Complaints Policy (4)

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Executive Summary

The philosophy behind the approach of The Walton Centre is based on the recognition that it is important to respond to complaints in a timely and transparent manner, and also to recognise and act upon the lessons identified. The complaints system underpinned by this policy must be integral to other care management and improvement systems such as audit, education and performance review, rather than exist as a detached system.

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1. Introduction

1.1. The Walton Centre is committed to providing the highest quality of care and services to patients, their families, carers and other organisations. The Trust welcomes feedback from patients, their families, visitors and the public about the services it provides. This includes feedback from concerns, complaints, and compliments. The purpose of this policy is to ensure that all concerns and complaints are investigated appropriately and to ensure that the Trust has effective procedures in place to handle the issues brought to the attention of staff.

The Trust has a moral, legal and financial duty to ensure that complaints are dealt with efficiently and effectively for the purpose of responding to individual concerns, wider organisational learning and development, and to prevent reoccurrence.

The policy aims to ensure that concerns and complaints are handled thoroughly without delay with the aim of reaching a satisfactory resolution whilst being fair, open and factual with all those involved. The Trust recognises that there is a need to view complaints positively as a valued contribution to the development of better quality healthcare by improving the care and services they provide. The Trust is therefore committed to identifying lessons learnt from concerns and complaints so that services can be improved.

1.2. This policy has taken account of the recommendations of various national reports, including Francis (2013), Keogh (2013), Winterbourne (2012), Healthwatch Shifting the Mindset (2020) to ensure that the Trust's approach to complaints meet those standards. The policy also takes account of the CQC Regulation 16 – receiving and acting on complaints (2014).

1.3. The Trust's complaint policy is written in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2011 and takes into account the NHS Constitution principles and values. It also takes into account the Parliamentary and Health Service Ombudsman's principles of good complaint handling (2009).

1.4. The policy aims to:

- Ensure that complaints and concerns are responded to in a timely, transparent and effective manner;
- Ensure that the complaints system and processes are integral to contributing to the highest standard of patient care and to correct them when they fall short of agreed standards;
- Contribute to the Trust's Training Needs Analysis;
- Ensure that where appropriate lessons are learnt to reduce future complaints and improve patient care;
- Maintain the Trust's positive reputation and continuing public confidence in its services;
- Minimise the human, organisational and financial impacts of complaints through effective management.

2. Scope

2.1. This policy deals with the way that The Trust records, manages and responds to complaints raised by patients, their families or other interested parties. The policy highlights any exclusions or time restraints that prevent complaints from being dealt with. The policy does not deal with the way that staff throughout The Trust deal with other general enquiries and concerns raised by patients, their families and other

interested parties. It does not deal with concerns raised by staff as these matters are dealt with under separate HR policies.

3. Definitions

- **Concern** - A concern is an oral expression of dissatisfaction about any matter reasonably connected with services supplied by the Trust. A concern should be resolved with the satisfaction of the complainant as soon as possible, or within a reasonable agreed timescale with the person raising the concern. An issue raised in writing (including email) may be treated as a concern, with the agreement of the person raising the concern.
- **Complaint** - is an expression of dissatisfaction, which requires a response. "All complaints whether oral or written, should receive a positive and full response, with the aim of satisfying the complainant that his/her concerns have been heeded, and offering an apology and explanation as appropriate, referring to any remedial action that is to follow".
- **Complainant** - the person raising the complaint. The majority of complaints are raised by patients but complaints may be made on behalf of patients by relatives, carers or other interested parties. Where the complainant is not the patient, however, the consent of the patient will be obtained by the Patient Experience Team. The response to a complaint will only be provided once the patient's consent has been received.
- **Claim** - allegations of negligence and/or demand for compensation made following an untoward incident, resulting in personal injury (to a patient, a member of staff, or a member of the public) or damage to property.
- **External body/agency** - an organisation that has an official advisory or regulatory role, which has been mandated to regulate the corporate and professional activities of NHS Trusts.
- **Root Cause Analysis** - a process for identifying the basis or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

4. Duties

4.1. Board of Directors:

- has a monitoring and assurance via two Board Committees, namely Quality Committee and Business and Performance Committee that provide assurance that The Complaints Policy is working effectively; to monitor themes and trends from complaints; and ensure systematic learning and appropriate actions are taken and lessons learnt are embedded.

4.2. Chief Executive Officer

- has delegated their duties for all complaints to the Deputy Chief Executive.

4.3. Deputy Chief Executive

- is accountable and responsible to the Trust Board for ensuring that resources, policies and procedures are in place to ensure the effective reporting, recording, investigation and treatment of complaints and that there are sufficient arrangements for the support of those staff involved
- will ensure that any clinical related incidents highlighted as a result of a complaint will be the subject to an appropriate investigation in line with relevant policies
- reviews and personally signs all letters of response in respect of complaints or allocating this duty to the Director of Nursing & Governance in their absence

4.4. **Director of Nursing & Governance**

- will quality review all complaint responses before they are sent to the Deputy Chief Executive Officer
- will be informed immediately if any complaint is of a very serious nature or contains serious allegations that could be detrimental to the Trust

4.5. **Executive Directors**

- through their Managers will ensure that all staff within their scope of responsibility are made aware of the policy, and that it is implemented effectively
- are responsible for ensuring that there are systems in place to monitor complaints within the Divisions and that they are investigated according to Trust policy
- are also responsible for facilitating the learning of lessons from complaints by ensuring that these are discussed at Divisional meetings
- have a responsibility to ensure that any lessons learnt from complaints that may affect other areas are made known to other relevant parts of the organisation to prevent reoccurrence and to facilitate the review of those systems and policies with operational managers

4.6. **The Medical Director**

- will independently review any complaint regarding medical care or treatment where the complaint is complex or the complainant remains dissatisfied with the response.
- they may also delegate their duties to the Deputy Medical Director.

4.7. **Deputy Director of Nursing & Governance**

- provides a link between executive level and complaints, incidents and claims
- is responsible for the operational delivery of the complaints and governance management system
- must ensure that any complaints made directly to their Division or areas of responsibility are referred to the Patient Experience Team

4.8. **The Head of Patient Experience is responsible for:**

- establishing and overseeing the process for the investigation of complaints received by the Trust;
- the operational management of complaints, ensuring the effective and efficient management of the complaints process;
- supporting the Deputy Director of Nursing & Governance , ensuring strong integrated links between claims, complaints and clinical risk management;
- identifying lessons learnt and ensuring remedial action is taken by the Divisions/ Trust to minimise future risk;
- liaison with other NHS bodies to co-ordinate timely responses to patients where more than one NHS organisation is involved;
- ensuring there is sufficient information and publicity available for patients, carers and staff to be able to make a complaint with ease and in an informed way;
- informing the Director of Nursing & Governance if any complaint is of a very serious nature or contains serious allegations that could be detrimental to the Trust

4.9. **Divisional and Departmental Managers are responsible and accountable for**:

- ensuring that all complaint investigations within their scope of accountability are completed within the required timescales for the complaint and draft responses produced to a high quality;

- ensuring that any complaints received within the Division are reported to the Patient Experience Team and investigated and documented accordingly, and actions taken to the level commensurate with the RAG status outlined in this policy;
- facilitating the development of an action plan to address if required and present to the appropriate forum following the conclusion of a complaint;
- ensuring that complaints with cross Trust impact are brought to the attention of other Divisions and Senior Managers;
- ensuring that lessons are learnt following the investigation of a complaint, which may apply to areas outside their remit and ensuring that those are brought to the attention of any other Divisions and Senior Managers through Divisional meetings;
- following a complaint, where appropriate, inviting discussion with the complainant/patient or relative in order to facilitate a positive outcome at the earliest opportunity;
- ensuring that modification to a local policy and procedure is undertaken following the outcome of a complaint investigation;
- ensuring that any complaint that might provoke media interest is considered and that appropriate liaison between the patient's clinician, patient and their families is undertaken; and
- appropriate liaison with the Patient Experience Team is undertaken to identify which stakeholders need to be informed of the complaint;
- monitoring the monthly reports for attendance at Trust induction for new staff within their area of responsibility;
- monitoring the monthly reports for completion of mandatory training for staff within their area of responsibility;
- ensuring complaints, trends and learning is discussed at Risk and Governance Meetings

4.10. **Line Managers will ensure that:**

- staff attend Trust induction which include complaints and training;
- staff working within their area of responsibility are aware of the complaint reporting procedure;
- staff co-operate in the investigation of any complaint;
- staff are guided through the complaint reporting process, and where required, to provide information in relation to complaints;
- staff are suitably supported following a complaint and referred to other services as appropriate e.g. occupational health, counselling services;
- any complaints received within their area of work are reported to the Patient Experience Team;
- all relevant documentation is gathered, completed and safely stored within their department; and
- any equipment or scene of the incident, leading to the complaint, where appropriate or practicable to do so, is secured

4.11. **The Patient Experience Team are responsible and accountable for:**

- facilitating the effective application of the Complaints Policy and associated policies, procedures and guidance documents, supporting complainants, staff and managers alike;
- collating responses for complaints, ensuring that the components of the complaint are all appropriately addressed;
- act as point of contact with complainants and provide updates on progress of complaint investigations;

- analysing complaint information and producing relevant reports identifying trends and lessons learnt for the Trust;
- managing and updating the complaint tracker and database to record and report all complaints;
- identifying and delivering corporate training and development needs, developing training criteria and training programmes for the delivery of complaint and other patient experience work;
- ensuring where necessary that statutory bodies have been notified within the appropriate timescales; and
- ensuring where necessary co-operation with other NHS bodies in responding jointly to complaints;
- recording actions/lessons learnt from complaints that are considered upheld on the database and report any open actions to the appropriate division to take forward;
- escalating any noted trends in subject, area or individuals that may be a theme in relation to concerns/complaints

4.12. **All staff affected, involved in a complaint will:**

- attempt to resolve any issues of concern to the best of their ability, raised by patients and their families, at the point of concern or "on the spot";
- co-operate with their employer to enable their employer to comply with their statutory duties;
- bring to the notice of their line manager any concerns or complaint matters;
- request appropriate support following their involvement in a complaint;
- inform the Patient Experience Team if they receive a complaint; and
- provide a statement of events when requested or when an investigation of a complaint is taking place

5. Process

5.1. Procedure for recording, managing and responding to complaints

5.1.1 All concerns and complaints must be given an appropriate level of investigation to identify the causes, where possible put things right and to ensure lessons are learnt for the future.

5.1.2 Not all complaints need to be investigated to the same extent or depth and Staff should be encouraged to deal with concerns and enquiries as they arise. Where this is not possible or practicable complaints will be managed by the Patient Experience Team.

5.1.3 A flowchart depicting the Process for the Management of Complaints can be found at Appendix 1

5.2. Who can make a complaint?

5.2.1 The NHS regulations state that a complaint may be made by:

(a) A patient, or
(b) Any person who is affected by, or likely to be affected by, the action, omission or decision of the NHS body, which is the subject of the complaint

5.2.2 A complaint may be made by a person acting on behalf of another person mentioned in any case where that person has:

(a) died
(b) is a child
(c) is unable by reason of physical or mental incapacity to make the complaint himself, (written permission will be requested from the patient) or

(d) requested the representative to act on his/her behalf

5.2.3 In the case of a patient or person affected who has died or who is incapable, the representative must be a relative or other person who, in the view of the Head of Patient Experience, had or has a sufficient interest in the patient's welfare and is a suitable person to act as a representative.

5.2.4 If the Trust is of the view that a representative does not or did not have a sufficient interest to the person's welfare or is unsuitable to act as a representative, the Head of Patient Experience must notify that person in writing, stating their reasons.

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

5.3. Publicity

5.3.1 It is important that patients and visitors know of their right to make a complaint. The Trust has developed a complaints information leaflet that provides advice and contact details for patients or patient's representatives who are dissatisfied with the service they have received from The Walton Centre. The leaflet is entitled 'How to raise your concerns, complaints or comment on the service we provide' and a copy is available on the website, together this contact details.

5.3.2 Where necessary, the Trust will provide assistance to support communication through an interpreter where the complainant's first language is not English. If necessary, assistance will also be available in other formats such as Braille, audio etc. Patients and their families are made aware of this in all complaints communications throughout the Trust.

5.4. Timescales for making a complaint

5.4.1 A complaint must be made within:

(a) twelve months of the date on which the matter, which is the subject of the complaint, occurred; or

(b) twelve months of the date on which the matter, which is the subject of the complaint came to the notice of the complainant

(c) where a complaint is made after the expiry of the twelve month period, the complaint will still be investigated if the Trust decides that:

- the complainant had good reasons for not making the complaint within the time period; and
- it is still possible to investigate the complaint efficiently and effectively

5.4.2 Any complaint concerning possible allegations of fraud and corruption should be passed immediately to the NHS Counter Fraud Service for action. These are then reported to the Director of Nursing & Governance to inform the Trust Board.

5.4.3 In cases were a complainant has or expressed their intention to contact the media, the Head of Communications will be informed and take appropriate action regarding Trust communication and media management.

5.4.4 Where it is determined that the matter will not be investigated, this should be communicated to the complainant within 10 working days of receipt of the complaint. This should set out the specific reasons why and details of appeal to the Parliamentary & Health Service Ombudsman as set out in 5.10 of this Policy.

5.5. What happens upon receipt of a complaint?

5.5.1 Complaints and concerns can be raised with any staff member wide range of staff and can be received at ward and departmental level. Upon receipt of a concern or an enquiry staff should do what they can to resolve the matter to the patient's satisfaction.

5.5.2 Where this is not possible or the person concerned wishes to make a complaint then the recipient should:

- Report the complaint to the Patient Experience Team: and:
- Advise the patient/complainant that they can contact the Patient Experience Team to discuss their complaint at:

By letter:
Patient Experience Team
The Walton Centre NHS Foundation Trust
Lower Lane
Fazakerley
Liverpool
L9 7LJ

By email to: patientexperienceteam@thewaltoncentre.nhs.uk
By telephone:
0151 556 3093 / 3091

5.5.3 The Trust understands that not all complainants will be able to, or be comfortable in putting their complaint in writing. In such cases anyone contacting the Patient Experience Team can provide details of their complaint over the phone, via email or in person. The details of the points to be investigated will be shared/agreed with the complainant prior to investigation.

5.5.4 Upon receipt of the complaint the Patient Experience Team will initially assess and grade the complaint, as set out in 5.6 of the Policy. If not already done so, the Patient Experience Team will register the complaint on the database. A member of the Patient Experience Team will be appointed the point of contact for the complaint and will make contact with the complainant. This will ensure that the complaint as set out in 5.6 of the Policy is graded appropriately. The Patient Experience Team will raise a letter of acknowledgement and ensure that it is sent to the complainant, in line with the principles of investigation set out in 5.7 of the Policy.

5.6. Grading of complaints

5.6.1 On receipt of a complaint the Patient Experience Team will allocate a Level 1, 2 or 3 grading to the complaint. This status will inform and direct the level of investigation required. The status of each complaint will be discussed with the Divisional Managers, Departmental Heads as required and can be amended during the lifetime of the complaint. The status of the complaint and any changes will be discussed with the complainant.

5.6.2 The table below provides a general guide for discussion with the complainant in relation to the investigative time required to deal with the complaint. Following discussion with the complainant the status / timescale may be amended. Timescales may also be amended in line with requirements in respect of external regulators. Any such new arrangements will be discussed with the complainant.

Complaint Grading	Definition Description	Timescale for investigation by Division	Timescales for Completion
Level 1	Unsatisfactory service or experience Simple non complex issues Delayed/cancelled appointments Minor breakdowns in	15 working days	25 working days

	communication **No real risk of litigation**		
Level 2	Moderate impact: Distress caused Several issues possibly involving more than one organisation Delayed discharge Cancelled surgery/procedures Failure to meet care needs Medical errors Staff attitude & behaviour Loss of property **Complaints with some potential for litigation**	30 working days	45 working days
Level 3	Major/serious impact major harm or loss. Multiple issues relating to potential serious failures causing serious harm. Events resulting in serious harm or death Abuse/neglect **Complaints with high probability of litigation**	50 working days	60 working days

5.6.3 The Patient Experience Team will also undertake an initial assessment of the complaint and will extract the key issues and questions raised by the complaint; this will be discussed and agreed with the complainant. This will be provided to the Divisional Management Team and Departmental Heads responsible via the appropriate division responsible for collating the statements of response to the various components in a draft response template to complete.

5.7. Principles and Standards of Investigation

5.7.1 In all cases complaints will be registered, and assessed to determine how they are best managed. In all cases contact will be made with the complainant by the Patient Experience Team to discuss their concerns and agree, if possible, the actions that will be taken to determine how the complaint will be managed. See Appendix 1 for flow chart.

5.7.2 A letter of acknowledgement will be sent to the complainant by the Patient Experience Team, within three working days of receipt of the complaint and contain the points that will be addressed , together with the direct telephone number of the member of the Patient Experience Team dealing with their complaint.

5.7.3 All letters of acknowledgement will include details of the Independent Advocacy Service, Healthwatch.

5.7.4 The Patient Experience Team will coordinate the investigation with the Neurological or Neurosurgical Divisional Managers for all complaints within their relevant areas of responsibilities, and with the relevant Department Heads for corporate complaints. The complaint will be sent electronically to the appropriate divisional generic email. These will be based on the grade of complaint as set out in 5.6 and in adherence to the Procedures for Complaints Handling.

5.7.5 The Patient Experience Team will keep the complainant advised as to the progress of their complaint. This will form part of the agreement with the complainant as set out in

5.5. A record of all contact with the complainant, regardless of who initiated it, will be maintained by the Patient Experience Team.

5.7.6 The relevant Divisional Manager or Departmental Head will forward any progress relating to the component parts of the complaint to the Patient Experience Team. This will include any remedial action already taken or proposed.

5.7.7 Progress of on-going complaints and any new complaints will be discussed at the weekly complaints meeting between the Patient Experience Team and Divisions.

5.8. **Responses to Complaints**

5.8.1 It is important to Trust that all responses to complaints should be of a high quality standard. The Patient Experience Team will monitor the progress of complaint investigations; this includes ensuring timescales are met, responses are appropriate and each point is addressed and that lessons are learnt are detailed in the response and recorded. It will be escalated to the Deputy/and or Director of Nursing & Governance, if responses to complaints are not received from the Divisions in a timely manner. Compliance with response timescales will be monitored at Quality Committee, and Divisional Governance & Risk Meetings.

5.8.2 When a complaint is made, staff must ensure that the patient's ongoing health needs are met. Under no circumstances should any member of staff display any form of discrimination towards either the patient or complainant as a result of the complaint. If it becomes apparent during any complaint investigation that patients, their family or friends are being discriminated against, the Head of Patient Experience/Deputy Director of Nursing & Governance will take appropriate action and escalate to the Director of Nursing and/or Medical Director to ensure that the discrimination is stopped immediately and where applicable, the matter will be referred to their line manager. This principle is enforced by the Patient Experience Team via training on induction, mandatory training and ad-hoc training sessions, and complaints leaflets.

5.8.3 Complainants are made aware that their complaint will not affect their care and treatment through statements in acknowledgement letters and the complaints leaflets.

5.8.4 The Patient Experience Team will receive and review the draft a response from the appropriate division after this has been approved by the relevant Divisional Manager and action plan (if necessary) on behalf of the Chief Executive.

5.8.5 All responses must:

- Acknowledge the person's right to complain and thank them for bringing the matter to our attention.
- Contain an expression of condolence where bereavement has occurred.
- Address each issue or question raised and comply with the duty of candour, meaning responses must be open and transparent about their care and treatment, including when it has gone wrong.
- Avoid technical terms and medical terminology and provide an explanation for any medical terminology contained within.
- All responses should be written in plain English.
- Be sympathetic in tone and contain an apology where appropriate.
- Inform the complainant if any lessons are to be learnt and what actions have been taken to prevent a reoccurrence and/or make improvements in service.
- Clearly state if an investigation has revealed the complaint unfounded or that the complainant's expectations of the service are unrealistic.
- Clearly state if an investigation has revealed that the patient or complainant has not acted or behaved appropriately.

- Inform the complainant of the options available to them if they remain dissatisfied including arranging a meeting.
- Identify risks, if any, which have arisen as the investigation has progressed and ensure that these are encompassed in the recorded actions.

5.8.6 The Head of Patient Experience will review the final draft to ensure that all aspects of the complaint have been addressed and responded to fully. Any response will give a clear explanation of events, ensure that all medical jargon is explained and where appropriate, an apology is offered and details of any corrective action outlined. The draft response will be approved by the Director of Nursing & Governance/or Deputy Director of Nursing & Governance in their absence.

5.8.7 All final response letters to complainants will be signed by the Deputy Chief Executive Officer or Director of Nursing & Governance in their absence.

5.8.8 Actions and learning identified as a result of complaint investigations will be recorded and monitored by the Divisions at their Divisional Governance and Risk meeting.

5.9. Local Resolution Meetings

5.9.1 There are certain situations where complaints can be addressed through a Local Resolution Meeting. The benefit of a Local Resolution meeting should be considered when appropriate.

5.9.2 Local Resolution meetings require careful arrangement and management and must be guided by the complainant. Meetings may be arranged prior to a written response or to discuss outstanding concerns following a written response. See Complaints meeting Procedure - Appendix 2.

5.10. What happens if the patient is dissatisfied with the response to their complaint

5.10.1 If the patient is still dissatisfied after the local complaints process has been completed they can ask the Parliamentary Ombudsman to investigate their case. Details of contacting the Ombudsman is contained in all response letters sent from the Chief Executive. They can be contacted at:

Health Service Ombudsman Or www.ombudsman.org.uk
Millbank Tower
Millbank
London
SW1P 4QP

5.11. When complaints can be excluded or ceased to be investigated

5.11.1 A complaint can be excluded or ceased to be investigated when:

(a) a complaint which is being or has been investigated by the Health Service Commissioner;

(b) a complaint arising out of an NHS body's alleged failure to comply with a data subject request under the Data Protection Act or a request for information under the Freedom of Information Act 2000;

(c) A complaint about which an NHS body is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint.

(d) The complaint has already been investigated under the NHS complaints procedure.

(e) The complaint related to any scheme established under section 10 or 24 of the Superannuation Act 1972.

5.11.2 There are other exclusions relating to NHS employees, other NHS bodies and independent providers. These are contained within the NHS (Complaints) Regulations.

5.12. Collaboration with other Organisations

5.12.1 If a complaint involves more than one NHS Provider, the Trust will co-ordinate an investigation in partnership with other Trusts in accordance with any wishes of the complainant. If a complaint is solely concerned with services provided by another hospital, the Patient Experience Team will forward the letter of complaint to the appropriate Trust.

5.12.2 Complaints are sometimes received by the Trust, which relate in part to the Local Authority. It is possible that a complaint received by the hospital Trust can include matters of concern regarding services provided by both the hospital and Local Authority Social Services. In these circumstances, the Trust is required to work with the Local Authority in providing a co-ordinated response as follows:

- Within 10 working days of receipt of the complaint, the Patient Experience Team will contact the complainant to ascertain whether he/she wishes details of the Local Authority complaint to be sent to the Local Authority and written permission to disclose personal information. Whilst there is no statutory period within which the complainant should reply to the Trust, the Trust requests a reply wherever possible within 7 days;
- The Trust then sends details to the Local Authority as soon as reasonably practicable;
- Both the Trust and the Local Authority are under a duty to provide information relating to the complainant, which is relevant and reasonable;
- The Trust and Local Authority are under a duty to attend any meetings reasonably required for consideration of the complaint; and
- The Trust and Local Authority must agree which of them will take the lead in co-ordinating the handling of the complaint and deal with the complainant.

5.13. Complaints received by the Local Authority which relate in part to the Trust (Social Services complaints procedure).

5.13.1 It is possible that a complaint received by the Local Authority can include matters of concern regarding services provided by both the Local Authority Social Services and hospital. In these circumstances under the Social Services complaints procedure regulations, the Local Authority is required to work with the hospital in providing a co-ordinated response in exactly the same way as described in 5.12.

5.14. Complaints received by the Trust which relate wholly to the Local Authority

5.14.1 If a complaint is received by the Trust, which does not related to any NHS function, but is a Local Authority complaint, the Trust takes the following action:

- Within 5 working days of receipt of the complaint, the Trust asks the complainant whether he/she wishes the complaint to be sent to the Local Authority. Whilst there is no statutory period within which the complainant should reply to the Trust, requests a reply wherever possible within 7 days
- If the complainant does so wish, the Trust then sends the complaint to the Local Authority as soon as reasonably practicable.

5.15. Complaints received by the Local Authority which relate wholly to the Trust (Social Services complaint procedure regulations):

5.15.1 If a complaint is received by the Local Authority, which does not relate to any Local Authority function, but is a Trust complaint, the Local Authority is required by the Social Services complaint procedure regulations to take similar action as described in 5.14.

5.16. Patients from Wales

5.16.1 The Trust collates information relating to where a complainant resides, to ensure that it satisfies any additional requirements such as The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. In essence under these regulations, which came into force in 2012, NHS bodies in England that receive notification of a concern under a relevant complaints procedure are under an obligation within the regulations to consider whether or not there is or may be a qualifying liability in respect of services that they have provided under an arrangement with a Welsh Health Board. If the Trust is of the view that there is/may be such a qualifying liability, the Trust is placed under an obligation in the Regulations to refer the concern to the Welsh Health Board. This information requires an assessment as to whether there is any qualifying liability and there are specific steps for the Trust to take in these circumstances. Under this policy, the Trust will make such an assessment where the initial assessment of the complaint is deemed to be 'Level 3'.

5.17. Confidentiality

5.17.1 Care must be taken not to disclose personal information unless the patient has given their permission to do so. If the person making the complaint is not the patient, the Trust will seek the patient's written permission to disclose personal information. A copy of the written consent should be saved within the complaint file and database. Verbal consent from the patient can be sought, if another person is raising a concern on their behalf. Even if the person making the complaint is the patient's next of kin, the wishes of the patient should be sought before releasing any personal and/or confidential information.

Where the patient does not have the capacity to give consent, the next of kin must give their consent for the complaint to be investigated. Where the patient is vulnerable, due consideration must be given to appropriate advocacy being provided to assist and support the patient in giving the consent (refer to Mental Capacity Act 2005) and an Independent Mental Capacity Advocate (IMCA), if appropriate, must be contacted. With regard to patients who do not have English as their first language, appropriate interpretation service must be made available.

NB Next of Kin (NOK) has no standing at law. However, if the patient is unable to consent the next of kin may be able to provide the treating clinicians with relevant information to assist in their decision making process. If the next of kin has a Lasting Power of Attorney, they can be involved in the decision making process.

5.17.2 If confidential information is required to be shared with other organisations then the appropriate documentation will be sent to the patient/service user involved, requesting their consent to investigate the complaint.

5.17.3 If a relative or carer makes a complaint relating to the care/treatment of a deceased patient, written authority must be sought from the next of kin or immediate family member in order for the Trust to investigate the complaint on behalf of the complainant. Complaints will be accepted for investigated if submitted from the Next of Kin of a patient that is recorded within the patient's health records.

5.17.4 Complaint correspondence may contain confidential information relating to patients and staff and must not be filed in a patient's health records.

5.18. Private Care

5.18.1 The NHS complaints procedure will cover any complaint made about the Trust's staff or facilities relating to care or treatment provided by the Trust but not to the private medical care provided by a Consultant outside of their NHS contract

5.19. **Clinical Incidents & Claims**

5.19.1 Clinical incidents highlighted from complaints are managed in accordance with this policy. For all clinical incidents reported as moderate harm or above, the Duty of Candour Policy is followed and an investigation will be carried out in line with the Trust's Incident Reporting Policy and Procedure.

5.19.2 Complaints that raise issues that are considered by the Trust as likely to be included in a future claim of clinical negligence are dealt with in accordance with this procedure and reported to the NHS Resolution. This is in accordance with the Trust's Claims Management Policy.

6. Persistent and Unreasonable Contact

6.1. Detailed guidance on the management of persistent and unreasonable contact is set out in Appendix 3.

7. Training

Training will be provided in accordance with the Trusts Training Needs Analysis.

8. Monitoring

Please see Appendix 4.

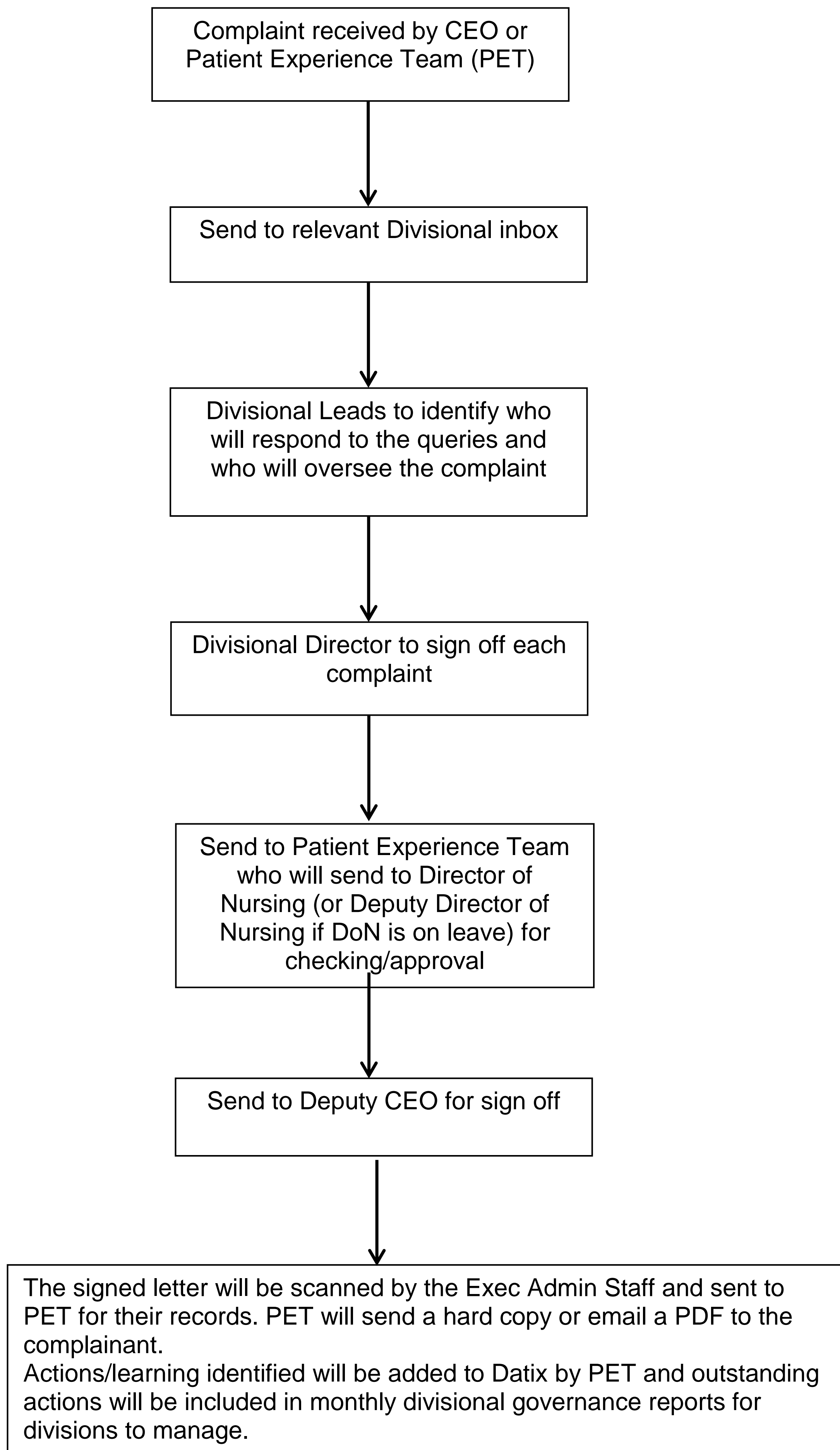
9. References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2011
- The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
- Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2010
- CQC Regulation 16 – Receiving and Acting on Complaints 2014
- Parliamentary and Health Service Ombudsman 2009:
  - Principles of Good Complaints Handling
  - Principles of Good Administration
  - Principles for Remedy
- 'My expectations for raising concerns and complaints' 2014. Parliamentary and Health Service Ombudsman, Local Government Ombudsman and Healthwatch
- The Francis Report 2013
- The Keogh Report 2013

9.1. Supporting policies/documents

- Incident Reporting Policy & Procedure
- Claims Management Policy
- Risk Management Strategy
- Duty of Candour Policy
- Claims Management Policy
- Safeguarding Policy
- HR Policies Investigation of Staff

Appendix 1 - Handling Complaints Flow Chart



Appendix 2 - Complaints Meeting Procedure

In the event that a complainant or their representative requests a local resolution meeting with staff to discuss their concerns, this should be facilitated. It is essential to have the relevant people in attendance and a clear idea of the areas of the complaint that will be discussed. It is vital that all parties are prepared and the meeting is conducted in a timely manner.

Arranging the Meeting

The Patient Experience Team (PET) will liaise with the complainants or their representative and explore who will attend with the complainant, e.g. family members/advocate/interpreter. A maximum of 5 including the latter will be advised due to being able to accommodate safely in a meeting room in order to enable social distancing.

PET is responsible for:

- Liaising with the complainant and the Division(s) to determine a mutually convenient time to meet and sending the meeting proforma to the relevant divisional lead to complete and return
- Arrange an interpreter if required or identify if there are any access requirements
- Arrange a suitable room, preferably not in a clinical area
- Arrange a pre-meeting for staff who will be in attendance for the meeting - this can either be on the same day as the meeting or a different date prior to the meeting, if this is required e.g. for complex complaints
- Confirm with complainant the concerns to be covered in the meeting and share this with the Division prior to the meeting to act as an agenda for the meeting
- Discuss the expectations of resolution with the complainant, e.g. what they wish to get from the meeting
- Inform all parties of the confirmed details of the meeting and provide directions for complainants
- Meet and greet complainants on arrival
- Ensure that a copy of the complaint file is available at the meeting
- Ensure that the case notes are available at the meeting
- Send a meeting reminder to all those in attendance 5 days prior to the meeting and then circulate the completed meeting proforma to the Division

Division are responsible for:

- Identifying who will be required to meet with the complainant to ensure that the right staff/disciplines can address the questions put to them
- It is vital that those who will be in attendance have prepared and reviewed health records and the complaint prior to the meeting to ensure that all planned questions can be answered
- Confirm who will take the role of Chair at the meeting
- Attend the pre-meeting

Pre-Meeting:

- Confirm who will take the role of Chair
- Clarify the purpose of the meeting and preferred outcome
- Clarify the Divisions position in response to each issue and that appropriate investigation has been undertaken
- Discuss how to manage the meeting
- Agree what, if any other action can be offered or lessons learnt since the initial investigation and how this will be taken forward
- Agree the intended outcome and how to close the complaint action

- Confirm that PET will scribe or record the meeting (the preference should have been discussed with the complainants prior to the meeting)

Meeting

- Chair to ensure introductions are made and explain the roles of the parties, if necessary and offer condolences if appropriate
- The Chair will discuss expectations and clarify with the complainant what outcome they wish to achieve – PET may have discussed this with complainants prior to the meeting
- All employees to adhere to The Walton Way and remain respectful at all times
- The Chair will ensure that an appropriate response is maintained to any challenging behaviour on behalf of the complainant and will give clear guidelines with regards to adopting a change of behaviour if necessary
- All staff should be open, honest and clear in their answers, avoid medical jargon and provide explanations for medical terminology used
- Ensure the complainants are aware what action has already been taken, if required and any further learning taken
- The Chair should clarify the outcome of the meeting and conclude
- The Chair will thank the complainants for attending and sharing their experience (and agree to provide a copy of the recording, if undertaken, once transferred to a disc or a copy of the notes once agreed by all those in attendance

Post Meeting

- PET to draft response and share with all those involved for input.
- Final response to go from Chair of the meeting, PET to send and update Datix and complaint file.
- If recording, PET to arrange for this to be put on a disc or preferred format.
- PET to add any additional actions onto Datix and Division to provide update once completed

Local Resolution Meeting Proforma

Complaint:		Web no:	
Walton ID number:			
Division to Complete:			
Notes /Complaint Reviewed:			
Staff required:			
PET to Confirm:			
PET staff in attendance:			
Complainant/family members attending:			
Any special requirements:			
Date and time of pre-meeting:			
Location:			
Date and time of local resolution meeting:			
Location:			
Case Notes available:			

Appendix 4 - Guidance for dealing with persistent and unreasonable contact

1. Introduction

This guidance covers all contacts, enquiries, concerns and complainants. It is intended for use as a last resort and after all reasonable measures have been taken to try and resolve a complaint within the Trust's Complaints Policy.

Persistent contact may be as a result of individuals having genuine issues and it is therefore important to ensure that this process is fair and the complainant's interests have been taken into consideration.

2. Purpose of the guidance

To assist the organisation to identify when a person is persistent or unreasonable, setting out the action to be taken.

3. Definition of persistent and unreasonable complainants

There is no one single feature of unreasonable behaviour. Examples of behaviour may include those who:

- Persist in pursuing a complaint when the procedures have been fully and properly implemented and exhausted.
- Do not clearly identify the precise issues that they wish to be investigated, despite reasonable efforts by staff, and where appropriate, the relevant independent advocacy services could assist to help them specify their complaint.
- Continually make unreasonable or excessive demands in terms of process and fail to accept that these may be unreasonable e.g. insist on responses to complaints being provided more urgently than is reasonable or is recognised practice.
- Continue to focus on a 'trivial' matter to an extent that it is out of proportion to its significance. It is recognised that defining 'trivial' is subjective and careful judgment must be applied and recorded.
- Change the substance of a complaint or seek to prolong contact by continually raising further issues in relation to the original complaint. Care must be taken not to discard new issues that are significantly different from the original issue. Each issue of concern may need to be addressed separately.
- Consume a disproportionate amount of time and resources.
- Threaten or use actual physical violence towards staff.
- Have harassed or been personally abusive or verbally aggressive on more than one occasion (this may include written abuse e.g. emails).
- Repeatedly focus on conspiracy theories and/or will not accept documented evidence as being factual.
- Make excessive telephone calls or send excessive numbers of emails or letters to staff.

4. Actions prior to designating a persons' contact as unreasonable or persistent.

It is important to ensure that the details of a complaint are not lost because of the presentation of that complaint. There are a number of considerations to bear in mind when considering imposing restrictions upon a complainant.

These may include:

- Ensuring the persons' case is being, or has been dealt with appropriately, and that reasonable actions will follow, or have followed, the final response.
- Confidence that the person has been kept up to date and that communication has been adequate with the complainant prior to them becoming unreasonable or persistent.
- Checking that new or significant concerns are not being raised, that requires consideration as a separate case.
- Applying criteria with care, fairness and due consideration for the client's circumstances – bearing in mind that physical or mental health conditions may explain difficult behaviour. This should include the impact of bereavement, loss or significant/sudden changes to the complainant's lifestyle, quality of life or life expectancy.
- Considering the proportionality and appropriateness of the proposed restriction in comparison with the behaviour, and the impact upon staff.
- Ensuring that the complainant has been advised of the existence of the policy and has been warned about, and given a chance to amend their behaviour.

5. Consideration should also be given as to whether any further action can be taken prior to designating the persons' contact as unreasonable or persistent.

This might include:

- Raising the issue with a Director with no previous involvement, in order to give an independent view.
- Where no meeting with staff has been held, consider offering this at a local level if it is considered that a positive outcome may arise, as a means to dispel misunderstandings (only appropriate where risks have been assessed).
- Where multiple departments are being contacted by the complainant, consider a strategy to agree a cross-departmental approach.
- Consider whether the assistance of an advocate may be helpful.
- Consider the use of ground rules for continuing contact with the complainant.

6. Ground rules may include:

- Time limits on telephone conversations and contacts.
- Restricting the number of calls that will be taken or agreeing a timetable for contacting the service.
- Requiring contact to be made with a named member of staff and agreeing when this should be.
- Requiring contact via a third party e.g. advocate.
- Limiting the complainant to one mode of contact.
- Informing the complainant of a reasonable timescale to respond to correspondence.
- Informing the complainant that future correspondence will be read and placed on file, but not acknowledged.
- Advising that the organisation does not deal with calls or correspondence that is abusive, threatening or contains allegations that lack substantive evidence. Request that the complainant provides an acceptable version of the correspondence or make contact with a third party to continue communication with the organisation.
- Ask the complainant to enter into an agreement about their conduct.
- Advise that irrelevant documentation will be returned in the first instance and (in extreme cases) in future may be destroyed.
- Adopting a 'zero tolerance' policy. This could include a standard communication line, for example: "The NHS operates a zero tolerance policy, and safety of staff is

paramount at all times. Staff have a right to care for others without fear of being attacked either physically or verbally."

7. Process for managing unreasonable or persistent behaviour

Where a persons' contact has been identified as unreasonable or persistent, the decision to declare them as such is made by the Chief Executive or Deputy Chief Executive.

The Chief Executive (or representative on their behalf) will write to the complainant, informing them that either:

- Their complaint is being investigated and a response will be prepared and issued as soon as possible within the timescales agreed.
- That repeated calls regarding the complaint in question are not acceptable and will be terminated, or;
- Their complaint has been responded to as fully as possible and there is nothing to be added.
- That any further correspondence will not be acknowledged.

All appropriate staff should be informed of the decision so that there is a consistent and coordinated approach across the organisation.

If the declared complainant raises any new issues then they should be dealt with in the usual way.

Review of the persistent status should take place at six monthly intervals.

8. Urgent or extreme cases of unreasonable or persistent behaviour

In urgent or extreme cases, adopt safeguarding and zero tolerance policies and procedures. Discuss the case with the appropriate Director to develop an action plan that may include the use of emergency services in some circumstances. In these circumstances, carry out a review of the case at the first opportunity after the event.

9. Record keeping

Ensure that adequate records are kept of all contact with unreasonable and persistent contact.

Consideration should be given as to whether the organisation should take further action, such as reporting the matter to the police, taking legal action, or using the risk management or health and safety procedures to follow up such an event in respect of the impact upon staff.

Appendix 5 - Monitoring

Minimum requirement to be monitored	Frequency of monitoring	Process for monitoring	Responsible individual/committee to undertake audit/ report	Responsible individual/committee for review of results	Responsible individual/committee for development of any action plans	Responsible individual/committee for monitoring of any action plans and implementation
Duties	Every 3 years	Review of Policy	Head of Patient Experience	Patient Safety Group	Patient Safety Group	Patient Safety Group
How the organisation listens and responds to complaints from patients, their relatives and carers	Monthly Annually	Monthly Reports via Divisions Quarterly Governance Reports Weekly meetings with Divisions	Head of Patient Experience Divisional Triumvirate	Executive Meeting Divisional Governance & Risk Meetings Patient Experience Group Quality Committee	Divisional Governance & Risk	Executive Meeting Divisional Governance & Risk Meetings Patient Experience Group
How joint complaints are handled between organisations	Annually	Review of policy	Head of Patient Experience	Head of Patient Experience	Divisional Triumvirate	Divisional Governance Group
How the organisation makes sure that patients, their relatives and carers are not treated differently as a result of raising a complaint	Annually	Annual Report	Head of Patient Experience	Quality Committee	Quality Committee	Quality Committee
How the organisation makes improvement as a result of a complaint	Monthly Quarterly Annually	Monthly Reports via Divisions Quarterly Governance Reports Weekly meetings with Divisions	Head of Patient Experience Divisional Triumvirate	Executive Meeting Divisional Governance & Risk Meetings Patient Experience Group	Patient Experience Group	Executive Meeting Divisional Governance & Risk Meetings Patient Experience Group
Monitoring the timeliness of response to complaints	Monthly	Monthly reports Quarterly reports	Head of Patient Experience	Executive Meeting Divisional Governance & Risk Meetings	Patient Experience Group	Quality Committee, Patient Experience Group and Divisional Governance & Risk Meetings.

Appendix 6 - Equality Impact Assessment (EIA) Form

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part 1

1. **Person(s) Responsible for Assessment:** Lisa Gurrell 2. **Contact Number:** 0151 556 3088

3. **Department(s):** Clinical Governance 4. **Date of Assessment**: 10 July 2020

5. Name of the policy/procedure being assessed: Complaints Policy

6. **Is the policy new or existing?**

Existing

7. **Who will be affected by the policy (*please tick all that apply*)?**

Staff X Patients X Visitors X Public X

8. How will these groups/key stakeholders be consulted with?

There were only changes in line with job roles/responsibilities which have been agreed with those involved. Minor clarity regarding process also reviewed.

9. What is the main purpose of the policy?
Guidance on how the Trust investigates manages and responds to complaints.

10. What are the benefits of the policy and how will these be measured?
Clear guidance and consistency in management of complaints. Complaints management is monitored on monthly basis at divisional level and quarterly via Quality Committee via the Governance Report. Progress is monitored closely at Executive Group Meetings on a weekly/and or monthly basis.
11. Is the policy associated with any other policies, procedures, guidelines, projects or services? *If yes, please give brief details*
Incident Reporting Policy & Procedure, Claims Management Policy, Risk Management Strategy

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?
This policy is intended to enable all patients to have the opportunity to raise concerns/complaints, including patients or their representatives with any protected characteristics.

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation/adjustments already put in place
Age			X	Monitored via contacts or concerns raised.	Paragraph asking to make contact if a complainant or patient they feel they have been subject to discrimination during the complaints process is in all acknowledgment letters/emails with details of who to contact.
Sex			X	As above	As above
Race			X	As above	As above
Religion or Belief			X	As above	As above
Disability			X	As above	As above
Sexual Orientation			X	As above	As above
Pregnancy/maternity			X	As above	As above
Gender Reassignment			X	As above	As above
Marriage & Civil Partnership			X	As above	As above
Other				As above	As above
If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) 13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? **No**					

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to EDI Lead for further support.

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
***You must complete Part 2 of the EIA before this policy can be ratified*.**

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Lisa Gurrell Date: 10.7.20

Signed: or/Sent from work email account

Appendix 7 - Policy approval checklist

The **Complaints Policy** is presented to the **Patient Experience Group** for Approval.
In order for this policy to be approved, the reviewing group must confirm in table 1 below that the following criteria is included within the policy. Any policy which does not meet these criterion should not be submitted to an approving group/committee, the policy author must be asked to make the necessary changes prior to resubmission.

<u>Policy review stage</u>

Table 1

The reviewing group should ensure the following has been undertaken:	**Approved?**
The author has consulted relevant people as necessary including relevant service users and stakeholders.	Y
The objectives and reasons for developing the documents are clearly stated in the minutes and have been considered by the reviewing group.	Y
Duties and responsibilities are clearly defined and can be fulfilled within the relevant divisions and teams.	Y
The policy fits within the wider organisational context and does not duplicate other documents.	Y
An Equality Impact Assessment has been completed and approved by the HR Team.	Y
A Training Needs Analysis has been undertaken (as applicable) and T&D have been consulted and support the implementation	Y
The document clearly details how compliance will be monitored, by who and how often.	Y
The timescale for reviewing the policy has been set and are realistic.	Y
The reviewing group has signed off that the policy has met the requirements above.	Y

Reviewing group chairs name:	**Date:**

<u>Policy approval stage</u>

✖ **The approving committee/group approves this policy.**

☐ **The approving committee/group does not approve the policy.**

Actions to be taken by the policy author:

Approving committee/group chairs name: L. Vlasman	**Date: August 2020**

Appendix 8 - Version Control

Version	Section/Para/ Appendix	Version/description of amendments	Date	Author/ Amended by
1.0	All	Review at expiry date	01/12/13	C. McConnell
2.0	All	Following review	20/02/14	C McConnell
3.0	All	Review contact numbers, titles, generic email addresses for Patient Experience	01.06.17	M. McKenna
3.1	5.6.2	Review of grading	13.06.17	M. McKenna
3.2	6.0 & Appendi x 1, 3	Inclusion of guidance for dealing with persi stent and unreasonable complaints	13.06.17	M. McKenna
3.3	Appendix 1	Update process map for the Management of Complaints	02.01.19	M. McKenna
3.3	Throughout	Update of titles throughout post organisatio nal change of Director	02.01.19	M. McKenna
	4.8	Inclusion of • act as point of contact with complainants and provide updates on prog ress of complaint investigations	02.01.19	M. McKenna
	5.7.5	Removal of para as it is a duplication	02.01.19	M. McKenna
	5.8.1	Inclusion of compliance with response time scales will be monitored at Quality Commit tee, Patient Experience Group and Divisio nal Governance & Risk Meetings.	02.01.19	M. McKenna
	5.10.1 - 4	Removal of paragraphs.	02.01.19	M. McKenna
	Appendix 2	Update monitoring table to include section 5.8.1	02.01.19	M. McKenna
3.4	5.6.2	Inclusion of column within table to Timesca le for investigation by Division	02.10.19	M. McKenna
	5.8.7	Insert - Actions that are undertaken as a re sult of complaint investigations will be moni tored at the Divisional Governance and Ris k meeting.	02.10.19	M. McKenna
4.0	All Added 5.4.2 & 5.4.3	**1. Reviewed expiry date &Introduction.** **3. Definitions** – added concern **4. Duties** – amended Chief Executive and added Deputy CEO, Director of Nursing & Governance and Deputy Director of Nursin g & Governance & Medical Director. **5.19** – reworded and renamed section to R CA, serious incidents and claims – update d in line with policies **5.3Publicity -** re-worded Included NHS Counter Fraud Media – Head of Communications to be inf ormed **5.1 Confidentiality –** added two paras and clarity re: NOK **5.6Grading of complaints –** added clarity for risks of litigation. **5.8.4** New section adding clarity for what responses should contain 5.17.3 New para added in relation to NOK 9.0 References updated 9.1 Supporting Policies updated. Appendix 1 - new flow chart added Appendix 2 - new Complaints Meeting Procedure	10.7.20	L Gurrell

		Appendix 3 - added to in sections 5 & 7 Appendix 4 - monitoring reviewed Appendix 5 - EIA – reviewed Appendix 6 - added to Appendix 7 - additions included Appendix 8 - new languages/format added		

Appendix 9 - Translation

If you require this leaflet in any other language or format, please contact the Patient Experience Team on 0151 556 3091 or 3093, or email patientexperienceteam@thewaltoncentre.nhs.uk stating the leaflet name, code and format you require.

Arabic	اذا كنت بحاجة إلى هذه النشرة بأي لغة أو تنسيق آخر، فيرجى الاتصال بفريق متابعة تجارب المرضى على الرقم 0151 556 3091 أو 3093، أو إرسال بريد إلكتروني إلى patientexperienceteam@thewaltoncentre.nhs.uk موضحاً اسم النشرة، والرمز، والشكل الذي تطلبه.
Chinese	如果你想索取本传单的任何其他语言或格式版本，请致电0151 556 3091或3093联络「病人经历组」，或发电邮至patientexperienceteam@thewaltoncentre.nhs.uk，说明所需要的传单名称、代码和格式。
Farsi	۰۱۵۱۵۵۶۳۰۹۱ شماره با یمارب تجربه یمت با لطفا,یگری‌د زبان یا هرفرم به بروشور ین‌ا به یازد صورت در یردبگ یرتماسز یمیلا با یا ۳۰۹۳یا patientexperienceteam@thewaltoncentre.nhs.uk خود نیاز مورد قالب و کد ، بروشور نام ذکر با
French	Si vous avez besoin de ce dépliant dans une autre langue ou un autre format, veuillez contacter Patient Experience Team (équipe de l'expérience des patients) au 0151 556 3091 ou 3093, ou envoyez un e-mail à patientexperienceteam@thewaltoncentre.nhs.uk en indiquant le nom du dépliant, le code et le format que vous désirez.
Polish	Jeśli niniejsza ulotka potrzebna jest w innym języku lub formacie, należy skontaktować się z zespołem ds. opieki nad pacjentem (Patient Experience Team) pod numerem telefonu 0151 556 3091 lub 3093, lub wysłać wiadomość e-mail na adres patientexperienceteam@thewaltoncentre.nhs.uk, podając nazwę ulotki, jej kod i wymagany format.
Punjabi	ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਕਿਤਾਬਚਾ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫ਼ਾਰਮੈਟ ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਪੇਸ਼ੈਂਟ ਐਕਸਪੀਰਿਅੰਸ ਟੀਮ ਨਾਲ 0151 556 3091 ਜਾਂ 3093 'ਤੇ ਸੰਪਰਕ ਕਰੋ, ਜਾਂ patientexperienceteam@thewaltoncentre.nhs.uk 'ਤੇ ਈਮੇਲ ਕਰੋ ਅਤੇ ਪਰਚੇ ਦਾ ਨਾਮ, ਕੋਡ ਅਤੇ ਆਪਣਾ ਲੋੜੀਂਦਾ ਫਾਰਮੈਟ ਦੱਸੋ।
Somali	Haddii aad u baahan tahay buug-yarahan oo luqad kale ku qoran ama isaga oo qaab kale ah, fadlan Kooxda Waayo-arragnimada Bukaanka kala soo xiriir 0151 556 3091 ama 3093, ama email-ka patientexperienceteam@thewaltoncentre.nhs.uk oo sheeg magaca iyo summadda buug-yaraha iyo qaabka aad u rabtid.
Urdu	اگر آپ کو یہ کتابچہ کسی دیگر زبان یا شکل میں درکار ہو تو، براہ کرم پیشنٹ ایکسپیرینس ٹیم سے 0151 556 3091 یا 3093 پر رابطہ کریں، یا کتابچے کا نام، کوڈ اور اپنی مطلوبہ شکل کا ذکر کرتے ہوئے patientexperienceteam@thewaltoncentre.nhs.uk پر ای میل کریں۔
Welsh	Pe byddech angen y daflen hon mewn unrhyw iaith neu fformat arall, byddwch cystal â chysylltu gyda'r Tîm Profiadau Cleifion ar 0151 556 3091 neu 3093, neu ebostiwch patientexperienceteam@thewaltoncentre.nhs.uk gan nodi enw'r daflen, y cod a'r fformat sydd ei angen arnoch.