patients, their families and members of the public who require advice or assistance. All YAS (or other) services are expected to provide this assistance also, where they are able to, and should only direct people to the Patient Relations team if they are unsure of the appropriate contact.

3.5 Concerns and Complaints

3.5.1 Concerns and complaints are expressions of dissatisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff in the course of their duties.

3.5.2 The Trust values and encourages early resolution which focuses on outcomes and aims to resolve as many complaints and concerns as early as possible. This is also what many people raising concerns and complaints value too.

3.5.3 Where a person specifically states that they wish the matter to be dealt with as a formal complaint at the outset, or where the complaint or concern raises issues for the Trust which are significant and are likely to present moderate to high risks for the organisation, this must be dealt with as a complaint in accordance with the procedure detailed in Appendix C. Any member of staff (including community engagement officers) or a volunteer receiving such a complaint or concern must pass this to Patient Relations for them to progress formally, or in the case of a NHS 111 complaint or concern, to the IUC Clinical Governance and Quality Team. This can be done via telephone or email.

3.5.4 For all other complaints and concerns, these may be made to any member of staff or volunteer. A staff member receiving a complaint or concern from a patient, their family member or a member of the public, should attempt to resolve the matter to the person's satisfaction by establishing what outcome the person is seeking which will resolve the matter for them and aim to deliver this if they are able to do so. This may be offering an appropriate apology and reassurance that the matter will be addressed or brought to the attention of the relevant manager.

3.5.5 Should the person raising the concern or complaint remain dissatisfied following attempts to resolve the matter by the staff member, or should the staff member not feel they are able to deliver the solution being sought, the staff member should advise the complainant they will pass the matter to a manager or team leader.

3.5.6 If the manager or team leader is unable to resolve the matter, details of the concern or complaint should be taken down and passed to Patient Relations by email or form and the complainant advised that they will receive contact from a Patient Relations Coordinator. Concerns which are resolved prior to passing to Patient Relations are not recorded on the 4Cs module of Datix.

3.5.7 Patient Relations will grade all concerns and complaints received in accordance with the risk grading criteria detailed in Appendix D. Where a person specifically states that they wish the matter to be dealt with as a formal complaint at the outset, and all concerns and complaints graded 2 or 1 will be progressed in accordance with the formal procedure detailed in Appendix C.

3.5.8 All complaints and concerns graded 3 will be resolved wherever possible by Patient Relations Coordinators by establishing what outcomes the complainant is seeking through personal contact with the complainant and agreeing a level of investigation and a timescale which is proportionate to the issues being raised. Attempts to resolve the matter as speedily as possible will be focused on delivering the outcomes being sought if appropriate. Should the matter be resolved in this way, the case will be recorded as a concern on the Datix system, in accordance with Appendix H. Issues raised where the individual does not require feedback at all are dealt with as concerns where the matter relates to a negative experience of a patient care episode.

3.5.9 The Coordinator may determine through contact with the complainant that the matter requires to be formally progressed. In such instances the case will be recorded as a complaint and progressed in accordance with the procedure detailed in Appendix C.

3.6 Timescales

3.6.1 The Coordinator will aim to make initial contact with the person raising the concern or complaint within 3 working days of receipt to enable an early decision whether the case needs to be progressed formally.

3.6.2 All complaints must be acknowledged in writing, giving a named contact (of the Coordinator) within 3 working days of receipt.

3.6.1 Individual timescales for resolution of concerns should be agreed with the person raising the concern on a case by case basis. The expectation is that most concerns should be resolved within 10 working days but may take up to 25 working days.

3.6.2 Individual timescales for resolution of complaints progressed formally should be agreed with the complainant on a case by case basis. The expectation is that most complaints should be resolved within 25 working days but may take up to 90 working days for those complaints graded 1. Actions to implement learning from complaints should be taken in a timely manner as they are identified, pending completion of the full investigation.

3.7 Consent for third party concerns and complaints

3.7.1 The principle adopted by this Policy is to work in accordance with the requirements of the Data Protection regulations and the Caldicott principles. Where it is possible to obtain consent from the person to whose care the complaint or concern relates, then this will be obtained. However, this Policy aims to enable dissatisfaction to be resolved and service issues to be identified and rectified, and therefore a pragmatic approach will be taken where obtaining consent is not possible or practical. This is expanded upon in the following paragraphs. Utmost care will be taken not to divulge unnecessary personal information in responding to concerns and complaints in these circumstances.

3.7.2 Complaints and concerns may be raised by a person acting on behalf of the patient who has received the services being complained about. In such cases, consent of the patient will be sought.

3.7.3 If consent is not received, the matters raised will still be investigated and any learning identified will be acted upon but only a general response (not discussing the specific circumstances of the individual case) will be made to the person raising the complaint or concern, where this is possible.

3.7.4 Where the patient is deceased, the consent of the 'nearest relative' will be sought. Where a complaint or a concern is progressed with the consent of the 'nearest relative', care will be taken to include only that information which is necessary to answer the issues raised. The 'nearest relative' will often but not always be the patient's next of kin. Care will be taken to ensure that the person identified as the 'nearest relative' is the most appropriate person to act on the patient's behalf.

3.7.5 Where the patient lacks capacity, the consent of the person who has 'Health and Welfare lasting power of attorney' will be sought.

3.7.6 Where the patient is a child or young person under the age of 16, required consent will be decided on a case by case basis which may result in the consent of the young person, or, a person who has 'parental responsibility' for the child or young person, being sought.

3.7.7 This process is detailed in Appendix C.

3.8 Anonymous Concerns and Complaints

3.8.1 Concerns and complaints which are raised anonymously will be recorded and investigated to the extent which is possible given the information supplied. Any service issues identified from the investigation will be acted upon and a record made of action taken.

3.9 Concerns raised by Healthcare Professionals

3.9.1 Patient consent is not routinely sought for concerns raised by healthcare professionals. Concerns raised will be investigated and any identified learning implemented. Responses made will take care not to disclose patient confidential information inappropriately.

3.9.2 Concerns which YAS staff or volunteers may have regarding non-YAS healthcare professionals are to be brought to the attention of the Quality and Safety team who will raise as quality alerts with the relevant NHS organisation. Such concerns fall outside of this Policy and the remit of the Patient Relations team.

3.10 Concerns and complaints raised by MPs and Elected Members of Local Authorities

3.10.1 Where a complaint or concern is raised by an MP and relates to services provided to an individual, the MP's statement that they are acting for their constituent will satisfy the requirement for consent where the person is also the patient to whom the concern or complaint relates. Where this is not the case, consent will be sought as outlined in section 3.7.above. This is in line with the Information Commissioner's Office guidance 'Data Protection Technical Guidance Note Disclosures to Members of Parliament carrying out constituency casework'.

3.10.2 Where a complaint or concern is raised by a Local Authority Member, explicit consent must be obtained from the patient (even if the patient is the person who has approached the member) before any personal sensitive information may be provided in the response.

3.10.3 Where the matter raised is not a concern or complaint about a service provided to a specific individual, the correspondence will not be progressed in line with this Policy and will be handled by the Corporate Communications Team.

3.10.4 All responses to MPs will be approved and signed by the Chief Executive.

3.10.5 The Trust will comply with the Information Commissioner's Office guidance 'Data Protection Technical Guidance Note Disclosures to Members of Parliament carrying out constituency casework'.

3.11 Concerns and complaints regarding multiple services provided by YAS

3.11.1 Where a concern or complaint is received which contains matters for more than one YAS service (for example, elements of the complaint may be for NHS 111 and elements for A&E services), a lead service will be identified based upon which service the bulk of the complaint relates to. This applies equally where one of the services has been provided by a YAS subcontractor.

3.11.2 A Coordinator will be allocated from each service, who will investigate and provide a draft response to the issues raised for their service. These will be provided to the lead Coordinator who will coordinate and provide a single response. The lead Coordinator will be responsible for all contact and liaison with the complainant, and for maintaining the complaint or concern record.

3.11.3 Once the lead service is allocated, this will remain the lead service throughout the process. The lead service will be responsible for signing-off the whole response in accordance with Appendix F.

3.11.4 For complex multi-service complaints, the end to end review process may be used to aid resolution and identification of improvements to how the services work together.

3.11.4 Any disputes regarding identifying the lead service will be decided by the Patient Relations Manager and the NHS 111 Head of Nursing and Quality Assurance, IUC.

3.12 Concerns and complaints regarding multiple organisations

3.12.1 All NHS and Local Authority Social Care Services are required to work together to provide a single response to complaints made about their services where the complainant has raised issues relating to multiple organisations in their complaint.

3.12.2 There are a number of Joint Complaint Protocols which have been agreed in the geographical area covered by YAS. Where these exist, YAS is committed to working in accordance with the protocols and will always seek to provide a single response jointly with health and social care partners in such circumstances.

3.12.3 Where protocols do not exist, YAS will work in line with the principles of joint working when approached by another organisation who has received a complaint or concern which partly relates to YAS services.

3.12.4 Where YAS is the organisation receiving the complaint, consent will be obtained from the complainant to share the complaint with other relevant organisations and contact will be made with the other organisations to agree a joint approach to resolving the complaint.

3.12.5 Staff who are approached by staff of other health or social care organisations for input to concerns and complaints should immediately refer the enquirer to YAS Patient Relations (within 24 hours) to enable appropriate joint working.

3.12.6 All written responses to complaints which another health or social care organisation is leading on must be approved and signed off in accordance with the sign-off process detailed in Appendix F. This applies to the overall response letter as well as the YAS contribution. Where YAS is the lead organisation, contributions from other organisations will be obtained in line with those organisations' sign-off protocols and YAS will sign off the overall response having shared this with those other organisations in advance.

3.12.7 YAS is committed to improving joint complaint handling for its patients. YAS strives to achieve single coordinated resolution for complainants and to actively encourage more effective links and relationships to aid improved joint complaint handling in the future.

3.13 Withdrawals

3.13.1 A person who has raised a concern or a complaint may choose to withdraw their concern or complaint at any point in the investigation up to receiving a response.

3.13.2 YAS will continue to investigate the matter and to make a record of findings and action taken. A clear record will be made of the complainant's wish to withdraw the complaint, along with evidence to support this, and no response will be made to the complainant.

3.14 Concerns and complaints about contractors

3.14.1 Concerns and complaints received about services provided by other organisations on behalf of YAS will be progressed in line with this Policy.

3.14.2 The expectation to comply with all YAS policies is included in all contracts and copies of all policies are made available to our contractors.

3.14.3 Contractors are required to contribute openly, honestly and fully with YAS investigations and to participate in any meetings with complainants as required by YAS.

3.15 Patient requests to meet with staff

3.15.1 Occasionally patients or their family members or friends ask if they can meet with members of staff who have been involved in delivering the service to them. This is usually with a view to personally pass on their gratitude for the service they delivered to the patient. This can also be for the purpose of helping the patient or their family emotionally.

3.15.2 When such requests are received, the Patient Relations team will review these on a case by case basis, and will pass all potential patient stories or publicity opportunities to the Quality Improvement Team or the Corporate Communications team to be progressed as appropriate. All other requests will be passed to the relevant service managers to progress at their discretion.

3.15.3 Where it is agreed that the meeting will go ahead, this will be arranged during staff shift time with the expectation that staff will be stood down to enable this.

3.16 Links with other procedures

3.16.1 Serious incidents

3.16.1.1 The process by which a complaint is declared a serious incident (SI) is detailed in Appendix C. When the issues raised by a complaint are declared a serious incident, the serious incident investigation process will be instigated and will determine the timescale in which a complaint response can be made. This is normally in excess of the time taken to respond to complaints and aligns to national serious incident standards (2015), currently 60 working days from time of reporting to the strategic executive information system (StEIS).

3.16.1.2 To align with the Trust Quality and Safety team process, Patient Relations will offer the complainant a meeting with the allocated Patient Relations Coordinator and the SI investigating officer at the beginning of the investigation. The purpose of this meeting is to give the complainant the opportunity to explain the issues which are important to them and to give the investigating officer the opportunity to clarify any detail.

3.16.1.3 The investigating officer will ensure the complainant's points are specifically addressed by their investigation.

3.16.1.4 Patient Relations will keep the complainant informed of progress.

3.16.1.5 On conclusion of the investigation, Patient Relations will offer the complainant a meeting to deliver the findings. This will be followed by a formal written complaint response. A copy of the SI report will be offered to the complainant.

3.16.1.6 NB - During 2019, NHS England published new guidance for NHS Providers of care highlighting upcoming amendment to management of serious incidents and investigations involving patient harm. Organisations including London Ambulance Service NHS Trust have been trialling this new guidance (Patient Safety Incident Response Framework – PSIRF) with a view to highlighting learning for cascade nationally, and the final version is expected to be introduced in a tiered way from April 2022. From April onwards and based on national implementation targets, the Trust expects to realign policies to match new ways of working.

3.16.2 Complaints/Concerns involving the death of a patient

3.16.2.1 Where a concern or complaint is made regarding a service provided and the patient has died, a meeting will be offered to the appropriate representative(s) of the family. A clinical review of the case will also be carried out.

3.16.2.2 In line with national guidance, persons raising complaints or concerns involving the death of a patient will be provided with the appropriate support and guidance where required. This may include signposting to bereavement support services and advice on actions required following a death.

3.16.3 Clinical case reviews

3.16.3.1 Where a complaint raises issues of a clinical matter, it may be necessary to explore the issues and identify any opportunities for learning through the Clinical Case Review Policy.

3.16.3.2 Where this is the case, the Coordinator responsible for the complaint will continue to investigate any other matters raised and will receive a copy of the CCR notes to inform those aspects of the complaint response.

3.16.3.3 CCRs will generally extend the timescale taken for the complaint response. The Coordinator responsible for the complaint will advise the complainant of the process being followed, the reasons for this and the estimated response timescale.

3.16.4 Being open

3.16.4.1 This Policy is in line with the Trust's Policy on Being Open and the Duty of Candour. All complaints and concerns are investigated and responded to in an open, honest and transparent way.

3.16.4.2 Separate contact will not be initiated under the Being Open Policy for any incidents which are also complaints as open communication with the patient and/or their representative will be handled via this Policy.

3.16.4.3 The process for supporting complainants including providing information during the course of investigation, where Duty of Candour would apply had the complaint not been made, should be handled in line with Duty of Candour processes for disclosure. This would involve making information available to complainants without the need for additional requests via the Subject Access Request (SAR) process.

3.16.5 Patient experience surveys

3.16.5.1 Patients and their families can let us know about their experience of our services without having to raise a concern or complaint if this is what they choose to do. The Trust carries out regular patient surveys and proactively seeks their views.

3.16.5.2 Through this process a patient or a family member may wish to raise a compliment, concern or a complaint. All patient survey material gives patients the option of raising a compliment, concern or complaint instead or as well as responding to the survey and contains fully accessible details of how to do so.

3.16.5.3 The Policy on Obtaining Service-User Experience Feedback requires that any member of staff wishing to engage with patients to seek their views, registers their initiative with the Quality Improvement Team. The Quality Improvement Team will ensure staff are advised to make patients with whom they are engaging aware of how to raise a compliment, concern or complaint.

3.16.6 F reedom of Information and Environmental Information Regulations

3.16.6.1 People raising complaints and concerns may request general information on how the Trust operates, or request copies of policies, in addition to the more specific points of concern which relate personally to the service they have received.

3.16.6.2 In such cases, the Coordinator handling the concern or complaint will seek to provide the requested information. If the request is substantial and will take significant processing time, the complainant will be advised that the matter has been forwarded to the Legal Services Department to be processed in line with the Freedom of Information process.

3.16.6.3 Complaints and concerns raised about the way in which a Freedom of Information (FOI) request has been handled will be dealt with in accordance with this Policy but the complainant will be signposted to pursue the matter with the Information Commissioner should they remain dissatisfied, not the Parliamentary and Health Service Ombudsman, in accordance with the Freedom of Information and Environmental Information Regulations. A complaint dealt with in this way will always be processed in accordance with the timescales laid down in the Trust's Freedom of Information Policy (i.e. 20 to 40 working days).

3.16.7 Subject access requests

3.16.7.1 People raising complaints and concerns may request copies of personal information in connection with the specific points of concern about the service they have received.

3.16.7.2 In such cases, the Coordinator handling the concern or complaint will send the request to the Legal Services Department to be processed and the complainant will be advised that their request has been passed to the Legal Services Department who will contact them directly to progress their request, in line with the timescales laid down in the Trust's Data Protection Policy. In some cases the Patient Relations Coordinator may remain the point of contact for the complainant and where possible the information will be sent along with the complaint response.

3.16.7.3 Complaints and concerns raised about the way in which a subject access request has been handled will be dealt with in accordance with this Policy but the complainant will be signposted to pursue the matter with the Information Commissioner should they remain dissatisfied, not the Parliamentary and Health Service Ombudsman, in accordance with Data Protection regulations.

3.16.8 Human resource procedures

3.16.8.1 Any complaints or concerns raised regarding members of YAS staff in relation to matters not connected with their duties on behalf of YAS will be forwarded to Human Resources, within 3 working days, for handling in line with HR procedures. The person raising the concern or complaint will be advised of this and also that

they will not receive further detail of the outcome regarding the individual member of staff.

3.16.8.2 Any complaints received, the subject of which results in a disciplinary fact find investigation being commenced, will be managed in line with the Standard Operating Procedure “Managing a safety investigation alongside a HR investigation”.

3.16.8.3 Complaints or concerns raised by or on behalf of existing staff in relation to YAS recruitment will not be dealt with by this Policy and will be handled by Human Resources.

3.16.8.4 Complaints or concerns raised by YAS members of staff in connection with their employment will not be dealt with by this Policy and are to be handled in line with the Trust’s ‘Issue Resolution (Grievance) Policy’.

3.16.8.5 Staff concerns about the practice of others in YAS will not be dealt with by this Policy. Dependent upon the nature of those concerns, they may be raised via the Incident Procedure or the ‘Freedom to Speak Up Policy’.

3.16.9 Criminal matters

3.16.9.1 Any concern or complaint which raises issues of a criminal matter will be escalated to the Executive Director of Quality, Governance and Performance Assurance and will be discussed with the Local Security Management Specialist and the Legal Services Department if necessary. This may lead to the Trust involving the Police or advising the complainant to report the matter directly to the Police.

3.16.10 Safeguarding adults and children

3.16.10.1 Any concern or complaint which raises safeguarding concerns will be reported immediately to the safeguarding team in accordance with the Trust’s ‘Safeguarding Policy (Children, Young People and Adults at Risk)’

3.16.10.2 Where it is identified that an investigation into the matters raised in a concern or complaint has already taken place through the safeguarding procedures, the documentation gathered for that process will be utilised as far as possible to enable the resolution of the concern or complaint.

3.16.11 Claims

3.16.11.1 Any concern or complaint which seeks financial remedy will be handled in accordance with this Policy and consideration will be given to the remedy being sought in line with the Trust’s Redress and Remedy in Complaint Resolution Policy.

3.16.11.2 If the outcome is that the matter cannot be remedied by the Policy for Redress and Remedy in Complaint Resolution and is more appropriate for consideration as a claim against the Trust, the complaint will be responded to and the complainant will be advised of the limitations of this Policy to consider the remedy they are seeking and how to pursue the matter as a claim.

3.16.11.3 All contact from patients, their families and members of the public who do not wish to pursue a concern or complaint but clearly state they wish to make a claim against the Trust only will lead to the complainant or their representative being signposted to the Legal Services Department to be processed in line with the Trust's Claims Management Policy.

3.16.12 Support to staff

3.16.12.1 The Trust's approach to concerns and complaints is that the Trust is responsible for the issues raised.

3.16.12.2 The Trust recognises, however, that some concerns and complaints raised are focused on the actions of individual staff members or volunteers and can feel very personal for those staff involved. In those cases, the Trust aims to support its staff and volunteers through those experiences and staff and volunteer involvement in complaint investigations is carried out in line with the Trust's 'Supporting Staff Involved in an Incident, Complaint or Claim Policy'.

3.16.12.3 The Trust also recognises that some concerns and complaints which relate to the actions of individual members of staff are upheld and action needs to be taken to improve practice and service delivery. This is often supportive and does not lead to the instigation of formal HR procedures. Positive action taken will be shared with complainants.

3.16.12.4 Occasionally, however, more serious issues are found from investigation of complaint and concerns, and formal HR procedures need to be invoked. In such instances, complainants do not have the right to this level of information and will be advised of this accordingly. This is managed in line with the NHS Improvement 'Just Culture' guide.

3.16.13 Concerns and complaints involving the media/social media

3.16.13.1 Where a complainant advises the Trust that they intend to contact the media in respect of their issues, the Corporate Communications team will be informed and will handle any enquiries from the media in connection with the matter.

3.16.13.2 The concern or complaint will continue to be progressed in line with this Policy.

3.16.13.3 Any postings on social media which meet the definition of a concern or complaint about YAS will be directed through the Complaints Procedure and will not be dealt with through the social media channels.

3.16.14 Learning from concerns and complaints

3.16.14.1 Themes and trends from cases received are analysed monthly and quarterly and are fed into the Trust's Learning Group.

3.17 Externally independent investigations

3.17.1 The Trust recognises the need to have arrangements in place for a complaint to be investigated independently or for some level of independent scrutiny in order to enable resolution to be achieved, and is therefore committed to working in accordance with the National Patient Experience Group (NASPEG) Protocol at Appendix I.

3.17.2 This is likely to be utilised very infrequently and would usually be where a complainant's relationship with the organisation has broken down considerably and to the extent where any internal consideration is unlikely to be accepted by the complainant.

3.18 Complaints to the Parliamentary and Health Service Ombudsman

3.18.1 Complainants have the right to approach the Parliamentary and Health Service Ombudsman (PHSO) with their complaint at any time throughout the process. The powers and the duties of the PHSO are laid down in the Health Service Commissioners Act 1993.

3.18.2 The PHSO will normally wish to satisfy themselves that the organisation which is the subject of the complaint has been given sufficient opportunity to respond to the complaint first before they accept a complaint for investigation.

3.18.3 The PHSO may decide to investigate a complaint before the organisation feels it has exhausted all opportunities to resolve the matter. The PHSO has discretion to do so, but will normally liaise with the organisation and the complainant to agree a way forward if they feel that is likely to result in a resolution.

3.18.4 The Trust is keen to ensure that all contact with the PHSO is consistent and in line with its standards of governance. The role of Ombudsman Liaison for the Trust will be the responsibility of the YAS Patient Relations Manager with cover provided by a designated Patient Relations Coordinator as required.

3.18.5 All enquiries or notification of intention to investigate from the PHSO must be referred to the Patient Relations Manager. The Patient Relations Manager (or designated Patient Relations Coordinator) will compile all formal responses to the PHSO. In cases which concern complaints about the NHS 111 service, this will be done in consultation with the NHS 111 Head of Nursing and Quality Assurance, IUC.

3.18.6 All formal responses to the PHSO enquiries and investigations will be approved by the Executive Director of Quality, Governance and Performance Assurance and signed by the Chief Executive.

3.18.7 Any member of staff or contractor receiving any contact from an officer of the PHSO must ensure the YAS Patient Relations Manager is informed or previously aware.

3.18.8 The PHSO may wish to have direct contact with any staff member or contractor involved in a complaint which is being investigated by them. This should not occur without the Patient Relations Manager (or designated Patient Relations Coordinator) being aware of the purpose of this and facilitating the direct contact.

3.18.9 The YAS Patient Relations Manager will ensure relevant operational management are consulted on any draft recommendations made by the PHSO prior to YAS accepting the draft report.

3.19 Unreasonable complainant behaviour

3.19.1 A minority of complainants can display unreasonable behaviour or be unreasonably persistent in pursuing their complaints. In order to ensure that these complainants do not take up a disproportionate amount of resource but still receive fair and appropriate consideration of the issues they raise, the Trust has arrangements in place for the

management of such behaviour in a way which is transparent, fair and consistently applied. This is detailed in Appendix J.

3.19.2 The incoming telephone line to the Patient Relations team requests that callers treat our staff with respect and warns that failure to do so may result in the call being terminated. Patient Relations staff are empowered to make the decision when they feel they are being treated disrespectfully by a caller and will advise the caller how they feel and give the caller an opportunity to adjust their behaviour. Should the behaviour persist, the call handler may advise the caller they are terminating the call. All calls that are terminated for this purpose will be downloaded and passed to the Patient Relations Manager for review and a decision to be made regarding any follow up actions.

4.0 Training expectations for staff

4.1 Staff in the Patient Relations team must be fully aware of all aspects of this Policy. They should be able to advise other colleagues on any aspect of the Policy as well as following the correct procedure for each case received. The Patient Relations team staff are trained in professional complaint handling and investigation.

4.2 All YAS staff must be aware of the expectations of them in the early resolution of concerns which are brought to their attention in the normal course of their duties. All YAS staff must be aware of the role of the YAS Patient Relations team. Information about this Policy is given at Corporate Induction, included in the YAS staff handbook and included in the YAS Statutory and Mandatory Training Workbook.

4.3 Skills Training for all YAS staff in patient facing roles will be provided in relation to handling and resolving dissatisfaction.

4.4 Managers acting as local investigators, Heads of Service, Area Managers and Team Leaders responsible for overseeing complaint resolution and reviewing themes and trends will receive support on using the 4Cs Datix system. This will build on the basic Datix training received from the Quality & Safety Team. This will be provided on a one-to-one basis or via team meetings by members of the Patient Relations team. A module on 4Cs investigations is also accessible as part of the Investigation Skills Training Day on the Management Essentials programme.

4.5 Further support and resources will also be available via the YAS internal website.

5.0 Implementation plan

5.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction. The Trust's contractors are required to ensure their staff are adequately informed and supported.

5.2 All individuals who have a direct role in the handling or approval of compliments, comments, concerns and complaints will receive individual briefing in respect of their role and offered support and advice on an ongoing basis from the Patient Relations team.

6.0 Monitoring compliance with this Policy

6.1 The key performance indicators for compliments, comments, concerns and complaints are included in the monthly Board Integrated Performance Report.

6.2 KPI reports by Service level, Business Unit level and by Clinical Commissioning Group are provided for the reporting of compliments, comments, concerns and complaints to Service Area meetings and to Commissioners.

6.3 Quality of case handling is monitored through case file audit. A monthly sample of cases is selected for end-to-end review against the requirements of this Policy. Any points of non-compliance will be raised with the individuals involved and their manager.

6.4 A weekly report of cases which are exceeding timescales due to lack of timely operational information or sign-off will be made to the Associate Director of Quality and Safety for escalation to Operational Executive Management.

6.5 An annual report of activity, as required by the Complaints Regulations, will be made within the Trust's Quality Accounts.

6.6 Additional methods of reporting on trends and service improvements to the public will be continually developed and expanded.

6.7 YAS is committed to the development of additional methods of engaging its patients and their families to ensure a fully patient centred approach in its handling of feedback.

7.0 References

Legislation

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 *www.legislation.gov.uk*

Health Service Commissioners Act 1993 *www.legislation.gov.uk*

Data Protection Act 2018 *www.legislation.gov.uk*

Guidance

'*Listening, Responding, Improving' issued by the Department of Health in February 2009* *www.dh.gov.uk*

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013 *www.gov.uk*

A Review of the NHS Hospitals Complaints System 'Putting Patients Back in the Picture' Right Honourable Ann Clwyd MP and Professor Tricia Hart *www.gov.uk*

Parliamentary and Health Service Ombudsman – Principles for Remedy, Principles for Good Complaint Handling, Principles of Good Administration *www.ombudsman.org.uk*

Caldicott Principles *www.dh.gov.uk*

Data Protection Technical Guidance Note Disclosures to Members of Parliament carrying out constituency casework – based on Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order 2002 S.I. 2002 No. 2905 *http://ico.org.uk/for_organisations/sector_guides/~/media/documents/library/Data_Protection/De*

tailed_specialist_guides/DISCLOSURES%20TO%20MPS_CARRYING_OUT_CONSTITUENCY_CASEWORK_WEB_MAY_07.ashx

CQC Regulation 20 Regulation 20: Duty of candour | Care Quality Commission (cqc.org.uk)
The duty of candour: guidance for providers (cqc.org.uk)

NHS-Resolution-Saying-Sorry.pdf 2018 version

8.0 Appendices

8.1 Appendix A - Definitions

1. **Complaint**: an expression of dissatisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff in the course of their duties to which a response is required; and where a person specifically states that they wish the matter to be dealt with as a formal complaint at the outset, or where the complaint or concern raises issues for the Trust which are significant and are likely to present moderate to high risks for the organisation.

2. **Concern**: an expression of dissatisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff in the course of their duties to which a response is required; and where attempts to resolve the matter as speedily as possible, focused on delivering the outcomes being sought are successful. Issues raised where the individual does not require feedback at all are dealt with as concerns where the matter relates to a negative experience of a patient care episode.

3. **Comment**: feedback from a patient, their family member or a member of the public giving a view of a general nature of a YAS service, which has not been proactively sought or solicited, and to which they do not require a response, as stated by the individual making the comment. Comments do not relate to specific patient care episodes.

4. **Compliment**: an expression of satisfaction made by a patient, their family member or a member of the public regarding a YAS service or the specific behaviour of a member of YAS staff.

5. **Patient Advice and Liaison Enquiry**: a request for advice and information about YAS services made by a member of the public to the Patient Relations team.

6. **Complaint Agreement**: an agreement made between the Coordinator (allocated to a complaint) and the complainant to verbally discuss the complaint, agree the points of the complaint, the outcome being sought, the timescale they aim to achieve and the frequency and mode of progress updates.

7. **Investigation Plan**: a documented plan of the investigation of a complaint which clearly specifies the information required to address the issues raised in the complaint to arrive at a conclusion.

8. **Serious Incident**: an incident that occurred during NHS funded healthcare which resulted in one or more of the following;
   - unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
   - a never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
   - a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
   - allegations, or incidents, of physical abuse and sexual assault or abuse; and/or

- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

9. **Advocate:** a person acting on behalf of a patient or their family member, carer or friend, to assist and support them in the process of raising a concern or a complaint. Advocacy Services for complaints against the NHS are funded by Local Authorities and are available in all geographical areas covered by YAS services.

10. **Consent:** permission from a patient. This may be permission for another person to act on their behalf in raising a concern or a complaint and for their personal information to be disclosed in the response to that concern or complaint. A patient may also be asked to give their permission for their medical records to be shared between NHS and Social Care organisation to enable their complaint to be considered.

11. **Nearest Relative:** a family member with close relationship to the patient regarding day to day health and care needs. This individual will be asked to confirm they consider themselves to be the nearest relative. The nearest relative is not necessarily the next of kin.

Appendix B - Roles & Responsibilities

Trust Board

The Trust Board has responsibility for assuring itself that an appropriate system is in place for managing complaints and that monitoring of themes and trends and learning of lessons is embedded in the Trust's governance systems. The Board will seek assurance via the Audit Committee and Quality Committee that these systems are functioning effectively and that YAS complies with the 2009 Complaints Regulations. The Quality Committee will, on behalf of the Board, receive the Complaints Annual Report.

The designated Board Member responsible for managing concerns and complaints is the Executive Director of Quality, Governance and Performance Assurance.

Trust Executive Group

The Trust Executive Group, led by the Chief Executive, has responsibility for disseminating this Policy to the Trust Management Group, Heads of Service and other Trust leads.

Executive Director of Quality, Governance and Performance Assurance

Responsible for ensuring that the duties within this Policy are carried out effectively in practice.

Ensuring that the management of complaints and concerns is an integrated part of the Trust Quality Strategy and that information from complaints and concerns is brought together with other information sources to identify common issues.

Ensuring that themes and trends are monitored and that, where necessary, risks are escalated and improvement plans are developed and implemented.

Receives notification of all complaints where Clinical Commissioning Groups, Care Quality Commission or Department of Health are involved.

Has a specific case management role in:

- Approving all complaint responses to be signed by the Chief Executive;
- Approving all financial remedies;
- Overseeing decisions regarding criminal matters raised through complaints;
- Decision-making on unreasonable complainant behaviour restrictions;
- Signing all Complaint review responses

Executive Directors

Have specific case management roles in relation to cases regarding the services for which they are responsible in relation to decision-making on unreasonable complainant behaviour restrictions and specialist advice/approval as required.

Ensure that cover arrangements are in place for periods of unavailability.

Chief Executive

Has a specific case management role in:

- Approval and sign-off of grade 1 complaints;

- Approval and sign-off of all complaint responses to MPs;
- Sign all formal responses to PHSO;
- Sign all letters to those making compliments;
- Consider appeals against unreasonable complainant behaviour restrictions.

Incident Review Group (IRG)

Is responsible for reviewing individual incidents, complaints and concerns from a multi-disciplinary perspective to ensure that all patient safety issues are identified and that an appropriate action plan for resolution and organisational learning is put in place.

Receives reports of themes and trends and identifies common issues across departmental boundaries.

Associate Director of Quality and Safety

Receives notification of all complaints where Clinical Commissioning Groups, Care Quality Commission or Department of Health are involved.

Responsible for the effective delivery of the Policy and provision of performance reporting through the Patient Relations Manager.

Provides cover for the role of Executive Director of Quality, Governance and Performance Assurance in connection with this policy.

Receives a weekly report of cases exceeding timescales due to lack of timely operational information or sign-off. Escalates with Operational Executive Management.

Ensures that this Policy is delivered effectively at an operational level.

Is the first escalation point for any risks to delivery of this Policy or matters of concern to the Patient Relations Department.

Provides performance reports to the Board.

NHS 111 Head of Nursing and Quality Assurance, IUC

Ensures that complaints, concerns and healthcare professional feedback relating to NHS 111 are investigated and resolved in line with Trust procedure.

Line manages the IUC Clinical Governance and Quality Coordinators who will coordinate investigations and produce draft responses for sign off, working in collaboration with the Call Centre Manager, Duty Managers, Associate Medical Director, Clinical/Non-clinical Team Leaders and Practice Developers.

Works with the Patient Relations Manager to share lessons learned and contribute to corporate reporting.

Signs off response letters relating to grade 2 and 3 YAS NHS 111 complaints, concerns and healthcare professional feedback.

Reports grade 1 and 2 cases to the Incident Review Group.

Submit reports to the Regional NHS 111 Risk and Clinical Quality Group.

Along with the Patient Relations Manager, agrees lead Coordinator for multi-service complaints.

Carries out the role of the Patient Relations Manager for feedback about NHS 111 as detailed in sections 9.4 and 9.5.

Patient Relations Manager

Advises on and manages unreasonable complainant behaviour arrangements.

Provides the Ombudsman Liaison role for the Trust

Manages the quality assurance process of the complaints/concerns handling process and agrees and oversees improvement measures where necessary.

Triangulates information on complaints and concerns with other sources of patient experience information within the Trust and reports this effectively to local teams and at a Trust-wide level to support risk management, performance management and service improvement.

Is responsible for leading the Patient Relations Department. The Department's responsibilities are:

Acting as a single point of contact for the patient in relation to the handling of their complaint or concern

Acknowledging complaints and concerns

Risk-rating each complaint and concern in line with the Trust's complaints risk matrix

Passing all the information regarding the complaint to the appropriate local/departmental Head of Service in line with agreed service area procedures and overseeing the investigation process to meet target timescales

Documenting all information relating to the complaint or concern in line with this Policy and other Trust procedures

Presenting all grade 1 and 2 cases to the Trust Incident Review Group

Liaising with the relevant Head of Service to ensure that a high quality, timely investigation is completed and that the final response letter is signed off

Responding to the complainant

Keeping records of numbers and types of complaints and concerns and the time taken to resolve each one to enable reporting into local and Trust-level dashboards.

Keeping records of resolution plans/service improvement plans relating to issues arising from complaints and concerns so these can be audited for completion.

Identifying lessons learned from complaints and concerns and ensuring these are reported appropriately

Providing management reports on complaints and concerns

Producing the Complaints Annual Report and the annual submission of data as required by NHS England.

Representing YAS on all national and regional patient experience and feedback networks.

The Patient Relations Manager also has specific case management roles in:

- Along with the NHS 111 Head of Nursing and Quality Assurance, IUC, agreeing lead Coordinator for multi-service complaints;
- Carrying out reviews of complaints as required.

Trust Management Group (Operational)

Ensures the effective delivery of this Policy within their operational services.

Ensures that lessons learned from complaints are used effectively to improve services and service delivery.

Ensures the early resolution of concerns and effective handling of dissatisfaction by all front line staff and managers within their respective service areas.

YAS Heads of Service

Promote a culture of early resolution of concerns raised within their service areas, amongst thei staff members and managers.

Agree a standard process for their service area for receiving notification of complaints and concerns from the Patient Relations Department and allocating local investigators.

Receive details of complaints and concerns relating to their business units and ensuring that each one has an allocated local investigator to work with the Patient Relations Department on investigation and resolution.

Ensure managers in their operational areas contributing to investigations have the necessary skills and training to complete this work effectively.

Ensure that the local investigators complete agreed actions and provide the necessary information for complaint/concern resolution back to the Patient Relations Department within the required timescale and to the required standard.

Receive reports about complaints and concerns relevant to their business units and monitoring themes and trends as part of their ongoing performance and quality management systems.

Where actions are required to resolve a complaint or concern and/or improve services for the future, ensure that these actions are delivered and that this is appropriately documented.

Promote a culture of learning throughout their business units and helping staff see complaints as an opportunity for improvement rather than an exercise in apportioning blame.

Consider patient comments regarding their service as forwarded from Patient Relations.

Agree conclusions and learning actions from complaints.

Implement learning actions agreed as a result of complaints and concerns.

Approve and sign-off responses to grade 2 and 3 complaints, including provision of cover during periods of unavailability.

Area Operation Managers/Team Leaders

Promote a culture of early resolution of concerns raised within their service areas, amongst their staff members.

Foster a culture of openness in their teams and reassuring staff that YAS operates an open culture where the emphasis is on learning and development and not on apportioning blame.

Attend training in investigation skills to ensure that they can contribute to effective investigations into complaints and concerns.

Work with the Patient Relations Department to investigate and resolve complaints in a timely manner and to the required standard.

Support their Head of Service to review and learn from themes and trends arising from complaints and concerns and develop service improvement plans.

Support staff involved in investigations into complaints and concerns; respond to questions and concerns and provide feedback about the outcomes of the investigation.

Review all staff statements provided for investigations and ensure these adequately cover the information requested. Reach a conclusion and effectively record this conclusion regarding the staff actions as reported in the statements.

Agree overall conclusions and learning actions.

Area Clinical Governance Leads

Provide clinical advice to Patient Relations Coordinators as required in the investigation of cases in a timely manner.

Accurately and effectively record advice on the case record demonstrating their decision-making process and referencing best practice, guidelines or policy.

Liaise with Area Clinical Leads to ensure clinical learning is taken forward appropriately.

All YAS Staff

All YAS staff and volunteers are responsible for:
Maintaining a professional manner at all times, behaving in a way which demonstrates respect for the individuals they care for.

Attempt to resolve concerns “real-time” wherever possible, escalating to a senior manager, when this is not possible, in a timely way.

Cooperating fully with any investigation into a complaint or concern raised by a patient to whom they provided care or into an issue relating to their area of responsibility in a timely manner and to the required standard.

Documenting any suggestion that a patient or carer is dissatisfied with the care provided at the time of provision on the patient care record (PCR) and reporting the matter in line with the Trust Incident Reporting Procedure.

Delivering any actions allocated to them as part of an individual resolution plan or a service improvement plan.

Appendix C - Complaints Resolution Procedure

(all reference to written communication is to comply with the requirements of the Regulations, as stated previously, all attempts to meet specific communication needs will be made, whilst ensuring regulatory requirements are met)

1.0 Acknowledgement

1.1 All complaints will be acknowledged in writing within 3 working days of receipt.

1.2 The written acknowledgement will give a named contact and advise of advocacy services available.

1.3 Where the complaint has been made verbally, the acknowledgement will contain a written account of the complaint and invite the complainant to make contact should they wish to make any amendments.

2.0 Complaint grading

2.1 All complaints will be graded in accordance with the grading structure detailed in Appendix D.

2.2 All grade 1 and 2 complaints will be placed on the Incident Review Group (IRG) log. All complaints classified as Serious Incidents will be progressed in accordance with section 3.15.1 of the Policy.

2.3 The Executive Director of Quality, Governance and Performance Assurance and Associate Director of Quality and Safety will be notified of all complaints involving Clinical Commissioning Groups, Care Quality Commission or the Department of Health.

3.0 Complaint agreement

3.1. The Coordinator allocated to a complaint will attempt to contact the complainant within 3 working days to verbally discuss their complaint, agree the points of the complaint and the outcome they are seeking. They will also agree the timescale they aim to achieve and the frequency and mode of progress updates.

4.0 Investigation approach

4.1 The allocated Coordinator will identify the people who need to be advised of the complaint and who are required as part of the local investigation team. The relevant Head of Service and/or Area Operations Manager will be notified on every occasion. Where the complaint relates to clinical care, a relevant Area Clinical Governance Lead will also be notified.

4.2 Where other expert advice is required these people will be included in the investigation team.

4.3 The Coordinator will outline the investigation plan which is proportionate and relevant to the points of complaint and desired outcome. The investigation plan must clearly specify the information required to resolve the complaint, i.e. posing specific questions which need to be answered to deal with the issues raised and arrive at a conclusion.

4.4 Proportionate to the issues raised, the complaint investigation needs to address:
- Relevant policies and procedures and/or practice guidance;
- Documented records of the case or job;
- Statements or recollections of events as appropriate;
- Any specialist opinion or advice.

4.5 Where IRG or an Area Clinical Governance Lead has decided that a Clinical Case Review needs to take place in connection with a complaint, this will feed into the overall investigation and the investigation plan will be adjusted to reflect this.

5.0 Arriving at conclusions

5.1 Having gathered the relevant information, the Coordinator will consider the evidence gathered and propose a conclusion whether or not the complaint is to be upheld on the basis of the evidence. Conclusions must logically follow from the information gathered by the investigation in relation to what happened in the case and whether this is what should have happened in accordance with documented procedure and/or specialist opinion.

5.2 Where it is not possible to conclude ‘beyond reasonable doubt’ a conclusion based on ‘balance of probability’ will be made.

5.3 Some complaints may not be able to be proven even to the level of balance of probability and in such cases, it is acceptable for the investigation to be inconclusive, in exceptional cases.

5.4 The Head of Service and/or Area Operations Manager will be asked to agree the conclusion.

6.0 Identifying learning and service improvements

6.1 All complaints which have parts upheld must result in learning actions.

6.2 Some complaints which have not been upheld may still give rise to some learning actions as the investigation may have found issues with the service delivered or areas where service could be improved.

6.3 What action needs to be taken to improve the service or to minimise the possibility of a recurrence should follow logically from the conclusion arrived at in respect of what the cause of the error or poor service was in that case.

6.4 The Coordinator, in consultation with the investigation team, should identify appropriate learning actions and these must be agreed by the Head of Service and/or Area Operations Manager.

6.5 Where a Clinical Case Review has taken place in connection with a complaint, the learning from the review will feed into the overall learning actions identified from the overall investigation.

6.6 The Head of Service and/or Area Operations Manager will be responsible for ensuring the actions agreed as a result of a complaint are implemented.

6.7 The Coordinator will be responsible for ensuring the actions and their completion are recorded on the complaint record.

7.0 Identifying and providing appropriate remedies

7.1 The Trust works in accordance with the Principles of the Parliamentary and Health Service Ombudsman. The PHSO has established 'Principles for Remedy'.

7.2 Where a complaint investigation finds that things have gone wrong and that a patient, their family member or a member of the public have experienced some hardship or have been disadvantaged as a direct result of the error or wrongdoing, an appropriate remedy will be considered in line with the Trust's Redress and Remedy in Complaint Resolution Policy.

8.0 Responding to complaints

8.1 All complaints will receive a written response. The written complaint response will be drafted in accordance with the framework detailed in Appendix G. The written response will make appropriate apologies, will offer further contact and will also advise the complainant of their right to pursue their complaint with the PHSO should they remain dissatisfied.

8.2 All written responses will be quality checked within the Patient Relations team accordingly, and will be approved and signed in line with the process detailed in Appendix F. This includes responses to complaints handled regarding services provided by sub-contractors. All Directors and managers responsible for approval and sign-off of complaint responses will ensure they have cover arrangements in place for periods of unavailability.

8.3 The written response will supplement verbal feedback of complaint outcomes where this is considered to be appropriate for the particular complaint and/or where the complainant has requested this.

8.4 Face to face resolution meetings may be held with complainants, proportionate to the issues of complaint raised. Resolution meetings may be held prior to or following the written responses, as appropriate to the case. All resolution meetings will be recorded and a follow up response will be made confirming the outcome.

8.5 Face to face complaint meetings will be voice recorded, where the complainant agrees, and a copy of the recording will be provided to the complainant.

9.0 Complaint reviews

9.1 Where a complainant makes further contact with the Trust following the response to their complaint, consideration will be given to the appropriate response to the issues raised.

9.2 Where the complainant is seeking clarity or the response made has led to further questions, an attempt to provide the necessary information will be made in the most appropriate format, as a follow-up to the initial complaint and by the Coordinator and Head of Service and/or Area Operations Manager responsible for the initial complaint. Any follow-up verbal contact must be confirmed in writing.

9.3 Where the complainant is raising new or additional issues which were not part of the initial complaint and have not therefore been addressed by the previous

investigation, this will be recorded as a new complaint and dealt with in accordance with this procedure.

9.4 Where the complainant is disputing the response they have received, the initial complaint record may be re-opened and progressed as a complaint review. Alternatively, where it is considered a review is unlikely to add any value to resolution or learning, the complainant will be reminded of their right to contact the PHSO.

9.5 A complaint review will be carried out either by the Patient Relations Manager or a Coordinator who was not originally allocated to the initial complaint.

9.6 The points of dissatisfaction and desired outcome will be established with the complainant and the initial investigation and response will be reviewed.

9.7 A decision will be taken whether additional investigation is required in line with the format detailed in section 4.0 above.

9.8 Additional clinical opinions will be sought, where appropriate, from a clinically qualified individual independent to that of the initial clinical advice received.

9.9 Where other expert opinions are required, these will be sought from relevant experts independent of that of the initial expert advice where possible. External expert advice may be sought in exceptional cases and where this is warranted.

9.10 Conclusions, learning actions and remedies will be considered in line with sections 5.0, 6.0, and 7.0 above.

9.11 The complainant will receive a further response in line with section 8.0 but this will be approved and signed by the Executive Director of Quality, Governance and Performance Assurance or the Chief Executive. This process is detailed in Appendix F.

Appendix D – Risk Matrix

For grading risk, the scores obtained from the risk matrix are assigned grades as follows;-

Key to managing risk scores:		
Risk score of 1 - 6	Low	Managed at a local team/departmental level. Local management to determine and develop risk treatment plans or to manage through routine procedures; and consider including on the risk register. This level of risk may be short-lived or aggregated into a higher risk.
Risk score of 8 – 12	Moderate	**Consider placing on Risk Register.** Managed at local team/departmental level, unless escalated to Directorate or Trust/Subject specific group. Where there is a severity score of 4 or 5 alone, this may be considered for escalation to the Risk & Assurance Group regardless of the likelihood score.
Risk score of 15 – 25	High	**Consider placing on Risk Register.** Managed at local team/departmental level and/or Directorate or Trust/Subject specific group depending on management control, treatment plan, or wider strategic implications for the Trust. Risk Leads consider escalation and review at Risk and Assurance Group (RAG) where consideration is given to escalating the risk into the Corporate Risk Report and/or Board Assurance Framework (BAF).

Risk scoring = Consequence x Likelihood (CxL)

	Likelihood score				
Severity score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Consequence Score (C) Guidance

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Risk Consequence score and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Safety **Harm to patients/staff and/or public (including physical and/or psychological harm)**	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, requiring minor intervention 1-2 people affected No long term consequences.	Moderate injury which impacts on a small number of people Some degree of harm up to a year. RIDDOR/MHRA/agency reportable incident	Major injury leading to long-term incapacity/disability Serious mis-management of care with long-term effects 16-50 people affected	Death /life threatening harm Multiple permanent injuries or irreversible health effects More than 50 people affected
Staff **Competence and training, poor staff attendance for mandatory/key training**	Insignificant effect on delivery of service objectives due to failure to maintain professional development or status	Minor error due to a lack of appropriate skills, knowledge and competence to undertake duties.	Moderate error due to limited skills, knowledge & competence to undertake duties	Major effect on delivery of service objectives due to failure to maintain professional development or status	Significant effect on delivery of service objectives due to failure to maintain professional development or status
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Critical report	Multiple breeches in statutory duty Prosecution

					Severely critical report, zero performance rating
Service/business interruption	Loss of ability to provide services (interruption of >1 hour)	Loss of ability to provide services (interruption of >8 hours)	Loss of ability to to provide services (interruption of >1 day)	Loss of ability to provide services (interruption of >1 week)	Permanent loss of service or facility
Business programmes/ projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance	Poor project performance shortfall in area(s) of secondary importance	Poor performance in area(s) of critical or primary purpose	Significant failure of the project to meet its critical or primary purpose
Financial loss/Contracting	Small loss of budget (£0 -£5,000)	Medium financial loss (£5,000 - £10,000)	High financial loss (£10,000 - £50,000)	Major financial loss (£50,000 - £100,000) Purchasers failing to pay on time	Huge financial loss (£100,000 +), loss of contract / payment by results Unrecoverable financial loss by end of financial year
Information governance risks	Minimal or no loss of records containing person identifiable data. Only a single individual affected.	Loss/compromised security of one record *(electronic or paper)* containing person identifiable data.	Loss/ compromised security of 2-100 records *(electronic or paper)* containing confidential/ person identifiable data.	Loss/ compromised security of 101+ records *(electronic or paper)* containing person identifiable data.	Serious breach with potential for ID theft compromised security of an application / system / facility holding person identifiable data *(electronic or paper)*.
Adverse publicity/ reputation/Public confidence	Rumours No public/political concern	Local media area interest – short-term reduction in public confidence	Extended local/regional media interest. Regional public/political concern.	Regional/national media interest with less than 1 day service well below reasonable public expectation	National media interest with more than 1 day service well below reasonable public expectation.
Litigation Claim	Legal challenge minor out of court settlement or repudiation at pre-action stage.	Civil action – with or without defence Claim valued at less than £10,000 Minor concerns relating to treatment highlighted e.g. not all observations recorded Allegations not substantiated and claim likely to be defended and discontinued at pre-action stage.	Civil action / Criminal prosecution / Prohibition notice Claim defendable Claim(s) valued between £10,000 and £100,000 Concerns relating to treatment/care identified which are not likely to have affected the outcome Low level risk of reputational damage.	Civil action / Criminal prosecution – without defence Claim(s) between £100,000 and £1 million Major concerns to treatment/care which could have affected the outcome Reputational damage (local level) Raises individual employee failings and or Trust policy concerns High likelihood that actions have directly contributed to staff or patient harm.	Criminal prosecution – without defence Claim(s) >£1 million Catastrophic / significant issues/concerns which are likely to have contributed to the outcome Reputational damage (national level)
Coroner's requests / inquests	No issues or concerns identified clinically or with reputation Inquest very unlikely to bring any allegations against Trust or employees Witness statements admitted under Rule 23.	Minor concerns relating to treatment highlighted e.g. not all observations recorded No allegations against Trust or employees No risk of criminal or civil litigation No risk of reputational damage	Concerns relating to treatment/care which are not likely to have affected the outcome Some allegations made against Trust and or employees Does not raise significant individual or Trust policy failings Defendable Low level risk of civil litigation claim (i.e. damages not in excess of £20,000)	Major concerns to treatment/care which could have affected the outcome Increased likelihood of receiving a Coroner's Prevention of Future Death report (PFD). Consideration given to instructing solicitors for advice YAS has Interested Person Status	Catastrophic / significant issues/concerns which are likely to have contributed to the outcome Escalation to relevant Directors/Trust Board High likelihood of a Coroner's Prevention of Furture Death report. Solicitors instructed

		YAS not an Interested Person – factual witness attending.	Low level risk of reputational damage (local level)	Some allegations made against Trust and or employees Raises individual employee failings and or Trust policy concerns Potential to issue Rule 43 Report against person or organisation Medium level risk of civil litigation claim (i.e. damages not in excess of £100,000) Reputational damage (local level) Inquest in front of a jury Family and/or other parties legally represented.	YAS has interested person status. Raises issues of national importance Potential to result in public national enquiry (i.e. London Bombings, Mid Staffordshire enquiry) Potential for criminal prosecution and high level award (civil litigation claim i.e. in excess of 100,000 to unlimited damages) Reputational damage (national level) Jury inquest Family and/or other parties legally represented.
Complaint	Minor injury not requiring first aid or no apparent injury Misunderstanding of an element of the service which can be corrected Distress, inconvenience or hurt feelings but no failing	Minor injury or illness, requiring minor intervention Single failure to meet internal standards Single failing resulting in delay to appointment or care, distress, inconvenience or hurt feelings Single failure to meet organisational policy Poor practice, apparent lack of consideration	Moderate injury sustained Single failing resulting in loss of appointment or care Repeated failure to meet internal standards for the individual Single failure to meet organisational code of conduct Repeated failure to meet organisational policy for the individual Unacceptable level or quality of treatment/service.	Major injury leading to long-term incapacity/disability Repeated failure to meet organisational code of conduct for the individual Repeated failings resulting in loss of appointment or care for the individual Inappropriate behaviour	Death /life threatening harm Grossly substandard care Failure to meet legislative requirements/breach of the law
Safeguarding children & Adults at Risk ***Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery***	No issues or concerns identified clinically or with reputation Progression to strategy meeting or multi-agency review unlikely No media interest Response to query responded to within 2 working days No, or minimal impact or breech of guidance/statutory duty	Minor concerns over patient care CDOP/Form B with uncomplicated information gathering Minor delay in response to external agency request (more than 5 working days) No allegations against Trust or employees Short term service impact from brief investigation	Moderate concerns about patient care, response times, clinical interventions CDOP requiring moderately complex information gathering and analysis Referral to LADO and Police. Disciplinary process commenced, suspension from front line duties Possible media interest anticipated	Major concerns with patient care that could have affected outcome Major injury leading to incapacity or disability Repeated failure to reach internal standards Regional media statement requested Abuse enquiry becomes public enquiry	Incident leading to death or permanent disability Healthcare did not take appropriate action/intervention to safeguard against abuse occurring Abuse that resulted in (or was identified through) a SCR, DHR, LLR Inquest requiring safeguarding information Staff/ex-staff member is found

		involving discussions Police, Social care and HR			guilty of abuse and convicted Media interest highly likely

Likelihood Score (L) Guidance

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to determine the frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Probability	< 5% 1 in 100,000 chance	6-20% 1 in 10,000 chance	21-50% 1 in 1000 chance	50-80% 1 in 100 chance	>81% 1 in 10 chance
	This will probably never happen/recur Will only occur in exceptional circumstances	Unlikely to occur Do not expect it to happen/recur but it is possible it may do so	Reasonable chance of occurring Might happen or recur occasionally	Likely to occur Will probably happen/recur but it is not a persisting issue	More likely to occur than not Will undoubtedly happen/recur, possibly frequently

Appendix E - Timescales

In accordance with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, response timescales will be agreed with the complainant on an individual case by case basis, and in all events within a maximum timescale of 6 months. However, the Trust is committed to a proportionate and timely response to complaints and therefore will aim to work in accordance with the following guide timescales, to avoid unnecessary delay. In exceptional circumstances, these timescales may be exceeded. In such circumstances the reason for this will be discussed and agreed with the complainant and will be recorded.

Guide Timescales (from receipt of concern or complaint)	
Written complaint acknowledgement	Within 3 working days
Resolution of a concern	Within 10 – 25 working days
Written complaint response	Grade 3: Up to 25 working days Grade 2: Up to 40 working days Grade 1: Up to 90 working days
Written complaint review response	Within 20 working days
Average response time target (concerns and complaints)	30 working days

Process step timescale guidance	
Informal concern resolution by operational services	0-5 working days from receipt
Case recording on Datix	0-1 working day from request
Responses to requests for statements, opinions, etc. from Coordinator	10 working days from request
Responses to requests for decisions on conclusions and learning actions	0-1 working day from request
Response quality check	0-1 working day from request
Response approval and sign-off	0-3 working day from request

*****Any cases in which timescales are exceeded due to lack of timely operational information or sign-off will be escalated to the Associate Director of Quality and Safety in the form of a weekly report.

Appendix F - Response Approval and Sign-Off

Correspondence	To be approved and signed by
Written complaint acknowledgement	Patient Relations Administrator
Concern resolution	Patient Relations Coordinator
Written complaint response (grade 3)	Head of Service
Written complaint response (grade 2)	Head of Service
Written complaint response (grade 1)	Approved by Executive Director of Quality, Governance and Performance Assurance Signed by Chief Executive
Written complaint response to MPs, Elected Members, Media and CQC	Approved by Executive Director of Quality, Governance and Performance Assurance Signed by Chief Executive
Formal responses to PHSO	Approved by Executive Director of Quality, Governance and Performance Assurance Signed by Chief Executive
Written complaint review response (grade 3)	Signed by Executive Director Quality, Governance and Performance Assurance
Written complaint review response (grade 2)	Signed by Executive Director Quality, Governance and Performance Assurance
Written complaint review response (grade 1)	Approved by Executive Director of Quality, Governance and Performance Assurance Signed by Chief Executive

Note: Where complaints involve more than one YAS Service a single signature will be obtained by the service to whom the bulk of the complaint relates. The signators for the other services will be asked to approve the part of the response relating to their service but YAS will not issue complaint responses with multiple signatures.

Appendix G - Complaint Response letter framework

All written responses to complaints will be made in line with the framework detailed below.

- Standard opening paragraph
  Thank you for your letter/email/telephone call in which you explain you are dissatisfied with the services you received on ……., etc.

- Your complaint is that:-
  Summarise the points of complaint. May be helpful to use bullet points or a numbering system if there are multiple points of complaint.

- The outcome you are seeking is:-
  Summarise the outcome the complainant is seeking as a result of their complaint. May be helpful to use bullet points or a numbering system if there are multiple outcomes being sought.

- Explain how we have investigated the complaint, i.e.
  - Looked at relevant policies and procedures
  - Examined records regarding your care
  - Conducted interviews with staff/gathered statements from staff
  - Obtained clinical or specialist opinions
  - Listened to calls, had calls reviewed, audited, etc.

- Explain what should have happened, i.e.
  - What do the policies and procedures say?
  - What is the normal/expected practice/standards?

- Explain what did happen compared to what should have happened above. Do not adopt a story-telling style of events the complainant is already fully aware of (from the investigation findings, referring to the evidence collected – include information which is relevant to the complaint only). If bullet points or numbering system used in the summary of the complaint, then relay the findings under the same headings. Have regard to the relevant weighting of the different types of evidence.

- Conclusions:-
  State whether what happened was in line with what should have happened by making reference back to the procedure and or opinions gathered. Provide a rationale for arriving at the conclusion.
  Include appropriate apologies at this point.
  Even if we didn't do anything wrong, could we have handled it better? Has the complainant got a point?
  An apology is appropriate if we have done something wrong and we must be clear what it is we are apologising for. Be careful not to include 'non-apologies' as these may antagonise. An example of a non-apology is "I am sorry if you were upset by this….."
- Actions/Recommendations/Learning:-
  If complaint agreed – what are we doing about it?

Refer to outcomes sought at this point – can we deliver these? If not, explain why and what redress/remedy can be offered which is appropriate.

- Standard closing paragraph
  Make it appropriate to outcome – e.g. I realise the outcome is not what you are seeking but I hope my letter has explained …….etc.
  Offer contact if further clarification or questions, etc.
  Inform of right to pursue with PHSO

General comments:-

- Include only what is relevant to the complaint being made
- Ensure all points of complaint are answered
- Do not include unnecessary information or comments
- Do not use judgemental language
- Do not use jargon or technical terms. If it is necessary to use a technical term then explain what it means
- Ensure that the format is appropriate to the individual complainant (e.g. large font, etc.)
- Read it back to yourself as if you are the complainant, is the response patient centred or system/organisationally led?
- Check for typing and grammatical errors

Appendix H - Case Recording

1. It is the role of the Patient Relations team to record all compliments, comments, concerns and complaints on the Datix 4Cs system.

2. The Datix 4Cs system provides a unique reference number and holds a record of all documentation, correspondence and progress notes regarding each case.

3. The minimum requirements for all cases are:-

    - Key dates for receipt, acknowledgement, response (where relevant), and closure;
    - All subject code fields, including area of business and CCG area;
    - All correspondence and notes of verbal contact (internal and external).

4. For complaints and concerns, additional recording requirements are:-

    - All investigation notes or reports and copies of documented evidence;
    - Reference to (or excerpts of) relevant policies and procedures or practice guidance used in the investigation;
    - Copies of statements/recollections of events;
    - Comments of operational managers in respect of statements/recollections of events;
    - Content of clinical or specialist advice sought;
    - Record of outcome – i.e. upheld, partially upheld or not upheld;
    - Learning actions agreed and evidence of implementation including dates, in the relevant action fields on the Datix record;
    - Remedies agreed and evidence of implementation including dates, in the relevant action fields on the Datix record.

5. All correspondence retained on the case record will be final signed copies. No draft correspondence will be retained.

6. All 4Cs records will be retained in accordance with the Trust's Records Management Policy.

Appendix I - Protocol for Independent Investigation and Review of Complaints

National Ambulance Services Patient Experience Group

1. Introduction

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, the Francis Report (February 2013) and the Review of the NHS Hospitals Complaints System by the Rt Hon Ann Clwyd MP and Professor Tricia Hart (October 2013) make reference to NHS organisations having arrangements in place for a complaint to be investigated independently or for some level of independent scrutiny in order to enable resolution to be achieved.

NASPEG members are committed to working together under a reciprocal agreement to fulfil this responsibility.

2. Criteria

An independent investigation or review would usually be considered where a complainant's relationship with the organisation has broken down to the extent where any internal consideration is unlikely to be accepted by the complainant, or where the complainant is sufficiently mistrusting of the organisation.

3. Process for investigation

The organisation that is subject to the complaint (the Trust) will identify and agree the need for an independent investigation or review in line with its own organisational policy and with the complainant.

The Trust will decide upon the level and type of direct contact required by the investigating officer and will clarify this with all parties. It may be decided that full consent is required to access personal records or that the complaint may be reviewed anonymously.

Where consent to share the complaint with and to access personal records by the investigating organisation is necessary, this consent will be obtained by the Trust from the patient. Where the patient is unable to consent, this will be obtained from their representative in line with that organisation's procedure.

The Trust will contact neighbouring ambulance trusts initially to seek their assistance to carry out an independent review, and every attempt will be made by the neighbouring trusts to meet the request. However, should a neighbouring trust be unable to assist, then all other ambulance trusts will be contacted.

Once another trust has agreed to undertake the independent review, the Trust will pass details of the complaint received, any previous investigation and correspondence, and contact details of the complainant where appropriate, to the investigating officer nominated by the assisting trust.

Where it has been agreed that there will be direct contact between the complainant and the investigating officer, the investigating officer will make direct contact with the complainant, discuss and agree the points of complaint and desired outcomes and agree timescales for the completion of the investigation or review.

The investigating officer will provide a copy of this agreement to the Trust and will request any further documentation or information they require to enable them to investigate or review the matter. This is likely to consist of relevant policies and procedures, case records and documentation, relevant statements from staff, etc. The investigating officer must be specific about their requirements.

Direct access to staff and records by the investigating officer would be allowed where agreed by the Trust. In such circumstances this would be facilitated by the Trust.

The Trust will be responsible for updating the complainant on progress, and the investigating officer is responsible for ensuring agreed timescales are met, and for informing the Trust of any likely delays and the reason why.

Should the investigating officer require clinical advice or clarification, they will source such information from other then the Trust at the centre of the complaint, eg from their own Trust's Consultant Paramedic, Clinical Department, etc. However, when evaluating the advice or clarification received, the investigating officer must take into due consideration locally approved policies, procedures and guidelines specific to the Trust at the centre of the complaint.

On completion of the investigation or review, the investigating officer will complete a report (see appendices for templates) which will be issued to the Trust. This will be quality checked by the Trust, and the investigating officer will respond to any requests for clarification or amendments of factual accuracy. This may lead to a reconsideration of the conclusions or recommendations by the investigating officer. The Trust may not simply change the conclusions or recommendations without discussion and agreement with the investigating officer. The quality standards of the Trust's own procedure would apply within this protocol.

A copy of the background investigation documentation will also be provided to the Trust on completion of the investigation/review in addition to the report, but will not form part of the report.

The Trust is then responsible for providing a copy of the report to the complainant, along with a covering formal response from the Trust.

The Trust will explain in their covering formal response that should the complainant have any comments, questions or concerns regarding the report, these should be directed to the Trust, not to the investigating officer. The Trust will then liaise with the investigating officer and the Trust will respond to the complainant regarding the additional points raised.

Following receipt of the report, should the complainant contact the investigating officer directly with any comments, questions or concerns, the investigating officer will refer all enquiries to the Trust.

4. Review of Protocol

The National Ambulance Services Patient Experience Group (NASPEG) will continually review the protocol, the extent and circumstances of its use, the experience of the commissioning trusts and the investigating officers, and any learning arising, as a standard item on its quarterly meeting agenda.

Submitted on behalf of the National Ambulance Services Patient Experience Group
8 December 2016

Appendix J - Template/headings for Reports

Independent Investigation Report

1. Complainant name and patient name
2. Details of complaint
3. Outcome sought by the complainant
4. Method of investigation
5. Relevant Policy and Procedure position
6. Clinical Advice (if necessary)
7. Findings
8. Conclusions
9. Recommendations
10. Name of investigating officer and date of report

Independent Review Report

1. Complainant name and patient name
2. Details of original complaint
3. Details of Trust response to complaint
4. Details of complainant's response to the response
5. Outcome sought by the complainant
6. Method of review
7. Relevant Policy and Procedure position
8. Clinical Advice (if necessary)
9. Findings
10. Conclusions
11. Recommendations
12. Name of investigating officer and date of report

*NB The template requirement may be simplified on a case by case basis where the purpose of the review is for internal use only.

Anonymous Independent Investigation Report

1. Details of complaint
2. Outcome sought by the complainant
3. Method of investigation
4. Relevant Policy and Procedure position
5. Clinical Advice (if necessary)
6. Findings
7. Conclusions
8. Recommendations
9. Name of investigating officer and date of report

Anonymous Independent Review Report

1. Summary of original complaint
2. Summary of Trust response to complaint
3. Summary of unresolved issues/matters requiring review
4. Outcome sought by the complainant

5. Method of review
6. Relevant Policy and Procedure position
7. Clinical Advice (if necessary)
8. Findings
9. Conclusions
10. Recommendations
11. Name of investigating officer and date of report

*NB The template requirement may be simplified on a case by case basis where the purpose of the review is for internal use only.

Appendix K - Unreasonable Complainant Behaviour

1.0 Introduction

1.1 The Trust is committed to dealing with all complainants fairly and impartially and to providing a high quality service. As part of this service we do not normally limit the contact complainants have with the Trust. However, we do not expect our staff to tolerate behaviour by complainants which is, for example abusive, offensive or threatening, or which because of the frequency of contact, hinders our handling of patient feedback and in such instances we will take action to manage this behaviour.

1.2 The Trust will make every effort to ensure our feedback service is accessible to all of our patients, their family members and members of the public. To achieve this outcome we will make reasonable adjustments to meet the individual and particular needs of anyone who contacts us.

1.3 When we consider that a person's behaviour is unreasonable we will tell them this, the reason why we find their behaviour unreasonable, and we will ask them to change it. If the unreasonable behaviour continues, we will take action to restrict their contact with the service.

2.0 Behaviours which may be considered unreasonable

2.1 The following behaviours may be considered as unreasonable:-

- Persisting in pursuing a complaint where the complaints procedure has been fully and properly implemented and exhausted.
- Changing the substance of a complaint or persistently raising new issues or seeking to prolong contact by unreasonably raising further concerns or questions upon receipt of a response whilst the issues are being dealt with. Care must be taken not to disregard new issues, which differ significantly from the original complaint as these may need to be addressed separately.
- Unwillingness to accept documented evidence as being factual or deny receipt of an adequate response despite correspondence specifically answering their concerns.
- Persistent focusing on a matter which is disproportionate to overall significance of the complaint and the outcome being considered.
- An excessive number of contacts with the Trust when pursuing their complaint, placing unreasonable demands on staff. Such contacts may be in person, by telephone, letter, fax or electronically. What is considered as excessive may differ in each individual case.
- Displaying unreasonable demands or expectations and failing to accept that these may be unreasonable once a clear explanation is provided to them as to what constitutes an unreasonable demand (i.e. insisting on responses being provided more urgently, from a particular individual, presenting similar or substantially similar requests for information).

2.2 The above list is not exhaustive and other behaviours which hinder the provision of our service may be considered unreasonable under these arrangements.

3.0 Process for managing unreasonable behaviour

3.1 Any member of staff dealing with a person in connection with a concern or complaint

who feels that the individual is acting in a way which could be considered unreasonable, must seek advice from the Patient Relations Manager on the appropriate action to take.

3.2 The Patient Relations Manager will review the circumstances of the contact and will advise on appropriate options to attempt to manage the behaviour being displayed.

3.3 The behaviour will be monitored and if it continues, and there is agreement that it constitutes unreasonable behaviour, the case will be considered by the Executive Director of Quality, Governance and Performance Assurance.

3.4 A decision will be taken by the Executive Director whether to place restrictions on contact with the individual regarding the way in which their concerns or complaints are handled, the nature of the restriction, and the review period.

3.5 The Patient Relations Manager will keep a record of all cases considered, the outcomes, the nature of the restrictions in place and the period of review. The Patient Relations Manager will keep a record of all correspondence with individuals in relation to agreed or imposed restrictions.

3.6 Where an individual's behaviour is having an immediate excessive impact on the Service, the Patient Relations Manager may take urgent action to restrict the individual's contact, record the reasons why this action was taken and inform the individual of this. The Executive Director of Quality, Governance and Performance Assurance will then consider the case in accordance with this process at their earliest opportunity.

4.0 Attempts to manage unreasonable behaviour

4.1 Attempts to manage an individual's behaviour will involve contact with the individual with an explanation why their behaviour is affecting our ability to resolve their concern or complaint and they will be asked to agree to a particular type of contact with us.

4.2 Options could be:-

- Contact in a particular form;
- Contact with a named officer;
- Telephone calls restricted to specific days and times;
- Telephone calls restricted to a specific duration;
- Contact through a third party, including an advocacy service;
- Formal closure of correspondence.

4.3 Attempts to manage behaviour will always precede a decision to place restrictions on an individual.

5.0 Types of restriction

5.1 Restrictions which could be placed on an individual will be proportionate and appropriate to the effect their behaviour is having on the Trust's services and its staff.

5.2 Options will generally be those listed above but without the agreement of the individual and will be imposed. Any contact made by the individual outside of the restrictions will not be responded to and a reminder of the restrictions will be issued.

6.0 Review of restriction

6.1 Individual cases will be reviewed by the Executive Director of Quality, Governance and Performance Assurance in line with the review period set.

6.2 Consideration will be given to the behaviour and contact of the individual throughout the period of the restriction of which a written record will be kept.

6.3 The review may result in restrictions being lifted, remaining in place or being strengthened. Where restrictions are not lifted, a new review period will be agreed.

7.0 Communication with individual

7.1 The individual will be formally informed in writing of the restrictions being placed upon them and the reason why. A formal record of this contact will be made. They will also be informed of the review period and the modification to their behaviour which is necessary for the restrictions to be lifted.

7.2 The individual will be given a right to appeal against the restrictions and informed of the process of appeal. The appeal will be considered by the Chief Executive giving consideration to the reasons put forward by the individual and the Executive Director's decision-making in applying the restrictions.

7.3 The individual will be advised of their right to pursue the matter with the Parliamentary and Health Service Ombudsman should they continue to feel the restrictions are unfair and unjust.

7.4 The individual will be formally informed of the outcome of each review and any future review period.

NB

- **No individual will have restrictions placed upon them as a result of other organisations' application of similar policies or arrangements. All restrictions placed will be on the basis of the Trust's experience of the individual's behaviour.**
- **The Trust may take additional action to that detailed in these arrangements which may involve reporting matters to the Police or taking legal action where it is felt that exceptional behaviour warrants this approach.**

Appendix L – Feedback Form

NHS Yorkshire Ambulance Service NHS Trust

Feedback Form					
Today's date:					
How would you like us respond to you: (Please circle choice)	Telephone / Email / Letter				
I would like to make a: (Please circle choice)	Complaint / Concern / Comment / Compliment				
YOUR DETAILS					
Surname:		**Forename:**		**Title:**	
Address (including postcode):					
Telephone No:		**Email address (if applicable):**			
PATIENT DETAILS (If different to above)					
Surname:		**Forename:**		**Title:**	
Address (including postcode):					
Telephone No:		**Email address (if applicable):**			
Does the patient know you are raising this on their behalf? (Please circle choice)	Yes / No				
Please note that if you are raising a complaint or a concern on behalf of another person, we will normally need to contact them directly to obtain their consent. It would assist if they were already aware that you are raising this on their behalf. **PTO**					

DETAILS OF FEEDBACK	
Please give details of what you would like to tell us. Please include as much detail as possible to help us. Eg. dates, times, location, etc. **Please tell us of any specific communication needs.** **(Please continue on separate sheet if required)**	
Please tell us what you would like to happen as a result of your feedback.	
Thank you for your feedback **Please now post your completed form to:** **Yorkshire Ambulance Service, Patient Relations Team** **Springhill, Brindley Way, Wakefield 41 Business Park, Wakefield WF2 0XQ**	