South East Coast Ambulance Service NHS
NHS Foundation Trust

Compliments, Comments, Concerns, Information Requests and Complaints Handling Policy

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Contents

1. Statement of Aims and Objectives

1.1. Welcoming and listening to feedback from our patients, their families / carers and members of the public is an essential part of South East Coast Ambulance Service NHS Foundation Trust's (SECAmb) quality and safety governance policies. The effective management of that feedback is necessary to ensure that our patients are confident their feedback, both good and bad, is acted upon in a consistent, fair, and timely manner. They need to know that it leads to positive changes in our service delivery and that we recognise the effect that the quality of our services has had upon them.

1.2. SECAmb must comply with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and associated guidance 'Listening, Responding, Improving' issued by the Department of Health in February 2009. SECAmb must meet the Care Quality Commission registration requirements as specified in Regulation 19. Several recommendations regarding complaint handling are contained within national reports and reviews and relevant content has been incorporated into the complaint handling processes with the Trust, as necessary. SECAmb also complies with the Principles of the Parliamentary and Health Service Ombudsman (PHSO) and the NHS Complaint Standards, Summary of expectations Spring 2021.

2. Principles

2.1. **The purpose of this document is to:**

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

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

2.1.3. This policy covers compliments, comments, concerns, and complaints relating to any aspects of the services provided by SECAmb and any organisation acting as a subcontractor.

2.1.4. Feedback about staff members which does not relate to their duties for SECAmb 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 member of staffs Operating Unit Manager and the Trust Human Resources Department. The policy is not intended for use by staff who may have complaints or concerns relating to their employment.

2.1.5. This policy is designed to reduce the risk of repeated failures by ensuring that necessary improvements are appropriately identified and acted upon because of feedback by providing a robust governance framework; and to

reduce the risk of escalated dissatisfaction through effective, early resolution wherever possible.

3. Definitions

3.1. Accessibility of process.

3.1.1. People can give their feedback in a variety of ways. This includes via telephone, email or by writing to our postal address.

3.1.2. All responses to feedback will be made in a plain language and will not contain specialist terminology without a clear explanation of its meaning.

3.2. Equality, Diversity and Human Rights

3.2.1. In handling and responding to complaints, complainants will be treated fairly with equal opportunities to make their view known. SECAmb appreciates that fairness requires all those who complaint to be treated as individuals, with dignity, respect, and compassion.

3.2.2. Where reasonable adjustments are appropriate to enable reasonable access, these will be provided.

3.2.3. The Trust is committed to pro-diversity and anti-discriminatory practice. Information is made available, including different languages on request that inform patients, families, carers, and members of the public about our complaints process.

3.2.4. Examples of reasonable adjustments include translation services (for example language line) or other formats if required.

3.3. Compliments

3.3.1. Compliment is the expression of gratitude made by our patients, their families / carers and members of the public regarding SECAmb service or the specific behaviour of a member of SECAmb staff.

3.3.2. Compliments can be made to any member of staff or volunteer and will be passed to and acknowledged by the PALS Team.

3.3.3. The PALS Administrator will record the details of the compliment on the Trust in-house Datix system.

3.3.4. The PALS Administrator will identify the staff member(s) to whom the compliment relates and will provide them with a letter of commendation, a copy of which will be held on their staff records as well as Datix.

3.4. Patient Advice and Liaison Enquiries

3.4.1. Patient Advice and Liaison Service (PALS), enquiries are dealt with by the PALS Officers and not all of these are required to be recorded on Datix.

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

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

3.4.4. The PALS service is there to assist patients, their families / carers and members of the public who require advice and assistance.

3.5. Lost Property

3.5.1. Requests to trace lost property can be made via the PALS Team by either telephone, letter, or email. All requests to trace property are passed to the local administrators for each operating unit to make the appropriate enquires to trace the item(s). The administrator will then make contact and respond to the request.

3.6. Comments

3.6.1. A comment is feedback received from a patient, their family member / carer or a member of the public giving a view of a general nature about a SECAmb service which has not been proactively sought and which they do not require a response. These do not relate to specific patient care episodes.

3.6.2. Comments will be passed on by the PALS team to the relevant senior management for the service and they will be responsible for making any service changes deemed appropriate.

3.7. Concerns

3.7.1. A concern is an expression of dissatisfaction made by a patient, their family / carer or a member of the public which does not require investigation and can be responded to by the PALS team. An example of this includes the level of noise from sirens. The PALS team will register these as a Level 1 on Datix and respond.

3.8. Statutory Information Requests

3.8.1. The Trust receives requests for information from patients, their families / carers, and members of the public. These can be varied such as Subject

Access Requests under the Data Protections Act 2018 or Access to Health Records. On receipt the PALS team will record details on Datix and ask for the requestor to complete the relevant form and provide I.D. When returned the request will be dealt within 30 days of receipt.

3.8.2. Any documents sent will be redacted, as appropriate.

3.8.3. The response may be sent via post, encrypted email or via email with the requestor's permission.

3.9. **Complaints**

3.9.1. Complaints are an expression of dissatisfaction made by a patient, their family / carer, or a member of the public regarding a SECAmb service or the specific behaviour of a member of staff in the course of their duties.

3.9.2. Where a person specifically states that they wish the matter to be dealt with as a formal complaint or where the complaint raises issues for the Trust which are significant and are likely present a risk to the organisation, they will be recorded on Datix as formal complaints.

3.9.3. To ensure proportionality on receipt of a complaint the PALS Team will grade the complaint according to their apparent seriousness based on the information that has been provided. A bespoke Complaints Investigation Grading Guide (Appendix A) is followed to ensure that grading is consistent. This initial grading is designed purely to help guide the investigating manager as to the level of investigation required and may be adjusted during or upon completion of the investigation.

3.9.4. Level 1 concerns, enquires, and information requests and level 2 complaints will be responded to by PALS Officers.

3.9.5. Level 3 complaints will be responded to by the Chief Executive Officer.

3.9.6. A complaint should be made no later than 12 months after the date on which the matter which is the subject of the complaint occurred or the date on which the matter which is the subject of the complaint came to the notice of the complainant.

3.9.7. This time limit may not apply if the Trust can be reasonably satisfied that:

3.9.8. The complainant had good reason for not making the complaint within the time limit; and

3.9.9. Notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

3.9.10. The decision to investigate complaints made outside the 12-month timeframe is the responsibility of the Head of Patient Safety in conjunction with the PALS Manager.

3.10. Timescales

3.10.1. All complaints, concerns, enquiries, and information requests must be acknowledged within three working days of receipt.

- Level 1 concerns, enquiries and information requests should be responded to within 25 working days.
- Level 2 complaints should be responded to within 35 working days.
- Level 3 complaints should be responded to within 45 working days.

3.11. Consent for third party concerns and complaints

3.11.1. The principle adopted by this policy is to work in accordance with the requirements of the Data Protection Act regulations and the Caldicott principles. Consent is required from the patient, their parent / legal guardian or person holding Lasting Power of Attorney for Health, for the outcome of any investigation to be released to a third person. If it is not possible to gain formal consent, for instance if the patient's condition is such it would be inappropriate to seek it, this will be agreed by the Caldicott Guardian.

3.11.2. Complaints and concerns may be raised by a person acting on behalf of the patient who received the service being complained about. In these cases, written consent from the patient will be sought. A copy of the Trust's Consent Form is attached Appendix B.

3.11.3. If consent is not received, the Trust has the right to stop the investigation process and close the complaint or concern. The Trust has the right to decide to continue with an investigation where lessons may be learned. Where the Trust can provide limited information without breaching any confidentiality, this may be shared with the complainant at the discretion of the Caldicott Guardian.

3.11.4. A letter will be sent to the person who raised the matters to confirm the investigation has been completed and learning put in place.

3.11.5. If a patient is deceased, the consent of the 'nearest relative' will be sought. Where a complaint or concern is progressed with the consent of the 'nearest relative' care will be taken to include only information that is necessary to answer the issue(s) raised. Care will be taken to ensure that the person identified as the 'nearest relative' is the most appropriate person to act on the deceased patient's behalf.

3.11.6. Should a patient lack capacity the consent from the person who has 'Health and Welfare lasting power of attorney' will be sought.

3.11.7. Where a patient is a child or young person under the age of 16 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.

3.12. Anonymous concerns and complaint

3.12.1. Concerns and complaints which are raised anonymously, or if the person raising the matter asks to remain anonymous, will be reviewed on a case-to-case basis.

3.12.2. Where, after review, a full investigation is not deemed necessary details will be passed to the local

3.12.3. Operations Manager for them to action as necessary.

3.12.4. If, after review, a full investigation is required this will be completed in the normal way and any learning identified will be put in place.

3.13. Concerns and complaints raised by Healthcare Professionals

3.13.1. Patient consent is not routinely sought for concerns and complaints which are raised by healthcare professionals.

3.13.2. Concerns and complaints will be investigated as non-statutory.

3.13.3. Responses made will take care not to disclose patient confidential information inappropriately.

3.14. Concerns and complaints raised by MPs and Elected Members of Local Authorities.

3.14.1. Where a complaint or concern is raised by an MP and relates to the services provided to an individual, the MPs statement that they are acting for their constituent will satisfy the requirement for consent providing the constituent is also the patient to whom the concern or complaint relates. If this is not the case consent will be sought as detailed in 3.11 above.

3.14.2. When a concern or complaint is raised by a Local Authority Member, explicit consent will be obtained from the patient, even if they have approached the member before any sensitive information is released.

3.14.3. Should the matter raised not be a concern or complaint about a service provided to a specific individual the correspondence will not be dealt with under this policy and will be passed to the Trust Communications Team.

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

3.14.5. The Trust will comply with the Information Commissioner’s Office guidance ‘Data Protection

3.14.6. Technical Guidance Note Disclosures to Members of Parliament carrying out constituency work’.

3.15. Concerns and complaints regarding multiple services provided by SECAmb

3.15.1. Where a concern or complaint is received and refers to more than one SECAmb service (for example NHS111, Emergency Operations Centre and/or Operations) a lead service will be identified by the PALS Team and put onto Datix reflecting this.

3.15.2. Investigations into the separate areas will take place and the PALS Officer will compile a single response.

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

3.16. Concerns and complaints regarding multiple organisations

3.16.1. All NHS and Local Authority Social Care Services are required to work together to provide a single response to concerns or complaints received about their services. SECAmb will always seek to provide a single response jointly with our health and social care partners in such circumstances.

3.16.2. When SECAmb is the organisation receiving the concern or complaint, consent will be obtained from the complainant to share the details with other relevant organisations and contact will be made with the other organisations to agree a joint approach to resolving the complaint.

3.16.3. If SECAmb are not the lead organisation we will request a draft of the response letter to approve before it is sent to the complainant.

3.16.4. SECAmb are committed to improving joint complaint handling for our patients and strive to achieve single coordinated resolution for complainants.

3.16.5. SECAmb actively encourage more effective links and relationships to aid improved joint complaint handling in the future.

3.17. Withdrawal

3.17.1. If a person who has raised a concern or a complaint chooses to withdraw their concern or complaint at any point, SECAmb will continue with the investigation and put in place any learning identified.

3.17.2. The Datix record will be marked as withdrawn with a clear reason recorded.

3.18. Concerns and complaints about contractors and / or volunteers

3.18.1. Concerns and complaints that are received about the services provided by other organisations on behalf of SECAmb will be dealt with in line with this policy.

3.18.2. All contractors are expected to comply with SECAmb policies, and this is included in all contracts.

3.18.3. Copies of all SECAmb policies are made available to our contractors.

3.18.4. Contractors are required to contribute openly, honestly, and fully with SECAmb investigations and to comply with the timescales for concern and complaint investigations.

3.19. Patients requests to meet with staff

3.19.1. Occasionally patients, family, carers may ask to meet with Trust staff to discuss their concern or complaint, when such a request is received the PALS Team will review these on a case-by-case basis and discuss with the relevant service managers.

3.19.2. Any meeting that is arranged must be done so in a safe environment.

3.20. Serious Incidents

3.20.1. As part of the initial review by the PALS Team when a concern or complaint is received consideration will be given as to whether it needs to be referred to the Serious Incident Team for review.

3.20.2. When a complaint has been reviewed and declared a Serious Incident through the Serious Incident Group, the complaint on Datix will be closed recording that it is now a Serious Incident, and the Serious Incident Team will contact the complainant to complete Duty of Candour and confirm new timescales.

3.20.3. The PALS Team will liaise with the Serious Incident Team to ensure that all matters raised will be addressed by the Serious Incident investigation. If not, they will ensure those matters not forming part of the Serious Incident Investigation are investigated and a response sent to the complainant.

3.20.4. The PALS Team will liaise with the Serious Incident Team before sending any response letter to the complainant.

3.21. Concerns and complaints involving the death of a patient

3.21.1. When a concern or complaint is received regarding the death of a patient consideration should be given to arranging for a clinician to meet with the family. A full clinical review of the case should also be carried out.

3.21.2. In line with national guidance, consideration should also be given to signposting to bereavement support services and advice on actions required following a death.

3.22. Clinical Case reviews

3.22.1. Where a complaint raises issues of a clinical matter, the PALS Officer will seek support from a Trust clinician within the Medical Directorate, who will explore the clinical issues more fully and ensure all learning is identified and acted upon.

3.22.2. Where this is the case the PALS Officer responsible for the concern or complaint will continue to investigate any other matters raised and liaise with the appointed clinician to compile the response.

3.23. Safeguarding adults and children

3.23.1. Any concern or complaint which raises safeguarding concerns will be immediately reported to the Safeguarding Team in accordance with the Trust's Safeguarding Policy.

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

3.24. Claims

3.24.1. All contact from patients, their families / carers or 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 referred to the Trust's Legal Team to be processed in line with the Trust's Claims Policy.

3.24.2. Being open

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

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

3.25. Patient experience surveys

3.25.1. Patients and their families / carers will be asked to complete a short survey online about how their complaint or concern was handled by the Trust. The link to the survey is included within all complaint response letters.

3.25.2. If a patient, their family, or carer do not have access to the online survey a printed version can be sent to them for completion and return.

3.26. Freedom of information requests

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

3.26.2. In such cases, the PALS Officer handling the concern or complaint will provide the information. If the request is substantial and will take significant processing time the complainant will be advised that the matter has been forwarded to the Trust Freedom of Information team to be processed in line with the Freedom of Information process.

3.26.3. Complaints and concerns about the way in which a Freedom of Information (FOI) request has been handled will be dealt with by the Trust Head of Information Governance / Data Protection Officer.

3.27. Human resource procedures

3.27.1. Any complaints or concerns that are received regarding members of SECAmb staff in relation to matters not connected with their duties on behalf of SECAmb will be passed to the Operating Unit Manager and the Operations Manager of the operating unit where the member of staff is based, within three working days. They will liaise with the Trust Human Resources (HR) Team to respond.

3.27.2. The person raising the concern or complaint will be advised of this and that they will receive further details of the outcome regarding the individual member of staff.

3.27.3. Any concerns or complaints received, the subject of which results in a disciplinary investigation being commenced will be managed in line with the Trust HR policies and procedures.

3.27.4. Concerns and complaints raised by or on behalf of existing staff in relation to SECAmb recruitment will be passed to HR for them to deal with in accordance with Trust policies and procedures.

3.27.5. Concerns or complaints raised by SECAmb members of staff in connection with their employment will not be dealt with by this policy but referred to the Trust HR team.

3.27.6. Staff concerns regarding the practice of others within SECAmb will not be dealt with by this policy. Dependent upon the nature of those concerns the Patient Experience Team will direct the member of staff to raise them either via a Datix Incident (IRW1) or though the Trust Freedom to Speak Up Policy.

3.28. Criminal matters

3.28.1. Any concern or complaint which raises issues of a criminal matter will be escalated to the member of staffs Operating Unit Manager and the Trust Legal Team if necessary. This may lead to the Trust involving the Police or advising the complainant to report the matter directly to the Police.

3.29. Support to staff

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

3.29.2. However, the Trust recognises that some concerns and complaints raised are focused on the actions of individual staff members or volunteers and may feel very personal for those staff involved. In such cases the Trust aims to provide appropriate support to staff and volunteers to help them through any investigation.

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

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

3.30. Concerns and complaints involving the media

3.30.1. Where a complainant advises the Trust that they intend to contact the media about their issues, the Trust Communications Team will be informed and will handle any enquires that may be received from the media in relation to the matter.

3.30.2. The concern or complaint will continue to be progressed in line with this policy and the Trust response will be reviewed by the Trust Communications Team before being sent out.

3.31. Externally independent investigations

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

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

3.32. Complaints to the Parliamentary and Health Service Ombudsman (PHSO)

3.32.1. The Trust recognises that complainants have the right to approach the PHSO with their complaint at any time during the process. The powers of the PHSO are described in the Health Care Commissions Act 1993.

3.32.2. The PHSO will normally wish to satisfy themselves that the Trust feels that it has exhausted all opportunities to resolve the matter at a local level before they consider accepting the complaint for investigation.

3.32.3. The PHSO may decide to investigate a complaint before the Trust feels it has exhausted all opportunities to resolve the matter. The PHSO has the discretion to do so but, will normally liaise with the Trust and the complainant to agree a way forward if they feel it is likely to be resolved at a local level.

3.32.4. The Trust is keen that all contact with the PHSO is consistent and in line with its standards of governance. The role of liaison with the PHSO will be the responsibility of the PALS Officer who handled the complaint investigation with support from the PALS Manager.

3.32.5. All enquiries or notification of intention to investigate from the PHSO must be referred to the PALS Manager. The PALS Manager will review all outcomes received from the PHSO and support the PALS Officer in compiling a formal response for the Chief Executive to review and approve.

3.32.6. Any member of staff or volunteer who receives any communication directly from the PHSO should inform the PALS Manager as soon as possible, and before sending any response.

3.32.7. The PHSO may wish to have direct contact with a member of staff or contractor or volunteer in a complaint they are investigating. This should not occur without the PALS Manager being aware and providing support to the member of staff, as required.

3.32.8. The PALS Officer will ensure the relevant Operating Managers are consulted on any draft recommendations made by the PHSO prior to SECAmb accepting the draft report.

3.33. Habitual and/or vexatious complainants

3.33.1. Habitual and / or vexatious complainants are becoming an increasing problem for NHS staff although SECAmb does not experience this to any great extent. The difficulty in handling such complainants causes undue stress to staff that may need support in difficult situations and places a strain on time and resources. SECAmb staff are trained to respond with patience and empathy to the complainant's needs and feelings, but there are times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

3.33.2. In determining arrangements for handling such a complainant, the need to ensure an impartial approach is crucial. Staff are presented with two key considerations:

3.33.3. To ensure that the complaints procedure has been correctly implemented as far as possible and that no genuine element of a complaint is overlooked or inadequately addressed. It should be appreciated that habitual and vexatious complainants can have issues which contain some genuine substance.

3.33.4. To be able to identify the stage at which a complainant has become habitual or vexatious.

3.33.5. A complainant, and / or anyone acting on their behalf, may be deemed to be habitual or vexatious complainant where previous or current contact with them shows that they follow two or more, or are in serious breach of one, of the following criteria:

3.33.6. Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted.

3.33.7. Change the substance of a complaint, continually raise new issues or seek to prolong contact by continually raising further concerns or questions upon receipt of a response after the complaint has been addressed. Care must be taken not to discard new issues, which are significantly different from the original complaint. These may need to be addressed as separate complaints.

3.33.8. Unwilling to accept documented evidence of treatment given as being factual, e.g., Electronic Patient Clinical Records, signed non-conveyance forms or deny receipt of an adequate response despite correspondence specifically answering their concerns; or do not accept that facts can sometimes be difficult to verify if a long period of time has elapsed.

3.33.9. Do not clearly identify the precise issues which they wish to be investigated, despite the reasonable efforts of the Trust and, where the concerns identified are not within the remit of the Trust to investigate.

3.33.10. Focus on a trivial matter to an extent, which is out of proportion to its significance, and continue to focus on this point. The Trust recognises that determining what a 'trivial' matter is can be subjective and careful judgement must be used in applying these criteria.

3.33.11. Have threatened or used actual physical violence towards any member of staff. This will cause personal contact with the complainant and / or their representative to be discontinued immediately and without prior warning and the complaint will thereafter only be continued through written communication.

3.33.12. Have while addressing a formal complaint had an excessive number of contacts, or unreasonably made multiple complaints with the Trust, placing unreasonable demands on staff. A contact may be in person or by telephone, letter, or email. Discretion must be used in determining the precise number of 'excessive contacts' applicable under this section, using judgement based on the specific circumstances of each individual case.

3.33.13. Have harassed or been personally abusive or verbally aggressive towards staff dealing with their complaint. It is recognised that complainants may sometimes act out of character at times of stress, anxiety, or distress and, where appropriate, allowances should be made for this, provided it is not to the detriment of the staff concerned. All incidents of harassment or aggression should be documented, reported, and investigated in accordance with the Trust's incident reporting procedure. The PALS Manager will investigate and review each incident, if the harassment, personal abuse, or verbal aggression warrants personal contact with the complainant and / or their representative may be discontinued immediately and without warning and the complaint will thereafter only be continued through written communication.

3.33.14. Are known to have tape recording meetings, or any conversations held either face to face or over the telephone without the prior knowledge and consent of other parties involved. It may be necessary to explain to a complainant at the outset of any investigations into their complaint(s) that such behaviour is unacceptable and can, in some circumstances, be illegal.

3.33.15. Display unreasonable demands or expectations and fail to accept that these may be unreasonable once a clear explanation is provided to them as to what constitutes an unreasonable demand (e.g., insist on responses to complaints or enquires being provided more urgently than is reasonable or recognised practice.

3.34. Options for dealing with habitual and vexatious complainants:

3.34.1. Where complainants have been identified as habitual or vexatious in accordance with the above criteria, the Head of Patient Safety will determine what action to take. The PALS Manager will implement such action and will notify complainants promptly in writing of the reasons why

they have been classed as a habitual or vexatious complainant and the actions to be taken.

3.34.2. This notification will be copied for the information of others already involved in the complaint i.e., SECAmb staff, Independent Complaints Advocacy Service, MPs etc. A record will be kept on Datix by the PALS Officer for future reference of the reasons why a complainant has been classified habitual or vexatious and the action taken.

3.34.3. The Head of Patient Safety may decide to deal with habitual or vexatious complainants in one or more of the following ways:

3.34.4. Try to resolve matters, before invoking this procedure, by drawing up a signed ‘agreement’ with the complainant which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint process. If these terms are contravened consideration would then be given to implementing other action as indicated in this section.

3.34.5. Once it is clear that a complainant meets any of the criteria listed above it may be appropriate to inform them in writing that they may be classified as habitual or vexatious complainants, copying this procedure to them, and advise them to take account of the criteria in any other dealings with the Trust. In some cases, it may be appropriate, at this point, to copy this notification to others involved in the complaint and suggest that the complainant seeks independent help in taking their complaint forward.

3.34.6. Decline further contact with the complainant apart from written correspondence or through a third party, for example an advocacy service.

3.34.7. Notify the complainant in writing that the Trust has responded to the points raised and has tried to resolve the complaint, that there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant will also be notified that any further communications on the current complaint will not be responded to.

3.34.8. Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from the Lead Commissioning CCG.

3.34.9. Inform the complainant that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust’s solicitors and / or, if appropriate, the Police.

3.34.10. In cases where the complaint is made against the Chair or Chief Executive of the Trust then the decision about whether the complainant is deemed to be habitual or vexatious will be taken by a Non-Executive Director of the Trust.

3.35. Withdrawing habitual or vexatious status

3.35.1. Once complainants have been determined as habitual or vexatious there needs to be a mechanism for withdrawing this status at a later date if, for example complainants subsequently demonstrate a more reasonable approach or if they submitted a further complaint for which the normal complaints procedure would appear appropriate.

3.35.2. Staff should previously have used discretion and careful judgement in recommending habitual and vexatious status at the outset and similar discretion and judgement should be used in recommending that the status is withdrawn.

3.35.3. Where it appears to be the case, a discussion will be held with the Head of Patient Safety and, subject to their approval, normal contact with the complainant and application of the NHS complaints procedure will be resumed.

3.36. Training expectations for staff

3.36.1. Staff in the PALS Team must be aware of all aspects of this policy. They should be able to advise colleagues on any aspect of the Policy as well as following the correct procedure for each case received.

3.36.2. All SECAmb staff must be aware of the expectations of them in the early resolution of concerns that are brought to their attention in the normal course of their duties. All SECAmb staff must be aware of the role of the PALS Team.

3.37. Implementation plan

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

3.37.2. All individuals who have a direct role in the handling or approval of compliments, comments, concerns, and complaints will be offered support from the PALS Team as needed.

4. Responsibilities

4.1. Trust Board

4.1.1. 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 lessons is embedded in the Trust governance systems. The Board will seek assurance via the Executive Director of Quality and Nursing that these systems are functioning effectively and that SECAmb complies with the 2009 Complaint Regulations. The Board will receive the PALS Annual Report.

4.1.2. The designated Board Member responsible for managing concerns and complaints is the Executive Director of Quality and Nursing.

4.2. **Chief Executive**

4.2.1. **Has specific responsibilities for:**

- Overall responsibility for the implementation of this policy, ensuring that lessons are learnt from complaints and, where appropriate remedial action taken.
- Approval and sign for all level 3 complaints
- Approval and sign off for all MP Complaint responses
- Executive Director of Quality and Nursing
- Responsible for ensuring that the duties within the 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 the other information to identify common issues.
- Ensuring that themes and trends are monitored and that, where necessary, risks are escalated, and improvement plans are developed and implemented.
- Receives notification of all complaints where Clinical Commissioning Groups, Care Quality Commission or Department of Health are involved.

4.3. **Has specific overview and approval of:**

- Approving all financial remedies
- Overseeing decisions regarding criminal matters raised through complaints

4.4. **Executive directors**

4.4.1. Have overview on cases regarding the services for which they have responsibility in relation to decision making on habitual and vexatious complainants and specialist advice / approval as required.

4.5. **Deputy Director of Quality and Nursing**

4.5.1. Receives notification of all complaints where Clinical Commissioning Groups, Care Quality

4.5.2. Commission or Department of Health are involved.

4.5.3. Provides cover for the role of Executive Director of Quality and Nursing in connection with this policy

4.6. **Head of Patient Safety**

4.6.1. The Head of Patient Safety has oversight for the PALS Team

4.6.2. The Head of Patient Safety has oversight for habitual and vexatious complainants

4.7. **PALS Manager**

4.7.1. The PALS Manager is responsible for the day-to-day management of the PALS Team which handles all compliments, concerns, information requests, complaints, lost property enquiries and signposting to teams for further information.

4.7.2. The PALS Manager is also responsible for producing statistical information to the Board, Quality Governance Group, Commissioners, and other governance level groups to support and inform decision making.

4.8. **PALS Officers**

4.8.1. **The PALS Officers are responsible for:**

- The input and updating of the Trust Datix system for complaints, concerns, and information requests
- Triaging the complaint or concern level
- Liaising with complainants to agree timescales and expectations
- To raise questions with for the complainant to the local management team
- To coordinate investigation findings with the local management team
- To be the point of contact for the complainant
- To coordinate and send all correspondence
- To provide support to the Head of Patient Safety, the PALS Manager and other senior managers as required

4.9. **EOC and NHS111 Complaints Investigator**

4.9.1. The EOC and NHS111 Complaints Investigator has responsibility to investigate complaints raised about the Trust Emergency Operations Centres

4.9.2. The EOC and NHS111 Complaints Investigator will complete Internal Complaint Investigation

4.9.3. Reports to enable the PALS Officers to prepare response letters for complainants

4.10. **PALS Administrator**

4.10.1. **The PALS Administrator is responsible for:**

- Acknowledging receipt of compliments received by the Trust
- Input and updating of the Trust Datix system for compliments
- Preparing and sending compliment letters on behalf of the Chief Executive
- Providing administrative support to the PALS Team and wider directorate as required.

4.11. **Operating Unit Managers**

4.11.1. **The Operating Unit Managers are responsible for:**

- Ensuring the effective delivery of this policy within their operational services
- Ensuring that lessons learned from complaints and concerns are used effectively to improve services and service delivery
- Ensuring that early resolution of concerns and complaints and effective handling of dissatisfaction by all front-line staff and managers within their respective areas.

4.12. **All SECAmb staff**

4.12.1. **All SECAmb staff, contractors and volunteers are responsible for:**

- Always maintaining a professional manner and behaving in a way which demonstrates respect for the individual they care for
- Attempt to resolve concerns “real time” wherever possible, escalating to a senior manager when this is not possible in a timely way

- Cooperating fully with any investigation into a complaint or concern raised by a patient, their family, carer, or a member of the public whom they have 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, their family, carer, or a member of the public is dissatisfied with the care provided at the time of provision on the Electronic Patient Clinical Record (ePCR) and reporting the matter by completing an IRW1 on Datix

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

5. Procedure

5.1. On receipt of a complaint the PALS Officer will enter the details onto Datix.

5.2. They will identify the Directorate, Op Area / Department, and the Station/Team/Office.

5.3. All complaints will be acknowledged within three working days of receipt.

5.4. The written acknowledgement will provide details of what is being investigated, give a named contact, and advise of advocacy services available.

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

5.6. All complaints will be graded in accordance with the Complaints Investigation Grading Guide detailed in Appendix X.

5.7. All complaints which potentially meet the Serious Incident criteria will be marked on Datix ‘Referred to SIG’ to enable the PALS Manager to submit these to the Serious Incident Team each Monday for review.

5.8. Any complaints involving Clinical Commissioning Groups, Care Quality Commission or the Department of Health will be flagged to the Deputy Director of Nursing and Quality.

5.9. The PALS Officer will attempt to contact the complainant verbally within 3 working days to verbally discuss their complaint, agree the points for investigation and the outcome that they are seeking. They will also confirm Trust timescales for completion of the investigation.

5.10. The PALS Officer will identify the people who need to be advised of the complaint and who are required as part of their local investigation team. The relevant Operating Unit Manager and Operations Managers will be notified on every occasion. They will also identify if the complaint relates to clinical care and will require clinical input.

5.11. The Operating Unit Manager and Operations Managers may ask an Operational Team Leader to support with the investigation.

5.12. If they identify that additional expert advice is required from other staff.

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

5.14. Proportionate to the issues raised, the PALS Officer needs to addressed.

5.15. Documented records of the case i.e., a copy of the ePCR.

5.16. Recollections of the events, as required.

5.17. Any specialist advice or opinion.

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

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

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

5.21. The Operating Unit Manager and / or the Operations Manager or the Operational Team Leader if one was involved, will be asked to agree the conclusion.

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

5.23. Some complaints which have not been upheld may still give an opportunity for some learning as the investigation may have found issues with the service delivered or areas where service could be improved.

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

5.25. The PALS Officer, in consultation with the Operating Unit Manager, the Operations Manager or the Operational Team Leader should identify the appropriate learning actions and a plan for them to be completed with a clear timescale.

5.26. The Operating Unit Manager, the Operations Manager or the Operational Team Leader will be responsible for ensuring that the learning is completed within the agreed timescale and for confirming this to the PALS Officer.

5.27. The PALS Officer will be responsible for recording that the learning has been completed on Datix.

5.28. All complaints will receive a written response.

5.29. The written complaint response will be drafted individually for each complaint response.

5.30. The written response will make the appropriate apologies, will offer further contact, and will also advise the complainant of their right to pursue their complaint with the PHSO should they remain dissatisfied.

5.31. The PALS Manager will ask for six complaint responses to be sent to them for quality assurance from each PALS Officer bi-monthly before they are sent.

5.32. If a complainant has asked for verbal feedback this must always be supported with a written response.

5.33. Face to face resolution meetings via Teams may be held with complainants at their request, providing that this is proportionate with the issues raised. Resolution meetings may be held prior to or following a written response, as appropriate to the case. The PALS Officer will be responsible for organising the meeting and will attend to chair and ensure that it is recorded. A copy of the recording will be provided to the complainant if requested.

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

5.35. Where the complainant is clearly seeking clarity from the response that has been provided or they have further questions on the original questions it is not necessary to reopen the complaint and seek a further investigation. The PALS Officer can attempt to provide the necessary information in the most appropriate format. Any follow-up verbal contact must be confirmed in writing.

5.36. Where the complainant is raising new or additional issues which were not part of the initial complaint and have therefore not previously been investigated or addressed this will be recorded as a new complaint and dealt with in accordance with this procedure.

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

5.38. A complaint review will be carried out by the PALS Manager or a PALS Officer who was not involved in the original investigation.

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

5.40. A decision will be taken by the PALS Officer and the Investigating Manager as to whether an additional investigation is required.

5.41. Additional clinical opinions may be sought, of appropriate from a level above that of the initial clinical advice received.

5.42. Where other expert opinions are required, these will be sought from relevant experts at a level above that of the initial expert advice where possible.

5.43. Conclusions, learning and remedies will be considered in line with the procedure detailed above.

5.44. The complainant will receive a further response, this will be signed off by the PALS Manager, the Head of Patient Safety, or the Chief Executive.

5.45. Additional Sub-headings can be introduced in bold text.

6. Education and training

6.1. Training is provided by PALS Manager for all staff who will be investigators of complaints as identified by the Operating Managers.

6.2. Training is provided on a bespoke basis in order to meet fluctuating demand and provide timely responses to service needs.

6.3. Training is delivered face-to-face or virtually.

6.4. Content of the training includes overview of policy; stating the principles in order to ensure honesty, transparency, timeliness and to reflect duty of candour; detailed discussion on procedure; introduction and application of templates for investigation to ensure comprehensive oversight is undertaken.

7. Monitoring compliance

7.1. The PALS Manager will provide the Head of Patent Safety with a monthly report providing them with information based on the below:

7.2. The number of new complaints received for the preceding month.

7.3. The number of complaints closed for the previous month

7.4. The number of complaints which were acknowledged within three working days of receipt and the reason for any not acknowledged within this timescale.

7.5. The number of complaints which have breached the Trust investigation timeframe, the date on which the complainant was contact to inform them of the delay and what action has been taken to support the investigating manager to complete their investigation.

7.6. The average timeframe the Trust has taken to respond to complaints in the previous month.

7.7. Identify any trends during the previous month.

7.8. The number of complaints which have been reopened due to dissatisfaction from the complainant, what action has been taken to rectify.

7.9. The number of complaints which have been upheld, partly upheld, or not upheld.

7.10. A review the learning identified from the complaint investigations that have been completed.

7.11. This information forms part of the Integrated Performance Report.

8. Audit and Review (evaluating effectiveness)

8.1. The effectiveness of the principles of this Policy will be audited by the Quality Commissioning Group initially after six months, after which it will be on an annual basis.

8.2. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

8.3. This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

8.4. All changes made to this policy and procedure will go through the governance route for development and approval as set out in the Policy on Policies.

9. Associated Trust Documentation

- Duty of Candour
- Serious Incident Policy
- Data Protection Policy
- Data Quality Policy
- Data Subject Access Request Policy and Procedure
- Information Governance Policy
- Information Risk and Security Management Policy
- Safeguarding Policy
- This Compliments, Comments, Concerns, Information Requests and Complaints Handling Policy replaces the 'Complaints Policy' dated 5 June 2018.

10. References

10.1. **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 1998 www.legislation.gov.uk*

10.2. **Guidance**

- *NHS Complaints Standards Summary of Expectations www.ombudsman.org.uk/organisations-we-investigate/nhs-complaint-standards/nhs-complaint-standards-summary-expectations*
- *'Listening, Responding, Improving' issued by the Department of Health in February 2009 www.dh.gov.uk*
- *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013 www.gov.uk*
- *A review of the NHS Hospitals Complaints System 'Putting Patients Back in the Picture' Right Honourable Ann Clwyd MP and Professor Tricia Hart www.gov.uk*
- *Parliamentary and Health Service Ombudsman – Principles for remedy, Principles for Good Complaint Handling, Principles of Good Administration www.ombudsman.org.uk*
- *Caldicott Principles www.dh.gov.uk*
- *Data Protection Technical Guidance Note Disclosures to Members of Parliament carrying out constituency casework – based on Data Protection (Processing of Sensitive Data) (Elected Representatives) Order 2002 S.I. 2002 No. 2905* Constituency casework of Members of Parliament and the processing of sensitive personal data (ico.org.uk)

11. Financial Checkpoint

11.1. This document has been confirmed by Finance to have no unbudgeted financial implications.

12. Equality Analysis

The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one (see 3.2 above). It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

Name of author and role			
Directorate		Date of analysis:	
Name of policy being analysed			
Names of those involved in this EA			

1. Trust policies and procedures should support the requirements of the Equality Duty within the Equality Act:	Eliminate discrimination, harassment and victimisation. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.	In submitting this form, you are confirming that you have taken all reasonable steps to ensure that the requirements of the Equality Duty are properly considered.

2. When considering whether the processes outlined in your document may adversely impact on anyone, is there any existing research or information that you have taken into account?	For example: Local or national research National health data Local demographics SECAmb race equality data Work undertaken for previous EAs	If so, please give details:

3. Do the processes described have an impact on anyone's human rights?	If so, please describe how (positive/negative etc):

4. What are the outcomes of the EA in relation to people with protected characteristics?			
Protected characteristic	Impact Positive/Neutral/Negative	Protected characteristic	Impact Positive/Neutral/ Negative
Age		Race	

Disability		Religion or belief	
Gender reassignment		Sex	
Marriage and civil partnership		Sexual orientation	
Pregnancy and maternity			

5. Mitigating negative impacts:
If any negative impacts have been identified, an Equality Analysis Action Plan must be completed and attached to the EA Record. A template for the action plan is available in the Equality Analysis Guidance on the Trust's website. Please contact inclusion@secamb.nhs.uk for support and guidance.

Protected characteristic:		Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

Protected characteristic:		Issue identified:		
Action required:				
Action lead:				
How will impact/outcome be measured?		Timescale:		
Resolution of actions:				

EA Sign off	
EA checkpoint (Inclusion Working Group member, preferably from your Directorate)	[Name and role]
By signing this, I confirm that I am satisfied the EA process detailed on this form and the work it refers to are non-discriminatory and support the aims of the Equality Act 2010 as outlined in section 1 above.	
Signed:	Date:

13. Quality Impact Assessment

Summary Quality Impact Assessment Form

Policy title	
Author	
Responsible management group	
Accountable Director	
Date undertaken	

Consider the impact of changes brought about by your policy and ensure there are no negative impacts that have not been considered and mitigated. For policies, there should be positive impacts if they are correctly designed. Please confirm that your policy will have a neutral or positive impact on the areas described and note any positive impacts you believe will be achieved through your policy.

The impact on Patient Safety after the change has occurred	Consider the following: - What is the impact on partner organisations and any aspect of shared risk? - Will this impact on the organisations duty to protect children, young people and adults? - Impact on patient safety? - Impact on preventable harm? - Will is affect the reliability of safety systems? - How will it impact on systems and a process for ensuring that the risk of healthcare acquired infections to patients is reduced? - What is the impact on clinical workforce capability care and skills?	
The impact on Clinical Effectiveness after the change has occurred	Consider the following: - How does it impact on implementation of evidence based practice? - How will it impact on clinical leadership? - Does it reduce / impact on variation in care provision? - Does it impact on ensuring that care is delivered in most clinically and cost effective setting? - Does it eliminate inefficiency and waste by design? - Does it lead to improvements in care pathway?	
The impact on Patient Experience	Consider the following: - What is the impact on race, gender, age, disability, sexual orientation, religion	

after the change has occurred	and belief for individual and community health, access to services and experience? - What impact is it likely to have on self-reported experience of patients and service uses? (response to national / local surveys / complaints / PALS / incidents) - How will it impact on the choice agenda? - How will it impact on the compassionate and personalised care agenda?	
The impact on Staff Experience after the change has occurred	Consider the following: - Staff satisfaction - Staff turnover / absentee rate - Bank and agency staff level - Equality impact on staff	
Other (including impact on Trust reputation, regulatory requirements and local health economy impact)	Consider the following: - Any impact on the reputation of the Trust - Any impact on the Trust's regulatory requirements - Any impact on the local health economy e.g. CCGs, acute providers	
Mitigations	Detail any actions put in place / to put in place to ensure that potential risks are managed or monitored to ensure appropriate action is efficiently taken. Consider the impact on the wider health economy and if any external stakeholders need to be engaged in the change to mitigate any risk, e.g. CCQs, acute providers	

Deputy Clinical Director	Name		Role	
	Decision		*Approve, Full QIA required, or Reject*	
	Comments, including clarity on decision and requirements			
	Signature		Date of decision	

14. Data Privacy Impact Assessment

Data Privacy Impact Assessment Reference Number: (Request from the Information Governance Team)		DPIAYYYY/XXXX
Project / Initiative / Service Name:		
Organisation department:		
Individual responsible for completing the DPIA:	Name:	
	Job Title:	
	Date:	
Overview: (Summary of the proposed change)		
Planned go-live date:		

No.	Question	Response
1	Will person-identifiable data (staff or service user) be collected?	
2	What data will be collected?	
3	Why is it being collected?	
4	Who is the ‘owner’ of the data?	
5	Does the project involve multiple organisations? (Give details)	
6	Will the data collected be stored electronically or on paper?	
7	Where will it be stored?	
8	What measures are in place to ensure the data remains secure? (technical and/or physical)	
9	Have patients/users/staff been informed of the changes which may affect their data?	
10	If applicable, have service users been asked to consent for the collection/sharing of their data?	

No.	Question	Response
11	Are there any new or additional reporting requirements for this project?	
12	Are there audit trails in the system?	
13	Will staff be trained in how to collect information or use the system?	
14	Will any information be transferred outside the organisation?	
15	If so, are information sharing agreements in place?	
16	What processes are in place to allow service users access to their data? What processes are in place for removal/destruction of data when it is no longer needed?	
17	If the project should stop, are plans in place for how information will be retained/archived/transferred?	

Stage 1 Authorisation: Information Asset Owner *Confirmation of ownership of the privacy risks and treatments identified in this document with any comments / recommendations for further reduction of privacy risk.*			
Reviewed by:		Date reviewed:	DD/MM/YY

Stage 2 Authorisation: Information Governance Manager (or delegate) *Confirmation that the DPIA is sufficient to address privacy risks and compliance with relevant legislation.*			
Reviewed by:		Date reviewed:	DD/MM/YY

Stage 3 Authorisation: Senior Information Risk Owner (SIRO) / Committee / Board *Confirmation that the DPIA is sufficient to address privacy risks and compliance with relevant legislation.*			
Noted by:		Date noted:	DD/MM/YY

Publication date:	DD/MM/YY	Webpage: *(URL)*	