London Ambulance Service
NHS Trust

Complaints Policy

Circulated To: LAS Departments, All Stations, EOC and PTS, Training and Resource Centres.

For Use By: All Staff

1. INTRODUCTION

1.1 The London Ambulance Service NHS Trust (LAS) is committed to an open, transparent, fair and non-judgmental approach to complaints received from users of the service, their family and friends or members of the public and stakeholders. The objective is to resolve the complaint to the satisfaction of the complainant and to learn lessons from complaints that lead to improvements in service. The ethos of the management of complaints within the LAS is set out in the Being Open Policy (also see 1.4 below).

1.2 The NHS publication "Organisation with a Memory (2000)" highlighted the need to identify organisational and systemic weaknesses that cause complaints, rather than focusing on blaming individuals. The LAS endorses this approach to complaints handling and is committed to the identification of the cause of complaints and making any changes that may be necessary to prevent reoccurrence.

1.3 The intention is that investigation of a complaint will not involve disciplinary action against a member of staff as its primary focus. However, an allegation of serious misconduct will require investigation and further action will be taken as appropriate. The disciplinary investigation and any action resulting from it will be conducted according to the LAS Disciplinary Procedure and not be investigated by staff from the Complaints Department.

1.4 A fundamental requirement of the complaints handling arrangements of the LAS is the development of an open and just culture that is receptive to adopting new practices and learning from complaints, by involving both complainants and staff (see Being Open Policy).

1.5 The Trust acknowledges the importance of an effective and efficient complaints policy and procedure. It also recognises that complaints provide useful management information about service quality, image and staffing issues etc. from the perspective of service users, their families, friends and the public.

1.6 The key aims of the policy are to ensure that:

1.6.1 complainants will be given the opportunity to understand all possible options for pursuing the complaint and the consequences of following these options

1.6.2 complainants shall receive any assistance necessary to enable them to complain if they wish and that no form of discrimination will arise following a complaint

1.6.3 complaints are investigated and the cause of the complaint is established.

1.6.4 appropriate responses are provided within required timeframes

1.6.5 corrective actions are undertaken

1.6.6 lessons are learned

1.6.7 staff are supported throughout.

1.7 To ensure that lessons are learnt and to minimise the likelihood of future occurrences, the cause of complaints needs to be established. All staff should assist in the process of establishing the underlying cause of each complaint.

1.8 The Trust will, whenever appropriate, use the management information resulting from complaints to effect improvements to work processes or systems to prevent recurrences.

1.9 Effective management of complaints will:

1.9.1 Assist in identifying pressures on the Trust's procedures and protocols.

1.9.2 Ensure complainants are heard and their dissatisfaction is appropriately responded to.

1.9.3 Act as a key tool in re-establishing the reputation of the Trust in the eyes of the complainant and those associated with the complaint.

1.9.4 Identify trends in poor performance of the Trust in meeting expectations of patients, carers and users of Trust services in addition to the general public.

1.9.5 Assist in ensuring that the Trust is an open, honest and transparent organisation and perceived as such by both the public and members of staff.

1.9.6 Identify how the service can be improved which may provide potential benefits to all patients.

1.10 The LAS Complaints Policy, Procedure and Management Guidance on complaints handling are intended to provide clear guidance to all staff on how complaints are to be managed. This is intended to ensure a consistent, fair and just approach to both complainants and any staff who may be involved in the complaint investigation.

1.11 The LAS will provide opportunities for patients, relatives, carers and staff to give feedback on the quality of service provided when dealing with complaints.

1.12 The LAS Complaints Policy and Procedure have been compiled with reference to the contents of the NHS publication "Guidance to support implementation of the National Health Service (Complaints) Regulations (2004). These also comply with the requirements of the National Health Service (Complaints) Regulations (2004) and The National Health Service (Complaints) Amendment Regulations (2006). In addition, the Healthcare Commission publication "Guidance for Trusts on Good Complaints Handling (2005)", the NHS National Patients Safety Agency publication "Being Open – communicating patient safety incidents with patients and their carers 2005" and the NHS Litigation Authority requirements on complaints handling have all been taken into account, in producing this policy.

1.13 This policy is not intended to duplicate issues which are clearly set out in the above regulations and guidance, but adapts and supplements these to meet local needs and recent developments within the NHS.

2. DEFINITIONS

2.1. For the purpose of this document a complaint is defined as:

"An expression of dissatisfaction from a patient or any person who is affected by, or likely to be affected by, the action, omission or decision of any member of the London Ambulance Service NHS Trust, whether justified or not".

3. POLICY STATEMENT

From section 8 and 9 of the National Health Service (Complaints) Regulations 2004

Persons who may make complaints

(1) A complaint may be made by -

(a) a patient; or

(b) any person who is affected by or likely to be affected by the action, omission or decision of the NHS body which is the subject of the complaint.

(2) A complaint may be made by a person (in these Regulations referred to as a representative) acting on behalf of a person mentioned in paragraph (1) in any case where that person -

(a) has died;

(b) is a child;

(c) is unable by reason of physical or mental incapacity to make the complaint himself; or

(d) has requested the representative to act on his behalf.

(3) in the case of a patient or person affected who has died or who is incapable, the representative must be a relative or other person who, in the opinion of the complaints

manager, had or has a sufficient interest in his welfare and is a suitable person to act as representative.

(4) If in any case the complaints manager is of the opinion that a representative does or did not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, he must notify that person in writing, stating his reasons.

(5) In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child and where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

(6) In these Regulations any reference to a complainant includes a reference to his representative.

Making a complaint

(1) Where a person wishes to make a complaint under these Regulations, he may make the complaint to the complaints manager or any other member of the staff of the LAS which is the subject of the complaint.

(2) A complaint may be made orally or in writing (including electronically) and -

(a) where it is made orally, the complaints manager must make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made; and

(b) where it is made in writing, the complaints manager must make a written record of the date on which it was received.

(3) For the purposes of these Regulations where the complaint is made in writing it is treated as being made on the date on which it is received by the complaints manager or as the case may be, other member of the staff of the LAS.

This policy is intended to be used by all staff so that the trust is compliant with all requirements of the NHS Complaints Regulations 2004, and will be reviewed routinely to ensure its details remain correct.

3.1 It is the Trust's policy that complaints from patients, or their representatives, will be dealt with as quickly as possible, with due regard to the respect and dignity of the complainant. The Trust will ensure they are dealt with thoroughly and honestly with the aim of satisfying the complainant and enabling learning outcomes to be shared with them.

3.2 This policy is based on the key principle that patients and service users shall express their views about the treatment and services they receive in the knowledge that:

3.2.1 no discrimination will occur as a result of making a complaint

3.2.2 the complainant will be treated with courtesy and respect

3.2.3 the complainant will be taken seriously

3.2.4 an acceptable level of investigation, adhering to an action plan that has preferably been established and agreed, with input from the complainant, will take place

3.2.5 the cause of the complaint will be established

3.2.6 the complainant will receive a response within defined time-frames

3.2.7 the response will address the complainants concerns and state what action is to be taken as a result of the complaint

3.2.8 the complainant will receive an appropriate apology

3.2.9 the complainants views will inform learning and improvements in service delivery, and

3.2.10 there is a system for taking action to address the full range of problems that have been identified as the cause of the complaint with the intention of preventing further occurrences.

3.3 All members of staff involved in a complaint will be treated fairly, openly and with dignity throughout the investigation process.

3.4 The NHS Complaints Regulations 2004, amended in September 2006, determine three stages to the complaints process. The first stage is concerned with local resolution. This means that the complaint is dealt with by the LAS to the satisfaction of the complainant. In the event that the complainant remains dissatisfied with the first stage resolution, he or she may request the Healthcare Commission to review the way that the complaint was handled or the outcome. This is known as the second stage of the above regulations. In the event that the complainant remains dissatisfied with the result of the Healthcare Commission review they are entitled to approach the Health Service Ombudsman and request his intervention (stage three).

3.5 The regulations make it clear that all NHS Trusts should endeavour to resolve complaints through local resolution and this document is produced with the aim of achieving a satisfactory resolution at local level.

3.6 This document details how effective and prompt management of complaints is key in improving patient care. The Complaints Department deals with formal complaints and the LAS Patient Advice and Liaison Service (PALS) handles enquiries or concerns about the LAS. Both departments work closely in resolving all issues raised by patients, their family and friends and members of the public.

3.7 The LAS Patient Advice and Liaison Service (PALS) operates to advise and support service users, their families or carers, the general public and health / social care professionals in their respective care, journeys and contacts with the LAS.

3.8 The LAS affords equal importance to PALS and the Complaints Department as mechanisms for achieving organisational change and improving patient care by creating learning opportunities arising from concerns brought to the Trust.

3.9 It is the choice of the individual whether to use the PALS or the formal NHS complaints procedure. Enquirers maintain the right to pursue a complaint at any stage – most usually if they remain dissatisfied at the conclusion of PALS enquiries. However, complainants should not use PALS to pursue a concern where the NHS Complaints Procedure has been exhausted. PALS may refer matters to the Complaints Department where it is appropriate to do so and ensure complainants know how to access the NHS complaints procedure and relevant advocacy services e.g. the Independent Complaints Advocacy Services (ICAS).

3.10 Close collaboration between PALS and the Complaints Department works to ensure a coherent and seamless approach to resolving concerns expressed by service users, members of the public, professional colleagues, etc.

3.11 This policy relates specifically to formal complaints received from patients, patient representatives and the public regarding LAS services.

3.12 This does not cover:

3.12.1 A complaint made by a primary care provider which relates either to the exercise of its functions by an NHS body or to the contract or arrangements under which it provides primary care services. (for more information please refer to the Department of Health website How to Complain - www.dh.gov.uk.)

3.12.2 Complaints from members of staff; LAS staff should be encouraged to use the Trust's Grievance Procedure to raise issues of concern about Trust policies, or the result of decisions by managers or other staff.

3.12.3 A complaint made by an employee of the LAS about any matter relating to their contract of employment

3.12.4 A complaint which is being or has been investigated by the Health Service Ombudsman.

3.12.5 A complaint arising out of an alleged LAS failure to comply with a data subject request under the Data Protection Act 1998 (LAS Data Protection Policy TP/012) or a request for information under the Freedom of Information Act 2000 (implemented on 1st January 2005).

3.12.6 A complaint about which the complainant has stated in writing clearly that they will be taking legal proceedings.

3.12.7 A complaint about which the LAS is taking or proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint

3.13 It should be recognised that often people coming into contact with the LAS have personal concerns and anxieties through which they feel vulnerable. If properly addressed and answered, concerns will often not develop into complaints.

3.14 All staff are empowered to resolve issues and concerns at a local level whenever possible or appropriate. Prompt action may prevent the issue from escalating to a formal complaint by the provision of explanations and apologies when appropriate.

3.15 We will work collaboratively with Independent Complaints Advocacy Service (ICAS) and value their contribution to the continuous improvement of our complaints procedure.

3.16 Effective completion and early evaluation of information provided on the Patient Report Form and Investigation Report is an essential part of complaints management as this may allow staff to identify any necessary improvements in patient care or service delivery before a complaint arises.

3.17 A complaint may be made in person, by telephone, fax or in writing (including email). Where a complaint is made orally a written record must be completed by staff (LA23). A complaint may be made by a third party with the consent of the complainant or in cases where the complainant lacks capacity.

3.18 The final written response to a complaint must be authorised and signed by the Chief Executive Officer of the LAS except in cases where for good reasons the Chief Executive Officer is not able to sign it, in which case it may be signed by a person designated to act on his behalf.

3.19 This policy is primarily concerned with improving the quality of services to patients; it is not concerned with disciplining our staff. However, on occasion a complaint investigation may reveal that there has been a serious or wilful act or omission by a member of staff. In such circumstances this procedure will be set aside to allow a full investigation to take place and this will be conducted according to the LAS Disciplinary Procedure. The complaints investigation will be completed separately to the disciplinary investigation.

3.20 Complaints handling within the LAS will be monitored through the Complaints Panel and Clinical Governance Committee (see governance arrangements below).

4. SPECIFIC RESPONSIBILITIES for COMPLAINTS MANAGEMENT

4.1 Board Appointee

4.1.1 The Board should appoint a complaints "champion(s)" who should be an executive or non-executive Board member. The role of the "champion" is to ensure that action is taken as a result of complaints and to monitor the effectiveness of complaints handling arrangements in the LAS and their compliance with NHS requirements.

4.1.2 The action plans produced as a result of complaints will form the basis for monitoring service improvements by the Board's complaints "champion".

4.2 Chief Executive Officer

4.2.1 The Chief Executive Officer has overall responsibility for the management of complaints.

4.2.2 The Chief Executive Officer or Deputy during absence will sign all final resolution letters.

4.3 Complaints Manager

The Complaints manager is responsible for

4.3.1 Developing Trust wide policies, procedures and strategies for the management and investigation of complaints, and develops outcomes for improving patient care as evidence of lessons learnt and action taken to prevent a recurrence.

4.3.2 The overall management of complaints throughout the Trust.

4.3.3 Ensuring that Complaints Officers follow the principles and practice for complaints handling within the Service as set out in this policy and the Complaints Procedure although the line management of Complaints Officers rests with the ADO/PIM in the operational areas.

4.3.4 Ensuring that all complaints are acknowledged within two days.

4.3.5 Ensuring that holding letters are sent out where necessary i.e. if a complaint cannot be completed within 25 days and that contact is maintained with the complainant in protracted investigations.

4.3.6 Ensuring that consent to disclose information has been received in appropriate cases.

4.3.7 Ensuring that complaints are handled in a timely and effective manner, to the satisfaction of the complainant and in accordance with legislation and Trust policy and procedure and provide ongoing support and advice to staff dealing with the complaint where appropriate.

4.3.8 Attending meetings with the complainant on behalf of the Trust to help resolve the complainants concerns when appropriate.

4.3.9 Maintaining a database of all formal complaints received by the LAS.

4.3.10 Producing information on the LAS Complaints Policy and Procedure and making it accessible to the public, via the Trust website and other communications media.

4.3.11 Ensuring that any person that requests complaints information in larger fonts, Braille or other languages etc. is assisted in every way possible.

4.3.12 Ensuring that all relevant information and assistance is provided to the Healthcare Commission as part of the independent review process.

4.3.13 Liaising with complaints managers at other NHS Trusts in cases when a complaint involves more than one Trust. Agree the most appropriate way to investigate the complaint and ensure that the complainant is advised.

4.3.14 Ensuring that the views of complainants in relation to the manner that their complaints were handled are audited with input and feedback from complainants.

4.3.15 Ensuring that complaints officers receive training appropriate to their role.

4.3.16 Reporting complaints information to the Complaints Panel and participate fully as a member of the Panel (see terms of Reference for Complaints Panel in the section below headed Governance arrangements).

4.3.17 Ensuring that the service is able to comply with the requirements of the Healthcare Commission in respect of complaints handling (currently core standard c14).

4.3.18 Producing reports on all aspects of complaints handling to meet internal and external requirements on a quarterly and annual basis to the Complaints Panel, Clinical Governance Committee and ultimately the Trust Board.

4.3.19 Monitor the progress of action plans, completion of recommendations and implementation of service wide changes arising from complaints.

4.4 **Assistant Directors of Operations.**

All Assistant Directors of Operations are ultimately accountable for the local complaints handling arrangements across the Trust within their areas of responsibility. The ADO responsible for the Emergency Operations Centre, the Urgent Operations Centre and the Head of Patient Transport Services are accountable for their areas of responsibility.

4.4.1 Responsible for the standard and timeliness of complaints handling within their operational area.

4.4.2 ADO's are ultimately accountable for the management of Complaints Officers and Investigation Officers in their respective areas. Day to day management will be the responsibility of Performance Improvement Managers.

4.4.3 Responsible for the quality and content of all draft responses sent to the Chief Executive (via the Complaints Manager) for signature and for ensuring that all concerns raised have been addressed.

4.4.4 Responsible for ensuring that complaint handling arrangements are applied consistently across the service and are in accordance with the latest LAS Policies, Procedures and Guidance Notes.

4.4.5 Ensure that arrangements are in place to allocated complaints to an appropriate officer dependent on the grading of each complaint using the Risk Management Matrix (see Risk Reporting and Assessment Procedure). In some cases the ADO may be the investigating officer.

4.4.6 Consider the value of meeting with the complainant, in appropriate cases, to respond directly to the complainants concerns.

4.4.7 Ensure that all available methods for resolving the complaint, including the use of mediation services, have been considered.

4.4.8 Ensure that arrangements are in place for all staff mentioned in a complaint to be informed and receive appropriate support.

4.4.9 Ensure that arrangements are in place for staff who are involved in the handling of complaints produce an action plan to achieve time-limited recommendations.

4.4.10 Ensure that arrangements are in place to monitor complaint outcomes and action plans and that these are implemented by a named individual within a specified time-frame.

4.4.11 Ensure that arrangements are in place to obtain a report on the progress of action plans on a regular basis.

4.4.12 The issues raised in individual complaints should be considered and, where applicable, initiate service improvements. Issues arising from complaints, problems and other user feedback should be standard items for discussion at team meetings.

4.4.13 Ensure that, when service-wide changes have been identified as a result of a complaint investigation, these are referred to an appropriate service wide forum so that they may be implemented in an appropriate and timely manner.

4.4.14 Responsible for ensuring that arrangements are in place for recommendations made by the Healthcare Commission, as a result of second stage review of complaints, are dealt with in an appropriate and timely manner.

4.4.15 Ensure that arrangements are in place for the complaints manager to be provided with regular updates/reports on all aspects of complaints management within the operational areas.

4.5 **Performance Improvement Managers.**

4.5.1 Responsible to the Assistant Directors of Operations for performance relating to complaints handling within operational area and compliance with all NHS complaints standards, set out in the LAS Complaints Policy and Procedure, including the acknowledgement of a written complaint within 48 hours and completion of a complaints investigation within 25 working days (unless otherwise agreed with complainant).

4.5.2 Responsible for the line management of Complaints Officers and other staff who may be dealing with a complaint in their respective areas.

4.5.3 Responsible for ensuring that staff who are the subject of complaints are fully informed and supported throughout the investigation process.

4.5.4 Ensure that arrangements are in place to allocated complaints to an appropriate officer dependent on the grading of each complaint using the Risk Management Matrix (see Risk Reporting and Assessment Procedure). In some cases the ADO may be the investigating officer or the PIM.

4.5.5 Consider the value of meeting with the complainant, in appropriate cases, to respond directly to the complainants concerns.

4.5.6 Responsible for ensuring that letters, particularly final response letters, comply with all aspects of complaints regulations, are compatible with good practice, written to the highest standard of quality and answer all concerns raised by the complainant.

4.5.7 Responsible for analysing the cause of complaints, to identify the cause aiming to use Root Cause Analysis as appropriate to the complexity and severity of the concerns detailed by the complainant, Identify emerging trends that may indicate underlying systemic problems.

4.5.8 Responsible for monitoring the production of action plans, assisting when necessary, ensuring that they are completed within specified time-frames and that lessons learnt from complaints are shared across the service.

4.5.9 Responsible for the production of reports on the progress of the action plan when delays in implementation are encountered.

4.5.10 Responsible for ensuring that staff who have been named in a complaint receive feedback on how the complaint was handled and resolved.

4.6 **Complaints Officers**

4.6.1 Responsible for the day to day handling of complaints by area under the direction of the PIM.

4.6.1 Accountable to the Performance Improvement Manager and responsible for managing complaints that they are allocated to investigate.

4.6.2 Responsible for meeting with the complainant as soon as possible, when appropriate.

4.6.3 Responsible for the investigation of complaints to an acceptable standard. Ideally, the complainant will be involved in the decision on how the complaint will be investigated or dealt with and agree the process that will be followed.

4.6.4 Responsible, at an early stage of the investigation, for determining the need to access specialist advice e.g. from the Medical Director, Senior Medical Adviser or Head of Education and Development. In some cases the benefit of external specialist advice may also be considered.

4.6.5 Responsible for ascertaining the full extent and origin of all complaints aiming to apply the Root Cause Methodology of Analysis when appropriate.

4.6.6 Responsible for ensuring that staff who are the subject of a complaint are informed and well supported at all stages in the investigation.

4.6.7 Responsible for ensuring that complaints are answered fully, and that letters are clear, well written and comply with regulations and procedures.

4.6.8 Ensure that all complaints are closed within specified time-frames.

4.6.9 Report any instances where a delay in completing the complaint is encountered or expected and ensure that the complainant is advised of the delay, and agreeing to an extension.

4.6.10 Ensure that the LAS Risk Register is continuously updated and complete with up to date progress reports related to risks concerning complaints.

4.6.11 Ensure that each complaint has an outcome which is recorded and held by the Complaints Manager.

4.6.12 Produce ‘Action Plans’ when appropriate and ensure that these are monitored and completed.

4.6.13 Ensure that ‘Lessons Learnt’ as a result of complaints are reported to the PIM and Complaints Manager.

4.6.14 Ensure that all ‘working copies’ of complaints files are kept in a secure location and sent to the central complaints department for storage once the complaint has been resolved.

5. OBJECTIVES

5.1 To ensure that people who complain are treated with respect, without fear of discrimination, listened to sympathetically and assisted in every way possible through the complaints process.

5.2 To treat every complainant as an individual with differing needs thereby requiring a personalised approach to the management of the complaint. This may involve the use of patients' advocates or interpreters. Other ways to achieve an acceptable outcome, including mediation, will be considered at an early stage.

5.3 To ensure that the complainant and all LAS staff are treated fairly throughout the complaints process and that staff receive all available support.

5.4 To ensure that all complaints are investigated promptly, to the degree necessary, honestly and openly.

5.5 To ensure that complainants are kept informed of the progress and outcome of the investigation with explanations or apologies, as appropriate, being given.

5.6 To ensure that action to rectify the cause of the complaint is identified, implemented and evaluated, thereby improving the quality of service. Where necessary this may involve revising procedures.

5.7 To ensure that any resultant change in practice or procedure resulting from a complaint is fed back to the complainant and others as appropriate. Feedback to others in the LAS will take place where appropriate as a means of ensuring consistency and best practice across the service.

5.8 To provide feedback to staff named in a complaint to advise how the complaint was handled and resolved.

5.9 To ensure that complaints are managed within the context of the LAS clinical governance and training programmes.

5.10 To ensure that data collated on complaints is utilised effectively within the LAS to assist in improving patient care. This will include such data as ethnicity, gender, disability. The Trust has a duty to ensure that we deliver an equitable service to all.

5.11 To ensure the service identifies and responds appropriately to incidents where there is a perception of racism, homophobia, sexism and/or victimisation of disabled people etc. as described in 4.9 above.

6. GOVERNANCE ARRANGEMENTS

Complaints monitoring is undertaken by the Complaints Panel and the business of the panel is reported as described in the terms of reference for the Clinical Governance Committee and the Complaints Panel which are included immediately below.

6.1 The Clinical Governance Committee

Terms of Reference for Clinical Governance Committee

Constitution

- The committee is established by the Board. Its terms of reference, membership, delegated powers and reporting arrangements are determined by the Board. It will normally meet six times a year with three of those meetings set aside for core work.

- The committee will be chaired by a non-executive director or an executive vice-chairman in the absence of the chairman.

- A quorum shall be one non-executive director and one executive director.

- The committee's minutes will be reported to, and considered by, the Trust Board.

- The functions of the Clinical Governance Committee

Functions and how these will be achieved

The committee's prime purpose is to ensure that high quality patient care is delivered throughout the London Ambulance Service. To this end, the Committee will, inter alia:

- Oversee the clinical guidelines and protocols that members of staff are expected to follow during their working lives at LAS (Note: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee).

- Require evidence that procedures and protocols are reviewed and further training is given (where appropriate) in response to the reporting and investigation of clinical incidents and complaints.

- Monitor progress in implementing the Clinical Governance Strategy and the Clinical Governance Development Plan.

The Committee will establish and monitor adherence to standards for good practice, and will recommend remedial actions where necessary. In so doing, it will use the framework of Standards for Better Health issued by the Healthcare commission and the standards within the NHSLA Risk Management Standard for the Provision of Pre Hospital Care in the Ambulance Service. To this end, the committee will work with the Risk Compliance and Assurance Group

- Receive and review regular reports from feeder Groups, in particular Standards for Better Health Group, the Risk Information Report (which combines data from risks complaints, claims and clinical incidents), the Complaints Group, the Infection Control Group and the Area Governance Groups.

- Receive and review evidence of compliance and collated information for the final declaration of the Annual Healthcheck and for any submission to the NHSLA

The Committee will review the risks associated with the LAS' clinical practice and will ensure that appropriate action plans have been put in hand to reduce the number of untoward clinical events. To this end, it will:

- Work with the Risk, Compliance and Assurance Group, which will grade risks and place them on the Risk register in accordance with the LAS Risk Scoring Matrix.

- Use aggregated data from the Risk information Report and other sources as it sees fit to ensure that clinical risk reduction programmes of a high standard are in place.

- Monitor the implementation of risk reduction programmes to ensure that identified risks are reduced, and that adverse events are detected early, investigated speedily and openly and that the lessons learned are promptly applied.

The Committee will ensure that quality improvement processes (e.g. clinical audit) are in place and integrated with the quality programme for the organisation as a whole. It will do this, inter alia, by requesting reports from the Clinical Audit and Research Steering Group in, for example, the extent to which day-to-day practice is evidence-based and is supported by research and development.

The Committee will satisfy itself that all personnel working for the London Ambulance Service receive education, training, continuing personal and professional development. It will do this by, inter alia:

- Requesting the relevant information from The Training Services Group and the Area Governance Groups, and other feeder Groups as appropriate

- Monitoring the Trust wide Training Needs Assessment.

The Committee will define and develop Key Performance Indicators which provide quantitative and qualitative information to be collated in the form of an annual clinical governance report to the Board. These will be changed annually and will contribute to a Trust-wide scoring system.

The Committee may recommend policy, as appropriate, to the Trust Board for formal approval. They may also commend further training or clinical service development as a result of evidence produce to the Committee.

The Committee is responsible for providing the Audit Committee with evidence that there is a reliable clinical risk management system in place; that action plans have been agreed to manage those risks and that these have been appropriately followed up in order to manage/reduce the level of risk.

Membership (*deputies to be proposed unless already stated)*
*1 Non Executive Director (chair)
*2 NED

*Medical Director (vice chair)
*Director of Communications
Head of Education and Development
Head of Clinical Audit & Research
*Head of Legal Services
*Head of Governance
Safety & Risk Advisor
*Deputy Director Operations
PPI Manager
*Head of Records Management
Diversity Manager
*Head of Complaints
Head of Operational Support
*Assistant Director of Operations EOC (deputy -Senior Operations Officer – Planning & Risk)
*Director of Communications (deputy -Head of Communications)
Area Governance representative
*User Representative(s)/
A&E Consultant
Head of Employment Services

*Indicates member of core committee

6.2 The Complaints Panel

Terms of Reference for Complaints Panel

To ensure that the Trust is dealing with patients' complaints and concerns received by the Complaints Department and the Patients Advice and Liaison Service (PALS) in line with the requirements of the NHS Complaints Procedure and the Health Care Standards.

To ensure that the Trust takes any necessary action to ensure changes are made for the benefit of patients, relatives and carers, and that any lessons arising are disseminated for learning across the London Ambulance Service NHS Trust.

- To consider the implications for the Trust of guidance on the management of Serious Untoward Incidents (SUIs), complaints and concerns issued by the Health Care Commission, National Patient Safety Agency, National Health Service Litigation Authority and other advisory bodies as appropriate.

- Provide quarterly reports to the Trust Board via the Risk Management Committee.

- To monitor SUI investigations, specifically timely implementation of recommendations, outcomes and improvements in patient care.

- To review the handling of and outcomes from all complaints involving the Trust referred to the Heath Service Ombudsman and Healthcare Commission.

- To monitor outcomes which affect the Service.

- To monitor emerging trends and issues from SUIs, complaints, coroner's inquests, concerns and potential high risk claims.

- To contribute to the production of the Trust's annual complaints report by ;

  i) Providing evidence that learning from patient feedback has taken place across the Trust

  ii) Improving the reporting of outcomes resulting from recommendations developed from the Trust's processes for managing SUIs, complaints and concerns

- Minutes to go to the Clinical Governance Committee

Membership		
Executive Director (Chair) Director of Communications Non Executive Director Senior Operations Manager Medical Director Chair of the LAS Patients Forum Head of Governance Head of Education and Development		EOC Manager responsible for complaints Complaints Manager Staff Representative Frontline staff (A&E, EOC,PTS) PPI Manager Head of Urgent Care Head of Legal Services

7. COMPLAINTS HANDLING PROCEDURE AND RELATED GUIDANCE.

The detailed arrangements for local handling of complaints are set out in the Complaints procedure. This procedure is supplemented by the guidance included in the Complaints Management Information for managers.

References:

The National Patient Safety Agency "Being Open"
Communicating Patient Safety Incidents with Patients and their Carers 2005
The Health Service (Complaints) Regulations 2004
The National Health Service (Complaints) Amendment Regulations 2006
Assurance Framework
Incident Reporting Procedure
Claims Policy
Complaints Procedure
Being Open Policy

Whistle blowing Policy
SUI Policy
Driving and care of Service Vehicles
Risk Reporting and Assessment Procedure
Health and Safety Policy
Disciplinary Procedure
Trust's Strategic Plan 2006/07 – 2012/13
Trust Service Plan 2006/07
Standards for Better Health (Department of Health July 21 2004)
The Annual health check in 2006/7 Assessing and rating the NHS (Healthcare Commission September 2006)
Risk Management Policy

Signature: 

Peter Bradley
Chief Executive / Chief Ambulance Officer