North East Ambulance Service NHS
NHS Foundation Trust

Complaints Policy

Document Control Sheet

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Signature of Chairman of Ratification Committee	
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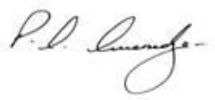
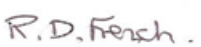
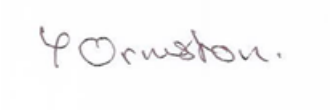
Table of Revisions

Version number	Status	Document section	Description of change	Author	Date revised
01	Live	All Sections	Full rewrite to replace existing policy	Complaints Manager	01 July 2014
02	live		Amended document with signatures & table of revision complete		14/01/2016
03	Live		Q-pulse numbering changed due to restructuring of the system and review date set at previous revision and table of revision amended to reflect change along with version numbers		20/01/2016
04	Live		Amended document with date of signatures		18/02/2016

Executive Directors Signature

Directors signature	Print name	Date
	Joanne Baxter	30 June 2014
	Paul Liversidge	30/06/2014
	Roger French	30 June 2014
	Yvonne Ormston	30 June 2014

Executive Directors who will be responsible for ensuring staff within their directorates abide by the policy should sign here to evidence they have seen the policy and agree to its content.

Contents

1. Introduction

The Trust is committed to providing an accessible, equitable and effective means for people (and/or their representative) to express their views about the services it provides.

If a person is unhappy about any matter of the Trust's service they are entitled to make a complaint, have it considered, and receive a response.

The Trust has taken on board recommendations from Hard Truths – The Journey to Putting Patients First (October 2013) in the development of this policy. Key findings in the report from the Clwyd review identified;

- Vulnerable people find the complaints system complicated and hard to navigate
- There is a low level of public awareness of the NHS Complaints Advocacy Service
- People are reluctant to complain and staff can be defensive and reluctant to listen to or address concerns
- Organisations do not always deliver their legislative responsibilities on complaints handling
- There is a need for quality, trained staff to deal with complaints effectively and appropriately.

Complaints, concerns and comments are viewed by the Trust as a significant opportunity for improvement and learning and by listening to our service users, patients, carers, hospitals; GPs etc, the Trust will be able to continually improve services, including listening to positive feedback.

The complaints procedure is not to apportion blame against staff but to investigate complaints with the aim of satisfying complainants whilst remaining fair to staff. It is also there to learn any lessons from complaints and facilitate improvement in service delivery.

It is acknowledged that some complaints will highlight serious incidents, which may highlight specific practice which may lead to disciplinary investigation.

It is our objective to satisfy complainants that the Trust, and its staff, takes their dissatisfaction seriously and to assure them that investigations will be thorough and objective.

Where appropriate, action will be taken to prevent a reoccurrence and to improve service delivery.

Complainants should be reassured that any contact with the Trust's complaints team will not adversely affect the service provided by the Trust and any person raising a concern will not be treated differently.

Early resolution is key to a successful outcome. Most comments or concerns can be resolved satisfactorily by a speedy response from the staff on the spot. Therefore all staff should attempt to do this where necessary and acknowledging dissatisfaction as it is raised and offering an apology should be encouraged. This can often provide patients and their families with the reassurance that action is or will be taken in relation to their concerns without them having to go through the formal complaints procedure.

Where the member of staff is unable to investigate or resolve concerns locally, the complaint should be referred to the PALS service to aid resolution or the Complaints team for formal investigation and response. The investigation process will be followed for all complaints and is not dependent on the severity of the complaint.

This policy should be used in conjunction with the Trust's 'Being Open' Policy

This policy includes the procedure for handling habitual or vexatious complaints. See page 17 section 5.10.

2. Purpose

The aim of this policy is to ensure the Trust have an easily identifiable and recognisable process for dealing with concerns and complaints. We will respond quickly, constructively and sensitively to concerns and complaints. The process will be efficient, effective and accessible, aiming to achieve an early resolution that is fair and proportionate.

The objective of the complaints policy is to ensure North East Ambulance Service NHS Foundation Trust (NEAS) responds to complaints in an objective and fair manner in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and with due regard for the rights of those concerned. It also considers recommendation from Clwyd and Hart (2013)

This policy is to ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement, rather than irritations to be managed defensively.

The policy also serves to ensure all staff are aware of their responsibilities in relation to the management and resolution of complaint.

3. Scope

This policy applies to all members of staff and in particular those involved in the handling, reviewing and management of complaints.

This policy sets out how the Trust will manage the resolution of complaints and concerns.

3.1 Policy Objectives

- It will be easy to use and widely accessible to all staff
- It will be fair, honest and impartial to all involved
- It will be open and accountable
- It will be customer focused, with time limits for action and procedures to keep everyone informed
- It will ensure complaints are dealt with as close as possible to the point at which they arise
- It will respect confidentiality and privacy
- It will ensure all of the points raised receive a full response
- It will help us to monitor and improve our standards and to learn lessons and make improvements in services to benefit patients and staff
- It will ensure changes made as a result of the concern/complaint, are documented and reported on

4. Roles & Responsibilities/Duties

4.1 Chief Executive

The Chief Executive is accountable to the Board of Directors for the effective handling of all complaints. All response letters will be signed by the Chief Executive to ensure the outcome of the investigation and any action taken as a result of the complaint ensures that the person making the complaint receives a comprehensive response in writing within the time scale contained in the Complaints Policy.

4.2 Director of Clinical Care and Patient Safety

The Director acts as the nominated signatory in the absence of the Chief Executive and has delegated authority from the Chief Executive to ensure

compliance with this policy and procedures governing all aspect of complaints handling in conjunction with the Complaints Manager and Head of Risk, Claims and Complaints. The Director has responsibility for reviewing all complaints with a clinical element.

4.3 Head of Clinical Care and Patient Safety/Consultant Paramedic

The head of clinical care and patient safety and/or Consultant Paramedic is a deputy for the Director and will review all clinical complaints before a written response is sent.

4.4 Head of Risk and Claims

The Head of risk and claims is responsible for ensuring that the complaints team manage the complaints process in line with this policy and produce regular reports for the Board, Quality Committee and Executive Team on compliance, themes and trends and learning.

4.5 Complaints Team

The Complaints Team will manage and facilitate the complaints process from end to end on behalf of the Director of Clinical care and Patient Safety and Head of Risk and Claims maintaining an accurate register of all complaints received on the Ulysses system. The complaints team will liaise with the investigating officers and report back to the Chief Executive and in all clinical cases this will also be reviewed by the Director and Head of Clinical Care and patient Safety, so the response to a complaint can be provided in full and within the time limits. See Appendix H

The complaints team will also provide the Service Line Managers and the Experience, Complaints, Litigation, Incidents and PALS Group (ECLIPS), complaints reports on trends, themes and outcomes, and actions taken by the trust in order that these can be monitored. The complaints team will be readily available to meet members of the public and provide support and advice to all staff.

4.6 Investigating Officer

The Investigating Officer can be any member of Trust staff who has undergone investigating officer or complaints handling training. The nominated lead for the complaints investigation will be responsible for ensuring the complaint is fully investigated using information provided by the complainant, system and staff members involved, including the ePRF where applicable, to ensure a thorough investigation of the complaint and all concerns raised, are fully addressed.

The investigating officer will provide the complaints team with an investigation report, including a detailed action plan where necessary on the required forms held on Ulysses.

The report should include the following:

- An apology that there has been cause for complaint
- Condolences if a death has occurred
- An apology where appropriate for poor service or care provided
- Is written in a factual, non-defensive manner
- Whether the complaint is Upheld, Not Upheld or Partly Upheld
- Details of all actions or recommendations found as a result of the complaint investigation.
- Ensure all detailed actions or recommendations are completed within timescales and that there is evidence of improvement
- Once actions or recommendations are completed, update the complaints team via e-mail with the outcome and completion date
- Ensure appropriate staff attend meetings with complainants as required
- The investigation should be full, fair and timely, and should not apportion blame.

The investigating officer will send the completed report and action plan via e-mail to the complaints team by the agreed policy deadline.

NB- In cases where the investigating officer considers it appropriate to seek an extension of the time limit, for example because of the complexity of the case, they should contact their senior manager, who in turn will discuss this option with a complaints manager, and the patient before a decision is made whether to request an extension is granted.

No pressure must be placed on the complainant to agree the extension, but the complaints team may, in suitable cases, consider it appropriate to explain, to the complainant, that a comprehensive response may not be possible to achieve, within the timescale agreed.

The key considerations are whether an extension will genuinely enable local resolution of a complaint to be achieved, and that the complainant is involved in the discussion.

The complaints team must ensure that they record the details of any discussion and agreed/disagreed extensions on the Ulysses system.
If requested by the complainant, a letter confirming the agreed extension date and the reasons why will be sent by the complaints team.

4.7 Clinical Practice Manager / Support Officer

The complaints team will refer complaints where there may be an element of clinical concern to any of the above prior to or following the investigation. If a clinical review is required, the reviewed report must include conclusions and any recommendations or actions to be undertaken and returned to the complaints team.

If the report has highlighted serious concerns, or where processes or procedures have not been followed, the case should be referred to the Root Cause Analysis Panel.

The complaints team will advise the investigating officer of the actions or recommendations made by the clinical team or the Root Cause Analysis panel, required to stop any reoccurrence of the incident.

4.8 Line Managers

Members of staff named in a complaint, either personally or by role, should be informed of the complaint by their manager. The Line Manager is responsible for providing immediate and ongoing support to staff involved in a complaint.

4.9 Frontline Staff

The management of frontline complaints or concerns is the responsibility of every individual member of staff. Every member of staff has a responsibility to ensure the people who use our services as patients, carers or visitors are treated with courtesy and consideration. Every effort should be made to make their health care experience as relaxed and informal as possible. Everyone must be aware of their responsibilities within the complaints procedure. Wherever possible, complaints should be resolved at the point when they are raised; only escalating to the formal complaints procedure if this cannot be achieved. See Appendix E

4.10 Root Cause Analysis Panel (RCA)

The RCA Panel is a multi-disciplinary panel with representation from the following directorates:

- Clinical Care and Patient Safety (clinical staff member)
- Risk and Claims
- Human Resources
- Clinical Training
- Operational Management

The role of the RCA panel is to review the complaints investigation and provide a report to the Complaints team detailing the panel's actions and recommendations.

4.11 Patient advice and Liaison Service (PALS)

PALS provide confidential advice and support, helping patients, families and carers to sort out any concerns they may have about any aspect of NHS care. The service

provides information and advice and can help to sort out problems quickly, on the complainants behalf. PALS act independently when handling patient and family concerns, liaising with staff, managers and, where appropriate, other relevant organisations, to negotiate prompt solutions.

There is an agreed protocol to refer issues and complaints for detailed investigation, when appropriate.

4.12 Experience, Complaints, Litigation, Incidents and PALS group (ECLIPS)

The purpose of the group is to ensure the Trust is compliant with legislative, mandatory and regulatory requirements in terms of the group's scope. Maintaining a sharp focus on the experience of patients and provide assurance, through learning from incidents and complaints, ensuring the recommended actions are closed and learning identified and implemented across the service area.

4.13 Quality Committee

The purpose of the Committee is to provide the Board with an independent and objective review of patient and public experience including the planning of care. Quality improvement through leadership, strategy and planning. The committee also ensures the Trust is complying.

5. Policy Content

5.1 What is a Complaint

A complaint usually relates to either a concern or dissatisfaction about a service provided by the Trust. Complaints can be expressed in a number of ways – in person, by telephone, in writing, by email or, with consent, through a third party. What we must do is understand why that person is unhappy, and then do something about it, quickly and effectively.

5.2 Who can complain

Patients themselves or a representative, e.g. family member, friend, MP or other agency who has been given consent to act on behalf of the patient, can raise complaints or concerns. The patient will be asked to sign a consent form when others are acting on their behalf. In cases where the Trust seeks consent from the patient, the response time will be 25 working days from receipt of signed consent.

Complaints can be made by the next of kin about a deceased patient's care, a child, or any patient who is unable by reason of physical or mental incapacity (or any other incapacity) to make the complaint themselves. In the case of a patient who has died or who is incapable, their representative must be a relative or other person who, in the opinion of the complaints manager, had or has 'sufficient interest' in their welfare and is a suitable person to act as their representative. The complaints manager will abide by the Information

Governance policy and Caldicott procedures regarding complaints where the patient is deceased.

In the case of a child, a suitable representative would normally be a parent, guardian or other adult person who has care of the child, or one who is authorised by the Local Authority / voluntary organisation in the case of children in care.

Assistance will be given to complainants in accessing the complaints procedure via Patient Advice and Liaison Service (PALS) and Independent Complaint Advocacy (ICA). This includes providing an appropriate and acceptable response to complainants who are unable to read English or have sight or hearing difficulties.

5.3 Time limits for Complaints

Patients, or an appropriate representative complaining on their behalf, should make their concerns known as soon as possible after the incident giving rise to the complaint. Normally, this should be within 12 months of the incident or the time when the patient first became aware of the cause of complaint, whichever is the earlier.

We can extend this time limit where it would be unreasonable for the complaint to have been made earlier and it is still possible to investigate the facts of the case. If we decide not to investigate the complaint the reasons for this decision must be provided to the complainant.

The complainant can request that the Parliamentary Health Service Ombudsman (PHSO) considers the complaint. We aim to be as helpful and supportive as possible in resolving concerns or complaints

5.4 Serious Complaints

If an allegation or suspicion of any of the areas below is received regarding the Trust functions it should immediately be reported to the Head of Clinical Care and Patient Safety and the Head of Risk and Claims and investigated as a formal complaint or referred to the appropriate agency e.g. Police if a possible criminal offence has been committed or Regulatory bodies:

- Physical abuse
- Sexual abuse
- Financial misconduct
- Criminal offence
- Safeguarding

It should also be reported as a Serious Incident (SI).

5.4 Exclusions

The following complaints will not be dealt under the NHS Complaints Regulations 2009:

- A complaint made by a local authority, NHS body, Primary care provider or independent provider.

- A complaint made by an employee of a local authority or NHS body about any matter relating to employment.

- A complaint which has previously been made and resolved to the same complainant and where local resolution has been exhausted.

- A complaint which is, or has been, investigated by a Health Service Commissioner under the 1993 Act.

- A complaint arising out of the alleged failure by the Trust to comply with a request for information under the Freedom of Information Act 2000.

- On the advice of the NHS Litigation Authority, the investigation of a complaint through the complaints procedure may cease immediately if the complainant explicitly indicates an intention to take legal action in respect of the complaint.

5.5 Liaising with External Agencies

When a complaint is received and it is identified that the complaint includes concerns in relation to an external agency i.e. another NHS Trust or Local Authority Social Services, the complainant will be asked if they would prefer a joint response or separate responses from each agency.

Where a separate response is required, consent will be obtained to pass the details of the complaint to the relevant agency.

Where a joint response is required, it will be agreed which agency will act as lead investigator and the appropriate consent will be obtained so that the information can be shared. See appendix F

5.6 Management and Investigation

The complaints team will arrange for the complaint to be investigated in the most appropriate manner to resolve it speedily and efficiently. The purpose of investigation is not only “resolution” but also to establish the facts, to learn, to detect poor practice and to improve services.

The complaints team will make an initial assessment of the complaint or concern and a decision will be taken by the complaints manager as to the best route for resolution.

Complaints must be acknowledged within three working days after receipt by the complaints team. The acknowledgement will be made verbally and a letter sent confirming the process and timescales.

The complaint will be sent to the relevant investigating officer and an action via Ulysses will send the information, informing the officer of the new

complaint and the timeframe for a response.

The response time is determined by the nature of the complaint, current Trust timescales for a written response are 25 working days and verbal responses are 10 working days.

The complaints team will notify the complainant verbally and in writing confirming the issues that are going to be investigated, the manner in which the complaint is to be handled or the likely timescales for the investigation and response.

Within 25 working days the Trust will send a formal response in writing to the complainant which will be signed by the Chief Executive or his nominated responsible person.

It is good practice for letters to be as conciliatory as possible and include apologies as appropriate.

The response will also:

- offer an explanation of how the complaint has been investigated
- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated
- report the conclusion reached including any matters where it is considered remedial action is needed
- include an apology where things have gone wrong
- report the action taken or proposed to prevent recurrence
- indicate that a member of staff is available to clarify any aspect of the letter
- advise of the complainant's right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure

The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided.

All statements, letters, phone calls and actions taken in an investigation will be documented on the Ulysses system. A complete complaint file is required should the complaint be referred to the Parliamentary and Health Service Ombudsman.

Where appropriate, alternative methods of responding to complaints must be

considered, this may be through an immediate response from front-line staff, a meeting, or direct action by a senior person.

It may be appropriate to conduct a meeting in:

- complex cases
- in cases where there is serious harm/death of a patient
- in cases involving those whose first language is not English
- in cases where the complainant has a learning disability or mental health illness (and other capacity challenges)

The Trust should offer every opportunity to exhaust local resolution. Once the final response has been signed and issued, the complaints team should liaise with relevant managers and staff to ensure that all necessary follow-up action has been taken.

The outcome will be monitored via the Ulysses system and reports sent on weekly basis to the relevant operational managers highlighting any issues still outstanding. The complainant and those named in the complaint, should be informed of any change in systems or practice that has resulted from their complaint.

The final response should invite the complainant to let the Trust know if they have any outstanding concerns. In such cases, consideration should be given to arranging further action which might resolve the complaint, including offering a meeting with the complaints manager and any other relevant staff involved. A response should be sent to the complainant confirming the outcome of any further action and advising them of the independent review process.

If the complainant subsequently remains dissatisfied, they may request the Parliamentary and Health Service Ombudsman to review their complaint.

5.7 Re-opened Complaints

If the complainant is unhappy with the response letter and feels the complaint has not been answered fully. The complaints team will reopen the complaint and note the further concerns on the Ulysses system. The complaint would either be sent back for further investigation to an investigating officer and a further response letter sent to the complainant, or a Local Resolution Meeting would be held with the relevant staff and the complainant. *NB: The Trust would allow a further 25 working days to respond to the reopened complaint.*

5.8 Consent/Confidentiality

Any information disclosed to a third party concerning a patient in the investigation of the complaint is confined to that which is relevant. Where possible, such information will only be provided with the knowledge and

consent of the patient.

In this regard:

- Complainants / Patients will be advised at the outset that investigation of a complaint may require examination of medical records and associated documents by those investigating

- a signed agreement to the disclosure of clinical information relevant to the complaint may be required from the patient.

5.9 Breaching Confidentiality

The following are circumstances when confidentiality can be breached even if prior consent had not been obtained or is refused:

- When the complainant / patient reveals any matter that may constitute a criminal offence

- Where there is a clear indication that a serious crime has been, or is about to be committed

- Someone's safety or life is believed to be at risk

- Information is requested by HM Coroner, a court or tribunal

- There are reasonable grounds to suspect abuse of a child or a vulnerable adult

5.10 Habitual Complainants

The Trust is committed to treating all complaints equitably and recognises that it is the right of every individual to pursue a complaint. The Trust endeavours to resolve all complaints to the complainant's satisfaction. However, on occasions, staff may consider that a complaint is habitual in nature, i.e. the complaint raises the same or similar issues repeatedly, despite having received full responses to all the issues they have raised.

Where a complainant has been identified as habitual or vexatious, the Chief Executive, or appropriate deputy in their absence, will determine what action to take. The Chief Executive, or deputy, will notify the complainant in writing of the reasons why they have been classified as a habitual or vexatious complainant and the action to be taken.

This notification may be copied for the information of others already involved in the complaint and a record will be kept with the complaints file on Ulysses. The records will include reference of the reasons why a complainant has been classified as habitual or vexatious.

The Chief Executive or deputy may decide to deal with the complainant by trying to resolve matters, before invoking this procedure, by drawing up a

signed “agreement” with the complainant or setting out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. The Trust may also insist on a particular form of contact, i.e. all communication to be in writing. The complainant should be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered.

5.11 Complaints Survey and Monitoring Questionnaire

Within 10 working days of the Chief Executive issuing his letter of response a questionnaire will be forwarded to the complainant by the complaints team.

On receipt of the completed Patient Experience Evaluation form, the complaints team will record the results on the Ulysses system.

Template held on Ulysses – PTN Experience Evaluation

5.12 Training

All staff will be expected to have a working knowledge of the Complaints Procedure and will be familiarised with this policy as part of their induction and Essential Annual training. It should be made clear to staff that all material relating to a complaint will be made available to all personnel involved in investigating the complaint.

It is the responsibility of all line managers to ensure that the lessons learned from complaints are used as part of the continuing professional development for all staff. There should additionally be training available to staff who respond to complaints to undertake investigator’s training/complaints handling so as to be able to provide the standard of investigation and investigation report required for complaint responses.

5.13 The Role of the Parliamentary and Health Service Ombudsman

The Ombudsman looks into allegations about poor treatment or service provided to patients through the Trust. The Ombudsman will look at complaints that have already been addressed by the Trust in the first instance but where a satisfactory conclusion has not been reached. The Ombudsman will check how the complaint has been addressed and will ask the Trust for details of the complaints file.

When contacted by The Parliamentary and Health Service Ombudsman, the complaints team will ensure that all information requested is sent and any recommendations made by the Ombudsman, following the review, are completed within the timescales set by The Parliamentary and Health Service Ombudsman.

5.14 Compliments/Letters of Thanks

Positive comments and letters of praise are also an important part of feedback about services and will be fed back to the staff concerned. All information will

be stored on the Ulysses systems and reposts sent on a weekly basis the service areas.

6. Glossary of terms

This policy uses the following terms:

7. Monitoring

7.1 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Procedures for handling complaints, concerns, compliments and comments via: Number of complaints year to date from 1st April Number of current outstanding complaints requiring a response still within timescales Number of complaints acknowledged within policy 3 days Number of complaints responded to within policy 25 days Number of complaints responded to out with policy 25 days with agreed extensions Number of complaints with 2 or more extensions Number of complaints outstanding without agreed extensions Number of complaints outstanding over 25 days per service line (as above) Number of appreciations year to date from 1st April
Who will perform the monitoring?	Complaints Team and Operational areas
What are you monitoring?	Complaints performance, trends and themes
When will the monitoring be performed?	Weekly
How are you going to monitor?	Via Ulysses reports
What will happen if any shortfalls are identified?	Complaints will communicate this to the relevant business areas, ECLIPS and Quality Committee and identify on Risk registers
Where will the results of the monitoring be reported?	Weekly to the service areas , monthly to the Board, and bi monthly to ECLIPS and Quarterly to Quality Committee
How will the resulting action plan be progressed and monitored?	The action plan will be monitored by the complaints team and progressed via the service areas, ECLIPS and Quality Committee
How will learning take place?	Learning will be via the action plans and monitored by the complaints managers, ECLIPS , Executive team and quality Committee

7.2 Key Performance Indicators (KPI)

Compliance with this policy will be monitored by the Clinical Care and Patient Safety Directorate and will report regularly through the Quality and the Board. All reports will be submitted by the complaint manager.

8. References

This document refers to the following guidance, including national and international standards:

- Hard Truths – The Journey to Putting Patients First (October 2013) Clywd report 2013
- The Local Authority Social Services and National Health Service Complaints (England)
- Freedom of Information Act 2000

9. Associated Documentation

This document refers to the following Trust policies and procedures:

- NEAS Trust's 'Being Open' Policy

This document is referenced from the following Trust policies and procedures:

List all policies and procedures referred to in this policy here

Appendices

Appendix A Equality Screening

Equality screening which must be conducted to determine if there is a potential differential impact. If there is, a full Equality Impact Assessment must then be carried out.

Date of screening	25 June 2014
Name of assessor	K White
Job title	Equality and Diversity Adviser
Signature of assessor	*Karen White*

Equality Group	Does this document have a potential impact on any of the equality groups?	If yes, please describe the potential impact	Is this impact legal and justifiable? If yes, please explain how
Age	No	N/A	N/A
Disability	Yes	Potential Positive Impact on disability covered by the Equality Act (2010) regulations Prevention of less favourable treatment for individuals within that equality groups	The policy meets legislative requirements and best practice guidance
Gender	No	N/A	N/A
Gender reassignment	No	N/A	N/A
Marriage and civil partnership	No	N/A	N/A
Maternity and pregnancy	No	N/A	N/A
Race	No	N/A	N/A
Religion or belief	No	N/A	N/A
Sexual orientation	No	N/A	N/A

Equality Impact Assessment required?	No
1. Identify the aims of the document	
From the screening, what are the key issues and which equality groups are affected?	
What is the aim of the document?	
What are the intended outcomes of the document	
How will you measure the outcomes?	
Who is intended to benefit and how?	
2. Legislative compliance	
Does the document prevent the promotion of equality of opportunity or good relations between	

different equality groups? Please state how.	
Does the document/service provision infringe an individual's human rights? Please state how.	
3. Considering alternatives	
Can changes be made to the document/service to reduce the impact? (such as amending the wording of a policy or changing a procedure) If Yes, please detail the changes and proceed to Section 6. If No, proceed to section 4	
4. Gathering information	
Please state the relevant qualitative information that is already available that is being used for this EIA.	
Please state the relevant quantitative information that is already available that is being used for this EIA.	
Are there any gaps in your information and if so how are you going to address those?	
5. Partnership working, consultation and involvement	
Do you need to involve, consult or work in partnership with any community group? Y / N If Yes, please state which community group(s).	
Do you need to involve, consult or work in partnership with any staff groups? Y / N If Yes, please state which staff group(s).	
Do you need to involve, consult or work in partnership any specialist services, groups or practitioners? Y / N If Yes, please state which services, groups or practitioners.	

Action		Benefits / Rationale	Lead	Timescale	Measures of Success	Age	Disability	Gender	Gender reassignment	Marriage and civil partnership	Maternity and pregnancy	Race	Religion or belief	Sexual orientation
1.														
2.														
3.														

Action		Benefits / Rationale	Lead	Timescale	Measures of Success	Age	Disability	Gender	Gender reassignment	Marriage and civil partnership	Maternity and pregnancy	Race	Religion or belief	Sexual orientation
4.														

Appendix B Review Process Checklist – Author to complete

Compliance Checks	Author to Complete			
	Yes/ No	Details	Comments	Action Needed
Has the document been consulted upon? (please detail stakeholders that have been consulted)	Yes			
Has the document been agreed by a sub group of the relevant Approval Committee? (if so, please specify the subgroup(s) here and confirm the date the document was endorsed by the group.	Yes			
Approval: JCC (if appropriate)?				
Why has this document been amended? i.e. full review, particular section/new etc.		Full Review		
Has table of revisions been completed?	Yes			
Has the document author clearly identified?	Yes			
Has the document sponsor been identified and consulted with	Yes			
Has the date of the Ratifying Committee meeting to which the document will been submitted been specified?	Yes			
Has the Ratifying Committee been correctly identified?	Yes			
Has the Originating Directorate been notified?	Yes			
Has the scope of the document been identified?	Yes			
Content: intended outcomes clearly described?	Yes			
Has the date the Document will next be reviewed been noted? (If less than the standard 3 years, please provide an explanation why)	Yes			
Has the monitoring table been correctly completed?	Yes			
Has the Equality Impact Screening been completed?	Yes			
If warranted from the above has the Equality Impact Assessment been completed?	Yes			
Has the financial implications been considered?	Yes			
Has the Document been assessed as to whether its circulation should be restricted/unrestricted? If so, the outcome of this assessment should be noted on the front sheet	Yes			
Does the policy need to be available to the public? If so once ratified Communication team need a copy	Yes			
Name a member from the subgroup to be present to respond to any questions if author unavailable		Joanne Baxter		

Date of Policy Review Group Submitted to	01 July 2014
Authors Name	Angela Longstaff
Authors Signature	Hard copy signed

Appendix C Compliance Checklist – Policy Review Group

Approving Sub Committee:	Policy Review Group to Complete		
Compliance Checks	Yes/No	Comments	Actions Needed
Has the front page document been completed fully?	Yes		
Has the author completed checklist? And has this been checked by the group?	Yes		
Style and Format			
Has the correct template been used?	Yes		
Procedural Documents must use the Arial font style bold text size 12	Yes		
Section and paragraph heading should be numbered and in bold.	Yes		
Is it the EIS and EIA if applicable the latest version?	Yes		
Is the title of the Document clear and unambiguous?	Yes		
Has the new version number been amended on the Control Sheet, and Footer of each section?	Yes		
Has the version control/revision table been updated?	Yes		
Has the Document type been identified? (Policy/Procedure?)	Yes		
Explanation of Terms Used			
Acronyms are first used with explanation.	Yes		
Glossary of Terms used if helpful to the procedural documents understanding.	No	Not required as terms explained through the document	
Consultation & Review Arrangements			
Is it clearly apparent that the document has been consulted upon?	Yes		
Has the monitoring table been completed?	Yes		
If the monitoring of this document involves members of other teams or Health Groups, have they been informed?	Yes		
Has the name/job title of the Non Executive Chairman of the Approval Committee been correctly identified?	no	Not asked for on the document	
Associated documents and supporting references			
Are there full references to other Trust Policies that the Policy refers to or is associated with.	Yes		
Following satisfactory review by Policy Review Group			
Has the ratification Committee been identified and is this the right committee?	Yes		
Is there timescales identified for monitoring and reporting to appropriate committee?	Yes		

Policy Review Group Outcome	Reviewed successful

Appendix D Quality Team Checklist

Quality Team Checklist	Yes/No	Comments
Document Control Sheet complete with signatures?	Yes	
Table of revisions complete?	N/A	New document
All footers and watermark updated?	Yes	
Page numbers updated?	Yes	
Review process checklist and compliance checklist complete?	Yes	
Previous version of policy archived?	Yes	
QPulse upload date complete?	25.09.14	
Policy available to relevant staff groups?	Yes	
Process completed: Quality Team	Date 25.09.14	Signature J Hair

Appendix E - Frontline staff responsibilities

Complaints Policy
Frontline staff responsibilities.
Arrangements for dealing first line Concerns / Complaints

People may wish to tell a member of staff or the person in charge of the service they are receiving , about a concern or query that they require help with. **All staff** are expected to provide prompt on the spot assistance to deal with any problems and answer queries as they arise. In dealing with any concerns raised, staff are required to give reassurances that any issues raised will be handled confidentially and the patient or person raising the concern will not be discriminated against either then or in the future as a result. Many concerns can be resolved satisfactorily at this level by means of a simple explanation or apology.

However, if staff are unable to resolve the problem themselves they are required to seek assistance immediately from someone who may be able to, usually their line manager PALS or the complaints team at HQ. Line managers will support staff to resolve any issues and discuss ways with them in which the problem can be resolved and provide advice to answer queries and questions raised.

Following discussions with Line Managers, or other colleagues, the staff member concerned will return to the person who has raised the concern to offer a solution or provide answers to any questions. This needs to be carried out as soon as possible.

Where immediate resolution is not possible via these measures and the person raising the concern is still not satisfied, the complaint / concern should be passed to the complaints team at HQ. The complaints team will then take over the process.

A flow chart identifying individual responsibility for dealing with informal concerns is also attached for information (Appendix H).

WHAT TO DO IF YOU NOTICE OR ARE INFORMED THAT SOMEONE IS UNHAPPY WITH THEIR CARE/SERVICE PROVIDED

Person who is made aware of a concern tries to resolve it, giving reassurance that ongoing care needs will not be adversely affected as a result of concerns being raised and that all issues will be treated in confidence. Alternatively, give contact details for the PALS or complaints team and ask if the person raising the concern would prefer this.
Try to resolve the concern **Inform your next line manger if the concern is not resolved** **If not resolved pass to the complaints team at HQ**
If the concern is not resolved the line manager will support you if required to discuss ways to overcome the concern.
Feedback to the person who has raised the concern
If person raising the concern is still not satisfied the complaints can be passed to PALS or the complaints team at HQ
Record details of all facts & information stated at the time and e-mail the complaints team with the outcome and any actions taken. These will be retained on the Ulysses system and sent to the relevant manager to ensure any key themes / trends are identified and actioned.

Appendix F – Joint Agency complaints handling

Procedure for dealing with complaints which involve another Organisation

1. Multi-Sector Complaints

1.1 Complaints Involving More than One Health Service Provider

Where a complaint spans more than one health service provider, discussions should take place between the relevant complaints managers, in conjunction with the complainant, with regard to which organisation will take the lead from an organisational perspective. In the case of a joint investigation, one officer should be nominated to co-ordinate the investigation and to be the main point of contact for the complainant during the investigation. The complainant should be provided with details of how the investigation will take place and the appropriate NHS timescales should apply.

The response will be signed by the Chief Executive or their nominated signatory of the organisation which took the lead in the investigation with a copy of the final response being copied to the other involved organisations.

1.2. Health and Local Authority Complaints

This section of the procedure covers complaints received by either NEAS or Local Authority which relate to both agencies:-

1.2.1. The Procedure

When a multi-agency complaint is received by either NEAS or the Local Authority, the complaints manager of the receiving authority will:

- Agree a written statement of grievance with the complainant if this is not already available.
- Acknowledge the complaint in writing within 3 working days.
- Send a copy to the other agency's Complaints Manager within 3 working days of receipt.
- The method of investigation will take into account the NEAS complaints procedure and those adopted by the relevant department of the Local Authority.

- The agreed process, with appropriate timescales, should be clearly documented for all concerned and agreement reached.

- One of the Managers should be nominated to take the lead and be the main point of contact for the complainant during the investigation.

Once the findings of the investigation are known relevant senior staff from each organisation involved should:

- Collectively decide on action as a result of the complaint.

- One of the main objectives of a complaints investigation is to highlight where services can be improved. Complaints relating to both health and local authority services are likely to identify areas of joint responsibility which need to be discussed and reviewed.

- Agree how the actions arising from the complaint will be monitored.

- Agree the response to accompany the report to the complainant. It is recommended that in most cases it will be a jointly signed response.

Appendix G – Flow Chart