

Email: foi.tsdfd@nhs.net
Our Ref: TSD10731

Dear Sir/Madam

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below:

For the period 1 January 2024 to the date of this request, please provide:

- 1. The total number of emails received by the Chief Executive from:**
 - **The Heart Campaign; and/or**
 - **Any individual acting on behalf of or publicly representing The Heart Campaign.**

116 emails were received by the Chief Executive. This figure includes emails sent to other organisations where the Chief Executive was copied in by the Chair of The Heart Campaign. Of these, 114 were received from the Chair of The Heart Campaign and two were received from a committee member of The Heart Campaign.

- 2. The total number of emails sent in response by:**

- **The Chief Executive; and**
- **Other Trust employees acting on behalf of the Trust.**

As of the 30 July 2026 The Chief Executive sent 79 emails in response to correspondence from The Heart Campaign and/or individuals acting on behalf of or publicly representing The Heart Campaign.

The Chief Executive also sent three proactive emails to the Chair of The Heart Campaign in November and December 2025 regarding health and safety arrangements for the planned protest on 6 December 2025.

At the time of responding to this FOI request, three emails from the Chair of The Heart Campaign were still in the process of being responded to.

- 3. The total number of meetings (virtual or in person) held between Trust representatives and representatives of The Heart Campaign.**

Two meetings were held between Trust representatives and representatives of The Heart Campaign during the requested period.

These were:

3 July 2025 – Chris Balch, then Chair of the Trust, met with Susie Colley.
3 September 2025 – Joe Teape, Chief Executive; Simon Tapley, Chief Strategy and Planning Officer; and Cath Parnell, Chief of Staff, met with

Susie Colley and Sally Allen-Gerrard, representatives of The Heart Campaign.

4. The total number of telephone calls recorded between Trust representatives and representatives of The Heart Campaign.

Zero.

5. Any estimate, recorded assessment, or calculation held by the Trust of:

- **Staff time spent responding to enquiries from The Heart Campaign;**
- **Executive time spent responding to enquiries from The Heart Campaign; or**
- **The financial cost of responding to enquiries from The Heart Campaign.**

The Trust does not hold this information. No estimate, recorded assessment or calculation has been made by the Trust in relation to staff time, executive time, or the financial cost of responding to enquiries from The Heart Campaign.

6. Where the Trust records this information, the total number of Subject Access Requests, Freedom of Information requests, complaints, formal enquiries, petitions, or consultation responses submitted by representatives of The Heart Campaign during the same period.

The Trust considers that confirming whether any identified representatives of The Heart Campaign submitted Subject Access Requests would disclose personal information about those individuals. The Trust therefore neither confirms nor denies whether it holds this information under section 40(5B)(a)(i) of the Freedom of Information Act 2000.

15 Freedom of Information requests were submitted by the Chair of The Heart Campaign during the requested period.

A search of complaints and Patient Advice and Liaison Service (PALS) records identified 14 concerns and one MP enquiry relating to the closure of the primary PCI service at Torbay. These were not identified as being submitted by representatives of The Heart Campaign and have therefore not been counted within scope of this part of the request.

No petitions or consultation responses submitted to the Trust by representatives of The Heart Campaign were identified during the requested period.

No formal enquiries received by representatives of The Heart Campaign during the requested period other than the emails already identified as

being received by the Chief Executive and noted in the answer to question 1.

7. Copies of any guidance, briefing notes, or internal policies used by the Trust when responding to high volumes of correspondence from campaign groups.

The Trust does not hold a specific policy, guidance or briefing notes relating solely to the management of high volumes of correspondence from campaign groups.

Depending on the nature of the correspondence received, the Trust may use a range of existing corporate policies, procedures and guidance documents, including the following attached documents:

- Media Management Policy.
- Complaints, Feedback and Patient Advice and Liaison Service (PALS) Policy.

Freedom of Information procedures and supporting Information Commissioner's Office guidance, including guidance relating to vexatious and repeated FOI requests where applicable.

Other issue-specific briefing materials, correspondence logs and governance arrangements developed in response to particular operational or strategic issues.

The Trust also holds broader communications and reputational risk management documents which may reference campaign-related activity, stakeholder correspondence and escalation processes.

The information supplied to you continues to be protected by the Copyright, Designs and Patents Act 1988. You are free to use it for your own purposes, including any non-commercial research you are doing and for the purposes of news reporting.

If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Complaints Manager at Torbay and South Devon NHS Foundation Trust, First Floor Bowyer Building, Torbay Hospital, Torquay TQ2 7AA or by email to tsdft.feedback@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the

complaints and/or internal review process provided by us. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link <https://ico.org.uk/global/contact-us/>

Yours sincerely,

Freedom of Information Team

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Contents

1	Introduction	2
2.	Definitions	4
3.	Who can provide feedback to the Trust?	5
4.	How will this feedback be managed?	6
5.	Complaints and other procedures	7
6.	Key roles and responsibilities – Complaints	8
7.	Key areas of responsibility when managing feedback	9
8.	Complaints received from Members of Parliament	15
9.	Ombudsman’s Investigations	16
10.	Learning from Feedback	16
11.	Reporting arrangements	16
12.	Training	17
13.	Contact details	17
	Appendix 1	20
	Appendix 2	21
	Appendix 3	23
	Appendix 4	27
	Appendix 5	34
	Appendix 6	35
	Appendix 7	37
	Appendix 8	40
	Appendix 9	41
	Appendix 10	45
	Appendix 11	46
	Appendix 12	47
	Appendix 13	48
	Appendix 14	Error! Bookmark not defined.

1 Introduction

- Torbay and South Devon NHS Foundation Trust (the Trust) recognises the value of feedback from patients, service users, carers, members of the public and others. The Trust aims to resolve any concerns locally and as soon as possible after they have been raised.
- Feedback is invaluable to the Trust and can provide an audit trail that gives an early warning of failures in service delivery. It provides an opportunity for the Trust to improve its services and reputation.
- This policy sets out the process when receiving feedback about the Trust and the roles and responsibilities of those involved in the process.

1.1. Handling Complaints - Delivering our Values

- The NHS Constitution makes clear what people should expect when they complain. The Care Quality Commission (CQC) requires registered providers of services to investigate complaints effectively, learn lessons from them, and implement changes as required.
- This policy follows the relevant requirements in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations).
- The Trust has written its Complaints Policy to reflect the principles of the NHS Constitution, and recommendations from Parliamentary and Health Service Ombudsman (PHSO) and Local Government and Social Care Ombudsman (LGSCO) reports^{1 2 3}.

The Trust subscribes to the NHS constitution values:



¹ Local Government and Social Care Ombudsman and the Parliamentary and Health Service Ombudsman 'People not structures: putting people at the heart of integrated care July 2024

² Parliamentary and Health Service Ombudsman 'Broken trust: making patient safety more than just a promise' June 2023

³ Parliamentary and Health Service Ombudsman 'Making Complaints Count: Supporting complaints handling in the NHS and UK Government departments' July 2020

1.2. Key Feedback Priorities

- Create a culture which encourages and welcomes feedback and acts on it to improve services.
- Provide clear and widely available information about how to feedback.
- If a formal complaint is raised, to provide complainants with sufficient support to enable them to participate fully in the complaints process.
 - a) Promote a prompt, open, flexible dialogue with the complainant throughout the duration of the investigation and the response to the complaint.
 - b) Conduct a thorough, honest, and balanced investigation and provide a full and understandable response.
 - c) Provide evidence of learning and follow up action, where appropriate.
- The Parliamentary and Health Service Ombudsman (PHSO)⁴ and the Local Government and Social Care Ombudsman (LGSCO)⁵ set out principles that are expected from public bodies when dealing with complaints. At the heart of an effective complaint handling system are four core pillars, these are based on:
 - a) Welcoming complaints in a positive way and recognising them as valuable insight for organisations
 - b) Supporting a thorough and fair approach that accurately reflects the experiences of everyone involved
 - c) Encouraging fair and accountable responses that provide open and honest answers as soon as possible
 - d) Promoting a learning culture by supporting organisations to see complaints as opportunities to improve services
- Ongoing training and development, continual assessment of performance and the active involvement of all staff are prerequisites of this procedure to ensure it delivers real improvements and sees complainants as equal partners.
- The Trust Board and Executive Team will ensure these priorities are met through monthly reporting to the Safety and Quality Assurance Group, which include themes arising in the complaints, monitoring and oversight of actions and performance monitoring of the complaints procedure.

1.3. Identifying a Complaint

- **Everyday conversations with patients and service users**

Our staff speak to people who use our services every day. This can often raise issues, requests for a service, questions or worries that our staff can help with immediately. We encourage people to discuss any issues they have with our staff, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

⁴ Parliamentary and Health Service Ombudsman (PHSO) 'NHS Complaints Standards: Summary of Expectations' December 2022

⁵ Local Government and Social Care Ombudsman 'Complaint Handling Code' February 2024

- **When people want to make a complaint**

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

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

- **Feedback and complaints**

People may want to provide feedback instead of making a complaint. In line with DHSC's NHS Complaints Guidance people can provide feedback, make a complaint, or do both. Feedback can be an expression of dissatisfaction (as well as positive feedback) but is normally given without wanting to receive a response or make a complaint.

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

Complaints can be made to us:

- in person
- by telephone - 01803 655838
- in writing - Feedback and Engagement Team, Torbay and South Devon NHS Foundation Trust, Bowyer Building, Torbay Hospital, Lowes Bridge, Torquay, TQ2 7AA
- by email - tsdft.feedback@nhs.net

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

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

2. Definitions

2.1. Complaints or Concerns

A concern or complaint is 'any expression of dissatisfaction that requires a response'. It is how the person raising a concern/complaint would like it addressed that helps define whether the expression of dissatisfaction requires an 'informal' or 'formal' response.

It is therefore not always the complexity or severity of a concern or complaint that defines its formality or informality as described below:

- **Concern:** issues of concern that are of a minor nature which are raised, often with front line members of staff, or PALS, at the time they occur, and can be resolved quickly.
- **Complaint:** any concern or issue, either verbal or in writing (including email correspondence) about any aspect of service provided by the Trust which the patient or representative (with the patient's consent) or any person has specifically asked to be addressed formally.

A Concern or Complaint can be made anonymously by any user of the Trust about any aspect of service provided. However, it must be considered that non-disclosure of relevant information may impact or prevent a complete investigation from being carried out.

2.2. Comment

An idea or suggestion which the Trust could use to improve experience, or the safety and effectiveness of, its service delivery. This may also be called a 'service request' (LGSCO).

2.3. Compliment

Somebody telling the Trust about something it did well.

2.4. Patient Safety Incident

A Patient Safety Incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

2.5. Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison service is a confidential service that is provided by the Trust and aims to provide information and support to help individuals and staff resolve problems and concerns arising from the provision of health services and related issues.

These definitions are for guidance only - it is acknowledged that not all feedback will always fit neatly into a definition and the wishes of the individual will be considered.

3. Who can provide feedback to the Trust?

- Every existing or former health or social care client, their friend, relative, carer or advocate has the right to bring to the attention of the Trust any aspects of a patient, client, or service user's care and treatment.
- The boundaries between services and organisations are not always clear to patients, clients, and members of the public. As a general rule, the Trust will review feedback received by or on behalf of patients and clients who receive services commissioned or provided by the Trust. Where services are not commissioned or contracted by the Trust, the enquirer would be asked to approach the service provider in the first instance. If the individual is dissatisfied with the response from the service provider, the Trust will then investigate.
- Where the feedback relates to a service provided by another organisation, as well as the Trust, a lead organisation will be identified to co-ordinate the investigation and provide the overall response. Consent will be gained from the individual to share their information with the other organisation(s).

- If the person concerned is unable to act for his or herself, or has died, the complaint can be accepted from a close relative, friend, or other body or individual suitable to act as a representative.
- When a complaint is made on behalf of another person the Trust will need to ensure that consent is obtained before a response is made. Where there are complex issues surrounding consent, including capacity, advice will be sought from the Data Protection Team.

4. How will this feedback be managed?

4.1 Patients, clients, relatives and carers are encouraged to feedback to staff about their experiences. In the event of concerns, best practice is to attempt to address the situation locally at the earliest opportunity by listening to the concerns raised in an appropriate and empathetic manner.

- Every effort should be made to resolve the complaint and satisfy the complainant there and then. If this is not possible, refer the complainant to a more senior person, such as the Senior Sister/Charge Nurse, Ward Manager, Matron, Associate Director of Nursing (ADN), Assistant Director (AD), Social Work Lead or the On-Call Manager, for further attempts to resolve the matter. Consider offering the support of the PALS.
- The confidentiality of the individual and their medical condition should be maintained, in line with Data Protection Act (2018). All information provided will be treated in confidence and only disclosed in order to investigate the issues raised.
- If the feedback comes from a third party, the consent of the individual should be obtained before sharing confidential information with the third party. If it is not possible to obtain such consent, for example, if the person has died or is incapable of giving it, senior managers will consider the particular circumstances in deciding whether to investigate. Advice is available from the PALS and Complaints Team and Data Protection Team.
- Whether the individual wants their concern investigated and resolved at a local level, or as a formal written complaint via the Chief Executive's office, should be established. If the latter, the individual should be provided with a copy of the feedback information leaflet.
- The complaint must be recorded on Datix/DCIQ, the Trust's Local Risk Management System (LRMS) using the Feedback module.

4.2 The PALS and Complaints Team will discuss with the person raising the issue(s) and work with them to resolve these in the best possible way. This is to ensure:

- Feedback is dealt with efficiently
- PALS is promoted as an informal, confidential, client focused service that deals with problems and concerns as quickly and effectively as possible
- People are treated with respect and courtesy
- Complaints are properly investigated
- People receive help to understand the complaints procedure
- People receive advice on where they may obtain assistance with the procedure

- People receive a response that provides an explanation and response to their complaint and are clear about the outcome of the investigation
- That action is taken, if necessary, to ensure the Trust learns from the feedback
- Good practice is recognised and acknowledged

5. Complaints and other procedures

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

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

- trigger a patient safety investigation which may be:
 - a local patient safety review (PSR) and action plan, or
 - a more detailed patient safety incident investigation (PSII)
- trigger our safeguarding procedure
- involve a coroner investigation or inquest
- trigger a relevant regulatory process, such as fitness to practice investigations or referrals
- involve a relevant legal issue that requires specialist advice or guidance.

5.3. When another process may be better suited to cover other potential outcomes, our staff will seek advice and provide clear information to the individual raising the complaint. We will make sure the individual understands why this is relevant and the options available. We will also signpost the individual to sources of specialist independent advice.

5.4. This will not prevent us from continuing to investigate the complaint. We will make sure that the person raising the complaint gets a complete and holistic response to all the issues raised. This includes any relevant outcomes where appropriate. The staff member dealing with the complaint will engage with other staff or organisations who can provide advice and support on the best way to do this.

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

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

In such cases the complaint investigation will be put on hold until those processes conclude.

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

5.7.

- notify the person raising the complaint (and any staff involved) immediately
- explain the reasons for the delay
- provide a new target timescale for completion.

5.8. Unless we have agreed a longer timescale with the person raising the complaint within the first 6 months, we will inform them if we cannot conclude the investigation and issue a final response within 6 months. Our Responsible Person or a Senior Manager will write to the person to explain the reasons for the delay and the likely timescale for completion. They will then maintain oversight of the case until it is completed, and a final written response issued.

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

5.10. If the person dealing with the complaint identifies at any time that anyone involved in the complaint may have experienced, or be at risk of experiencing, harm or abuse then they will discuss the matter with relevant colleagues and initiate our safeguarding procedure.

6. Key roles and responsibilities – Complaints

6.1. The Chief Executive is responsible for ensuring the Trust complies with the complaints regulations. The Chief Executive will delegate the responsibility for the effective delivery of the Trust's policy to the Chief Nurse.

6.2. The Chief Nurse will, in turn, delegate to the Deputy Chief Nurse the responsibility for the management of the Trust's complaints handling in line with this policy.

6.3. The Deputy Chief Nurse will be responsible for the operational management of the PALS and Complaints Team comprising of the Complaints and Patient Advice and Liaison Service (PALS). The PALS and Complaints Team will support the Trust in the delivery of this policy.

6.4. The Trust Board and senior managers have key responsibilities to ensure that the culture of the organisation reflects the fact that the Trust takes feedback and complaints seriously and expects them to be acted on.

6.4.1. At Care Group level, the Associate Director of Nursing and Professional Practice (ADNPP) or Associate Director for Operations (ADO) will be responsible for ensuring complaints are investigated and responded to in line with the policy and for ensuring, where appropriate, that lessons are learnt, and remedial action is implemented and evaluated.

- 6.4.2. During complaint investigations staff will be required to provide comments, and when indicated, written statements.
- 6.4.3. The corporate responsibility for ensuring lessons are learned across the organisation is primarily through the “Feedback and Engagement” group led by the Deputy Chief Nurse.

7. Key areas of responsibility when managing feedback

7.1. Chief Executive’s office and Chief Nurse.

- 7.1.1. The Chief Executive’s office will receive written feedback addressed to the Chief Executive (CE). The Chief Executive’s Office will ensure that letters are date stamped on the same working day and passed to the PALS and Complaints Team.
- 7.1.2. Feedback received by email, or electronically through the Trust’s public website, will be passed to the PALS and Complaints Team and dealt with in the same way as a letter written to the CE.
- 7.1.3. Telephone calls from individuals wishing to provide feedback will be forwarded to the PALS and Complaints Team.
- 7.1.4. The Chief Executive’s Office will receive response letters answering formal complaints from the PALS and Complaints Team by email. Once signed by the Chief Executive, the response letter is scanned and emailed to the PALS and Complaints Team for inclusion in the Datix/DCIQ folder. In the absence of the Chief Executive the response letters will be signed by the Chief Nurse.
- 7.1.5. The Chief Executive’s Office will dispatch the signed letter by first class post and clearly marked “Private and Confidential.”
- 7.1.6. For any complaint from someone which specifically states they have or are applying for a gender recognition certificate, please seek immediate advice from the Trust’s Equality and Diversity Lead before commencing the complaint process. The PALS and Complaints Team will confirm with the enquirer how they would like to be addressed.

7.2. PALS and Complaints Team

- 7.2.1. Review feedback to assess whether it falls within the parameters of the NHS Complaints Regulations.
- 7.2.2. On the day of receipt of the letter or email, where possible, contact the individual to:
 - Thank the enquirer for letter or email
 - Confirm or establish precise nature of the feedback

If it is a complaint:

- Complaints must be made no later than 12 months after the date the incident occurred or, if later, the date the matter came to the notice of the complainant. This time restriction may be waived if the Trust is satisfied the

complainant has good reasons for not raising it earlier *and* that it is possible to investigate the complaint effectively and fairly.

- This procedure only relates to complaints made by members of the public about services provided, or funded, by the Trust. It does not relate to requests for information under the Freedom of Information Act 2000 or Data Protection Act 2018. Staff grievances are covered by separate Trust policies. Nor does it relate to the management of potential litigation cases which are dealt with under a separate policy.
- If the representative is making a complaint on behalf of someone else, the Trust will write and ask for consent. If consent has not been received within 20 working days, then the Trust will write again and close the complaint until consent is received.
- If a representative makes a complaint on behalf of a child, the Trust must not consider the complaint unless satisfied there are reasonable grounds for the complaint being made by the representative and not the child. The Trust will ask for consent from the child where appropriate, seeking advice from the Data Protection Team and the service involved.
- If the Trust is not satisfied, it must explain the decision in writing to the representative.
- If a representative makes a complaint on behalf of a person who lacks capacity within the meaning of the Mental Capacity Act 2005, and the Trust is satisfied that the representative is not acting in the enquirer's best interests, the Trust must write to the representative explaining why the complaint will not be further considered.
- Other options available will be discussed, for example, the role of Devon Advocacy Consortium (DAC). If necessary, advise the enquirer that they can ask the Integrated Care Board (ICB) to investigate.
- Establish the enquirer's expectations and discuss the likelihood of meeting these. This should include if there is a request for a written response or Local Complaints resolution meeting.
- Discuss the standard response time of 12 weeks and agree a timescale for a full response to the complaint. If it is immediately evident that the scale and number of issues that form the complaint may mean we will be unable to respond in 12 weeks then discuss that possibility of a longer timescale with the complainant.
- Identify any requirements for reasonable adjustments in relation to Equality and Diversity e.g. response in another language, large format.
- Confirm the preferred means of communication, e.g. letter, email or telephone. Advise the person of the policy around emailing any patient identifiable information to insecure email accounts.
- Within 3 working days of receiving the letter, prepare and send an acknowledgement (Response Plan) letter to the complainant. Enclose a copy of Trust Complaints Leaflet and health complaints leaflet.

- If the complaint carries the risk of litigation, or a potential admission of liability, discuss this with the Trust's Litigation Department.
- Log the complaint on to the Datix risk management system (Feedback module) and give a unique identification number to the complainant.
- Review the Datix risk management system to see if a patient safety incident has been logged and, if so, let the Care Group know an incident form has been completed via the complaint synopsis.
- Email the complaint letter or initial contact details, the Trust acknowledgement letter, the 2-step investigation document and information received to: Care Group Associate Director for Nursing and Professional Practice (ADNPP) or Associate Director of Operations (ADO), Complaints Coordinator (if applicable), PALS and Complaints Manager and where applicable service Manager. The Deputy Chief Nurses and Deputy Chief AHP will receive complaints aligned to their Care Groups and have oversight of all complaints.
- Where the complaint refers to issues in two or more Care Groups, identify which Care Group will take the lead in coordinating the response.
- Where the complaint concerns a Clinical Director, ensure the Medical Director is copied into the original complaint information.
- Where the complaint concerns a Care Group Manager or Associate Director, this will be transferred to the Chief Operating Officer for investigation.
- Where the complaint concerns an ADNPP, this will transfer to the Deputy Chief Nurse/ AHP for the Care Group identified and the Chief Nurse.
- Record the pertinent issues identified during dialogue with the complainant on the database and send this and a copy of the complaint letter to the relevant Care Group.
- Update the complainant as necessary of progress.
- The timeline for review and approval of a complaint is 12 weeks in total, broken down as follows:
 - ADNPP and investigators have 8 weeks to review from the date the complaint pack is sent to the ADNPP
 - ADNPP to share response letter with Deputy Chief Nurse/Deputy Chief AHP for review. A 2-week review period is allocated for this.
 - The final version of the letter is then shared with the Chief Executive for review, approval, and signature. A 2-week review period is allocated for this.
- The final signed letter will be submitted to the PALS and Complaints Team via their central e-mail address. A copy of any other documentation, such as details of remedial action, will be saved to the Datix/DCIQ file.
- For the complaints relating to adult social care provision within the Torbay system (where the trust holds delegated responsibility for ADC) this will be reviewed by the Deputy Director for Adult Social Services, together with the

ADO for the relevant Torbay Care Group. The final version is sent to the Chief Executive for approval.

- In closing the complaint, consider any learning for the Trust's Feedback and Engagement group.
- Add actions to the Datix/DCIQ file and monitor until they are closed. Liaise with Care Groups on progress of actions.
- Ensure any second contacts are managed in line with the formal complaint process.
- If consent has been given to contact them, survey complainants to gain feedback on their experience.

If Feedback:

- Discuss with the individual how they would like their issue resolved
- Engage the support of the PALs Service if appropriate
- Collaborate with relevant staff for learning and feedback

7.3. Care Group/ Departments – Complaint

- 7.3.1.** Receive copy of complaint letter or email and associated documentation from PALs and Complaints Team on a 2-step investigation pack.
- 7.3.2.** Identify all aspects of the complaint that need investigation and response. See Appendix 1, "Guidance on conducting an Investigation into a Complaint"
- 7.3.3.** Initiate the investigation by requesting statements from the staff involved in the care or incident being complained about. The approach to an investigation must match the seriousness of the issues raised and appropriate escalation to a senior manager should be undertaken to determine the level of action required. Provide "Guidelines on writing a Statement as part of an investigation into a complaint or incident" to all staff asked to provide one. Appendix 2.
- 7.3.4.** Allocate a lead person for the investigation who will be responsible for updating the ADNPP or ADO on the progress of the investigation.
- 7.3.5.** Identify and obtain the documentation to be reviewed to gain a full and complete picture of the case.
- 7.3.6.** If, during the investigation, it becomes apparent that the complaint is more serious than originally thought, the lead should discuss this with the ADNPP or ADO urgently. Consider appointing a Single Point of Contact (SPOC).
- 7.3.7.** Maintain contact with the complainant to ensure the complainant is kept properly informed about any significant change to the agreed timetable and focus for the investigation and final response.
- 7.3.8.** Keep full, accurate and timely records (including dates and times) of such contacts and any significant elements of the investigation on the Datix risk management system (Feedback module). Remember that all

documentation, whether electronic or hard copy, are potentially disclosable to third parties.

- 7.3.9.** The ADNPP or ADO to review the relevant investigation documentation and the draft letter of response, in the name of the Chief Executive. See Appendix 3, “Guidance on preparing a letter of response”.
- 7.3.10.** If the response asserts that, in our view, the complainant’s care and/or the Trust’s position were appropriate, the investigator must provide evidence to support such claims, by for example, referring to national guidance or best practice.
- 7.3.11.** If the response carries the risk of an admission of liability, discuss this with the PALS and Complaints Team and the Litigation Department.
- 7.3.12.** Where appropriate, complete an incident form and utilise any incident investigation reports that have been completed for an existing incident.
- 7.3.13.** If there are delays in receiving responses from relevant staff, then this can be escalated through the line management system for resolution.
- 7.3.14.** The ADNPP or ADO or a senior member of staff nominated by them, who was not involved with the investigation, to review the response and ensure it meets the standards set out in “Guidance in preparing a letter of response” – see Appendix 3. When satisfied, to sign the Investigation Plan.
- 7.3.15.** The ADNPP or ADO will review the final draft with the System Director for Nursing and Professional Practice aligned to the Care Group and the response will be reviewed for quality and accuracy.
- 7.3.16.** All adult social care complaints also require the Assistant Director for Adult Social Care to review and approve aligned to the delegated accountability for adult social care held by TSDFT.
- 7.3.17.** The ADNPP or ADO will send the final version to the PALS and Complaints Team for final formatting and include the Deputy Chief Nurse for the relevant Care Group into this submission.
- 7.3.18.** Once this review is completed the PALS and Complaints Team will email the final response letter and the completed Investigation Plan to the Chief Executive.
- 7.3.19.** Share the response letter with staff involved in the complaint together with details of remedial and follow-up action.
- 7.3.20.** Implement any remedial or follow-up action that has been agreed. Keep records of action taken on the risk management system, including dates, key personnel and evidence to demonstrate compliance. Ensure PALS and Complaints Team are aware of actions and status of these.
- 7.3.21.** All maternity complaints are approved by the Director of Midwifery and Gynaecology and will then be progressed to the Chief Executive (via the PALS and Complaints Team)

7.4. Complaints addressed to staff other than the Chief Executive

Letters of complaint sent to members of staff other than the CE, will either be acknowledged, in writing and within 3 working days, by the staff member to whom the letter is addressed or passed to the PALS and Complaints Team who will complete the acknowledgement. If, in exceptional circumstances, it is appropriate for the addressee to respond to the complaint directly, this must be discussed with the PALS and Complaints Team to ensure a consistent approach is taken.

7.5. Ensuring patients or their relatives/carers are not treated differently or unfairly as a result of a complaint

- Every assistance will be given to individuals who wish to make a complaint, including the provision of interpreter services or any other service or body which may serve to enhance the communication of the complaint to the organisation.
- People must be supported in expressing their concerns and must not be led to believe either directly or indirectly, that they may be disadvantaged because they have made a complaint. Making a complaint or raising a concern does not mean that a service user or complainant will receive less help or that things will be made difficult for them. The Trust will adhere to the Duty of Candour & Being Open Policy (2783).
- The Care Quality Commission's Key Lines of Enquiry covers this issue, it states "making a complaint will not cause them to be discriminated against or have any negative effect on their care, treatment or support."
- Everyone can expect to be treated fairly and equally regardless of age, disability, gender reassignment, marriage and civil partnership, race, religion and belief, gender, and sexual orientation.
- The Trust does not expect any patient to be treated differently as a result of making a complaint and a complaint must not be recorded in an individual's care records.

7.6. Complainants who cannot be satisfied by the Trust's procedure

- Occasionally a situation may arise where, despite every effort made by the Trust, the complainant remains dissatisfied and continues to make complaints. The Trust will make every effort to answer the concerns raised and will offer reasonably opportunities to do that. However, if the complainant continues to raise concerns and the Trust believes it has done all it can to answer the complaint the complainant will be reminded of their rights to request an Independent Review from the Ombudsman and the decision may be made to close the complaint. This decision will be taken by the ADNPP/ADO and PALS and Complaints Team.
- The PALS and Complaints Team will write to the complainant informing them of this decision and that no further action will be taken by the Trust on their complaint, but reiterating the alternatives open to the complainant.

7.7. Handling unreasonable complainants

On rare occasions, despite our best efforts to resolve a complaint, a complainant can become unreasonable. The Department of Health has issued guidance on handling unreasonable complaints and the Trust has adopted this as best practice. See Appendix 5, “Handling unreasonable complainants”.

7.8. Remedy

- If the investigation into the complaint has established that the Trust is in the wrong, it must try to put things right.
- A full explanation of what went wrong plus details of what action has or will be taken to change and improve practices are essential. These should be accompanied by a full and sincere apology.
- Over and above this the Trust should, wherever possible, put someone in the position they would have been if the fault had not occurred. This may, for example, mean financial compensation for travel costs or for the loss of personal property.
- The issue of financial compensation for inconvenience and distress is complex and the existing guidance focuses on principles. When the issue of financial compensation for inconvenience and distress is raised it should be discussed with senior service delivery unit staff and the PALS and Complaints Team. Decisions reached must be done so after full reference to the Ombudsman’s “Principles for Remedy” and the Treasury’s advice on “Managing Public Money” – Annex 4.14 - Complaints and Remedy. See Appendix 6, “Managing Public Money” – Annex 4.14 – Complaints and Remedy, and Appendix 7, Ombudsman’s “Principles for Remedy”.

8. Complaints received from Members of Parliament

8.1 When complaints are made by Members of Parliament (MP) on behalf of their constituents, if a patient has visited an MP in their surgery, written to them requesting their representation on their behalf in making a complaint, or contacted them by telephone, consent is not required under the current complaints’ regulations. In most cases the MP encloses a copy of the constituent’s letter.

8.2 If the MP states that they have received their constituent’s permission, the Trust will assume this to be the case and therefore there is no requirement to seek permission. Information is only disclosed on a need-to-know basis. Nothing more than the relevant information pertaining to the complaint is given in the final response. The Trust will endeavour to ensure a speedy response and clarify the situation with the MP.

8.3 If an MP is representing a constituent who is acting on behalf of a patient, then consent must be obtained from the patient. Information must never be disclosed without the permission of the patient. If the MP has obtained this permission, then they must provide us with the written document.

8.4 In all of the above situations, under the Local Authority Social Services and National Health Services Complaints Regulations 2009, the final decision about how to proceed rests with the Deputy Chief Nurse who will, if appropriate, seek

guidance and assistance from the Trust's Caldicott Guardian regarding the Data Protection Act 2018 and patient confidentiality. The Trust must be satisfied that the complainant is acting in the patient's best interest. In certain cases, it may be necessary to seek advice from the Trust Solicitor.

9. Ombudsman's Investigations

- If, after everything possible has been done to resolve a complaint, the complainant remains dissatisfied, they can ask the Parliamentary and Health Service Ombudsman (PHSO) or Local Government Ombudsman (LGSCO) to review the matter.
- The Trust's information leaflet and final response letters will explain this right and provide the relevant contact details.
- All dealings with the Ombudsman's office will be handled through the CE and the PALS and Complaints Team.
- When investigating a complaint, the Ombudsman will seek access to all relevant records and documentation kept by both the PALS and Complaints Team and the Care Group. All such records and documentation must be made available within the requested timescale.

10. Learning from Feedback

- All staff have a responsibility to acknowledge where care has not been of the required standard and to do everything in their power to learn and to amend practice.
- Learning from complaints should happen throughout the organisation depending on the issues of concern. In some instances the issue may relate to a single department, but the theme may be applicable to other areas. It is the role of the senior staff in the Care Groups to ensure that issues and the resulting action plans are appropriately shared.
- The PALS and Complaints Team will work with the Care Groups to ensure actions are monitored and accurately recorded on the Datix risk management system.
- Where appropriate staff should incorporate the learning into their annual appraisal process with their manager.
- The capture and sharing of significant learning from complaints is led by the Trust's *Feedback and Engagement Group*, See Appendix 8, Terms of Reference.

11. Reporting arrangements

- The PALS and Complaints Team will provide a monthly report to the Safety Quality Assurance Group (SQAG)
- The Care Group can be set up with live dashboards of their complaints data via the Datix Administrator as required.
- Each complainant who has given their consent will be invited to complete a quality response survey approximately 3 months after receipt of the Trust's final response letter. The survey will cover aspects of complaint management and quality of

investigation and response. The PALS and Complaints Team will review these responses and share them with the Care Groups and the Feedback and Engagement Group. They will also be part of the quarterly reports.

- The PALS and Complaints Team will meet its obligations to provide reports to the Department of Health and to other statutory bodies as required and as specified in the Regulations.

12. Training

The Trust understands the importance of staff training and development to ensure it to deliver effective complaints handling. The PALS and Complaints Team will deliver training for front-line staff. When requested, the department will also provide whatever support and training it can to individual departments and staff groups.

13. Contact details

PALS and Complaints Team
First Floor
Bowyer Building
Torbay Hospital
Loves Bridge
Torquay
TQ2 7AA
Tel: 01803 655838

Devon Advocacy Consortium (DAC)
Tel: 0845 231 1900

The Local Government and Social Care Ombudsman
0300 061 0614, email advice@lgo.org.uk
Postal address: The Local Government and Social Care Ombudsman, PO Box 4771, Coventry, CV4 0EH.

Further information about the Local Government and Social Care Ombudsman is available at: www.lgo.org.uk

The Parliamentary and Health Service Ombudsman
0345 015 4033, email phso.enquiries@ombudsman.org.uk
Postal address: The PHSO, Citygate, 51 Mosley Street, Manchester, M2 3HQ.
Further information about the Parliamentary and Health Service Ombudsman is available at: <https://www.ombudsman.org.uk/>

Appendix 1

Guidance on investigating a Complaint

- The aim of an effective investigation should be to gather sufficient clinical, factual, and other information to identify what has occurred and what action, if any, is required.
- Before starting the investigation it is important to understand all the elements of the complaint and to clarify what the complainant thinks would resolve matters. Unless the complainant's letter is particularly clear about the expectations the complainant has, an early telephone call to them is often the best way of clarifying what the complainant would like to achieve. Such a call can also reinforce the importance we are giving to the complaint.
- Consider a planning meeting when there is more than one Care Group involved in answering a complaint.
- When asking for responses from anyone involved make sure your request is quite clear.
- Use the 2-step investigation plan – Appendix 10.
- **Remember – do not file investigation information in the individual's records.**

Appendix 2

Guidelines on writing a statement as part of an investigation into a complaint or incident

Introduction

As part of the investigation into a complaint or incident, you may be asked to write a statement. The advantages of making accurate and honest statements are:

- A full and accurate recollection of events is more likely to be made if recorded as soon after the event as possible.
- You will be able to confidently give evidence if a legal case arises.
- It enables the Trust to manage complaints and incidents positively and effectively.

Preparation for writing your report

You will need:

- A copy of the complaint or incident form
- A copy of the clinical records if appropriate

Take your time to reconstruct, as far as is possible, your thinking of the problem at the time in question.

The Report

You should include

- Your name
- Professional qualifications with dates and PIN number, if appropriate
- Your post in the Trust
- Position at the time of the incident being complained about or the incident
- Date and time of the incident being complained about or the incident
- Other staff working in the area at the time of the incident being complained about or the incident
- Names, addresses and designations of witnesses of the incident being complained about or the incident
- Duty hours at the time of the incident being complained about or the incident.

Then write the “story” of what happened as far as you were involved, in as much detail as possible.

- Write only what you saw, heard and did.
- Give full names and grades of other personnel you mention.
- Be as accurate as possible with dates and times.

Do not report verbatim what is written in the case notes.

Do not write that someone did something unless you have evidence for it.

When you have completed your statement sign and print your name and date it

A statement should be

- A record of what you did and why
- An accurate reconstruction of what happened
- Honest, even if you must state that practice was not of a standard you were taught to expect
- Thorough, as a full recollection of the patient and the circumstances including whether you were involved in the care of other patients, with demands on your time; or any small detail which may be important, e g if it was a weekend, bank holiday or the weather was unusual
- A record of why you did certain things rather than others
- Provided within the requested time scale to ensure the investigation is concluded in a timely manner and to ensure your recollection is as fresh as possible

A statement should not

- Be written hastily
- Be dismissive
- Seek to blame others
- Make statements beyond your knowledge and recollection
- Comment on the aftermath and not the incident
- Make subjective or petulant statements
- Comment on what you would have done according to normal practice
- Be filed in the clinical notes

If you cannot remember something do not make it up

Summary

- Use the case notes and records to help you and take time to write the report.
- If you are at all concerned about its format and content, remember you will not be penalized for telling the truth.
- There are a number of people who will be able and willing to advise and assist you, for example, your line manager, Consultant, ADNPP/ADO, Clinical Governance coordinator, PALS and Complaints Team.
- Remember that all statements are disclosable under the Freedom of Information Act.

Appendix 3

Guidance on preparing a letter of response

Responses should be thorough, clear, honest and open and should reflect a learning culture where complaints are welcomed, resolved and lessons learned. Bear in mind that each complaint is unique, and your response needs to be sensitive to this. However, there are basic guidelines on response letters that should be followed in each case.

- 1 Follow the principles of Plain English, especially regarding font size, sentence length, layout, use of capitals, underlining, and the use of jargon and abbreviations.
- 2 Ensure you respond to the correct person. If you are not writing to the patient, you must have written authority from the patient before you can tell the complainant the results of the investigation.
- 3 Start your letter with a brief reference to the last letter sent by the Trust, e.g. "Further to our letter of ". Don't assume that the acknowledgment letter was the last letter. If the division has sent a holding letter this may be the last correspondence.
- 4 Use the following formats
 - Date – 10 March xxxx
 - Our reference: MM/your initials /complaint reference, i.e. Our reference: MM/DS/SD 6321 or MM/Com depending on which risk management system is being used.
- 5 Confirm that the Trust is now able to respond to the complaint and summarise what the complaint was about. Do not go into great detail but the complainant must be confident that the Trust has understood the essence and context of the complaint. E.g. "Further to my letter of xxx, I am now able to respond to your complaint about the xxxx".
- 6 If the date of the response is outside the timescale that was originally agreed with the complainant, include a specific apology for the delay in the reply, e.g. "I am sorry for the delay in responding to you" and explain the reason for the delay.
- 7 After the introduction, offer an apology or an acknowledgment of how the complainant is feeling. This acknowledgement is important and helps to set the tone of the letter.

Even if the Trust has acted entirely appropriately it is clear that the complainant did not see it that way at the time. Possible responses could be something like –

"I would like to apologise for the distress which this incident has caused you."

"I am very sorry if you felt that Doctor/Nurse/Mrs..... was rude to you."

“I was saddened to hear that your mother has died, and I do appreciate that this must be a very difficult time for you. Please accept my condolences”.

“I was concerned to learn that you felt that you were not treated sympathetically when you attended xxxx”.

- 8 Refer to the fact that we have completed our investigation and express the hope that the complainant finds the information helpful.
- 9 Respond to each part of the complaint and explain the findings of the investigation. This can be complex, so it is advisable to break it down into smaller sections. Dealing with the issues chronologically can be a useful approach. If the complainant has used a particular format for summarising their concerns, use this as a guide to compiling your response. For example, the complainant may have numbered their points, and you could structure your response using the same numbers.
- 10 Use language that will be familiar to the complainant, avoids jargon and unfamiliar abbreviations. If you must use medical terminology, explain it so a lay person can understand it.
- 11 If the complainant has used the actual names of members of staff, use them yourself. Include the job title when you refer to a member of staff by name for the first time.
- 12 Use direct but personal language. Use “I”, “you”, “we” as much as possible. Rather than “It was considered...” say “We / The doctor / Sister Smith considered...”
- 13 Double check that you have covered every point made in the complaint, no matter how trivial.
- 14 Avoid telling the complainant something that they know and have experienced. Rather than saying “On Monday 6 May 2024 you were admitted for your hysterectomy”, better to say, “I understand that you were admitted for your hysterectomy on Monday 6 May 2024”.
- 15 As you deal with each section of the complaint, you should make the Trust’s position clear. This means either that you acknowledge we made a mistake, apologise for it and explain what we are doing to prevent it happening again, or that we do not accept the complaint and give the reason why. Refer to national guidance or Trust Policies when claiming that our care was appropriate.
- 16 Be thorough and honest about what the Trust can or cannot do to prevent the same thing happening again. If we need to take remedial action, state when this will be completed and how the Trust will monitor the improvements.
- 17 It can be helpful to offer a meeting with the complainant. This is particularly the case when there has been a bereavement or if there are a lot of medical issues involved. Face to face meetings, where complex issues can be discussed openly and sensitively, and in language which is understandable can often resolve

issues and is time well spent. If you are considering offering a meeting you should refer to the notes, “Best Practice on Meeting with Complainants”.

18 Always check the appropriate electronic database or within the Care Group to get the latest information about the complainant or the person affected. It is professional to demonstrate that the Trust is aware of their current situation. For example, we may have arranged or changed an appointment, or perhaps the patient has died.

19 When you have dealt with all the issues, make the last paragraph positive.

- “In conclusion, I very much hope that this helps to explain why Please accept my apologies for the distress and anxiety that you experienced.”
- “I was very pleased to learn that your wife has fully recovered and has now returned home.”
- “I understand that you now have a date for your surgery. I hope this goes well and that you are soon fully recovered”.
- “I understand you had an appointment with Dr on xxx I trust the outcome was satisfactory and you are now making a good recovery.”

20 In conclusion consider use one of the following:

- If not upheld

“In summary, I am confident that, based on the results of our investigation, the care you received was appropriate. However, I am sorry that you feel your care was not to the standard that you would have expected and would like to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services.”

- If partially upheld

“In summary, I believe that certain aspects of your care did not reach the high standard of care that we aim to provide to all patients. I apologise for this and would like to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving.”

- If upheld

“In summary, I believe that your care did not meet the high standard that we aim to provide to all of our patients. I would like to apologise for the shortfalls we have identified, and to thank you for bringing this matter to my attention. The Trust welcomes comments from patients, relatives and carers as these help us to improve our services. I hope my letter has reassured you that we are addressing those aspects of patient care which need improving.”

If the complaint is either upheld or partially upheld, then please include a list of actions that will be taken as a result of this complaint.

21 The end of the letter must include the following text -

If you have any further questions or concerns, or if there are aspects of this response that you are unhappy with, please do not hesitate to contact the PALS and Complaints Team on 01803 655838 (unless there is a specific reason that the investigator would like to be contacted directly).

22 Please add the Ombudsman's details at the end of the response

You can put your complaint to the Parliamentary and Health Service Ombudsman (the Ombudsman). The Ombudsman can carry out independent investigations into complaints about poor treatment or service provided through the NHS in England. The Ombudsman's services are free.

If you have any questions about whether the Ombudsman may be able to help you, or about how to make a complaint, please contact their helpline on 0345 015 4033, email phso.enquiries@ombudsman.org.uk or fax 030 0061 4000. Further information about the Ombudsman is available at: www.ombudsman.org.uk.

You can write to the Ombudsman at:

The Parliamentary and Health Service Ombudsman
Citygate
51 Mosley Street
Manchester M2 3HQ

Or the LGSCO details:

The Local Government and Social Care Ombudsman
0300 061 0614, email advice@lgo.org.uk fax 024 7682 0001 or postal address:

The Local Government and Social Care Ombudsman
PO Box 4771
Coventry CV4 0EH

Further information about the Local Government and Social Care Ombudsman is available at www.lgo.org.uk

Appendix 4

Best Practice on Meeting with Complainants

Face-to-face (or virtual if requested) meetings with complainants can offer the best chance for reaching a satisfactory resolution to a difficult complaint. However, if meetings are not properly planned and managed it can become even harder to find an acceptable outcome. The following points have been drawn to offer staff guidance and best practice on meeting with complainants.

1. Well before the planned meeting, ask the complainant to clarify, as specifically as they can, those issues that remain outstanding and what they are looking for by way of a resolution. This last point can be difficult for complainants but in our experience if they can be clear about how they want the complaint resolved we have a better chance of finding a resolution. It also means that if they say, for instance, that they want a member of staff disciplined, or they want compensation, we have the opportunity to get back to them promptly to say that such demands cannot be dealt with through a complaints meeting.
2. Once you are clear about what the complainant is looking for, decide which members of staff need to attend. This should include not only the people who can best answer the complainant's concerns but people who will be open and constructive.
3. If the complainant has asked that a particular member of staff is present, but you feel that their presence will not promote resolution of the complaint, you need to give the complainant good reasons as to why the named person will not be at the meeting. These reasons need to be given to the complainant well before the meeting takes place as you need to minimize the risk of unwelcome surprises at the meeting.
4. Hold a pre-meeting with the staff attending the meeting to make sure there is agreement on:
 - the purpose of the meeting, i.e. what you want to achieve
 - any areas which are not open for discussion, i.e. areas where you feel you have already gone as far as you can to satisfy the complainant
 - who will chair the meeting (see 7, below)
 - where the meeting will take place
 - how much time will be given to the meeting
5. Make sure that any member of staff who will be attending the meeting but who has not been able to come to the pre-meeting, knows what has been decided.
6. If, at the pre-meeting, you decide that it is not going to be possible or appropriate to deal with any particular issues that the complainant has identified, you must tell them this before the meeting and give clear and transparent reasons. Again, remember you want there to be no surprises.
7. When deciding on the best person to chair the meeting remember that the Chair does not necessarily need to have been involved in the issue which is the subject of the complaint.

However, they do need to have:

- excellent interpersonal and mediation skills
 - credibility with all the other participants
 - a grasp of the relevant issues
 - the ability to summarise key discussions and decisions and secure agreement on these points
8. Before the meeting, tell the complainant which members of staff will be there, who will chair the meeting, how much time will be given to the meeting, how the meeting will be recorded and any other relevant information.
 9. Make arrangements for a proper record to be made of what was said at the meeting. Best practice is for the meeting to be recorded electronically. However, all parties need to be comfortable with this approach and you must get their signed permission well before the meeting. If it is decided not to record the meeting, someone needs to take notes. Importantly, this needs to be someone who will have no other role at the meeting as it is unrealistic for the notes to be taken by someone who may need to be involved in the discussion. Rather than make a verbatim record of everything that is said, the note-taker must understand that the role of a note-taker is to record the important facts, comments and decisions from the meeting. They therefore need to be sufficiently skilled and experienced in notetaking. They also need to have the skills to be able to transcribe their notes quickly and accurately after the meeting.
 10. Use an appropriate venue. Make sure everyone knows where it is and arrange to collect visitors from a central point.
 - Does it need to be wheelchair accessible?
 - Are there enough comfortable chairs?
 - Will the layout enable all participants to see each other?
 - Will you be free from disturbance – phones, callers etc?
 - Is the lighting and ventilation adequate?
 - Provide water/coffee and refreshments.
 - Remember that some complainants have gathered many documents which they will have with them. Make sure there is an appropriate table or desk for them.
 - If possible, book the room for longer than the agreed meeting time. This is particularly important if the complainant is being supported by family and friends or a Support Empower Advocate Promote (SEAP) advocate. The complainant may want time after the meeting to debrief and we should facilitate this.
 11. Once the venue and time and date have been agreed, confirm these arrangements in writing to the complainant. Do not rely on verbal messages.
 12. Before the meeting ends make sure there is agreement about what is going to happen next. Be clear about who will be responsible for what and set clear and realistic timescales. Make sure the complainant has a contact person/number.

Appendix 5

1. Guidance on handling unreasonable complainants – Department of Health Dealing with difficult complainants

Prolific complainants can be difficult to deal with

People who bring prolific complaints to the NHS can be difficult to deal with. Whether they are right to persist with their complaint or not, they need your support to resolve the issue.

You will be aware of your trust's complaints procedure that tackles how to handle prolific complainants. But ensuring that such complaints are resolved relies on how you manage the individual. Labelling people as persistent, habitual or vexatious complainants should be the weapon of last resort.

If you label a complaint as vexatious from the start, then it will never be anything else. This may get in the way of your ability to understand why the complainant is so persistent and may only prolong the time it takes to reach a conclusion.

All complaints are real - whatever you think

It is important to remember that if a person contacts you with what they believe is a complaint, then it is to them, whatever you think. If the complainant raises the same or similar issues repeatedly despite receiving a full response, there may be underlying reasons for this persistence.

How do you identify a prolific complainant?

A prolific complainant is someone who raises the same issue despite having been given a full response. They are likely to display certain types of behaviour such as:

- complains about every part of the health system regardless of the issue
- seeks attention by contacting several agencies and individuals
- always repeats full complaint
- automatically responds to any letter from the trust
- insists that they have not received an adequate response
- focuses on a trivial matter
- is abusive or aggressive.

What do you do if the complainant is difficult?

If you are faced with a complainant who you believe is unreasonably persistent you need to identify appropriate action with the relevant clinician. Remember that this action should be tailored to the complainant's needs and include regular feedback and reviews.

Policy outline - vexatious or unreasonably persistent complainants

Regardless of the manner in which the complaint is made and pursued, its substance should be considered carefully and on its objective merits.

Complaints about matters unrelated to previous complaints should be similarly approached objectively and without any assumption that they are bound to be frivolous, vexatious, or unjustified.

Particularly if a complainant is abusive or threatening, it is reasonable to require him or her to communicate only in a particular way - say, in writing and not by telephone - or solely with one or more designated members of staff; but it is not reasonable to refuse to accept or respond to communications about a complaint until it is clear that all practical possibilities of resolution have been exhausted.

It is good practice to make clear to a complainant regarded as unreasonably persistent or vexatious the ways in which his or her behaviour is unacceptable, and the likely consequences of refusal to amend it before taking drastic action.

Decisions to treat a complainant as unreasonably persistent or vexatious should be taken at an appropriately senior level; and senior management - probably the board or a committee of the board - should monitor such decisions.

2. Criteria of a Habitual or Vexatious Complainant

Complainants (and/or anyone acting on their behalf) may be deemed to be habitual or vexatious where current or previous contact with them shows that they have met two or more (or are in serious breach of one) of the following criteria:

2.1 Persisting in pursuing a complaint where the NHS Trust complaints procedure has been fully and properly implemented and exhausted. For example, where investigation is deemed to be 'out of time'.

2.2 The substance of a complaint is changed, or new issues are raised persistently, or complainants seek to prolong contact by unreasonably raising further concerns or questions upon receipt of a response whilst the complaint is being dealt with. Care must be taken not to disregard new issues which differ significantly from the original complaint – these may need to be addressed as separate complaints. Consider whether:

- The complainant makes the same complaint repeatedly, perhaps with minor differences, after the complaint has been investigated. This would include where people insist that the minor differences constitute new complaints.
- The complainant seeks to prolong contact by changing the substance of a complaint or by continually raising new issues and/or questions whilst the complaint is being addressed.
- The complainant focuses on a peripheral matter to an extent that is out of proportion to its significance regarding the complaint and continues to focus on this point. It should be recognised that determining what is peripheral can be subjective, and careful judgement must be used in considering this aspect.

2.3 Complainants are unwilling to accept documented evidence as being factual or deny receipt of an adequate response despite correspondence specifically answering their questions/concerns. This could also extend to complainants who do not accept that facts can sometimes be difficult to verify after a long period of time has elapsed.

2.4 Complainants do not identify clearly the precise issues they wish to be investigated despite reasonable efforts to help them do so by staff and, where appropriate, their advocates.

2.5 where the concerns identified are not within the jurisdiction of the Trust to investigate.

2.6 Complainants focus on a peripheral matter to an extent that is out of proportion to its significance and continue to focus on this point. It should be recognised that determining what is peripheral can be subjective, and careful judgement must be used in applying the criterion.

2.7 Physical violence has been used or threatened towards staff or their families/associates at any time. This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented and reported, as appropriate, to the Local Security Management Specialist (LSMS) or police.

2.8 Complainants have, in the course of pursuing a registered complaint, had an excessive number of contacts (or unreasonably made multiple complaints) with the Trust placing unreasonable demands on staff. Such contacts may be in person, by telephone, letter, fax or electronically. Discretion must be exercised in deciding how many contacts are required to qualify as excessive, using judgment based on the instances of each individual case.

2.9 Complainants have harassed or been abusive, including racist, sexist or homophobic abuse, or verbally aggressive on more than one occasion towards staff dealing with their complaint – directly or indirectly – or their families and/or associates. If the nature of the harassment or aggressive behaviour is sufficiently serious, this could, in itself, be sufficient reason for classifying the complainant as vexatious. It must be recognised that complainants may sometimes act out of character at times of stress, anxiety or distress and reasonable allowances should be made for this. All incidents of harassment or aggression must be documented, dated and reported to the Security Manager (LSMS).

2.10 Complainants are known to have electronically recorded meetings or conversations without the prior knowledge and consent of the other parties involved. It may be necessary to explain to a complainant at the outset of any investigation into their complaint(s) that such behaviour is unacceptable and can, in some circumstances, be illegal.

2.11 Complainants display unreasonable demands or expectations and fail to accept that these may be unreasonable after a clear explanation has been provided as to what constitutes an unreasonable demand (for example insisting on responses to complaints or enquiries being provided more urgently than is reasonable or recognised practice).

3. Options for dealing with Habitual or Vexatious Complainants

3.1 When complainants have been identified as habitual or vexatious, in accordance with the above criteria, the Chief Executive or a Director will convene a panel to review and decide what action to take. The panel should include the Chief Executive or a

Director, the Experience and Engagement Lead and a Feedback and Engagement Officer. It is recommended that a Non-Executive Director also attends, particularly at a first review, although the review can go ahead if a Non-Executive Director is unavailable to attend.

3.2 The Chief Executive or Director will implement such action and notify complainants promptly and in writing, of the reasons why they have been classified as habitual or vexatious and the action to be taken.

3.3 This notification must be copied promptly for the information of others already involved in the complaint such as practitioners, conciliators, advocates and members of parliament. A record must be kept, for future reference, of the reasons why a complainant has been classified as habitual or vexatious and the action taken

3.4 The Chief Executive or Director may decide to deal with habitual or vexatious complainants in one or more of the following ways:

a) Once it is clear that complainants meet any one of the criteria of the Procedure for Dealing with Habitual and Vexatious Complainants, it may be appropriate to inform them in writing that they are at risk of being classified as habitual or vexatious. A copy of this procedure should be sent to them, and they should be advised to take account of the criteria in any future dealings with the Trust and its staff. In some cases, it may be appropriate at this point to copy this notification to others involved in the complaint and suggest that complainants seek advice in taking their complaint further.

b) Try to resolve matters before invoking this procedure, and/or the sanctions detailed within it. If the Trust is to continue dealing with the complaint, it may be appropriate to draw up a signed agreement which establishes a code of behaviour for the parties involved. If this agreement is breached consideration should then be given to implementing other actions as outlined below.

c) Decline further contact with the complainant either in person, by telephone, fax, letter or electronically – or any combination of these – whilst ensuring that one form of contact is maintained. Alternatively, further contact could be restricted to liaison through a third party.

d) Notify complainants in writing that the Chief Executive or Director has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. Complainants should be notified that correspondence is at an end and that further communications will be acknowledged but not answered.

e) Inform complainants that in extreme circumstances the Trust reserves the right to refer unreasonable or vexatious complaints to solicitors and, if appropriate, the Local Security Management Specialist (LSMS) or the police.

f) Temporarily suspend all contact with the complainant(s), or investigation of a complaint, whilst seeking legal advice or guidance from the Security Manager (LSMS), Department of Health or other relevant agencies.

g) In exceptional circumstances, consideration can be given to the possibility of referring the matter to the relevant department of the Parliamentary Ombudsman's Office.

3.5 If this policy is to be implemented, it should be remembered and explained to the complainant(s) that any course of action taken as a result only relates to contact with the Trust over their specific complaint(s). It does not, and is not intended to, have any impact on any other dealings between the Trust and the complainant(s) on other, unrelated issues.

4. Withdrawing Habitual or Vexatious Status

4.1 Once complainants have been classified as habitual or vexatious, the PALS and Complaints Team will arrange for such status to be reviewed after a period of 12 months, the review to again be carried out by the Chief Executive or Director, as before. If it is decided that habitual or vexatious status will be re-imposed for a further period of 6 or 12 months, all relevant parties involved will be informed of this decision. However, there also needs to be a mechanism for withdrawing this status earlier if, for example, complainants subsequently demonstrate a more reasonable approach. If they submit a further complaint, relating to a new matter(s), the normal complaints procedures would apply.

4.2 Staff should have already used careful judgement and discretion in recommending or confirming habitual or vexatious status and similar judgement/discretion will be necessary when recommending that such status should be withdrawn. Where this appears to be the case, discussions will be held with the Chief Executive or Director and subject to their approval, normal contact with complainants and application of the NHS Trust Complaints Procedures will be resumed.

Appendix 6

“Managing Public Money” – Annex 4.14 – Complaints and Remedy

A

ANNEX 4.14 COMPLAINTS AND REMEDY

Prompt and efficient complaint handling is an important way of ensuring customers receive the service to which they are entitled and may save public sector organisations time and money by preventing a complaint escalating unnecessarily.

If their services have been found deficient, public sector organisations should consider whether to provide remedies to people or firms who complain. This is separate from administering statutory rights or other legal obligations, eg to make payments to compensate. Remedies may take several different forms and should be proportionate and appropriate.

Dealing with complaints

A4.14.1 Public sector organisations should operate clear accessible complaints procedures. They are a valuable source of feedback which can help shed light on the quality of service provided, and in particular how well it matches up to policy intentions. So all complaints should be investigated. The Parliamentary and Health Service Ombudsman (PHSO) has published Principles of Good complaint Handling to help public bodies when dealing with complaints (see paragraph A.4.14.18).

A4.14.2 Systems for dealing with complaints should operate promptly and consistently. Those making complaints should be told how quickly their complaints can be processed. Where groups of complaints raise common issues, the remedies offered should be fair, consistent and proportionate.

A4.14.3 Public sector organisations should seek to learn from what their complaints reveal. If an internal or external review, or a PHSO investigation, shows there are systemic faults, defective systems or procedures should be overhauled and corrected.

Remedies

A4.14.4 As section 4.12 explains, when public sector organisations have caused injustice or hardship because of maladministration or service failure, they should consider:

- providing remedies so that, as far as reasonably possible, they restore the wronged party to the position that they would be in had things been done correctly, and
- whether their policies and procedures need change, to prevent the failure reoccurring.

The remedies available

A4.14.5 Remedies can take a variety of forms, including (alone or in combination):

- an apology;
- an explanation;
- correction of the error or other remedial action;
- an undertaking to improve procedures or systems; or
- financial payments, eg one off or as part of a structured settlement.

Appendix 7

Ombudsman's "Principles for Remedy".

Good practice with regard to remedies means:

1 Getting it right

- Quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship.
- Considering all relevant factors when deciding the appropriate remedy, ensuring fairness for the complainant and, where appropriate, for others who have suffered injustice or hardship as a result of the same maladministration or poor service.

2 Being customer focused

- Apologising for and explaining the maladministration or poor service.
- Understanding and managing people's expectations and needs.
- Dealing with people professionally and sensitively.
- Providing remedies that take account of people's individual circumstances.

3 Being open and accountable

- Being open and clear about how public bodies decide remedies.
- Operating a proper system of accountability and delegation in providing remedies.
- Keeping a clear record of what public bodies have decided on remedies and why.

4 Acting fairly and proportionately

- Offering remedies that are fair and proportionate to the complainant's injustice or hardship.
- Providing remedies to others who have suffered injustice or hardship as a result of the same maladministration or poor service, where appropriate.
- Treating people without bias, unlawful discrimination or prejudice.

5 Putting things right

- If possible, returning the complainant and, where appropriate, others who have suffered similar injustice or hardship, to the position they would have been in if the maladministration or poor service had not occurred.
- If that is not possible, compensating the complainant and such others appropriately.

-
- Considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation).
 - Providing the appropriate remedy in each case.

6 Seeking continuous improvement

- Using the lessons learned from complaints to ensure that maladministration or poor service is not repeated.
- Recording and using information on the outcome of complaints to improve services.

These Principles are not a checklist to be applied mechanically. Public bodies should use their judgment in applying the Principles to produce reasonable, fair and proportionate remedies in the circumstances. The Ombudsman will adopt a similar approach in recommending remedies.

Appendix 8

Patient Experience and Engagement Group

Terms of Reference April 2023

Aims & Purpose of the Group

The aim of this group is to ensure that there is a culture of continuous, positive improvement to patient/user and carer experiences and that this remains at the core of the Trust's business.

The group's purpose is to provide operation oversight, understanding and delivery of the Trust's programme of work designed to deliver the Trust's responsibility and objects in meeting its Experience and Engagement work, therefore always ensuring people who use our services are at the centre of our organisation.

The group will ensure the statutory, regulatory and organisational responsibilities are aligned to patient experience, and are achieved.

Where deficits are identified, the group will update the Trust risk register to ensure clear and good governance, including exception reporting as necessary, is followed.

Where investigations and reports are generated, share and embed learning across the organisation and our local system pathways.

The group will work in partnership with our local stakeholders who are responsible for, or who are involved with, creating or delivering patient experience and engagement programmes.

1. Membership, Frequency and Quorate Status

1.1 Membership

- Patient Representatives (Co-opt)
- Deputy Chief Nurse - Chair
- Care Group Associate Directors
- Child and Family Health Devon Clinical Lead
- Quality and Experience Lead
- Representatives from the Trust's Feedback and Engagement Team
- The Advocacy People and other advocacy organisations
- Representative from NHS Devon Integrated Care Board
- Representative from Mount Stuart Hospital
- Equality and Diversity Lead
- Healthwatch
- Development Manager for Carers Services
- Clinical Effectiveness representative

- Torbay and South Devon NHS Foundation Trust Governor
- Estates and Facilities representative
- Deputy Director of Adult Social Services

Group members may co-opt other members or deputise as and when required.

1.2 Frequency and Quorate status

- The group will meet every month.
- The group will be quorate if at least 4 members are present including a Chair or nominated Deputy Chair

2. Specific Responsibilities

The group will:

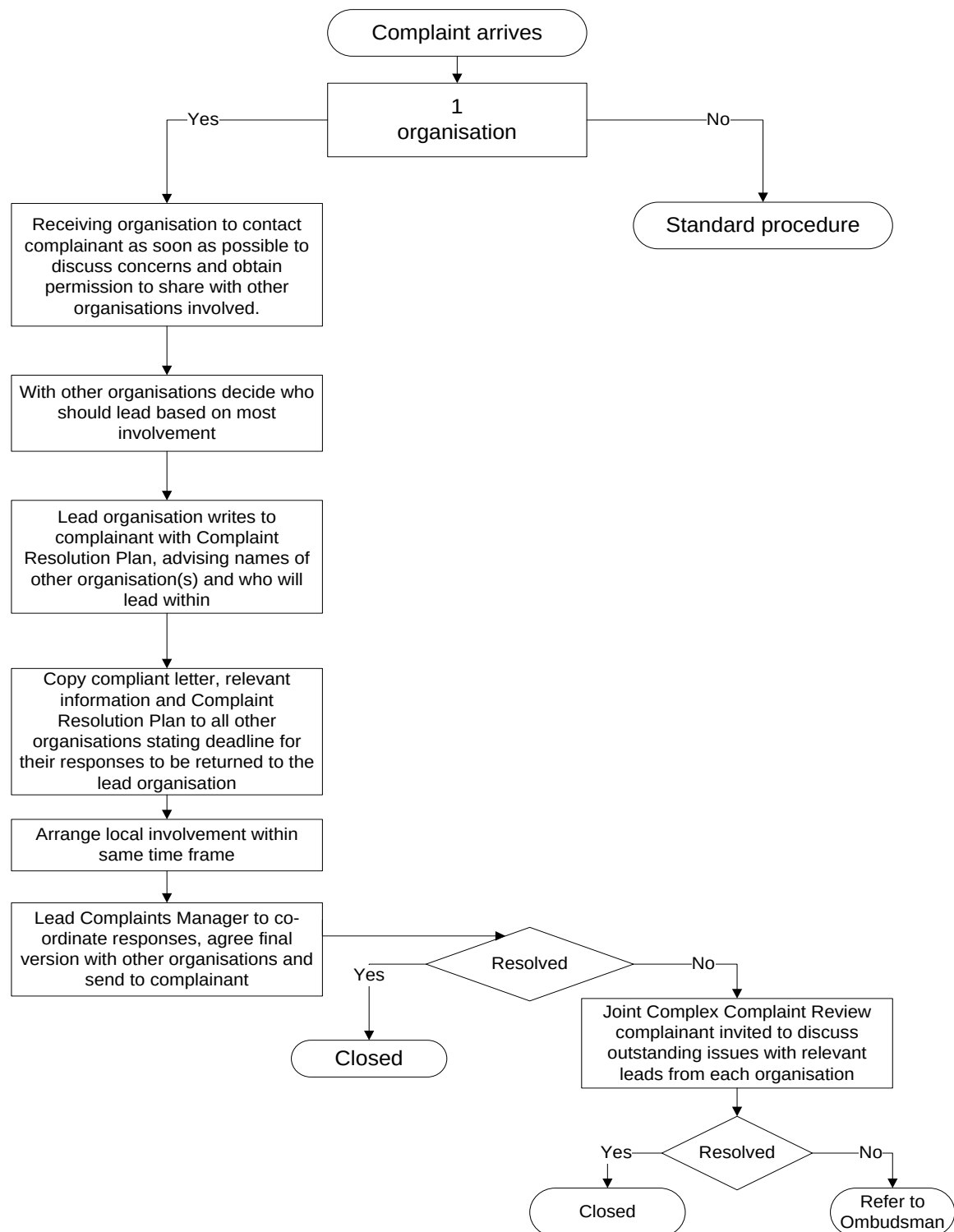
- 2.1 Contribute to the development and implementation of a Trust strategy for feedback and engagement
- 2.2 Formulate a yearly work plan for experience and engagement and review bi-monthly.
- 2.3 Monitor progress on Trust-wide initiatives
- 2.4 Agree indicators for measuring patients' experiences
- 2.5 The Group will review:
 - Patient stories and discussions with patients about the range and quality of services provided by the Trust with the aim of promoting the proactive engagement of patients and local representative groups. Promote patient's culture outside the group
 - Complaints where significant learning has been captured and shared
 - Cases referred to and being investigated by the Ombudsman
 - Learning from experiences such as Schwartz rounds
 - Learning from other forums e.g. specific quality improvement projects
 - Significant complaints where a second contact has been received
 - Complaints where there has been a significant failure to meeting agreed response deadlines
 - Commissioned surveys, whether national or local
 - Specific engagement work as directed by the Trust
 - Specific speciality engagement and involvement panels e.g. for cancer/cardiac services
 - Engagement work carried out by other organisations e.g. Healthwatch
 - Feedback in any other relevant forum, including digital media
 - Quality improvement projects related to Always Events
 - The national programme related to experience and engagement

- 2.6 Develop and maintain partnerships with patients, service users and with key stakeholder groups in the wider community in order to better understand the experience, and meet the needs, of those who use our services.
- 2.7 Ensure that feedback and engagement is at the forefront of clinical teams and other services' priorities, gaining assurance that services are working proactively with service users and/or their representatives to improve their services.
- 2.8 Obtain oversight of any Trust Engagement and Experience work, CQC surveys and associated external surveys from groups such as Healthwatch of action or improvement plans.
- 2.9 Review the relevant dashboards monthly for any emerging trends and propose any necessary remedial or positive action based on the findings.
- 2.10 Consider trends within feedback and engagement by periodically using all available data and seek out further data as required.
- 2.11 Store data considered by the group centrally on a drive accessible to the Feedback and Engagement Team and to the Deputy Chief Nurses/AHP.
- 2.12 Identify local and national areas of good practice and disseminate throughout the organisation.
- 2.13 Share identified learning and good practice across the Trust and in a variety of formats, for example, intranet, internet, presentations to specific groups.
- 2.14 Ensure the Care Group Leadership Teams share learning through the Clinical Governance and Trust Corporate Governance structures.
- 2.15 Report to the Quality Assurance Committee (QAC) via the monthly report return or by exception as necessary
- 2.16 Link to and work with other groups, such as the Patient Safety Group, Clinical Effectiveness Group
- 2.17 Monitor the Trust's performance against the Care Quality Commissions 5 domains and Key Lines of Enquiry ensuring our services are safe, well led, responsive, effective and caring

These Terms of Reference will be reviewed every twelve months or earlier as required.

Appendix 9

Multi Organisation Complaints Process



Appendix 10

Complaint Investigation and Reporting Pack

Please complete this document then please return to the responsible ADNPP or ADO and the PALS and Complaints Team, by the deadline provided at the top left of this page. Any questions please contact the PALS and Complaints Team by email, tsdft.feedback@nhs.net or call 01803 655838/ext 55838.

Complaint Reference Number		Complainant's Details: Patient/ Service User Details (include NHS/Hospital number if known):
Complaint Received Date		
Investigation Due Date		
Complaint Handler		
Responsible ADNPP/ ADO/equivalent		
Investigator(s):		
Details of the complaint (PALS and Complaints Team to complete):		

<u>Investigation</u>	
Who was asked to investigate the complaint?	
Were the comments received written or verbal?	
If written, has a copy of the email response or statement/s been provided? OR:	
Has a brief record of the conversation/s been provided?	

	<u>Action Plan</u>	How will we evidence the action is complete?	Who is responsible?	Completion Deadline	
	What is the action?			Target	Actual
1					
2					
3					
4					
5.					

1. Draft Response Please write your response below

It is important to ensure that the written response is:

- accurate and grammatically correct
- sensitively written
- of an appropriate tone and style
- that all the issues contained within the complaint have been addressed

The written response will include:

- summary of the nature and substance of the complaint
- investigation undertaken and summary of the conclusion
- action which has been/will be taken to resolve the complaint
- an apology, where appropriate
- action(s) to be taken in light of the complaint to improve services

The response should be written as if from the Chief Executive

Private and Confidential

Address

Address

Address

Address

Address

Trust Headquarters
Torbay Hospital
Lowes Bridge
Torquay
TQ2 7AA

Telephone: 01803 655838

Email: tsdft.feedback@nhs.net

Website: www.torbayandsouthdevon.nhs.uk

Our Ref:

Date:

Our Ref:

Dear [Insert Complainant's name]

Re: [Insert with person effected details, when not the same as above]

[Enter an **introduction** here]

Thank you for your letter, dated, raising a number of concerns. I am sorry that your experience of the service failed to meet your expectations.

I am now in a position to respond to your complaint regarding [insert details].

[Enter the **body of the response** here]

Enter and respond to the points from the response plan here:

1. Point 1 from the response plan
2. Etc.

[Enter a **summary** (if required) and **ending** here]

[Information regarding **next steps**]

I hope this response is helpful but if you have any questions or concerns about my letter please contact (name and job title) on 01803 xxx.

However, if you remain dissatisfied, you can put your complaint to the Health Service Ombudsman. The Ombudsman can carry out independent investigations into complaints about poor treatment or service provided through the NHS in England. The Ombudsman's services are free.

If you have any questions about whether the Ombudsman may be able to help you, or about how to make a complaint, please contact their helpline on 0345 015 4033, email phso.enquiries@ombudsman.org.uk. Further information about the Ombudsman is available at: www.ombudsman.org.uk.

You can write to the Ombudsman at:

The Parliamentary and Health Service Ombudsman
Citygate
51 Mosley Street
Manchester
M2 3HQ

Yours sincerely

Chief Executive



Partners in Care

Appendix 11

Patient Advice and Liaison Service (PALS)

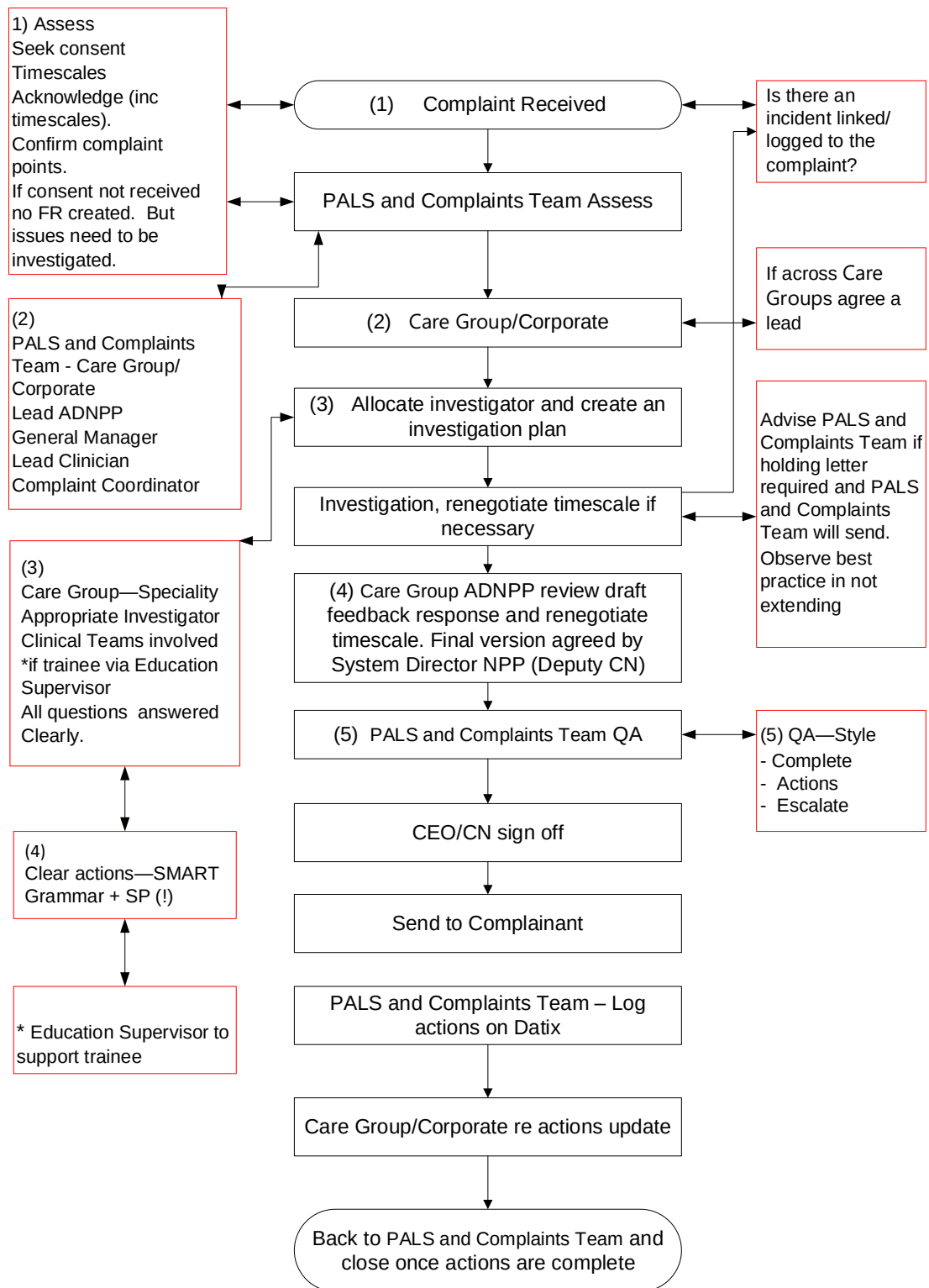
The Patient Advice and Liaison Service is a confidential service that is provided by the Trust.

The function of the service is to:

- Provide information and support to help patients, services users, families and carers resolve problems and concerns arising from the provision of health services and related issues.
- Act as a readily accessible point of contact for individuals based across the Integrated Care Organisation (ICO). The service is a first point of call for people contacting the Trust in person or by phone and enabling Trust staff to respond promptly and efficiently to their feedback.
- Provide an informal, confidential, client focused service that deals with problems and concerns as quickly and effectively as possible.
- Provide accurate and appropriate information to patients, carers and their families about local health services and, where appropriate, put them in contact with local support groups.
- Promote PALS to ensure it is easily accessible for patients, families and carers to bring any needs or concerns to the attention of the service. To ensure all staff are fully aware of the PALS and support patients to access the service.
- Co-ordinate complex cases, some bereavement related, which may require responses covering joint investigations with several departments and/or partner organisations.
- Liaise between service users, relatives and carers and medical and managerial staff. Provide relevant briefing material where necessary and facilitate mediation of a mutually satisfactory outcome.
- Be familiar with the Trust's complaints procedure and be able to direct patients, carers and their families to the Devon Advocacy Consortium
- Work effectively with a wide range of healthcare professionals, managers and clerical staff, to ensure the Trust continues to learn from patient experience so that feedback (and dissemination of examples of good practice) acts as a catalyst for change to contribute to the improvement and development of patient focused care.

Appendix 12

Flowchart for the Management of Complaints



Appendix 13

Linked to:

Quality Matters – Compliments, Feedback and Complaints about Adult Social Care

[Compliments, feedback and complaints about adult social care](#)

(Accessed 24/10/2024)

Appendix 14



Children & Family Health Devon

MP Complaint Process



Devon Partnership
NHS Trust

The Trust has made a commitment to MP's that all enquiries will be responded within three working days.



Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	1473		
Document title:	Complaints, Feedback and Patient Advice and Liaison Service (PALS) Policy		
Purpose of document:	This policy sets out the process when receiving feedback about the Trust and the roles and responsibilities of those involved in the process.		
Date of issue:	25 February 2025	Next review date:	25 February 2028
Version:	10	Last review date:	25 February 2025
Author:	Patient Safety Specialist (Feedback & Engagement)		
Directorate:	Trustwide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Feedback and Engagement Group Care and Clinical Policies		
Date approved:	25 February 2025		
Links or overlaps with other policies:			

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	☐	☐
Does this document have training implications? <i>If yes please state:</i>	☐	☐
Does this document have financial implications? <i>If yes please state:</i>	☐	☐

Is this document a direct replacement for another?		
<i>If yes please state which documents are being replaced:</i>	☐	☐
This version will supersede all previous versions of this policy document G1473		

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
29 March 2012	1	New	Director of Nursing and Governance
24 July 2012	2	Revised	Director of Nursing and Governance
17 July 2014	3	Revised	Director of Nursing, Professional Practice and People's Experience
20 January 2017	4	Revised	Quality Improvement Group
18 May 2017	5	Point 2.6 added "Duty of Candour"	Patient Safety Lead
20 February 2018	5	Review Date Extended 2 Years to 3 Years	
1 March 2019	6	Revised	Feedback and Engagement Group
21 August 2020	7	Amendment – Addition of COVID sentence in Appendix 4	Quality and Experience Lead
24 August 2021	8	Amendments to reflect CARE GROUP structure and changes in sign off process and update TOR	Deputy Chief Nurse
21 January 2022	9	Amendments	Feedback and Engagement Group Care and Clinical Policies Quality Assurance Committee
25 February 2025	10	Revised	Feedback and Engagement Group Care and Clinical Policies

The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future.

It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

There is a legal duty placed upon all staff to apply the Mental Capacity Act 2005 in all circumstances where a person is required to consent to 'acts in connection with care and treatment' and where there is reason to doubt the person's mental capacity to do so.

Guidance can be accessed via [Pages - Mental Capacity Act \(torbayandsouthdevon.nhs.uk\)](https://pages.torbayandsouthdevon.nhs.uk/Pages/MentalCapacityAct)

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) (for use when writing policies)

Policy Title (and number)	G1473 Feedback, Complaints and Patient Advice and Liaison Service (PALS) Policy	Version and Date	10 February 2025
Policy Author	Patient Safety Specialist (Feedback & Engagement)		
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☒	Staff ☒	Other, please state... ☐	
Could the policy treat people from protected groups less favourably than the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes ☐ No ☒	Gender Reassignment	Yes ☐ No ☒
Race	Yes ☐ No ☒	Disability	Yes ☐ No ☒
Gender	Yes ☐ No ☒	Pregnancy/Maternity	Yes ☐ No ☒
Sexual Orientation			Yes ☐ No ☒
Religion/Belief (non)			Yes ☐ No ☒
Marriage/ Civil Partnership			Yes ☐ No ☒
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers¹; travellers²; homeless³; convictions; social isolation⁴; refugees)			Yes ☐ No ☒
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language⁵ used throughout?			Yes ☒ No ☐ NA ☐
Are the services outlined in the policy fully accessible⁶?			Yes ☒ No ☐ NA ☐
Does the policy encourage individualised and person-centred care?			Yes ☒ No ☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy⁷?			Yes ☐ No ☒ NA ☐
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes ☒ No ☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
The policy was scheduled for review and any necessary revision			
Who was consulted when drafting this policy?			
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐	
Staff ☐	General Public ☐	Other, please state... Healthwatch Torbay ☒	
What were the recommendations/suggestions?			
No amendments requested to the draft shared			
Does this document require a service redesign or substantial amendments to an existing process? PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below			Yes ☐ No ☒
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	

AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form	Patient Safety Specialist (Feedback & Engagement)	Signature	
Validated by (line manager)	Deputy Chief Nurse	Signature	

Please contact the Equalities team for guidance:

For Devon CCG, please email d-ccg.equalityanddiversity@nhs.net & d-ccg.QEIA@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pdf.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.

Unclassified

Media management policy

Unclassified

Document Information

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Date of Issue:	01 November 2022	Next Review Date:	April 2028
Version:	2	Last Review Date:	17 April 2025
Author:	Associate Director of Communications and Partnerships		
Director Responsible	Executive Director of Transformation and Partnerships		
Approval Route			
Approved By: Trust Management Group		Date Approved: 01 November 2022	
Links or overlaps with other policies:			
We are committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership. We are committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

Amendment History

Issue	Status	Date	Reason for Change	Authorised
New	First published	01 November 2022	Replacing previous media management protocol	Trust Management Group
Review	Updated	17 April 2025	Minor amendments to reflect job title changes and new social media channels	Executive Operational Group (08.04.25) Executive Committee (17.04.25)

Unclassified

Title: Media management policy

Version: 2

Classification: Policy

Directorate: Trustwide

Due for Review: 04-2028

Responsible
for review: Associate Director of Communications and
Partnerships

Ratified by: Executive Director of Transformation and
Partnerships

Applicability: As indicated below

Contents

- 1. Introduction**
- 2. Purpose**
- 3. Scope**
- 4. Definitions**
- 5. Roles and responsibilities**
- 6. Principles**
- 7. Our process**
- 8. High profile or VIP patients**
- 9. Serious or major incidents**
- 10. Media monitoring**
- 11. Independent Press Standards Organisation**
- 12. Social Media**
- 13. Freedom of Information Act requests**
- 14. Appendix 1 – news release template**
- 15. Appendix 2 – media enquiry proforma**
- 16. Appendix 3 – out of hours media enquiries – guidance for duty managers / on call directors**
- 17. Appendix 4 – interview guidelines**
- 18. Appendix 5 – Equality Impact Assessment (EqIA)**
- 19. Mental Capacity Act and Infection Control statement**

1. Introduction

It is vitally important that we have high standards of communication, engagement and involvement with:

- people who use our services and their carers
- our staff, our governors and members
- the public
- local, regional and national partners and regulators
- the media.

We recognise that a wide range of people have a valid and legitimate interest in our organisation and the services we provide and that, as a public sector organisation, we must be held accountable. Our communications must be clear, accessible, concise, honest, transparent and professional while ensuring that we protect and safeguard confidentiality and consent at all times.

We welcome and value media interest in our services, our dedicated staff and the stories of people who use our services. We aim to support and accommodate such interest where appropriate while recognising the need to make sure that media activity does not impact on any individuals right to privacy or have any detrimental effect on the safe and effective provision of clinical care - taking all appropriate steps to minimise disruption to services, teams and individuals.

A good relationship with the media is important. It supports us not only to raise awareness of our work, build public confidence in the services we provide and support the delivery of our vision of better health and care for all but also because it aids us to get urgent messages to the public as and when required.

2. Purpose

This protocol aims to ensure that we proactively manage our reputation through effective media handling.

The purpose of this protocol is to:

- make sure any risks to the confidentiality of staff and people who use our services are robustly mitigated
- set out clearly our processes, arrangements and procedures for proactive and reactive media handling
- provide advice to staff on the appropriate actions and procedures which must be followed if they are approached by the media or if they are involved in a situation that may attract media attention

3. Scope

This policy applies to all our staff, volunteers, non-executive directors and governors.

It should be read alongside our social media policy, approved and invited visitors policy, audio-visual recordings by people who use our services and members of the public policy and our organisational style guide and branding document.

4. Definitions

Audio visual recordings	is the term used for originals or copies of audio recordings, photographs and other visual images of people who use our services, staff or visitors that may be made using any recording device, including mobile phones.
Confidentiality	is a duty of confidence that arises when one person discloses information to another person where it is reasonable to expect that information to be held in confidence.
Media	is the term used to describe journalists or other representatives of print or broadcast media organisations eg newspapers, television. This also includes associated technical or creative people such as camera and sound crews and photographers.
Print media	is the term used in this protocol to refer to newspapers, journals, publications, flyers.
Broadcast media	is the term used in this protocol to refer to television and radio.
Outdoor media	is the term used in this protocol to refer to billboards, signage (including digital signage), posters, advertising on vehicles.
Web media	is the term used in this protocol to refer to the Internet, emails, online advertising.
Social media	is the term used in this protocol to refer to digital tools that support people to create and share content quickly on their phones, tablets or laptops including X, Facebook, Instagram, LinkedIn, TikTok and many more.
Public areas	is the term used to describe any location within our sites that is accessible to the general public and does not have secure entry, including reception areas and catering areas.
Clinical and restricted access areas	is the term used to describe any area within our sites in which clinical care is provided to inpatients or outpatients. This includes wards, theatres, departments and clinics.

It also includes any areas associated with healthcare or any other aspect of our business which has a secure door, requires a pass or authorisation from a member of staff to gain entry.

5. Roles and responsibilities

The Chief Executive holds overall responsibility as the organisation's Accountable Officer which includes protecting and safeguarding our patients and staff, ensuring we meet our duty of care to protect personal information (including images) as well as the aims and objectives of this protocol.

The Executive Team are responsible for providing advice to the Associate Director of Communications and Partnerships in relation to this protocol.

The Associate Director of Communications and Partnerships is responsible for maintaining

and monitoring this protocol, providing advice and guidance to staff and ensuring people are aware of their responsibilities within the protocol.

The communications team will:

- manage all media requests in line with this protocol
- establish and maintain productive relationships with local, regional and national journalists
- provide briefings to the Board, Governors and other external stakeholders as appropriate for any planned or reactive media activity
- ensure that, where appropriate, privacy and confidentiality disclaimers are signed; taking advice from the Director of Corporate Governance and Information Governance teams, where appropriate.

The **Caldicott Guardian** has responsibility to ensure that patient identifiable information is safeguarded.

The **Data Protection Officer** (or their designate) is responsible for providing advice on the management of privacy and compliance with Information Governance standards as directed by the Department of Health and Social Care (DHSC).

Senior managers, clinical and service leads are responsible for making sure that their staff are aware of this protocol and that people comply with it within their areas of responsibility.

All staff are responsible for reading this protocol, understanding their personal responsibilities and adhering to it at all times.

6. Principles

When working with the media, our principles are:

- we will always be transparent, open and honest
- wherever possible, we will co-operate with the media due to the public interest in the NHS, and their ability to get news to a wider audience in a shorter space of time than any of our own communication methods
- we will respect the confidentiality of people who use our services and our staff at all times
- we will respond to all media enquiries in an appropriate and timely manner, if we are unable to respond within the given deadline we will explain why
- media contact will not be allowed to detract from our primary purpose of care delivery and our duty of care must not be detrimentally affected by any planned or reactive media activity
- no pressure will be put on staff or people who use services to participate in media activity
- only those colleagues with the appropriate knowledge and expertise and who have received media training will represent us as spokespeople or be asked to contribute to broadcast media interviews.
- we will appropriately challenge and constructively engage with our media contacts where we feel that the enquiry or story is an unfair reflection which causes distress to our people and/or could discourage the people we care for from seeking help.

7. Our process

The Communications team handles all media activity and must be the first point of contact for any enquiries from the media.

Anyone working in any of our services who receives a media enquiry must direct the enquiry or the journalist to the Communications team using the contact details below.

Staff must not, themselves, attempt to handle media enquiries related our services, our staff or people who use our services unless authorised to do so, for example, the on-call director may handle media enquiries out of hours.

We aim to provide a response to all media enquiries received. Each response will be provided on a case by case basis and may include written statements, interviews, verbal briefings or updates.

Members of staff, volunteers, non-executive directors and governors should only engage in media activity on our behalf or in relation to our services or activities after consulting the Communications team and receiving permission to do so.

No one should speak on behalf Torbay and South Devon NHS Foundation Trust without the prior approval of the Communications team, who will, as appropriate, advise executives, and/or seek their approval before proceeding.

If members of staff are asked to speak to the media in a personal or professional capacity about matters which do not relate our services, our activities or our organisation, they are free to do so but are encouraged to make the Communications team aware at the earliest opportunity so that we can provide professional advice and guidance and ensure that they are appropriately supported.

Staff side / trade union representatives

Staff side / trade unions representatives are free to comment to the press in their roles. However, in the spirit of partnership, we would expect that those staff side / trade union representatives who are also our employees to inform the Communications team of any planned or reactive activity in advance of publication or broadcast.

Contacting the Communications team

Members of the Communications team are based at Torbay Hospital and can be contacted between 9am and 5pm, Monday to Friday, on

- Tel: 01803 654286
- Email: tsdft.communicationsteam@nhs.net

On-call managers and directors can contact the Associate Director of Communications and Partnerships out of hours for advice and support as required.

For any urgent communications and press matters received out-of-hours, please call the Torbay hospital switchboard on 01803 614567 who will put you through to the on-call manager.

On receiving a media enquiry

All media enquiries received are logged with the name of the journalist, the publication or media outlet that they work for, the nature of the enquiry, the deadline they are working to, and their contact details.

Depending on the nature of enquiry the Communications team may discuss handling strategies with NHS Devon communications colleagues and/or the regional communications leads (NHS England and NHS Improvement South West). They may also discuss handling strategies and approaches with operational and clinical colleagues.

Following appropriate discussion, the Communications team will make a recommendation to the Chief Executive and/or the relevant executive directors or senior managers on how to respond.

This process supports:

- consistent messages to be given to the media and, where appropriate, ensure alignment with system (NHS Devon) and regional or national messaging
- multiple queries on the same issues to be handled by one member of the Communications team without overlap or confusion
- quick identification of alternative sources of information and insight when a specific person is unavailable or on leave.

Approval/sign off process

All news releases and statements are approved by the most appropriate senior manager, executive director or the Chief Executive or Chair.

However, the level at which decisions are taken and formality of the procedures followed should be proportionate to the complexity of the media activity involved.

Distribution process

All reactive media statements, once approved, are shared with the journalist who made the enquiry. They may also be shared with executive directors, non-executive directors, senior managers and leaders, governors and other key stakeholders as appropriate, depending on the nature of the enquiry and the response given. A decision on the distribution will be made by the Associate Director of Communications and Partnerships (or their deputy) on a case by case basis.

All proactive news releases, once approved, are shared with a wide range of people, organisations and partners including our governors, local, regional and trade media, local and regional NHS colleagues, Healthwatch, Torbay Council and local MPs. All proactive stories are posted on the news section of our website and our intranet as well as being shared on our social media channels (currently Facebook, Instagram, X and LinkedIn).

Governors receive a fortnightly update on media and social media activity while the Board of Directors receive a monthly update through the Chief Executive's report to Board (Board does not meet in August or December, therefore two months data is included in the September and January reports).

Telling our stories

We encourage our teams to work with our Communications teams to proactively identify good news stories that we can share and to address any operational or clinical challenges, changes or issues that we need people to be aware of or understand.

Our staff are best placed to identify stories and news from their areas. We are particularly keen to share stories which show how we are supporting better health and care across Torbay and South Devon and which align to our strategic objectives as an organisation:

- what matters to you matters
- building healthy communities
- improving quality
- building a healthy culture at work
- creating partnerships
- improving sustainability

Whether it is promoting a new service, explaining why a service is changing how it operates or asking people to contribute to research our Communications team are here to support any individual or team who has a story to share.

We can offer advice, help write and distribute news releases, set up interviews, organise filming and photography, and advise on the production of publicity material.

See our appendices for useful templates and visit the Communications page on [ICON](#) for more information, support and advice.

No news releases should be sent to the media (local, regional, national or trade) without prior approval from the Communications team.

Our tone of voice – how we write and speak

How we write and speak affects how people feel about us. The words we use have the power to offer comfort and encouragement at difficult times and to build trust and confidence. They can bring people together and create a sense of shared purpose and community. They also have the ability to create doubt, uncertainty and confusion.

Our tone of voice is directly affected by the words we choose to use and simply changing those words can make us more or less welcoming. It can make the difference between someone applying for a job with us or feeling reassured that their loved one will be cared for as they would wish. It can make the difference between someone feeling able to ask for help or make a telephone call. It is therefore vitally important that we get this right, as it could potentially make the difference between someone getting the help they need, or not.

Our tone of voice guidelines and infographic set out our expectations around how we speak and write about our services, our staff, people who use our services and our communities and they are available on our Communications page on [ICON](#)

The Communications team can offer specialist advice and support if this is required.

Interview training, support and advice

Senior leaders and executives receive media training which is arranged by the Communications team.

All other staff put forward for interviews will be fully supported before, during and after the interview by the Communications team. This support includes drafting briefing documents and key messages, accompanying staff to recording studios/media houses for interviews as and when needed.

Filming requests

We often receive requests for TV interviews, and documentary and location filming. All proposals will be considered and accommodated where possible or appropriate. If you receive a request for filming or would like to film in our hospitals for a project you are doing, contact the Communications team for advice and approval.

In order to consider your request, we will need to know:

- name and organisation of the journalist and company
- what it is for – film, documentary, TV show, conference, etc
- target audience
- duration – both of the filming and of the broadcast
- when it will be shown
- purpose – why you want to do it, how it links to our vision and strategy
- proposed subject/s covered by filming (including staff and people who use our services)

All requests have to be approved via the Communications team, who will consult and advise the relevant executive director.

The Communications team can advise on the various steps that need to be taken when dealing with a TV filming request, such as arranging parking, liaising with film crews, obtaining relevant consent, etc.

Any film crews or photographers who are found to be on any of our sites without prior consent from the Communications team will be asked to leave.

If you see a film crew or photographer on any of our sites, and they are not accompanied by our staff or security, please inform the Communications team immediately.

Consent and confidentiality

We all have a duty to protect patient and staff confidentiality. We cannot give out any information that will lead to the identification of people who use our services or staff members. This includes confirming whether they work for us, or use any of our services, without their informed consent.

Where a media enquiry is received in relation to a specific patient the communications team will liaise with the relevant clinical team to obtain appropriate consent from the patient before releasing any information. If the patient is unconscious or incapacitated, the next of kin may be asked to give consent for information to be released, if they so wish.

If an enquiry is received about a specific staff member, and it is considered appropriate to respond to the enquiry, the Communications team will liaise with the individual and relevant management colleagues to obtain appropriate consent before releasing any information.

If a patient chooses to put information in the public domain about their condition or their experience of using our services, our duty of confidentiality remains and we will not comment on individual cases in our media responses. Our position is always to encourage people to talk to us directly about any concerns they may have about their treatment and care.

In certain circumstances, for example following an inquest or a legal settlement, or in relation to a safeguarding enquiry, limited information may be shared. Decisions will be made on a case by case basis and in conjunction with advice from our litigation team, Caldicott Guardian, Head of Safeguarding and other relevant colleagues depending on the individual circumstances involved.

Condition checks

Occasionally, the media may request information about a particular patient's progress, especially if the case has attracted high media coverage.

During office hours, these requests are dealt with by the Communications team unless the patient, their family or the police has requested otherwise. The reason for this is to ensure that confidentiality is upheld and reporting is as accurate as possible, as it can be very distressing for people who use our services, or their families, to see incorrect reporting.

Even though the level of detail issued in response to a condition check is very basic (eg critical, serious but stable, improving), ward staff still need to seek consent from the patient or relatives before any information is released. Without consent, no patient information can be disclosed.

If a ward or department is contacted directly by the media regarding a patient's condition, they must direct the call to the Communications team. If the request is made out of hours, it must be directed to switchboard for the on-call manager.

Sub Judice/Coroner's Court/Inquiries

Media enquiries that relate to issues which are sub-judice, due to be heard in a coroner's court, or that are the subject of an internal or external inquiry need to be handled sensitively.

Statements will be issued by the Communications team if appropriate (in consultation with the

appropriate director) without offering detail or further information which might prejudice proceedings.

8. High profile or VIP patients

We may occasionally care for high profile patients including celebrities, VIPs or prisoners in custody, who can be the subject of intense media interest. They are all entitled to the same level of confidentiality as other patients and their privacy and dignity must be protected at all times. It is therefore likely that special arrangements will need to be made and extra vigilance applied to help protect their privacy in hospital.

The Clinical Site Manager must inform the Chief Executive's office and Communications team as soon as it becomes apparent that there is a patient in any of our hospitals who could attract media attention in line with our security procedures. This could include a patient with an existing high profile, such as a celebrity, or someone who has been injured in a high-profile incident, such as an act of terrorism. The Communications team will work with clinical teams and security to ensure media interest is managed effectively and that patient confidentiality is protected.

All staff should remain aware that high-profile patients can draw significant press and public interest throughout their time in hospital. This may result in members of the press or public attempting to gain access to wards or departments.

On wards where high-profile patients are present, extra care should be taken by staff to ensure that only legitimate visitors are allowed onto wards and that staff ID is checked appropriately.

Where high-profile patients are present, additional security may be necessary which can be arranged in consultation with the Communications and Security teams.

Wards may experience an increase in calls as the press and/or general public attempt to find out the location of the high-profile patient and information about their care. Reception and ward staff must be prepared for such approaches and should refer any suspicious calls to the Communications team.

Some very high-profile individuals, for instance members of The Royal Family, or the Prime Minister, will attract 24/7 news coverage which may need specialist management. The Communications team will work with our major incident and security teams to identify the appropriate level of management required, and then the wider Communications team will identify available support and ensure that key stakeholders are briefed accordingly.

All staff should also be aware that some colleagues, patients, visitors and general members of the public may try to use personal devices to capture photos, video footage or audio clips of high-profile patients. The use of such devices to record patients in wards and departments without prior permission is strictly prohibited, in line with our audio-visual recordings by people who use our services and the public policy.

Members of the public or the media may decide to bring in person gifts for high-profile patients to the hospital in an attempt to gain access to the patient. To prevent people accessing the ward, such gifts should be accepted and logged by staff on the hospital main reception and then passed on to the Communications team who will arrange for them to be delivered to the ward.

9. Serious or major incidents

These types of incidents can generate the rapid appearance of large numbers of reporters, photographers and camera crews. Sometimes these are related to the treatment of high-profile people or an unexpected occurrence such as a major transport incident or local disaster.

Special arrangements are in place for media handling during a major incident in line with our major incident plan. Staff must ensure they are familiar with these plans

10. Media monitoring

Key local and national newspapers and various online media and social media outlets are monitored by the Communications team on a daily basis, to allow us to identify where our stories are being picked up by the media, and also, what is being said about us.

We do not have a licence (from the Newspaper Licensing Agency - NLA) to copy media articles, which means that staff may not copy – either in print or electronically – articles from publications covered by the NLA. (See [here for further details](#))

11. Independent Press Standards Organisation

All media outlets must adhere to the standards set out in the Editors' Code of Practice. The vast majority of the media who have contact with us are respectful of the rules, and will not cause any issues. However, if they do, we will take action as we will not tolerate the media harassing our staff or negatively affecting the safe delivery of care.

Please contact the Communications team on 01803 654286 if you have any concerns about the actions of the media in relation to our staff, our services or our sites.

If you would like further information about the rules press must adhere to and the role of the IPSO, please visit <https://www.ipso.co.uk/IPSO/index.html>.

12. Social media

We currently have four corporate social media accounts: LinkedIn, X, Instagram and Facebook. Administration of these accounts sits with the Communications team. Individuals, teams and services can send content for our corporate social media accounts to our Communications email and we will let you know if, when and how we will share it.

Teams, services, professional groups and individuals who wish to use social media for work purposes must comply with our Social Media Policy which is available on ICON [here](#).

13. Freedom of Information Act requests

The media occasionally uses the Freedom of Information Act to obtain information from organisations, sometimes openly but sometimes without disclosing who they are.

All FOI requests are handled by our Information Governance team. Should an FOI request be received by the Communications team it will be forwarded to the Information Governance team for processing.

For all FOI requests which are from the media, or suspected to be from the media, the Communications team will support the Information Governance Team to provide a response.

Appendix 1 – News release template

Promoting a success story

TITLE: One line title – what has happened that is successful?

Who: Who is the story about? If possible please provide a high resolution photo and state who is in the photo including job titles, where staff are shown, and other relevant information where other people are included eg carers, volunteers, GPs, local charity representatives etc.

What: 150 words max. What is the success story about? What happened? How have our staff contributed to the success?

Where and when: Location / time / date of the success story.

Quote: 80 words max. Include quote(s) from a key person/people involved in the success story, whether it is a member of staff or a member of the public etc. Include titles where relevant.

Image: If possible please supply high resolution image (at least 1MB).

CARE: You must ensure that you have permission(s) to share someone's story and/or use their photograph or include them in video footage. This applies to staff as well as members of the public. Please ensure the [Interview, Photo and Video Consent Form](#) is completed and signed.

For more information, please contact the Communications Team on 01803 654286.

Unclassified

Appendix 2 – media enquiry form

Date		Organisation		Deadline	
Time		Journalist		Contact Number	
<i>Call handler</i>				<i>Time of response</i>	

Details of enquiry:

Details of response:

Follow-up action required:

Time taken to deal with call & response time:

Appendix 3 – out of hours media enquiries – guidance for duty managers / on-call directors

It may be helpful to follow these guidelines, which reflect the way press calls are handled by our 'press office' (the communications team) in office hours, and help us to be consistent in the way we manage media queries:

Condition checks

- the media need to be able to give us the name of the person they want a condition check for. If they don't have the name, explain we need it. The police may be able to release the name to them - we mustn't.

We follow this protocol to:

- a. avoid issuing a condition for the wrong patient
- b. maintain patient confidentiality
- c. allow police time to inform relatives.

Exceptions:

- d. cases of **meningitis** or similar major infectious disease - the CCDCs at the local **Health Protection Unit** deal with these. Usually the patient is NOT named, but the Health Protection Unit may decide to issue a condition check. Once this has been done, and if the patient is improving, we will issue updates. If not, we leave it to the CCDC/Health Protection Agency to deal with.
Advice: refer the media to the Health Protection Unit/Health Protection Agency (see out-of-hours contact details below) OR duty Public Health doctor (through Switchboard).
 - e. easily identifiable **groups of casualties** eg. a boat crew - subject to the limitations given below.
- when you have been given the name, ask when the Press believe the patient was admitted. You will need to ask ED (ext. 54003) whether the patient has been admitted and if so where.
 - ask for the sister or nurse in charge.
 - e. check the safest description of the condition - don't be too optimistic
 - f. stick to standard descriptions such as: critical, serious, stable, comfortable, improving, making good progress.
 - g. make sure that the patient (or relatives) are OK about the information being given to the Press
 - h. if injuries were due to a violent incident, make sure Police are not actively involved; if they are, all press queries should be re-directed to the Police.
 - when you go back to the press, stick to the brief condition, and don't get drawn into any details about the diagnosis, treatment, circumstances etc. If the patient/family don't want the condition check released, tell the Press you are unable to release any information. If the Police are actively involved, tell the Press they must speak to the Police.
 - log your reply in case we get further calls and copy in the communications team (press office) via tsdft.communicationsteam@nhs.net

Incidents

Major Incidents

- we should have been alerted through the emergency services, but the Press may alert us. **Check with Emergency Services.**

- If it's a genuine alert, refer to [Major Incident Plan](#). [All press and external info will be handled by the Chief Executive/Chief Medical Officer/Chief Nurse/Associate Director of Communications and Partnerships. You can assure Press they will be contacted as soon as any information can be issued.]

Alleged operational incidents

- e.g. police called in, a fire, someone threatening to jump from a roof....

- **check** what the emergency services are saying. If what they are reporting to the Press is correct, **confirm** it with the Press.
- if no emergency services have been involved, you will need to decide what details to release. It's best to **keep it simple**. Avoid describing events, just state the basic facts.
 - eg. We can confirm that a man was on the roof for half-an-hour. He was brought down by staff and was uninjured. Police were in attendance.
 - NOT a man in his 20s must have climbed up a ladder and made threats before someone managed to grab him...!
- **avoid commenting**. Any comments will be made in normal office hours. There may be all kinds of reasons why we need to know more before we comment - there may be an enquiry launched, there may be an inquest, there may be other legal issues.
- remember patient [confidentiality](#).
- give what **reassurance** you can - the incident is resolved, it involved just one person, no-one was hurt.

Appendix 4 – interview guidelines

Preparation:

- are you the right person to be interviewed?
- never give an on-the-spot interview - always take time to prepare, even a few minutes will help
- ask the journalist for some background to the piece s/he's doing (including who else is being interviewed), what areas s/he'll want to cover and what the first question will be
- find out whether your piece is live or recorded
- make sure you know your facts and the corporate point of view
- imagine the worst question you could be asked and prepare an answer (but only give it if you're asked!!)

General:

- avoid jargon and use examples wherever possible
- pick two or three key points and take every opportunity to make them – even if you repeat yourself
- try to be interviewed away from noise and bustle
- use positive language - problems are opportunities!
- try to lead rather than be led eg when faced with a negative/difficult question use a connector to put your point across ... 'the important thing is ...'
- don't guess or speculate - if you don't know, say so
- don't lie or argue

Radio:

- news pieces are always very short - keep your answers short and punchy
- try to use 'word pictures'
- no-one can see you, so you can use written notes on a card
- pace is often faster than television

TV:

- be careful about the backdrop
- check your appearance in the mirror (hair neat, tie straight, buttons and zips fastened etc)
- look at the interviewer **not** the camera

Unclassified

Appendix 5

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	Media management policy		Version and Date	2, 01 November 2022	
Policy Author	Associate Director of Communications and Partnerships				
An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.					
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes ☐ No ☒	Disability	Yes ☐ No ☒	Sexual Orientation	Yes ☐ No ☒
Race	Yes ☐ No ☒	Gender	Yes ☐ No ☒	Religion/Belief (non)	Yes ☐ No ☒
Gender Reassignment	Yes ☐ No ☒	Pregnancy/ Maternity	Yes ☐ No ☒	Marriage/ Civil Partnership	Yes ☐ No ☒
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)					Yes ☐ No ☒
Please provide details for each protected group where you have indicated 'Yes'.					
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion					
Is inclusive language ⁵ used throughout?					Yes ☒ No ☐
Are the services outlined in the policy/procedure fully accessible ⁶ ?					Yes ☒ No ☐
Does the policy/procedure encourage individualised and person-centered care?					Yes ☒ No ☐
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?					Yes ☐ No ☒
If 'Yes', how will you mitigate this risk to ensure fair and equal access?					
EXTERNAL FACTORS					
Is the policy/procedure a result of national legislation which cannot be modified in any way?					Yes ☒ No ☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)					
To facilitate a standardized approach to policy documents across the Trust. EPR requirement updated and ratified					
Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?					
Communications team, executive team					
ACTION PLAN: Please list all actions identified to address any impacts					
Action	Person responsible		Completion date		
AUTHORISATION:					
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them					
Name of person completing the form	Angela Cappello		Signature	A Cappello	
Validated by (line manager)	Jane Harris		Signature		

Any issues Please contact Diversity & Inclusion Lead

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travellers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves.” (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Unclassified

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training program.