NHS
Yorkshire
Ambulance Service
NHS Trust

Patient Feedback Policy (Including Complaints Management)

Author: Head of Nursing and Patient Experience

Approved: July 2025

Document Reference	PO - Patient Feedback (Including Complaints Management) Policy – July 2026
Version	V:1.0
Responsible Director (title)	Executive Director Quality/Chief Paramedic
Document Author (title)	Head of Nursing and Patient Experience
Approved by	Clinical Governance Group
Date Approved	July 2025
Review Date	July 2026
Equality Impact Assessed (EIA)	Yes
Document Publication	Internal and External

Document Control Information

Version	Date	Author	Status (A/D)	Description of Change
V0.1	March 2025	Lesley Butterworth	D	New Policy to incorporate 4C's Policy (v8.0), Obtaining Service User Feedback Policy (v5.3) and Financial Remedy (v3.4) into one Policy document. NHS Complaint Standards model complaint handling procedure for NHS providers of NHS Services in England (Dec 2022) used to develop new Policy document
v0.2	May 2025	Lesley Butterworth	D	Stakeholder comments combined
V0.3	June 2025	Lesley Butterworth	D	SOPs attached
V0.4	June 2025	Lesley Butterworth	D	Updated section 3.5 to strengthen following EIA feedback.
V1.0	July 2025	Risk Team	A	Policy approved within July Clinical Governance Group

A = Approved D = Draft

Document Author = Lesley Butterworth – Head of Nursing & Patient Experience

Associated Documentation:

- Being Open (Duty of Candour) Policy
- Data Protection Policy
- Information Governance Framework.
- Management of Safeguarding Allegations Against Staff Policy
- Patient Safety Incident Response Plan
- Records Management Policy
- Redress and Remedy Policy
- Safeguarding Policy (Children, Young People and Adults at Risk)
- YAS Local IRG terms of reference
- Comments Standard Operating Procedure
- Patient Experience and Involvement Framework
- Complaints SOP
- Compliments SOP
- Concerns SOP
- Dealing with Requests for Information SOP
- Financial Remedy in Relation to Complaints SOP
- Managing Unreasonable Complaint Behaviour SOP
- Obtaining Service User Feedback SOP
- Patient Advise Liaison Service SOP
- Service to Service Feedback SOP

Staff Summary

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.
This Policy sets out how YAS handle complaints and the standards we will follow. This procedure follows the relevant requirements in the Local Authority, Social Services and National Health Service Complaint Regulations 2009, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations) and the Care Quality Commission registration requirements as specified in Regulation 19.
This Policy covers patient feedback 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.
We have processes in place to make sure that the responsible person (the Chief Executive) and relevant Senior Managers regularly review insight from the complaints we receive, alongside other forms of feedback on our care and service. They will make sure action is taken on learning arising from complaints so that improvements are made to our service.
The responsibility for investigating patient feedback concerns is overseen in each operational service area by the Local Incident Review Group (LIRG) where cases are discussed, given a risk grading and allocated for investigation. Staff allocated to investigate patient feedback cases will be the relevant Team Leader or Operations Manager.
We make sure staff who deal with feedback are properly supported and trained to identify when it may not be possible to achieve a relevant outcome through the feedback process on their own. When this happens, the staff member dealing with the complaint will inform the person making the complaint and give them information about any other process that may help address the issues and has the potential to provide the outcomes sought.
We will maintain confidentiality and protect privacy throughout the complaints process in accordance with UK General Protection Data Regulation and Data Protection Act 2018. We will only collect and disclose information to those staff who are involved in the consideration of the complaint. Documents relating to a complaint investigation are securely stored and kept separately from medical records or other patient records. They are only accessible to staff involved in the consideration of the complaint.
We will make sure that everybody who uses (or is impacted by) our services (and those that support them) know how they can make a complaint by having our complaints procedure and/or materials that promote our procedure visible in public areas and on our website. We will provide a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to our complaints process online.
When we receive a complaint, we are committed to making sure it is addressed and resolved at the earliest opportunity.
Not every complaint can be resolved quickly and sometimes we will require a longer period of time to carry out a closer look into the issues and carry out an investigation. This will always involve taking a detailed and fair review of the issues to determine what happened and what should have happened.
Individual timescales for resolution of complaints progressed formally will be agreed with the complainant on a case-by-case basis and logged in Datix. The expectation is that most complaints should be resolved within 30 working days but may take up to 90 working days for those complaints that are more complex.

We will make sure staff specifically complained about are made aware of the complaint and we will give them advice on how they can get support from within our organisation, and externally if required.

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 Co-developed with organisations from across the health sector and advocacy and advice services, the NHS Complaint Standards provide a single vision of good practice for complaint handling. This complaint handling Policy describes how we will put into practice the core expectations given in the Standards.

1.3 This Policy sets out how YAS handle complaints and the standards we will follow. This Policy follows the relevant requirements in the Local Authority, Social Services and National Health Service Complaint Regulations 2009, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations), and the Care Quality Commission registration requirements as specified in Regulation 19.

1.4 This policy should be read in conjunction with the more detailed guidance modules available on the Parliamentary and Health Service Ombudsman's website. Good complaint handling guides for the NHS | Parliamentary and Health Service Ombudsman (PHSO)

1.5 The Complaint Standards and this Policy also support delivery of our Trust Values of Kindness, Trust, Improvement and Respect.

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 and uses feedback from or on behalf of patients. This includes:

- Patient experience and involvement activities (see Patient Experience and Involvement Framework)
- Compliments
- Comments
- Concerns
- Complaints
- Service to service queries submitted by a partner organisation relating to care provided to a patient by YAS.

2.1.2 Define the roles and responsibilities for handling patient feedback within the Trust and across organisational boundaries.

2.1.3 Set out the standards, structure and systems via which incidents (including Patient Safety Incident Response Framework (PSIRF)) and safeguarding concerns and risks identified through patient feedback are managed and acted upon.

2.2 This Policy covers patient feedback 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 (YAS).

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.

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 Requests for information for specific YAS departments, raised by another organisation are not covered by this Policy and are dealt with by the receiving team in line with their own processes. If there is uncertainty about if a request should be logged as a service to service or patient feedback request for information, then this should be discussed with the Patient Relations Manager.

2.6 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 dissatisfaction through effective, early resolution wherever possible.

2.7 Accountability, roles and responsibilities

2.7.1 Overall responsibility and accountability for management of complaints lies with the ‘Responsible person’ (as defined by the 2009 Regulations). In our organisation this is the Chief Executive.

2.7.2 We have processes in place to make sure that the responsible person and relevant Senior Managers regularly review insight from the complaints we receive, alongside other forms of feedback on our care and service. They will make sure action is taken on learning arising from complaints so that improvements are made to our service.

2.7.3 They demonstrate this by:

- Leading by example to improve the way we deal with compliments, feedback and complaints.
- Understanding the obstacles people face when making a complaint to us and taking action to improve the experience by removing them.
- Knowing and complying with all relevant legal requirements regarding complaints.
- Making information available in a format that people find easy to understand.
- Promoting information about independent complaints advocacy and advice services.
- Making sure everyone knows when a complaint raises concerns which are a patient safety incident, or a safeguarding or legal issue and what must happen.
- Making sure that there is a strong commitment to the duty of candour so there is a culture of being open and honest when something goes wrong.
- Making sure we listen and learn from complaints and improve services when something goes wrong.

2.7.4 Our Complaints Manager (as defined by the 2009 Regulation) is the Patient Relations Manager. They are responsible for managing this Policy and for overseeing the handling and consideration of any complaints we receive. All compliments, comments, concerns and complaints are coordinated by the Patient Relations Team which is part of the Nursing and Patient Experience Department within the Quality and Professional Standards Directorate.

2.7.5 Within each operational service there are specific roles who are responsible for Patient Experience. These are:

Service Area	Responsible Person/Letter Signatory	Operational Lead	Clinical Lead	Governance Lead
Remote Care – EOC	Associate Chief Operating Officer	Head of Operations	Clinical Response, Governance & Assurance Manager	
Remote Care – IUC	Associate Chief Operating Officer	Head of Operations	Quality and Governance Manager	
Patient Transport Services	Managing Director	Head of Service and Standards		
A&E – Humber and North Yorkshire	Director of Partnerships and Operations	Head of Operations	Consultant Practitioner	Quality, Governance and Assurance Manager
A&E – West Yorkshire	Director of Partnerships and Operations	Head of Operations	Consultant Practitioner	Quality, Governance and Assurance Manager
A&E – South Yorkshire	Director of Partnerships and Operations	Head of Operations	Consultant Practitioner	Quality, Governance and Assurance Manager

2.7.6 The responsibility for investigating patient feedback concerns is overseen in each operational service area by the Local Incident Review Group (LIRG) where cases are discussed, given a risk grading and allocated for investigation. As cases progress there may be further discussion at the relevant LIRG to ensure that cases move swiftly through the system. Staff allocated to investigate patient feedback cases will be the relevant Team Leader or Operations Manager.

2.8 This Policy is supported by several guidance documents which can be found in the appendices. Where appropriate these are cross referenced within the Policy itself.

3.0 Process

3.1 Identifying feedback

3.1.1 Everyday conversations with our users. Our staff speak to people who use our service every day. This can often raise issues, requests for a service, questions or worries that our staff can help with immediately. For example:

- A patient who is not satisfied with their outcome when they ring 111 may be passed to a team leader for further explanation.
- A patient whose PTS ambulance is late may be contacted by the PTS logistic team to offer an apology and explanation.
- The family of a patient who loses their mobile phone in one of our A&E ambulances following an emergency attendance may contact our PALS team and be reunited with the lost property.
- A patient may pass their compliment on a crew to a team leader when they are waiting for hospital handover.

3.1.2 We encourage people to discuss any feedback they have with our staff, as where they are dissatisfied, we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

3.2 When People are Satisfied

3.2.1 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, via Care Opinion or NHS website etc). apart from compliment letters. All written compliment letters will receive a written response from the Chief Executive arranged by Patient Relations. Full details can be found in Compliments Standard Operating Procedure, which outlines the procedures to be followed.

3.2.2 Themes and Trends from Compliments will be collated and presented along with other feedback data at relevant, service, area and Trust meetings. Good practice and learning from Compliments will be highlighted.

3.3 General Feedback/Comments

3.3.1 We may receive comments on our services from a variety of sources which are general in nature and do not require specific responses. Comments can be made to any member of staff or volunteer and will be passed to the Patient Relations team and acknowledged in the format in which they were received (i.e. verbally, by email, via Care Opinion or NHS website etc). Full details can be found in Comments Standard Operating Procedure, which outlines the procedures to be followed.

3.3.2 Themes and Trends from comments will be collated and presented along with other feedback data at relevant, service, area and Trust meetings. Good practice and learning from comments will be highlighted.

3.4 Proactive Feedback

3.4.1 YAS recognised the importance of actively seeking feedback and working with service users to assess service quality and help to inform improvements and developments. Excellent experience of care is an essential part of an outstanding health and social care service as well as clinical safety and effectiveness. Gaining Service User feedback is aligned with national priorities as set out in the Government Policy and NHS documents such as, Equity and Excellence Liberating the NHS (DOH, 2010), Patient experience improvement framework, (NHSI,2018) and the Patient Safety Strategy (NHSE, 2021).

3.4.2 There are several processes in place which allow the Trust to seek feedback from users of the service, these include;

- Surveys
- Friends and family test
- Focus Groups
- Patient Stories
- Research Public and Patient Involvement
- Co-production
- Critical Friends Network

3.4.3 All service user feedback activity carried out on behalf of the Trust will be carried out in accordance with the following principles:

- Abide by all relevant Laws and Regulations and NHS Policy.
- All activity should be conducted in an ethical manner.

- Feedback should be gained in a manner that ensures minimum disruption to patients and service users.
- No patient and/ or service user shall be excluded and, where appropriate, positive action should be taken to make activity accessible to seldom heard communities.
- Be open with activity and results.
- All activity will be conducted in a safe and professional manner.

3.4.4 Full details can be found in Patient Experience and Involvement Framework and Obtaining Service User Feedback SOP, which outlines the procedures to be followed when obtaining feedback from patients and service users.

3.5 **When People are Dissatisfied**

3.5.1 We recognise that we cannot always resolve issues as they arise and that sometimes people will want to make a complaint. The NHS Complaint Standards define a complaint as: an expression of dissatisfaction, either spoken or written, that requires a response. It can be about:

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

3.5.2 People do not have to use the term ‘complaint’. We will use the language chosen by the patient, service user, or their representative, when they describe the issues, they raise (for example, ‘issue’, ‘concern’, ‘complaint’, ‘tell you about’). We will always speak to people to understand the issues they raise and how they would like us to consider them.

3.5.3 For more information about the types of complaints that are and are not covered under the 2009 Regulations please see The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

3.5.4 If we consider that a complaint (or any part of it) does not fall under this Policy we will explain the reasons for this. We will do this in writing to the person raising the complaint and provide any relevant explanation and signposting information.

3.5.5 Complaints can be made to us:

- In person – by speaking to a member of YAS staff
- By telephone - 0330 678 4140
- In writing -
- Patient Relations Team
  Yorkshire Ambulance NHS Trust
  Springhill 2
  Brindley Way
  Wakefield 41 Business Park
  Wakefield
  WF2 0XQ
- By email – yas.patientrelations@nhs.net

3.5.6 We will consider all accessibility and reasonable adjustment requirements of people who wish to make a complaint in an alternative way. We will record any reasonable adjustments we make.

3.5.7 We will offer complainant information in alternative languages and where required utilise the Trust's commissioned interpreter and translator service.

3.5.8 In order to meet our Statutory responsibilities under the Public Sector Equality Duty, we will collect and monitor equality data (e.g. race, disability, gender) about complainants to identify patterns or disparities.

3.5.9 We will acknowledge a complaint within three working days of receiving it. This can be done in writing, electronically or verbally.

3.5.10 We may receive anonymous or general feedback that would not meet the criteria for who can complain (see below). In this case we would normally take a closer look into the matter to identify if there is any learning for our organisation unless there is a reason not to.

3.6 Who can give Feedback/Complain

3.6.1 As set out in the 2009 Regulations, any person may make a complaint to us if they have received or are receiving care and services from our organisation. A person may also complain to us if they are not in direct receipt of our care or services but are affected, or likely to be affected by, any action, inaction or decision by our organisation. When we investigate a complaint, we need the patient's consent to investigate the details of their care. This consent can be given either verbally or in writing.

3.6.2 If the person affected does not wish to deal with the complaint themselves, they can appoint a representative to raise the complaint on their behalf. There is no restriction on who may represent the person affected. However, they will need to provide us with their consent from their representative to raise and discuss the complaint with us and to see their personal information (including any relevant medical records).

3.6.3 If the person affected has died, is a child or is otherwise unable to complain because of physical or mental incapacity, a representative may make the complaint on their behalf. There is no restriction on who may act as representative but there may be restrictions on the type of information we may be able to share with them. We will explain this when we first look at the complaint.

3.6.4 If someone else is making the complaint on the patient's behalf, we will ask the patient to confirm that they are happy for us to share information and respond to the complaint. The patient has the right to withdraw their consent at any time. If the patient is unable to give consent because they do not have the mental capacity to do so, we will ask to see evidence of a Lasting Power of Attorney for Health and Welfare. If this is in place, we will seek consent from that person. If no consent can be obtained, we will still carry out an investigation where appropriate. However, our response will not include any personal information about the patient.

3.6.5 If a complaint is brought on behalf of a child; we will need to be satisfied that there are reasonable grounds for a representative bringing the complaint rather than the child. If we are not satisfied, we will share our reasons with the representative in writing. 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.

3.6.6 If at any time we believe that a representative is not acting in the best interests of the person affected we will assess whether we should stop our consideration of the complaint. If we do this, we will share our reasons with the representative in writing. In such circumstances we will advise the representative that they may complain to the Parliamentary and Health Service Ombudsman if they are unhappy with our decision.

3.7 Timescale for Making a Complaint

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

3.7.2 If a complaint is made to us after that 12-month deadline, we will consider it if:

- We believe there were good reasons for not making the complaint before the deadline, and
- If it is still possible to properly consider the complaint.

3.7.3 If we do not see a good reason for the delay, or we think it is not possible to properly consider the complaint (or any part of it) we will write to the person making the complaint to explain this. We will also explain that, if they are dissatisfied with that decision, they can complain to the Parliamentary and Health Service Ombudsman.

3.8 Feedback and other procedures

3.8.1 We make sure staff who deal with feedback are properly supported and trained to identify when it may not be possible to achieve a relevant outcome through the feedback process on their own. When this happens, the staff member dealing with the complaint will inform the person making the complaint and give them information about any other process that may help address the issues and has the potential to provide the outcomes sought.

3.8.2 This can happen at any stage in the complaint handling process and may include identifying issues that could or should:

- Trigger a patient safety investigation and/or duty of candour
- Trigger our safeguarding, including management of safeguarding allegations against staff, processes
- Legal process such as a claim or subject access request (SAR)
- Involve a coroner’s investigation or inquest
- Trigger a relevant regulatory process, such as fitness to practice investigations or referrals
- Involve Human Resources procedures
- Trigger an Information Governance/Right to Rectification process
- Involve a relevant legal issue that requires specialist advice or guidance.

3.8.3 When another process may be better suited to cover other potential outcomes; our staff will seek advice and provide clear information to the individual raising the complaint. We will make sure the individual understands why this is relevant and the options available. We will also signpost the individual to sources of specialist independent advice. This will not prevent us from continuing to investigate the complaint. We will make sure that the person raising the complaint gets a complete and holistic response to all the issues raised. This includes any relevant outcomes where appropriate. The staff member

dealing with the complaint will engage with other staff or organisations who can provide advice and support on the best way to do this.

3.8.4 If an individual is already taking part or chooses to take part in another process but wishes to continue with their complaint as well, this will not affect the investigation and response to the complaint. The only exceptions to this are if:

- The individual requests or agrees to a delay.
- There is a formal request for a pause in the complaint process from the police, a coroner or a judge.

3.8.5 In such cases the complaint investigation will be reviewed by the Patient Relations Manager who may decide to put the case on hold until those processes conclude. We will continue to keep people informed if this is the case and will seek to minimise delays which are in our control.

3.8.6 If we consider that a staff member should be subject to remedial or disciplinary procedures or referral to a health professional regulator, we will advise the person raising the complaint, however we will not inform them of the outcome of any such procedures. We will share as much information with them as we can while complying with data protection legislation. If the person raising the complaint chooses to refer the matter to a health professional regulator themselves, or if they subsequently choose to, it will not affect the way that their complaint is investigated and responded to. We will also signpost to sources of independent advice on raising health professional fitness to practise concerns.

3.8.7 If the person dealing with the feedback identifies at any time that anyone involved in the complaint may have experienced, or be at risk of experiencing, harm or abuse then they will discuss the matter with relevant colleagues and initiate our safeguarding, including management of safeguarding allegations against staff, processes.

3.9 Confidentiality of complaints

3.9.1 We will maintain confidentiality and protect privacy throughout the complaints process in accordance with UK General Data Regulation (GDPR) and Data Protection Act 2018. We will only collect and disclose information to those staff who are involved in the consideration of the complaint. Documents relating to a complaint investigation are securely stored and kept separately from medical records or other patient records. They are only accessible to staff involved in the consideration of the complaint.

3.9.2 Complaint outcomes may be anonymised and shared within our organisation and may be published on our website to promote service improvement.

3.10 How We Handle Complaints

3.10.1 We publish clear information about our complaints process and how people can get advice and support with their complaint through their local independent NHS Complaints Advocacy service and other specialist independent advice services that operate nationally.

3.10.2 We will make sure that everybody who uses (or is impacted by) our services (and those that support them) know how they can make a complaint by having our complaints Policy and/or materials that promote our Policy visible in public areas and on our website. We will provide a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to our complaints process online.

3.10.3 We will make sure that our service users' ongoing or future care and treatment will not be affected because they have made a complaint.

3.10.4 When we receive a complaint and carry out an investigation, we always make sure to be open and honest in our response. This is part of our **duty of candour** – which means being truthful, explaining what happened clearly, and saying sorry if something has gone wrong. At Yorkshire Ambulance Service (YAS), we believe it's important to apologise when a mistake has been made, no matter what the level of harm. Our aim is to be transparent, support learning, and make improvements where needed.

3.11 What We Do When We Receive a Complaint

3.11.1 We want all people, patients, their family members and carers to have a good experience while they use our services. If somebody feels that the service received has not met our standards, we encourage people to talk to staff who are dealing with them and/or to contact our Patient Advocacy and Liaison Service (PALS) to see if we can resolve the issue promptly.

3.11.2 We want to make sure we can resolve complaints quickly as often as possible. To do that, we train our staff to proactively respond to service users and their representatives and support them to deal with any complaints raised at first point of contact.

3.11.3 All of our staff who have contact with patients, service users (or those that support them) will handle complaints in a sensitive and empathetic way. Staff will make sure people are listened to, get an answer to the issues quickly wherever possible, and any learning is captured and acted on. Our staff will:

- Listen to the service user to make sure they understand the issue(s)
- Ask how they have been affected
- Ask what they would like to happen to put things right
- Carry out these actions themselves if they can (or with the support of others)
- Explain why, if they cannot do this, and explain what is possible
- Capture any learning to share with colleagues and improve services for others.

3.12 Stage One - Complaints that can be Resolved Quickly

3.12.1 Our frontline staff often handle complaints that can be resolved quickly at the time they are raised, or very soon after. We encourage our staff to do this as much as possible so that people get a quick and effective answer to their issues.

3.12.2 In keeping with the 2009 Regulations, if a complaint is made verbally (in person or over the phone) and resolved by the end of the next working day, it does not need go through the remainder of this Policy. For this to happen, we will confirm with the person making the complaint that they are satisfied we have resolved the issues for them. If we cannot resolve the complaint within that timescale we will handle it in line with the rest of this Policy.

3.13 Acknowledging Complaints

3.13.1 For all other complaints, we will acknowledge them (either verbally or in writing/email) within three working days. We will also discuss with the person making the complaint how we plan to respond to the complaint.

3.14 **Focus on Early Resolution**

3.14.1 When we receive a complaint; we are committed to making sure it is addressed and resolved at the earliest opportunity. Our staff are trained to identify any complaints that may be resolved at the time they are raised or very soon after. If staff consider that the issues cannot be resolved quickly, we will take a closer look into the matter (see section 3.17 onwards).

3.14.2 When our staff believe that an early resolution may be possible, this will be passed to the service area Governance Team who will ensure someone is tasked with addressing the matter. Staff are authorised to take action to address and resolve the issues raised and put things right for the person raising them. This may mean giving a quick explanation or apology themselves or making sure a colleague who is more informed of the issues does. Our staff will resolve complaints in person or by telephone wherever possible.

3.14.3 If we think a complaint can be resolved quickly; we aim to do this in a matter of days. We will always discuss with those involved what we will do to resolve the complaint and how long that will take.

3.15 **If We Can Resolve a Complaint**

3.15.1 If we can answer or address the complaint early, and the person making the complaint is satisfied that this resolves the issues, our staff have the authority to provide a response on our behalf. This will often be done in person, over the telephone, or in writing (by email or letter) in line with the individual circumstances.

3.15.2 We will capture a summary of the complaint in our Datix system including how we resolved it, and we will share that with the person making a complaint. This will make sure we build up a detailed picture of how each of the services we provide is doing and what people experience when they use these services. We will use this data to help us improve our services for others.

3.16 **If We Are Not Able to Resolve a Complaint**

3.16.1 If we are unable to find an appropriate way to resolve the complaint to the satisfaction of the person making it, we will look at whether we need to take a closer look into the issues.

3.17 **Stage Two - A closer look into the issues**

3.17.1 Not every complaint can be resolved quickly and sometimes we will require a longer period of time to have a closer look into the issues and carry out an investigation. In these cases, we will make sure the complaint is discussed by the service area's Local Incident Review Group (LIRG) who will allocate an appropriate member of staff who will take a closer look into the issues raised. This will always involve taking a detailed and fair review of the issues to determine what happened and what should have happened.

3.17.2 We will make sure staff involved in carrying out a closer look are properly trained to do so. We will also make sure they have:

- The appropriate level of authority and autonomy to carry out a fair investigation.
- The right resources, support and time in place to carry out the investigation, according to the work involved in each case.

3.17.3 Where possible, complaints will be looked at by someone who was not directly involved in the matters complained about. If this is not possible, we will explain to the person making the complaint the reasons why it was assigned to that person. This should address any perceived conflict of interest.

3.18 Clarifying the complaint and explaining the process

3.18.1 The Patient Relations Coordinator dealing with the complaint will:

- Engage with the person raising the complaint (preferably in a face-to-face meeting or by telephone) to make sure they fully understand and agree:
    - The key issues to be looked at.
    - How the person has been affected.
    - The outcomes they seek.
- Signpost the person to support and advice services, including independent advocacy services, at an early stage.
- Share a realistic timescale for how long the investigation is likely to take with the person raising the complaint, depending on:
    - The content and complexity of the complaint.
    - The work that is likely to be involved.
- Agree how they will keep the person (and any staff specifically complained about) regularly informed and engaged throughout.
- Explain how they will carry out the closer look into the complaint, including:
    - What evidence will be considered.
    - Who will be spoken too.
    - How they will decide if something has gone wrong or not.
    - Who will be responsible for the final response.
    - How the response will be communicated.

3.19 Carrying Out the Investigation

3.19.1 Staff who carry out investigations will give a clear and balanced explanation of what happened and what should have happened. They will reference relevant legislation, standards, policies, procedures and guidance to clearly identify if something has gone wrong.

3.19.2 They will make sure that any staff members specifically complained about are made aware at the earliest opportunity (see ‘Support for staff’ below).

3.19.3 They will make sure the investigation clearly addresses all the issues raised. This includes obtaining evidence from the person raising the complaint and from any staff involved or specifically complained about.

3.19.4 If the complaint raises clinical issues; they will obtain a clinical view from someone who is suitably qualified. Ideally, they should not have been directly involved in providing the care or service that has been complained about. This may include seeking advice from a Consultant or Advanced Paramedic, Senior Nurse or Doctor.

3.19.5 In exceptional circumstances it may be necessary to ask for an investigation to be undertaken by someone from another NHS Ambulance Trust. If this is deemed to be necessary, this will be discussed at the relevant LIRG and escalated to the Patient Relations Manager who will use the National Ambulance Patient Experience Subgroup reciprocal agreement (Appendix C) to arrange an investigator.

3.20 **Timescales for Resolution**

3.20.1 Individual timescales for resolution of complaints progressed formally will be agreed with the complainant on a case-by-case basis and logged in Datix. The expectation is that most complaints should be resolved within 30 working days but may take up to 90 working days for those complaints that are more complex.

3.20.2 We will aim to complete our investigation within the timescale shared with the person making the complaint at the start of the investigation. Should circumstances change we will:

- Notify the person raising the complaint (and any staff involved) immediately.
- Explain the reasons for the delay.
- Provide a new target timescale for completion

3.20.3 Fortnightly reviews of the caseload will take place with oversight of the Patient Relations Manager. This review will focus on complaints nearing completion date to ensure barriers are identified and an action plan is put in place to ensure progress.

3.20.4 Unless we have agreed a longer timescale with the person raising the complaint within the first 6 months, we will inform them if we cannot conclude the investigation and issue a final response within 6 months. Any complaints over 6 months old with no response issued will be escalated to the Head of Nursing and Patient Experience who will review the case, write to the person to explain the reasons for the delay and the likely timescale for completion. They will then maintain oversight of the case until it is completed, and a final written response issued.

3.21 **Providing a Remedy**

3.21.1 Following the investigation, if the person investigating the complaint identifies that something has gone wrong, they will seek to establish what impact the failing has had on the individual concerned. Where possible they will put that right for the individual and any other people who have been similarly affected. If it is not possible to put the matter right, they will decide, in discussion with the individual concerned and relevant staff, what action can be taken to remedy the impact.

3.21.2 In order to put things right, the following remedies may be appropriate:

- An acknowledgement, explanation and a meaningful apology for the error.
- Reconsideration of a previous decision.
- Expediting an action.
- Waiving (or recompensing) a fee or penalty.
- Issuing a payment or refund.
- Changing policies and procedures to prevent the same mistake(s) happening again and to improve our service for others.

3.21.3 This Policy does not replace the Trust's Claim Management Policy. 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 for it to be processed in line with the Trust's Claims Management Policy.

3.21.4 Where a financial remedy has been requested this will be reviewed using the Parliamentary and Health Service Ombudsman financial remedy guidance and Severity of injustice scale. This review will be undertaken by the Senior Manager responsible for signing the response letter and the Patient Relations Manager. If they are unable to reach agreement on appropriate financial remedy this will be escalated to the Head of Nursing and Patient Experience and the Executive Director of Quality/Chief Paramedic who will review and make a final decision. If it is agreed that the impact fits into level five or above of the severity of injustice scale, then these cases will be discussed with the Legal Services team with a view to referring to the Trust's insurers.

3.21.5 If a financial remedy is agreed, this will be processed following the Compliments SOP, Comments SOP, Concerns SOP and Complaints SOP and paid from the budget of the service area responsible.

3.22 The Final Written Response

3.22.1 As soon as practical after the investigation is finished, the Patient Relations Coordinator will draft a written response which will go through the following quality assurance process:

- Checked for accuracy and that we have answered the key lines of enquiry (KLOE) agreed with the person giving feedback – local investigator.
- Quality assurance 1 – Senior Patient Relations Coordinator or Patient Relations Manager.
- Quality assurance 2 – Head of Operations or Governance Lead.
- Sign off – Responsible senior manager.
- Final review – Chief Executive.

3.22.2 The response will be sent to the person raising the complaint and any other interested parties. The response will include:

- A reminder of the issues investigated, and the outcome sought.
- An explanation of how we investigated the complaint.
- The relevant evidence we considered.
- What the outcome is.
- An explanation of whether something went wrong that sets out what happened compared to what should have happened, with reference to relevant legislation, standards, policies, procedures and guidance.
- If something went wrong, an explanation of the impact it had.
- An explanation of how that impact will be remedied for the individual.
- A meaningful apology for any failings.
- An explanation of any wider learning we have acted on/will act on to improve our service for other users.
- An explanation of how we will keep the person raising the complaint involved and updated on how we are taking forward all systemic learning or improvements relevant to their complaint.
- Confirmation that we have reached the end of our complaint procedure.
- Details of how to contact the Parliamentary and Health Service Ombudsman if the individual is not satisfied with our final response.
- A reminder of where to obtain independent advice or advocacy.

3.23 **Support for Staff**

3.23.1 We will make sure all staff who look at patient feedback have the appropriate: training, resources, support and time to investigate and respond to complaints effectively. This includes how to manage challenging conversations and behaviour.

3.23.2 We will make sure staff specifically complained about are made aware of the complaint and we will give them advice on how they can get support from within our organisation, and externally if required.

3.23.3 We will make sure staff specifically complained about can give their views on the events and respond to emerging information. Our staff will act openly and transparently and with empathy when discussing these issues.

3.23.4 The person carrying out the investigation will keep any staff complained about updated. These staff will also have an opportunity to see how their comments are used before the final response is issued.

3.24 **Referral to the Ombudsman**

3.24.1 In our response on every complaint, we will clearly inform the person raising the complaint that if they are not happy with the outcome of our investigation, they can take their complaint to the Parliamentary and Health Service Ombudsman.

3.25 **Complaints Involving Multiple Organisations**

3.25.1 If we receive a complaint that involves other organisation(s) (including cases that cover health and social care issues) we will make sure that we investigate in collaboration with those organisations. The people handling the complaint for each organisation will agree who will be the 'lead organisation' responsible for overseeing and coordinating consideration of the complaint.

3.25.2 The person investigating the complaint for the lead organisation will be responsible for making sure the person who raised the complaint is kept involved and updated throughout. They will also make sure that the individual receives a single, joint response.

3.26 **Monitoring, Demonstrating Learning and Data Recording**

3.26.1 We expect all staff to identify what learning can be taken from complaints, regardless of whether mistakes are found or not.

3.26.2 Our Senior Managers take an active interest and involvement in all sources of feedback and complaints, identifying what insight and learning will help improve our services for other users.

3.26.3 We maintain a record of:

- Each complaint we receive
- The subject matter
- The outcome
- Whether we sent our final written response to the person who raised the complaint within the timescale agreed at the beginning of our investigation

3.26.4 To measure our overall timescales for completing consideration of all complaints and our delivery of the NHS Complaint Standards, we seek feedback on our service from:

- People who have made a complaint and any representatives they may have.
- Staff who have been specifically complained about.
- Staff who carried out the investigation.

3.26.5 We seek this feedback by sending surveys to people who have been involved in complaints, collating results and reporting these internally. We then use these data to improve our processes.

3.26.6 We monitor all feedback and complaints over time, looking for trends and risks that may need to be addressed. These are reported to operational quality groups, Patient Experience Steering Group, Patient Safety Learning Group, Clinical Governance Group and Quality Committee.

3.26.7 In keeping with the 2009 Regulations section 18, as soon as practical after the end of each financial year, as part of our annual report, we will produce and publish a report on our complaint handling. This will include how complaints have led to a change and improvement in our services, policies or procedures.

3.27 Complaints about a Private Provider of our NHS Services

3.27.1 This complaint handling Policy applies to all NHS Services we provide.

3.27.2 Where we outsource the provision of NHS Services to a contractor or private provider, we will make sure they follow these same complaint handling procedures.

3.27.3 We will maintain meaningful strategic oversight of the performance of these organisations to make sure they meet the expectations set out in the NHS Complaint Standards.

3.28 Complaining to the Commissioner of our Service

3.28.1 Under section 7 of the 2009 Regulations, the person raising the complaint has a choice of complaining to us, as the provider of the service, or to the lead commissioner of our service West Yorkshire Integrated Care Board (ICB). If a complaint is made to our commissioner, they will determine how to handle the complaint in discussion with the person raising the complaint.

3.28.2 In some cases it may be agreed between the person raising the complaint and the commissioner that we, as the provider of the service, are best placed to deal with the complaint. If so, they will seek consent from the person raising the complaint. If that consent is given, they will forward the complaint to us, and we will treat the complaint as if it had been made to us in the first place.

3.28.3 In other cases, the commissioner of our services may decide that it is best placed to handle the complaint itself. It will do so following the expectations set out in the Complaint Standards and in a way that is compatible with this Policy. We will co-operate fully in the investigation.

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 included via the link to the Patient Relations Pulse pages in the New Starter Guide

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

4.4 Every complaint will have a designated manager acting as local investigator. All staff responsible for overseeing complaint resolution and reviewing themes and trends will receive support on using the Feedback module in the 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 Microsoft Team meetings by members of the Patient Relations team.

4.5 Further support and resources will also be available via the Patient Relations pages on Pulse.

5.0 Implementation Plan

5.1 The latest approved version of this document 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.

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 ICB are provided through Business Intelligence Dashboards 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 by the Patient Relations Manager against the requirements of this Policy. Any points of non-compliance will be raised with the individuals involved and their manager and support in put in place to ensure learning.

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

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

6.6 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

7.1 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

7.2 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
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 This Policy includes the following appendices:
Appendix A – Definition
Appendix B – Roles and Responsibilities
Appendix C - National Ambulance Patient Experience Group (NASPEG) reciprocal investigation arrangements

Appendix A - Definitions

Compliments	Positive feedback received from patients, their families, or members of the public about the services provided by Yorkshire Ambulance Service NHS Trust (YAS).
Comments	General feedback received from patients, their families, or members of the public that does not require specific responses.
Concerns	Issues raised by patients, their families, or members of the public that require attention and resolution
Complaints	Expressions of dissatisfaction, either spoken or written, that require a response. Complaints can be about an act, omission, or decision made by YAS or the standard of service provided.
Service to Service	Inbound is a query submitted by a partner organisation that relates to a specific patient interaction and had the query been submitted by the patient or a family member it would be dealt with under this Policy. A service to service is not a simple request for information from another organisation of a specific team (e.g. legal, safeguarding or patient safety), these should be processed by the receiving team in line with their own processes for sharing information.
Patient Relations Team	The team responsible for coordinating and managing all compliments, comments, concerns, and complaints within YAS.
Local Incident Review Group (LIRG)	The group responsible for overseeing the investigation of patient feedback concerns in each operational service area.
Patient Advocacy and Liaison Service (PALS)	The service that assists patients, their families, and members of the public in resolving issues promptly.
Duty of Candour	The obligation to be open and honest when something goes wrong, including providing a clear explanation and apology
Datix	The system used by YAS to log and track complaints, concerns, and feedback.
Financial Remedy	Compensation provided to patients, their families, or members of the public when a complaint investigation identifies that something has gone wrong and has had an impact on the individual concerned.

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 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/Chief Paramedic

Trust Executive Group (TEG)
The Trust Executive Group, led by the Chief Executive, has responsibility for disseminating this Policy to the Trusts Senior Leaders.

Clinical Governance Group (CGG)
The Clinical Governance Group is responsible for approving this Policy and for ensuring implementation and monitoring through regular updates from the Patient Experience Steering Group.

Patient Experience Steering Group (PESG)
The PESG will receive regular updates on performance and themes and trends emerging from patient feedback.

Local Incident Review Groups (LIRG)
LIRGs are held in each operational service area, they will be attended by a Senior Patient Relations Coordinator who will present feedback cases for discussion.

LIRG will review cases, confirm the relevant risk grading and identify a local investigator for the case. Dependent on how the LIRG operates some cases may be filtered out at a pre-LIRG or governance huddle. Where this is the case, the Datix will be updated to reflect where and by whom the decision not to progress to LIRG has been made to ensure that cases have a full audit trail.

As cases progress, they may be further discussed at LIRG if information is received which may change the risk grading or if the case is not progressing in line with this Policy, LIRG will be the first point of escalation.

Central Incident Review Group (CIRG)
Feedback cases will be escalated to CIRG from LIRGs when;

- There is need for further discussion or oversight from senior leaders
- The case is determined by LIRG to be graded moderate or above
- There is a requirement for discussion with subject matter experts, who are not present at LIRG.
- For any other reason as determined by LIRG.

Feedback cases listed for discussion at CIRG will be presented by the governance lead for the service area and the relevant Senior Patient Relations Coordinator will be present.

Chief Executive
The Chief Executive is the Responsible Person under the Local Authority, Social Services and National Health Service Complaint Regulations 2009, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations). The Chief Executive is responsible for ensuring the Trusts compliance with the arrangements made under those regulations, and in particular ensuring that action is taken, if necessary, in the light of the outcome of a complaint.

The Chief Executive will review and send a cover letter for all formal complaints received by the Trust. The Chief Executive will also sign letters to those making compliments, review responses to the PHSO and consider appeals against unreasonable complainant behaviours.

Executive Director of Quality/Chief Paramedic
The Executive Director of Quality/Chief Paramedic holds the portfolio responsibility for patient experience and feedback.

The Executive Director of Quality/Chief Paramedic will make final decisions on financial remedy in relation to complaints if there is an ability to reach a decision at senior leadership level.

The Executive Director of Quality/Chief Paramedic will review and send a cover letter for formal complaints in the absence of the Chief Executive.

Senior Leaders
The following roles are responsible for ensuring that the Policy is embedded within their area of the Trust:

- A&E Operations – Directors of Partnership and Operations
- Remote Patient Care – Associate Chief Operating Officer
- Central Services – Associate Chief Operating Officer
- Patient Transport Services – Managing Director
- Other Trust areas – Responsible Executive Director

These senior leaders will review and sign all formal complaint responses which relate to their service area. Where a complaint is about more than one area the Patient Relations Manager will advise who should be the signatory following review of the case and discussion with the relevant senior leaders.

These senior leaders will also be responsible for ensuring that each patient feedback is welcomed, steps are taken to resolve dissatisfaction close to the point of contact and that each formal complaint has a local investigation lead identified, that investigations take place efficiently and without undue delay and that learning is taken from complaints. This will be via a feedback learning plan which will be overseen by the relevant senior leaders meeting structure.

Head of Nursing and Patient Experience
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 Commissioning bodies, NHSE, Care Quality Commission or Department of Health and Social Care are involved.

The Head of Nursing and Patient Relations will make decisions on unreasonable complainant behaviour restrictions and will lead transformation of the processes which underpin this Policy when that is required.

The Head of Nursing will be the point of escalation for feedback cases that are over six months old. These will be reviewed and escalated to the relevant responsible senior leader as appropriate.

Patient Relations Manager
The Patient Relations Manager is the nominated 'complaints manager' under the Local Authority, Social Services and National Health Service Complaint Regulations 2009, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations). This role is responsible for managing the procedures for handling and considering complaint sin accordance with the arrangements made under the Regulations.

Advises on and manages unreasonable complainant behaviour arrangements. Including taking immediate action when necessary to protect the welfare of the staff in the Patient Relations Manager (this must be reviewed within three working days by the Head of Nursing and Patient Experience)

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
- Providing an initial risk-rating for each complaint and concern in line with the Trust's complaints risk matrix
- Ensuring that Local Incident Review Groups are attended by a Senior Patient Relations Coordinator to present cases.
- Documenting all information relating to the complaint or concern in line with this Policy and other Trust procedure
- Liaising with the relevant Governance team 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.
- Carrying out reviews of complaints as required.

Quality & Governance Leads
Each operational service area has a Quality/Governance Lead role, these roles are responsible for ensuring that patient feedback cases are processed in line with this Policy. This includes;

- Ensuring cases are listed for review at LIRG.
- Escalating cases to CIRG where required.
- Monitoring feedback cases (including service to service) that are allocated to their area to ensure they are progressing and are closed appropriately.
- Providing advice and guidance to operational managers who are undertaking activities (including local resolution) under this Policy.
- Reporting demand and performance relating to their area to relevant groups to ensure that the area leadership team has visibility of cases related to feedback.

Consultant Paramedics
As chair of LIRG the Consultant Paramedics are responsible for ensuring each feedback case is allocated a local investigator and has an appropriate risk grading.

The Consultant Paramedic will ensure that clinical advice is given by a suitable senior clinician (eg Specialist or Advanced Paramedic or a subject matter expert).

Operational Heads of Service
Operational Heads of Service are responsible for ensuring that investigations relating to feedback cases are undertaken fairly and efficiently and that timescales are met.

The Head of Service is also responsible for quality checking final responses before the letter progresses to the responsible director for sign off. This quality check is to ensure that the investigation has been completed fully, and that the response answers all the elements of the complainants' concerns. The Head of Service should also ensure that the response includes an apology if this is appropriate and that where learning is identified there are plans in place to embed this in the service area.

Operational Managers
First and second line managers in the Operational Service areas are responsible for;

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

Fostering 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.

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

Aiming to resolve complaints suitable for stage one/local resolution as quickly as possible following the principles outlined in the PHSO Early Resolution guide.

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

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

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

Speaking to their staff members to ensure information provided for investigations and ensure adequately cover the information requested.

Reaching a conclusion in relation to complaints investigations (both stage one and two).

Effectively recording any input on patient feedback cases on the Datix system.

All YAS staff

All YAS staff and volunteers are responsible for:

- Always maintaining a professional manner, acting in line with YAS values and behavioural framework, always demonstrating, respect for the individuals they care for.
- Attempting to resolve concerns “real-time” wherever possible, escalating to a 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 - National Ambulance Patient Experience Group (NASPEG) reciprocal investigation arrangements

Protocol for Independent Investigation and Review of Complaints

National Ambulance Services Patient Experience Group

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.

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.

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.

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