NHS
East Kent
Hospitals University
NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

POLICY DOCUMENT

Managing Informal Concerns and Feedback - PALS

Version:	1
Author:	Sue Holland – Head of Complaints, PALS and Bereavement Services
Approving committee:	Patient Experience Committee
Date approved:	18 March 2020
Date ratified by Policy Authorisation Group:	25 March 2020
Director responsible for implementation:	Chief Nurse/Director of Quality and Patient Experience
Date issued:	27 March 2020
Next scheduled review date:	26 March 2023
Applies to (include subsidiary companies):	All Trust staff and 2gether Support Solutions

We care

Version Control Schedule

Version	Date	Author	Status	Comment
1	January 2020	Sue Holland	Draft	New policy – replacing previous Policy for Management of Complaints, Concerns, Comments and Compliments

Policy Reviewers

Name and Title of Individual	Date Consulted
Amanda Hallums, Chief Nurse/Director of Quality and Patient Experience	16 March 2020
Deputy Chief Nurses	28 January 2020
Care Group Heads of Nursing	28 January 2020
Care Group Governance Matrons	28 January 2020
Phil Elliott, Head of Information Governance	28 January 2020
Lesley Williams, Policy Manager	28 January 2020
PALS team	28 January 2020
Patient Experience team	28 January 2020
Senior Matrons/Deputy Heads of Nursing	10 March 2020

Name of Committee	Date Reviewed
Complaints and Feedback Steering Group	09 March 2020
Patient Experience Committee	05 March 2020

Summary of Key Changes from Last Approved Version

Complete re-write to separate complaints and PALS, which also reflects the changes to the complaints process effective 01 January 2020.

Associated Documentation

Managing Complaints Policy

Risk Management Policy

Raising Concerns (Whistleblowing) Policy

Contents

1. Policy Description 4
2. Introduction 4
3. Definitions 4
4. Purpose and Scope 5
5. Duties 7
6. The different ways a PALS can be made 8
7. Consent to investigate a PALS 9
8. Timescales for PALS 10
9. PALS involving other NHS bodies 10
10. Expectations 10
11. Learning from PALS 11
12. Confidentiality and record keeping 13
13. Staff support 13
14. When PALS cross other processes 13
15. Managing difficult/challenging PALS 14
16. Media and the press 15
17. Policy Development, Approval and Authorisation 16
18. Review and Revision Arrangements 16
19. Monitoring and Assurance 16
20. Policy Implementation 17
21. Document Control including Archiving Arrangements 17
22. References 18
23. Appendices 18
Appendix A – PALS process flowchart 19
Appendix B – PALS consent process. 20
Appendix C - PALS Escalation Process 22
Appendix D – Equality Analysis 23
Appendix E – Policy Implementation Plan 25

1. Policy Description

1.1. The Trust provides a Patient Advice and Liaison Service (PALS) to offer confidential advice, support and information on health related matters. It is the objective of the Trust to ensure informal issues raised by service users are managed promptly, fairly and justly.

1.2. This document sets out the policy for managing informal concerns or feedback (known as PALS) at East Kent Hospitals University NHS Foundation Trust (the Trust), and applies to all staff, volunteers, students, contractors, locums and those on honorary contracts.

2. Introduction

2.1. The Trust will ensure the views of patients, relatives and carers are heard and acted upon; this reflects the Trust's values: we want our patients and their families to feel safe, cared for and confident in their treatment. All staff must adhere to the terms of the PALS policy. The policy will help support service users who wish to provide feedback or raise concerns. It is the personal responsibility of all Trust staff to act when a PALS is made to them.

2.2. The Trust recognises PALS as being a valuable tool for improving the quality of health services, learning and a chance to apologise at an early stage for any mistakes. Careful handling of PALS is an essential requirement for the Trust; the emphasis should always be on an early resolution. PALS are one way of identifying users' perspectives of the service provided. PALS can be an early indicator a service is not functioning effectively and appropriate trend analysis of the factors which prompted the complaint can provide valuable insight into where improvements may be required. PALS are intrinsically linked with complaints, incidents and possibly claims.

2.3. PALS will be delivered in line with the regulations laid out in the PALS Core National Standards and Evaluation Framework (Department of Health, 2003) and the standard operating procedure relating to the provision of PALS within the Trust.

2.4. The delivery of PALS will also support the principles and guidelines set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

3. Definitions

3.1. **Patient Advice and Liaison Service (PALS):** This is a service provided by the Trust looking into informal concerns or feedback, all feedback/concerns/actions carried out by this service are known as "PALS". The service involves problem

solving an immediate issue and is sometimes called an ‘informal complaint’. The issues are current, sometimes involve patients in hospital and are resolvable within a short time frame, ideally within ten working days. A case is resolved through liaison with services/care groups and discussion with the patient/person raising the concern. Should the person raising the concern be dissatisfied with the outcome of their case, they should be advised of their right to pursue the matter as a formal complaint.

3.2. **Formal complaint:** An expression of dissatisfaction by a patient or their representative which the patient or representative wishes to be investigated in accordance with the Local Authority Social Services and National Health Service Complaints Regulations (2009). A complaint requires a formal investigation and written reply. PALS can be made verbally or in writing.

3.3. **Client:** the person who raises the concerns with the Trust. This can be a patient, a friend or family member, carer, visitor or an advocate for the patient.

3.4. **Datix**: The Trust’s database to assist with managing PALS, producing reports and storing complaint information.

3.5. **Gillick Competence:** a young person under 16 who has the legal competence to consent to medical examination and treatment if they have sufficient maturity to understand the nature and implications of that treatment.

4. Purpose and Scope

4.1. Putting patients first is one of the Trust’s core values. The Trust is committed to providing an accessible, fair and effective service for those persons who wish to express their concerns or make a complaint with regard to the care, treatment or service provided by the Trust. The role of PALS is also to listen to the views and support the needs of patients, relatives, carers and members of the public who use our services.

4.2. The Trust has a commitment to ensure clients are treated equally and will not be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation; nor placed at a disadvantage by making a complaint. The Trust aims for all users of the Trust’s services to have their PALS dealt with empathetically, respectfully, promptly, confidentially, impartially and with courtesy.

4.3. The way we respond to our clients is important in indicating to them how seriously their comments are taken. Good PALS handling and early resolution is seen by the Trust as an integral part of its quality work to ensure the highest standard services for local people.

4.4. The process for PALS is outlined in Appendix A.

4.5. This policy will:

4.5.1. Ensure appropriate PALS management in line with the PALS Core National Standards and Evaluation Framework (Department of Health, 2003), the complaint Regulations and also the Parliamentary and Health Service Ombudsman's Six Principles of Good Complaint Handling;

4.5.2. Act as a reference guide for staff and service users;

4.5.3. Mandate PALS are acknowledged and actioned within five working days;

4.5.4. Ensure the Trust is responding to PALS in line with internal and external performance targets;

4.5.5. Ensure actions are being implemented and monitored arising from PALS;

4.5.6. Ensure any themes from PALS are recognised, learning is undertaken, with appropriate actions being implemented.

4.6. PALS not covered by this policy:

4.6.1. A PALS made by a responsible body (i.e. another health or social care organisation).

4.6.2. A PALS made by a current or previous employee about any matter relating to their employment.

4.6.3. A complaint previously investigated and resolved.

4.6.4. A complaint the subject matter of which is being or has been investigated by a local commissioner under the Local Government Act 1974 or a health service commissioner under the 1993 Act.

4.6.5. A PALS arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000.

4.6.6. A PALS which relates to any scheme established under section 10 (superannuation of persons engaged in health services etc. or section 24 (compensation for loss of office etc.,) of the Superannuation Act 1972 or to the administration of those schemes.

5. Duties

5.1. Board of Directors and other committees

5.1.1. **The Board of Directors** will receive assurance on compliance with this policy and designate one of its members to take responsibility for ensuring compliance with the policy. The Trust Board is kept informed on a monthly basis via the approved monthly Integrated Performance Report.

5.1.2. **The Trust's Quality Committee**, which is a sub-committee of the Board, is responsible for monitoring and reviewing the risk, control and governance processes in the organisation to manage PALS. This is in order to assist the Board of Directors to be fully assured the most efficient, effective, economic risk, control and governance processes are in place and that the associated assurance processes are appropriate.

5.1.3. **The Complaints and Feedback Steering Group** has responsibility for monitoring the PALS process, trends, response rates and learning outcomes and reporting to the Quality Committee.

5.2. **Chief Executive Officer (CEO)** is responsible for ensuring the implementation of this policy, maintaining an overview of PALS and in particular, ensuring any actions are taken in light of the outcome of PALS.

5.3. **Chief Nurse/Director of Quality and Patient Experience** is responsible for ensuring patient safety and that quality of services are maintained on a day to day basis. He/she will take a lead role in ensuring the PALS policy and process is followed and for the integration between the Trust's PALS and Complaints functions, along with internal and external governance and assurance processes.

5.4. **Care group management (triumvirate) and governance teams** must ensure the systems and processes outlined in this policy and supporting procedure are in place to manage PALS within their area of responsibility. The care group triumvirate are responsible for all PALS involving their area. The care group triumvirate and governance team will also be responsible for ensuring any learning and associated action plans arising from PALS are implemented, and risks identified are assessed and added to the risk register, if appropriate, in line with the Trust Risk Management Policy.

5.5. **The Head of Complaints, PALS and Bereavement Services (Head of CPBS)** will routinely manage the PALS process under the guidance of the Chief Nurse/Director of Quality and Patient Experience. The Head of CPBS is responsible for liaison and co-ordination of the Complaints team, Bereavement Services, as well as the Patient Advice and Liaison Service (PALS). The Head of CPBS is also responsible for:

5.5.1. Compiling regular analytical reports covering themes and trends in PALS received;

5.5.2. Board reporting on a quarterly basis and annually;

5.5.3. Ensuring PALS training is available to staff Trust-wide.

5.6. **The PALS Manager** is responsible for the day to day operational management of the PALS team including, quality assurance of the service and information provided to clients, manage / oversee complex non-standard PALS. He/she will provide advice and support to the care groups. The PALS Manager will also be responsible for the monitoring of complaint Key Performance Indicators and reporting on these (via the Head of CPBS) to the Chief Nurse/Director of Quality and Patient Experience

5.7. **The PALS team** are the first point of contact and support for clients and the care group governance teams. They are responsible for day to day case management of PALS, including acknowledging all PALS and data on to Datix, the Trust's PALS database. They are responsible for daily monitoring and triaging of new PALS cases received. They are responsible for collating up to date information on voluntary organisations, support groups and advocacy groups, along with the Trust services.

5.8. **The Care Groups** are responsible for investigating a PALS, for arranging any appointments or meetings for the client and for providing the client with an update.

6. The different ways a PALS can be made

6.1. PALS may be made by:

6.1.1. Verbally, either in person or by telephone;

6.1.2. By email;

6.1.3. Via the Trust website using the on-line form;

6.1.4. By Letter to:

The PALS Team
The Trust Offices
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG

6.1.5. Or to a member of Trust staff outside of the PALS team. In this circumstance, staff should review the issues raised by the patient and

seek to resolve these at a local level, if possible. If staff are in any doubt of the correct action to take, they should contact the PALS team for advice.

6.1.6. The PALS team will ensure all clients are able to access the service; access to translation services, interpreters and advocates will be offered.

7. Consent to investigate a PALS

7.1. In cases where a patient representative raises a PALS on behalf of a patient, consent will be obtained from the patient for permission to release any details to the representative. Consent can be taken verbally, in person or over the phone, or provided in writing via an email or letter. Details of consent will be recorded on Datix. Consent process and information is detailed in Appendix B.

7.2. Only when consent is received can the PALS be instigated for a third party. PALS without consent will be shared with the care group for learning and for them to take any actions as deemed appropriate. These details will not be shared with the client without the patient's consent.

7.3. Where a PALS has been made on behalf of a child or young person (CYP), consideration should be given to their age and Gillick competency, see Appendix B.

7.4. For young people aged 16 or 17, the young person can make the PALS themselves; they have the lawful ability to do so unless they lack capacity. If the person with parental responsibility raises the complaint on behalf of the young person, consent should be sought from the competent young person, see Appendix B.

7.5. Only when consent is received will the PALS process start. PALS without consent will be shared with the care group for learning and for them to take any actions as deemed appropriate. These details will not be shared with the client without the patient's consent.

7.6. If a patient is unable to consent due to capacity issues, support and advice will be sought from the Head of CPBS/Deputy Head of CPBS, Legal team and Adult Safeguarding team in conjunction with the clinical team to ensure patient concerns are appropriately investigated.

7.7. If concerns are raised by a care home/supported living, advice will be sought from Head of CPBS/Deputy Head of CPBS to ensure concerns are appropriately actioned.

7.8. Consent will, unless it is not possible be required from a patient with learning disabilities if a complaint is made on their behalf by a relative or friend. In cases

such as these where patient is unable to consent, advice from the Head of CPBS/Deputy Head of CPBS must be sought to assess if the PALS has been made in the best interests of the patient.

7.9. When a complaint is made or concerns raised by a patient who has capacity, but who may need additional support through the PALS process, the PALS team will assist the individual.

8. Timescales for PALS

8.1. PALS received by the Trust will be acknowledged and passed on to the Trust's services within five working days and responded to the client within a further five working days.

9. PALS involving other NHS bodies

9.1. PALS about other NHS bodies and/or social care should be signposted to the correct organisation. If the client gives permission the PALS team can contact the new organisation's PALS team and provide the client's contact details and concerns, or clients can be given the information about who can help.

10. Expectations

10.1. It is the Trust's expectation that clients will be provided with a resolution in a shorter timeframe than the Trust's formal complaints process of 30 working days. Clients should be provided with the information answering the concerns raised. When the Trust is unable to provide information because it is unavailable, this will be fully explained in order that our responses are open, clear and transparent.

10.2. Details of any pending or work in progress improvements to services should be provided to client in order that they can appreciate any steps being taken to enhance services.

10.3. Appropriate and quantified apologies for any errors or wrong doings by the Trust services or staff should be provided to the client.

10.4. All communication with clients, including written, will be explained without clinical jargon.

10.5. If any clients need any translation services or help to access the PALS or Trust's other services, this should be offered on all occasions.

10.6. Care groups who are experiencing difficulties in resolving PALS should contact the PALS Manager as soon as possible.

10.7. There is an escalation process detailed in Appendix C describing the process to be followed when care groups have overdue PALS or have failed to meet internal performance deadlines.

10.8. Clients may ask the PALS team to escalate their concerns to a formal complaint if they do not feel they have received an appropriate solution. This will be considered by the Complaints team.

10.9. The PALS team can escalate concerns to the Complaints team for investigation under the formal complaints process, if they do not feel PALS is the appropriate route for concerns raised. The complaints process is detailed in the Managing Complaints Policy.

11. Learning from PALS

11.1. An inherent part of PALS management is ensuring actions taken to improve services. The Trust will use any comments, compliments, PALS and complaints received to:

11.1.1. Work with departments to ensure patients get the right information in the right way and at the right time;

11.1.2. Identify services working well;

11.1.3. Help identify potential service problems through trends in PALS raised as an early warning system;

11.1.4. Highlight potential system failures and/or human error to identify a need for improvement;

11.1.5. Provide the information required to review services and procedures effectively, to respond to requests for patient experience data for service reviews/evaluations.

11.2. By listening to feedback, the Trust can identify ways to improve the way in which things are done.

11.3. The care group governance teams will also monitor any action plans provided to ensure they are carried out, showing learning through the Complaints and Feedback Steering Group.

11.4. An annual report will be prepared for circulation within the Trust and is publicised on the Trust's website. The report will specify:

11.4.1. The number of PALS received by the Trust in the period;

11.4.2. The themes and trends of PALS received;

11.4.3. Action taken to improve services as a consequence of PALS.

12. Confidentiality and record keeping

12.1. Staff must comply with the Trust's Information Governance policies in all matters relating to the handling of PALS.

12.2. Records of PALS will not be held in any patient's healthcare records. PALS will be stored electronically within Datix and the Trust's servers, accessed by the Complaints, PALS and Bereavement Service department and the care group governance teams. Staff must not discuss PALS with patients or their carers during clinic appointments or inpatient stays.

12.3. PALS details will not be held in staff personal files unless in relation to a disciplinary matter.

13. Staff support

13.1. Receiving dealing with PALS can be stressful for staff to deal with. There are services available to help and support staff; in the first instance advice and support should be sought from the staff member's line manager.

13.2. The health and well-being pages on Staff Zone detail support available to staff. The Occupational Health department can also offer support and outline resources available: Tel: 01227 864206 or email occupationalhealth.kch@nhs.net

13.3. Staff may also wish to obtain support from the professional organisation or trade union.

14. When PALS cross other processes

14.1. PALS are a part of the overall governance framework and as such work with and alongside other governance processes. PALS can lead to a:

14.1.1. A formal complaint

14.1.2. Claim

14.1.3. Incident/RCA/Serious Incident

14.1.4. Police investigation

14.1.5. Social services investigation

14.1.6. Human Resources investigation

14.1.7. Safeguarding investigation

14.1.8. Allegation

14.2. It is key when logging a PALS to ensure all the details and work carried out to resolve the PALS are fully detailed.

14.3. The PALS may form part of an investigation or as a result an incident may be logged. It is important to triangulate with the Complaints team.

15. Managing difficult/challenging PALS

15.1. The Trust is committed to dealing with all PALS fairly and impartially and to providing a high-quality service. However, we do not expect our staff to tolerate abusive, offensive or threatening behaviour, or which makes it difficult for us to resolve a PALS or consider a formal complaint. This policy explains how we will manage such behaviour.

15.2. It is important we are able to communicate with someone bringing a PALS to us so we can make sure we fully understand it. We do not normally limit the contact people have with us.

15.3. We do not expect our staff to tolerate any form of behaviour considered abusive, offensive or threatening, or that becomes so frequent it makes it more difficult for staff to complete their work or help other people. We will act under this policy to manage this type of behaviour and this applies to all contact made with us, including the use of any social media platform.

15.4. We will make reasonable adjustments to ensure our service is accessible to everyone. It is important we provide a safe environment for our staff to work in, which may mean we decide to restrict how someone can contact us.

15.5. At all times, if the concerns have come from a patient, their health care needs will continue to be addressed. Any clients who are patients will not be discriminated against in any way. It is important, however, to identify the stage at which a client has become unreasonable/disproportionate and for action to be taken accordingly.

15.6. We will usually only act to restrict someone's contact with us after we have considered whether there are any other adjustments we could make to prevent unreasonable behaviour from occurring. Any restrictions imposed will be appropriate and proportionate. The options we are most likely to consider are:

15.6.1. asking for contact in a particular form (for example, email only);

15.6.2. only allowing contact with a specific member of staff or at specific times;

15.6.3. asking the person to enter into an agreement about their future behaviour; and/or

15.6.4. actions designed to specifically meet the needs of the client.

15.7. In all cases we will write to tell the client why we believe their behaviour is unreasonable, what action we are taking and how long that action will last. We will also tell them how they can challenge the decision if they disagree with it. If,

despite any adjustments we have made, a person continues to behave in a way which is unreasonable, or disproportionate, we may decide to end contact with that person.

15.8. There will be occasions where we decide that a person's behaviour is so extreme it threatens the immediate safety and welfare of our staff or others. In these instances, we will stop all contact immediately, reporting what has happened to the Police or taking legal action. In such cases, we may not warn the person before we do this.

15.9. We may consider behaviour to be unreasonable or disproportionate if a client:

15.9.1. Continues pursuing a PALS or a complaint when either of the Trust’s procedures have been fully exhausted.

15.9.2. Raises new issues constantly to prolong contact or when the substance of a PALS is changed significantly. This can include raising further concerns when resolution is still ongoing, or raising further issues on the same subject on receipt of a response/solution. This behaviour must be evidenced as outside the normal part of the process and must be seen as disproportionate to consider this policy.

15.9.3. Displays unreasonable demands or expectations or fail to accept these may be unreasonable when a clear explanation is provided, which may include documented evidence. This can include when clients continue to question minutia taking up a disproportionate amount of time.

15.9.4. Does not identify clearly the specific issues they wish to be resolved. This can include failure to agree concerns despite reasonable efforts by the PALS team.

15.9.5. Has harassed or bullied staff.

15.9.6. Used or threatened physical violence towards staff.

15.9.7. Has made an excessive number of contacts to the Trust in person, or by telephone, letter or email.

15.10. At all times if the Trust consider a person's behaviour is unreasonable the Trust will tell them why and will ask them to change it. If this behaviour continues, the Trust will act including deciding whether to restrict the person's contact with the PALS team. This decision will be taken by a Deputy Chief Nurse and Head of CPBS.

16. Media and the press

16.1. PALS should be dealt on a strictly confidential basis. However, some may come to the attention of the media through the actions of clients, staff or unconnected

third parties. The Communications team should handle all media communications.

16.2. In all cases where a client or third party advises they will be seeking attention from the media, the communications team should be alerted immediately. This should also include any action to, or if staff are aware social media has been used to share details of the PALS.

17. Policy Development, Approval and Authorisation

17.1. Head of CPBS has written the policy; it has been approved by Patient Experience Committee.

17.2. This policy will be ratified by the Policy Authorisation Group.

18. Review and Revision Arrangements

18.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

18.2. It will be ratified by the Policy Authorisation Group every three years, or when there are significant changes and/or changes to underpinning legislation in accordance with section 9.3 of the policy for the Development and Management of Trust Policies (and other Procedural Documents).

19. Monitoring and Assurance

19.1. The following table outlines the monitoring arrangements in place for the management of PALS:

Policy Objectives	Monitoring methods	Assurance
Clinical areas / departments respond to PALS issues and document the findings.	Annual /quarterly/ monthly report. On-going monitoring using a standard template feedback form from the care groups to detail action.	Logged on DATIX. Non-compliance is reported to Head of CPBS and escalated to Heads of Nursing (HON) or appropriate care group triumvirate member.

Policy Objectives	Monitoring methods	Assurance
PALS enquiries are responded to within the appropriate time scales.	Standard agenda item at PALS staff 1:2:1 meetings. PALS provide listing reports of open cases – monthly.	Monthly reports are sent to HON or appropriate care group triumvirate member and discussed in Complaints and Feedback Steering Group. Summarised in quarterly/ annual report.
Key PALS themes will be reported to enable learning from PALS enquiries. Reporting key issues, themes and activity.	Monthly reports are sent to HON. Escalation of early warning signs to service leads and HONs, or appropriate triumvirate member.	Summarised version sent to Quality Committee and included in the quarterly and annual report.

20. Policy Implementation

20.1. Refer to Appendix F.

21. Document Control including Archiving Arrangements

21.1. Archiving of this policy will conform to the Trust's Information Lifecycle and Records Management Policy, which sets out the Trust's policy on the management of its information.

21.2. This policy will be uploaded to the Trust's policy management system.

21.3. The Policy for Management of Complaints, Concerns, Comments and Compliments, which this document supersedes, will be retained within the Trust's policy management system for future reference.

22. References

PALS Core National Standards and Evaluation Framework (Department of Health, 2003)

2009 Complaints Regulations

CQC KLOEs

PHSO Principles of Remedy

PHSO Unreasonable Behaviour Policy

PHSO Redress policy

Learning from mistakes

My Expectations

Assurance of Good Complaints Handling for Acute and Community Care – a toolkit for commissioners, NHS England

23. Appendices

Appendix A – PALS process flowchart

Concern received from client (patient or interested party) on ward or in clinic.

Client to speak to Nurse in Charge, or Ward/Clinic Manager or Matron and raise concerns. Consent should be obtained from the patient to help.

Staff member attempts locally to find a solution to the concerns raised, assist and advise the client.

If the issue is unable to be resolved locally, the client or staff member should contact PALS via phone, in person, email, website or letter.

PALS team to create a Datix account to record the concerns and progress. PALS team to acknowledge with client, ask for consent

and pass to relevant care group within 5 working days.

PALS passed to Senior Matron or the relevant Operations Manager (care group) for resolution. It is the care group's responsibility to resolve and respond to the client within a further 5 working days.

The care group must advise PALS team of the outcome and any learning. PALS team close the Datix account.

PALS team are advised the issues have not been resolved by the client. PALS team use escalation process to achieve outcome.

If the client advises the concerns remain unresolved, PALS team to pass on the concerns to Complaints team for formal investigation.

Appendix B – PALS consent process.

The Trust may need to obtain consent from the patient, if the PALS received is from someone other than the patient, or the concerns need to be passed to another Trust or healthcare provider.

In order for the Trust to resolve a PALS the Trust may need to access the patient's electronic and/or paper health records and share this information. Reassurance must therefore be obtained that the person asking for the information has a right to receive it and the Trust must evidence that they have the authority of the patient to act on their behalf.

Responses to PALS can be provided without patient consent if there is no patient information being shared, such as details about care and treatment. As an example, generic information about the process for triaging patients can be shared, but not how a particular patient was triaged or what the outcome was for them.

PALS can only be looked into when consent has been received.

Although it is preferable to obtain written consent, given the immediate nature of PALS, verbal consent can be obtained from the patient. However, for audit purposes, verbal consent should always be recorded on Datix including the date and time taken.

Consent is required if:

- If the PALS relate to an external organisation and we are passing it over to them, we need consent from the patient
- The client is not the patient, we need consent from the patient
- If the patient does not have capacity, we can accept a copy of a Power of Attorney for Health and Welfare
- If there is no Power of Attorney for Health and Welfare, then we will take an individual view. In this case the Head or Deputy Head of PET must be asked for advice.
- If the PALS has come from an MP there is implied consent, unless the client is not the patient. In this case patient consent must be obtained, unless the patient is unable to provide consent – see above.
- If the patient is deceased, the situation must be handed sensitively. In most cases consent will still be required, if the deceased's care and treatment is to be shared. For difficult or sensitive situations the Head or Deputy Head of CPBS must be asked for advice.
- If the patient is 13 years old and over consent should be obtained, unless they do not have capacity, or their health needs mean this is unachievable (advice from

clinicians will be taken). Please see NHS website for further details: https://www.nhs.uk/conditions/consent-to-treatment/children/

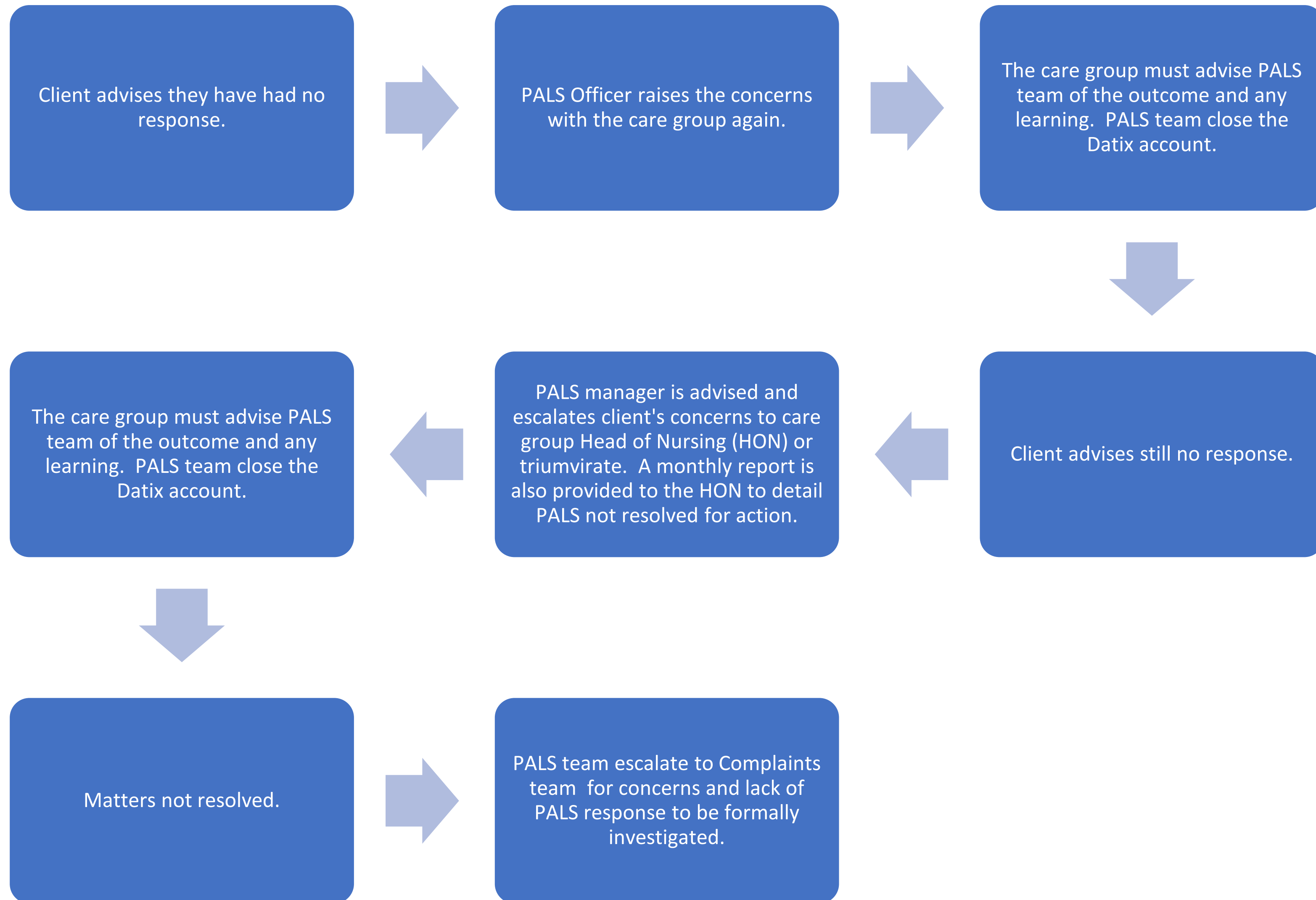
Outline:

Consent is asked for at the start of the PALS; if this is not received the PALS will be closed and not responded to.

Process when consent received:

- Change the status on Datix from awaiting consent to the appropriate status
- Change the date received field to the date consent was received
- Record on Datix Notepad the date and time verbal consent received or date written consent received
- Send the PALS query to the appropriate care group and confirm consent has been received

Appendix C - PALS Escalation Process



Appendix D – Equality Analysis

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	**Sue Holland**	
Job title	Head of Complaints, PALS and Bereavement Services	
Care Group/Department	Corporate	
Date completed	16 March 2020	
Who will be impacted by this policy	[x] Staff [x] Staff (Other) [x] Service Users	[x] Carers [x] Patients [x] Relatives

Assess the impact of the policy on people with different protected characteristics. When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.		
Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**Yes**	**Neutral**
Disability	**Yes**	**Neutral**
Gender reassignment	**Yes**	**Neutral**
Marriage and civil partnership	**Yes**	**Neutral**
Pregnancy and maternity	**Yes**	**Neutral**
Race	**Yes**	**Neutral**
Religion or belief	**Yes**	**Neutral**
Sex	**Yes**	**Neutral**

We care

Sexual orientation	**Yes**	**Neutral**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	No
Did the consultation analysis reveal any difference in views across the protected characteristics?	N/A

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	No

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	This policy does not impact on any of the protected characteristic groups.

Appendix E – Policy Implementation Plan

To be completed for each version of policy submitted for approval.

Policy Title:	PALS (Patient Advice and Liaison Service)
Version Number:	1
Director Responsible for Implementation:	Amanda Hallums – Chief Nurse/Director of Quality and Patient Experience
Implementation Lead:	Sue Holland – Head of Complaints, PALS and Bereavement Services

Staff Groups affected by policy:	All staff groups.
Subsidiary Companies affected by policy:	2gether Solutions – they must follow the Trust policy. The policy has been shared with 2gether Solutions.
Detail changes to current processes or practice:	Changes to individual responsibilities have been consulted and communicated prior to the process implementation of 01 January 2020.
Specify any training requirements:	None
How will policy changes be communicated to staff groups/ subsidiary companies?	Trust News Head of Patient Experience will share with the Governance Matrons to disseminate to the care groups.