Patient safety incident response policy

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Authoriser	Trust Board	
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1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Leeds Teaching Hospitals NHS Trust approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Leeds Teaching Hospitals Trust sites:

- Leeds General Infirmary
- St James's University Hospital
- Seacroft Hospital
- Wharfedale Hospital
- Chapel Allerton Hospital

- Leeds Children's Hospital
- Leeds Dental Institute
- Or as a direct consequence of actions of LTHT employees whilst on duty in other locations

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Response types that are outside the scope of this policy include:

- Complaints
- Human Resources (HR) investigations
- Professional standards investigations
- Coronial inquests
- Criminal investigations
- Claims management
- Financial investigations and audits
- Safeguarding concerns
- Information governance concerns
- Estates and facilities issues which do not impact on patient safety

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. Our patient safety culture

We are committed to promoting an environment that fosters positive safety and just culture, of which PSIRF forms a key component. A key priority within the Trust 7 commitments for 2023/24 was to support a culture of research and innovation. This priority is very much aligned to the patient safety culture sought to deliver the PSIRF.

With regards to culture and delivery of the PSIRF, evidence of a patient safety culture will be provided through a low threshold for reporting incidents and escalating concerns allowing the greatest range of learning opportunities.

Alongside the opportunities to learn from incidents, the Trust is committed to learning from excellence. This will be enhanced through the implementation of Learn from Patient Safety Events Service (LFPSE) and the introduction of reporting Good Care via the Trust incident management system. Although this will require time to embed it will provide a different source of data to enable the Trust to reflect on opportunities to learn, improve and share excellence.

4. Patient safety partners

The NHS Patient Safety Strategy (2021) recognises the importance of involving patients, families, carers, advocates, and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety.

The Involving Patients in Patient Safety framework sets out how NHS organisations should involve patients in patient safety. The framework is split into two parts:

- Involving patients in their own safety
- Patient Safety Partner (PSP) involvement in organisational safety

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across healthcare in England. It is a vital part of the new PSIRF that aims to allows members of the general public to advocate for the local population to influence and improve safety across our services. PSPs can be patients, carers, family members or other lay people, including NHS and Social Care staff from other organisations.

PSPs each bring their own unique perspective and insight on patient safety as users of services across different parts of the NHS. They may also have experience of harm as a result of a patient safety incident or healthcare related incidents and can therefore help inform the development of safety solutions that cross organisational boundaries. PSPs are also pivotal in the development and continuous improvement of our policies and procedures relating to the involvement of patients, families, carers, and advocates who have been involved in patient safety incidents.

At LTHT our Patient Safety award winning Partner Programme was founded in 2019 to recruit members of the public and include them in our quality and safety workstreams. Initially partners were recruited to work alongside staff on Quality Improvement projects. Since then, it has been identified that partners are key to the Trust delivery of NHSE's Framework for Involving Patients in Patient Safety.

The Trust use the insight of our Patient Safety Partners to:

- inform our PSIRF journey and development of our Patient Safety Incident Response Plan through membership of the PSIRF Programme Board;
- ensure the patient and family perspective is at the heart of our improvement work and providing challenge to our improvement plans;
- support CSU level involving patients in patient safety through membership of CSU Quality Assurance Groups.

5. Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Within our patient safety response, we will directly address if there are any particular factors of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

6. Engaging and involving patients, families and staff following a patient safety incident

Leeds Teaching Hospital Trust recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, carers and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The voices of all those involved in a patient safety incident are an integral part of our PSIRF policy. We have adopted the Patient Safety Incident Investigation Patient and Family Guide and the Investigation Guide developed by National Institute for Health and Care research (NIHR). These are supported through the Trust PSIRF

Programme Board with direct engagement from our Patient Safety Partners. The aim is to provide procedures, guidance and training to support staff in how to discuss patient safety incidents with patients, families, advocates, and staff, as well as identifying any immediate support needs of the Patient and their family and signposting them to available support as required.

PSIRF does not replace the Legal and Professional requirements in accordance with Duty of Candour. Leeds Teaching Hospitals NHS Trust will continue to apply the Care Quality Commission Regulation 20 for notifiable patient safety incidents. The Trust advocate and support the provision of truthful information, an apology and reasonable support when harm has been caused as a result of a patient safety incident.

6.1 Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold. There are no further national rules or thresholds to determine what method of response should be used to support learning and improvement for each type of incident.

This change will result in some moderate harm and greater incidents receiving less review than they would previously. Conversely, some low and no harm incidents will receive more review due to the fact they will represent greater opportunity for learning and improvement in systems where the issues are not well understood.

With the implementation of the new PSIRF framework, LTHT are now able to balance effort and resources between learning through responding to incidents or exploring issues and improvement work. Responding proportionately to balance learning and improvement efforts requires a thorough understanding of the local patient safety incident profile and ongoing improvement work.

6.2 Resources and training to support patient safety incident response

We are committed to ensuring there are adequate trained and competent staff to conduct learning responses set out in our plan which meets the standards set out by NHSE in the Patient Safety Incident Response Standards.

In 2024 LTHT will deliver an in-house training programme which will be available to all staff who are undertaking learning responses. This will be delivered in collaboration with organisational learning, medical education, patient safety team and improvement teams.

Staff who are undertaking PSII learning responses will complete the training programme offered by HSIB along with internal support to apply learned theory in practice.

6.3 Our patient safety incident response plan

Our plan sets out how Leeds Teaching Hospital Trust intends to respond to patient safety incidents during 2024-26. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

6.4 Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 18 to 24 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous time period.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken on renew of each to ensure efforts continue to be balanced between learning and improvement. This more in-depth review

will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

7. Responding to patient safety incidents

7.1 Patient safety incident reporting arrangements

The main method for staff to report patient safety incidents is via the Trust electronic incident management system (Datix). This is a central Trust database of incidents, learning and actions that have been implemented as a result of their review. This system allows managers and senior staff members in departments to have oversight of all incidents in their area and enables them to record how they have reviewed and responded to the incident as well as how they have provided feedback to the staff who have raised their concerns. the system also allows senior managers and executives oversight of patient safety incidents and is a vital source of data to identify areas of concern, opportunities for improvement as well as good practice to help inform the Trusts overall safety profile.

Patient Safety Incidents can also be identified via a number of different routes including Learning from Deaths (Medical Examiner (ME) reviews, Structured Judgment Reviews (SJR), complaints, Multi-Disciplinary Team (MDT) discussions, Freedom to Speak Up (FTSU) concerns and audits. Once identified via these alternative routes, the incident is added to the electronic incident reporting system for full and transparent review, investigation, and learning.

The Trust is also required to fulfil a number of requirements to report or notify various organisations or regulatory bodies external to the Trust of specific incidents and adverse events. For further information please see PR080 Incident Reporting Policy.

7.2 Patient safety incident response decision-making

7.2.1 Local reporting of patient safety incidents (PSIs)

The full details of the Patient Safety Incident reporting arrangements are detailed within the Trust Incident Reporting Procedure (PR080). The procedure provides a structure for reporting incidents at Leeds Teaching Hospitals NHS Trust, including external notification requirements.

All staff (including bank, agency, locum and volunteers) has the responsibility to report all patient safety incidents and near misses via the Trust electronic incident management system, Datix.

A record of the patient safety incident or near miss should be contemporaneously and objectively recorded in the patient's clinical records.

All incidents reported as causing moderate, severe, catastrophic harm will be discussed at the Trust weekly risk management meeting to ensure Trust oversight.

Incidents requiring consideration as a potential patient safety incident investigation (PSII) will be reviewed and discussed at the Trust weekly quality meeting. Incidents which meet the criteria for a PSII will be reported onto the Strategic Executive Information System (StEIS) or Learning from patient Safety Events (LFPSE) on its implementation.

7.2.2 National reporting of patient safety incidents (PSIs)

The Trust undertakes its external reporting and notification requirements in line with Patient Safety Incident Response Framework (PSIRF - 2020). Some of the key national reporting activities are:

- The Trust currently reports patient safety incidents to the national reporting and learning system (NRLS) through weekly data uploads. Following implementation of the Learning From Patient Safety Events (LFPSE) process, this reporting will become automatic and NRLS will be phased out.

- Patient Safety Incidents which meet national or local priorities for conducting a PSII will be reported on StEIS, until a date has been agreed nationally to cease the use of StEIS.
- Management, oversight and monitoring of individual PSII's will be the responsibility of the Trust Board.
- Reporting PSIs and PSIIs to the new 'Learning From Patent Safety Events' (LFPSE) system will follow when this replaces the NRLS and further guidance is issued.
- Statutory Care Quality Commission notification requirements will be met by reporting incidents to the national reporting and learning system (NRLS) and its successor system. One notable exception is the death of a patient detained under the Mental Health Act which, in line with national guidance, will be reported directly to the CQC.
- The Trust will notify the Integrate Care Board of patient safety incidents requiring patient safety Incident Investigation and performance against the Patient Safety Incident Response Plan.

7.3 Responding to cross-system incidents/issues

The Trust work with both local and national partners, as a provider of specialised care. The Trust have well established networks to discuss and review incidents, issues and examine learning opportunities.

The Trust are also a member of the West Yorkshire Association of Acute Trusts (WYATT) shared learning group which shares findings and learning from incidents and provides an opportunity for Trusts to consider the potential for the incident to occur within their Trust.

The Trust are part of the Leeds place Patient Safety Specialist network and share findings and learning from investigations.

The Trust will work with the Integrate Care Board (ICB) who will support the co-ordination of cross-system response. The Trust will engage with the ICB and seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system.

7.4 Timeframes for learning responses

Under the new PSIRF framework there are no national target timeframes for completion of PSIIs or other learning responses. Instead, realistic, achievable timescales should be discussed and agreed by all those involved in the incident and its review, including the patient, their families, carers, and advocates where appropriate. These discussions should consider the complexity of the incident being reviewed, if it is an individual incident being reviewed or a cluster of similar incidents, the availability of those that need to be involved, and the current workload of the team that will be completing the review.

In some circumstances, particularly where demand for incident investigations and learning responses exceeds the Patient Safety Teams capacity, it may be appropriate to pause some PSIIs that are being completed for reasons other than those associated with national priorities. These incidents can then be restarted when capacity allows, but this approach and the delayed timescales must be discussed and agreed with all those involved in the incident and its review.

7.5 Safety action development and monitoring improvement

Learning from incident responses informs actions to make to make safety improvements where gaps have been identified. Whilst these relate specifically to the patient safety event being reviewed and the departments involved in the patient safety event, there is often scope for wider learning throughout the trust, including other Clinical Service Units (CSUs) and departments.

Formal actions identified in patient safety learning reviews and patient safety incident investigations are agreed with the investigators, the risk management team and the CSU leadership team. Actions are then agreed and signed off at the Quality and Safety Assurance Group (QSAG). These actions are then recorded on the trusts risk management system, Datix. These actions are assigned to an owner and are monitored and audited for completion and compliance by the CSU through their regular governance processes.

Learning from patient safety events is shared across relevant committees and forums, however it is recognised that it can be hard to consistently reach colleagues who would be implementing the learning.

A Learning from incidents group works together to identify learning that can be applied to a wider audience, and this is shared through a learning from incidents bulletin that is available electronically on the trust intranet and in a printed format.

Through the West Yorkshire Association of Acute Trusts (WYAAT), learning from incidents is shared with neighbouring NHS trusts to support wider learning and reduce potential harm across the region.

The Trust are working towards aligning learning from incidents with the Quality Improvement team to incorporate learning into wider improvement strategies and to ensure learning is embedded and regularly reviewed. Current processes for sharing learning are documented in appendix 1.

7.6 Safety improvement plans

The Leeds Improvement Method is an integral part of the way we do business across the Trust, constantly evaluating our work processes and making changes to improve services for patients and the working environment for staff. The strategic triangle below shows how our vision, values and goals link together to enable us to provide the best possible care for our patients. All of this is underpinned by the Leeds Improvement Method, spreading a consistent approach to continuous improvement.

Our processes for improvement are described in our Quality Improvement Strategy and Clinical Quality Strategy. The recommendations from our Patient Safety Incident Investigations and Patient Safety Reviews will flow through these processes linking them in directly to the Trusts Quality Improvement work.

At the conclusion of a PSII an improvement is developed in collaboration with existing Trust quality improvement frameworks including the Quality Improvement Steering Group, Kaisen Promotion Office (Trust improvement methodology team) and the Quality Improvement Collaboratives. The Trust-wide Lessons Learned Group will also be informed to facilitate cascade of relevant information across the organisation through various mediums including the lessons learned bulletin, quality and safety matters bulletins and video.

Improvement plans will be shared with the relevant Quality Improvement Collaborative to enable delivery of actions, monitoring and evaluation of improvement outcomes. The Quality Improvement Collaboratives provide update reports on progress to the Quality Improvement Steering Group.

The Quality Improvement Steering Group will have oversight and undertake monitoring of all improvement plans created following a PSII. The Quality Improvement Steering Group reports to the Trust Quality, Safety and Assurance Group. The group promote a positive culture of continuous learning and improvement using Leeds Improvement Methodology to facilitate Trust-wide learning and improvement.

Monitoring through the use of audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired

outcomes. When changes have led to measurable improvements then these will be shared and implemented with other areas of the organisation and peer organisations.

Current Improvement Collaboratives:

- Care of Patients with Sepsis
- Deteriorating Patients
- Reduction in the Incidence of Falls
- Reduction in the Number of Pressure Ulcers
- Reduction in Harm - Maternity Care
- Reducing HCAI
- De-escalation
- Positive Patient Identification

8. Oversight roles and responsibilities

LTHT has clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents

All Staff

All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff are required to be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the Risk Management pages of the Trust intranet.

Incident Reviewers

Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required as noted within the Patient Safety Incident Response Plan. The reviewer(s) must have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training courses.

Being Open Leads

- Responsible for ensuring the organisation's legal duty of candour is discharged for appropriate incidents.
- Identify those affected by patient safety incidents and their support needs by being the single point of contact.
- Provide them with timely and accessible information and advice.
- Facilitate their access to relevant support services.
- Obtain information from review/PSR teams to help set expectations.
- Work with the patient safety team and other services to prepare and inform the development of different support services.

CSU Clinical Directors

Clinical Directors have a responsibility to:

- Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information.
- Ensure that incidents are reported and managed in line with internal and external requirements.
- Ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in reviews/PSIIs as required.
- Work with the patient safety team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).

Patient Safety Partners

As part of our commitment to working with members of the public we have a partner programme in place. This is where members of the public join our Quality and Safety

Improvement work. Those who Partner with us have expectations as part of their contribution to the PSIRF:

Partners will undertake the training required to the national standard for their role as specified in the National Patient Safety Syllabus as well as other relevant training. They will participate in investigation oversight groups and be active members of the PSRIF Programme Board, Quality Improvement Steering Group, QI Collaboratives and other work streams with the aim of helping us design safer systems of care and prioritise risk.

- Encourage Patients, Families and Carers to play an active role in their safety.
- Contribute to action plans following investigation, particularly around actions that address the needs of patients.
- Contribute to staff patient safety training

The organisation commits to protecting our partners from emotional harm which may arise from their work with us therefore, they are able to access the support through the Trust Health and Wellbeing Services.

Risk Management Department

- The senior Risk Management and Quality Team will meet on a weekly basis to review reported incidents and ensure that PSIIs are undertaken for all incidents that require this level of response (as directed by the organisation's PSIRP).
- Develop and maintain the local risk management systems and relevant incident reporting systems (including StEIS and its replacement once introduced) to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Lead the development and review of the organisation's PSIRP.
- Ensures the organisation has procedures that support the management of patient safety incidents in line with the organisation's PSIRP (including convening review and PSII teams as required and appointing trained named contacts to support those affected).
- Establishes procedures to monitor/review PSII progress and the delivery of improvements.

- Works with the executive lead to address identified weaknesses/areas for improvement in the organisation's response to patient safety incidents, including gaps in resource including skills/training.
- Supports and advises staff involved in the patient safety incident response.
- Ensure staff members involved in the management of patient safety incidents have access to the requisite knowledge, skills and tools to undertake patient safety reviews to the required national standards.

Patient safety incident investigators

- Patient safety incident investigators will have been trained over a minimum of two days in systems-based investigation methodology, tools and techniques.
- Ensure that PSIIs are undertaken in-line with the national PSII standards.
- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.
- Provide liaison with patients and families subject to a patient safety incident investigation

Clinicians/Specialist Advisors

Staff responsible for reviewing and incident may need to involve specialist advisors to assist in their review (e.g. Safeguarding, Health and Safety, Medical Physics, Pharmacy, Radiation Protection Advisor, Clinicians with experience in a particular medical or surgical technique). The Lead Investigator is responsible for determining when specialist advice is required and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, review of recommendations.

Medical Examiner

The medical examiner's key role is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths.

- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

Whilst medical examiners are NHS employees, they have separate professional accountability and their independence, which is vital to the scrutiny they provide, is overseen by the national medical examiner.

Medical examiners scrutinise all deaths to:

- agree the proposed medical cause of death and ensure the overall accuracy of the medical certification of the cause of death
- identify problems in treatment or care and, as necessary, report to the trust's clinical governance process
- discuss the cause of death with the bereaved and listen to any concerns
- ensure the referral of deaths to the coroner as required by the law; this includes deaths where there are concerns that failure in care contributed to death or where the bereaved raise significant concerns about the care provided to their relative
- liaise with, and assist, the coroner with medical information
- educate and provide advice to other clinicians about death registration and the coronial process

Quality & Safety Assurance Group (QSAG)

The Quality and Safety Assurance Group (QSAG) has responsibility for reviewing the incident management function. QSAG reports to the Quality Assurance Committee and provides assurance on reports/evidence received. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of QSAG will seek assurances from CSUs that risks are being adequately addressed. Where there are remaining concerns these will be escalated to the Quality Assurance Committee.

Quality Assurance Committee (QAC)

The Quality Assurance Committee has responsibility for reviewing completed reports and system improvement plans for effectiveness. The Committee will receive a report at each meeting of the organisation's progress against this PSIRP.

Chief Medical Officer - Executive lead for supporting and overseeing implementation of the PSIRF

The Chief Medical Officer has delegated responsibility for Risk Management and has the organisational lead for ensuring that there are adequate arrangements in place for patient safety incident investigations and reviews and for monitoring, reviewing and updating these arrangements. In addition, that there is adequate assurance to demonstrate learning is being shared and changes to practice as a result of patient safety incident investigations and reviews are implemented across the Trust.

Chief Executive

The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974). As part of this role the Chief Executive has overall responsibility for ensuring there are effective risk management systems and processes in the Trust to enable the organisation to meet its statutory obligations relating to the health and safety of patients, staff and visitors. The Chief Executive is ultimately responsible for ensuring that all investigations are dealt with effectively and appropriately.

Trust Board

The Trust Board has a responsibility to ensure that it receives assurance that this plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. This will be achieved through reporting processes as well as receiving assurance via the Quality Assurance Committee and the Audit Committee. The Trust Board receives a bi-monthly report on patient safety incident investigations within the Trust and monitors the lessons learned from these. Where concerns are identified relating to the robustness of lessons learned or actions planned the Trust Board will seek assurances that these concerns are being acted upon.

9. Complaints and appeals

Local and national arrangements for complaints and appeals relating to the organisation's response to patient safety incidents are available via: Leeds Teaching Hospitals Patient Liaison and Advice Service.

The Trust fully upholds the NHS Constitution, aspiring to put the patient at the heart of everything it does. Any concerns or complaints raised about a services provided by Leeds Teaching Hospitals will be taken seriously and will be managed in a way that reflects the Leeds Way Values (patient-centred, fair, collaborative, accountable and empowering).

Leeds Teaching Hospitals NHS Trust encourages service users to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff. The Trust's complaints policy focuses specifically on those concerns or complaints that require management through the Patient Advice and Liaison Service (PALS) and the Complaints Team.

The Trust's Complaint Policy (PC086) sets out the principles and processes involved when any person wishes to raise a concern or complaint. This includes the need for the Trust to provide an apology and an opportunity for learning when complaints are responded to, where this is relevant.

If you wish to raise a concern or complaint, please contact the PALS team for advice in one of the following ways:

- telephone: 0113 2066261
- textphone: 07468753025 (if you are D/deaf or speech impaired)
- email: patientexperience.leedsth@nhs.net
- download a complaint form from our website

The PALS team will support you to decide how the issues you are raising will be managed