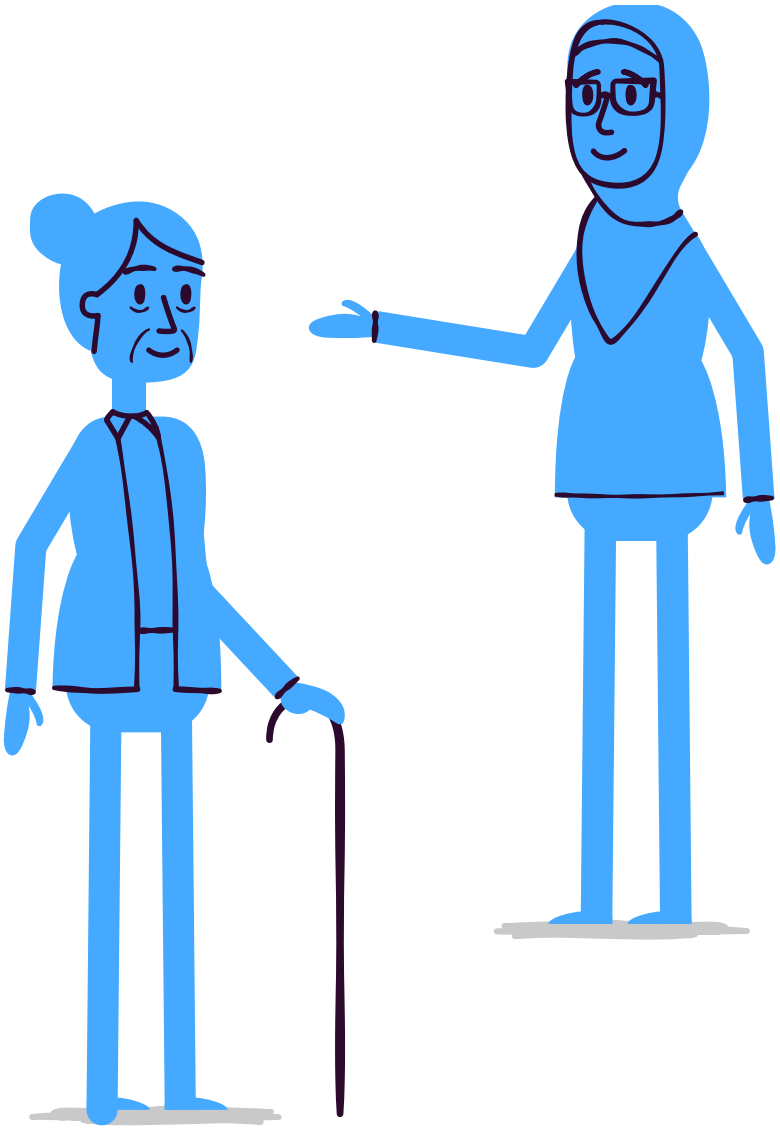
Carrying out the investigation



Complaint Standards NHS

Parliamentary and Health Service Ombudsman

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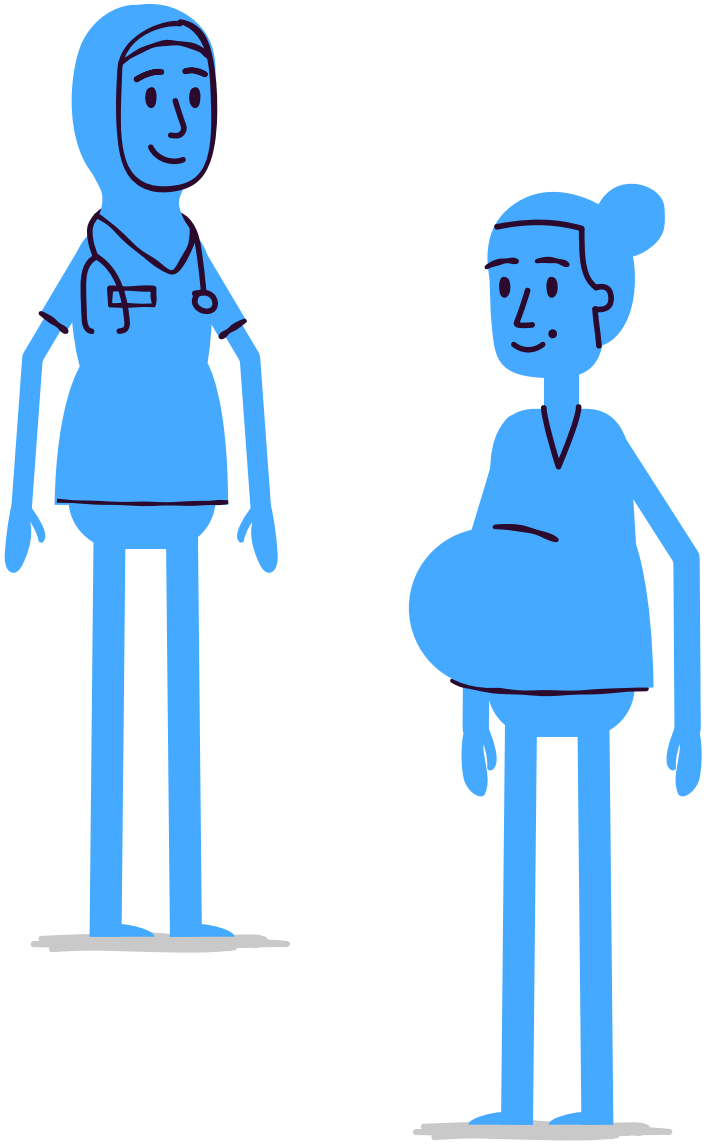

Welcome to this guide

This guide is one of the Good Complaint Handling series. These are designed to help you meet the expectations in the NHS Complaint Standards.

The guide explains what you need to do when you carry out an investigation, including:

- clarifying the complaint
- planning your investigation
- calculating timescales for responding to complaints
- identifying and gathering evidence
- reaching a conclusion
- issuing a final response letter.

Read this guide alongside the Model complaint handling procedure. You can find guides on related topics on our website.

What standards and regulations are relevant to this guide?

The Complaints Standards set out expectations to help you deliver good complaint handling in your organisation.

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 set out what the law says you must do.

What the Complaint Standards say

Being thorough and fair

- Organisations make sure all staff have the appropriate level of training, skills and authority to look into complaints thoroughly.
- Organisations make sure all staff who look at complaints have the appropriate resources, support and protected time to consistently meet these expectations.
- Staff discuss timescales with everyone involved in the complaint and agree on how people will be kept informed throughout. They provide regular updates, as agreed with the parties, throughout.
- Staff look for ways they can resolve complaints at the earliest opportunity.
- Staff make sure everyone involved in a complaint (including those specifically complained about) knows how they will look into the issues. This includes what information complaints staff will need, who they will speak to, who will be responsible for providing the final response and how they will communicate their findings.
- Staff give everyone involved in a complaint the opportunity to give their views and respond to emerging information where appropriate. They take everyone's comments into account and act openly and transparently and with empathy when discussing this information.
- When a complaint does not suit early resolution and needs more detailed consideration and investigation, this is done fairly. Where possible, staff who have not been involved in the issues complained about should look at the complaint. If this is not possible, the person looking into the complaint should openly demonstrate they are acting fairly when they consider all the issues.

Giving fair and accountable responses

- Staff give a clear, balanced account of what happened based on established facts. Each account compares what happened with what should have happened. It clearly references any relevant legislation standards, policies or guidance, based on objective criteria.
- In more complex cases, staff make sure they share their initial views on a complaint with everybody involved and give people the opportunity to respond. Staff take any comments into account in their final response to the complaint.
- Organisations support and encourage staff to be open and honest when things have gone wrong or where improvements can be made. Staff recognise the need to be accountable for their actions and to identify what learning can be taken from a complaint. They are clear about how the learning will be used to improve services and support staff.
- Wherever possible, staff explain why things went wrong and identify suitable ways to put things right for people. Staff give meaningful and sincere apologies and explanations that openly reflect the impact on the individual or individuals concerned.

What the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Regulation 13, paragraph (7) says

At the time it acknowledges the complaint, the responsible body must offer to discuss with the complainant, at a time to be agreed with the complainant—

a. the manner in which the complaint is to be handled; and

b. the period ('the response period') within which—

(i) the investigation of the complaint is likely to be completed; and

(ii) the response required by regulation 14(2) is likely to be sent to the complainant.

(8) If the complainant does not accept the offer of a discussion under paragraph

(7), the responsible body must—

i. determine the response period specified in paragraph (7)(b) and

ii. notify the complainant in writing of that period.'

Regulation 14(1) states that: 'A responsible body to which a complaint is made must—

a. investigate the complaint in a manner appropriate to resolve it speedily and efficiently; and

b. during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation.'

With reference to the time period for investigation, regulation 14 paragraph (3) says here is a "relevant period" for handling a complaint.

This means: 'the period of 6 months commencing on the day on which the complaint was received, or such longer period as may be agreed before the expiry of that period by the complainant and the responsible body.

(4) If the responsible body does not send the complainant a response in accordance with paragraph (2) with the relevant period, the responsible body must—

a. notify the complainant in writing accordingly and explain the reason why; and

b. send the complainant in writing a response in accordance with paragraph (2) as soon as reasonably practicable after the relevant period.'

What you need to do

‘The important principle is ‘investigate once, investigate well’.

Your aim is to carry out one investigation that deals with the concerns raised thoroughly. The alternative is running multiple investigations, one after the other. This can result in long, open-ended, investigations and correspondence, taking up too much time and resources.

Tip

Make sure you always record:

- each complaint received
- the subject of the complaint
- the outcome
- whether your final written response was sent to the person who made the complaint within the timescale agreed at the start of the investigation (see 'Manage timescales for your response' on page 11).

Clarify the complaint

The first step is to take the time to fully understand:

- the complaint
- what you are investigating
- the outcome the person making the complaint is looking for.

If you don’t invest this time at the start, problems can start right from the beginning. If you invest time at the start, you can avoid problems arising later on.

Find out more: See our guide on this very important step: A closer look – clarifying the complaint.

Plan your investigation

Having an investigation plan will help you stay focused and make sure you do not miss anything crucial. It will help you keep track of progress and stay on top of timescales so you can adjust schedules and update everyone involved.

Tips for making a good plan:

Focus on the matters you are investigating.

Use resources effectively and proportionately.

Work cost effectively, while still meeting customer service and legal requirements.

Discuss your plan with colleagues and seek the views of others involved in investigating the complaint, to make your plan is robust.

For straightforward, single-issue investigations, you can make your plan quickly.

For an incident that involves serious failings or numerous issues, invest more detailed planning, in discussion with colleagues who will help with your investigation.

Share the outline of your investigation plan with:

- the person making the complaint
- their advocate (if they have one)
- any member(s) of staff complained about.

Ask them if they think you have missed anything and consider their comments and suggestions before finalising your plan.

Develop a good investigation plan: step-by-step guide

1 **Step 1:**

Make sure the plan includes your agreed communication plan, setting out how and when you will update the parties involved and any reasonable adjustments that are needed.

2 **Step 2:**

Set out the issues to be investigated, which you have agreed with the person making the complaint.

3 **Step 3:**

Set out the outcomes requested by the person making the complaint.

4 **Step 4:**

Include an assessment of risk and consideration of any broader patient safety or public interest concerns (taking account of other individuals who may be affected by the same issues, and any systemic concerns).

5 **Step 5:**

Set out the evidence you will need to obtain and consider in order to address each issue. This will always include:

- evidence to establish what happened
- evidence to establish what should have happened.

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Step 6:

If you are delegating any parts of the investigation to someone else, include:

- details of who that is
- what exactly you are asking them to investigate, and how
- the agreed timescale for completion and submission of their response.

If the complaint involves clinical matters, include details of who will provide you with a view (on behalf of your organisation) on whether the care or service provided was appropriate. This should be someone suitably qualified who has not been directly involved in the person's care.

Include estimated timescales for:

- sharing your findings with the parties involved and asking for their comments
- completing your investigation
- drafting your final response to the complaint
- securing quality assurance and sign off by the responsible person, or their delegate.

Manage timescales for your response

Once you have worked out what will be involved in investigating the complaint, and how long each stage is likely to take, you need to set a realistic timeframe for completion.

Each complaint will have its own timescale, depending on the requirements and complexity of the case. An investigation that involves several Heads of Complaints, departments or organisations will take much longer than a complaint about one single issue. You need to explain this to everyone involved at the start.

If the investigation cannot be concluded and the final response issued within six months (or longer, if that is agreed with the person making the complaint at the start), you must write to the person to:

- explain why there has been a delay
- set out how long it is likely to take to complete the process.

This is in line with the 2009 regulations.

Tip

Make sure this letter is sent by the responsible person or a senior manager. They are then responsible for overseeing the case until the final written response is issued.

If something happens (or you discover something) that means you need to revise your target completion date, inform the person making the complaint, their representative and any staff they have complained about immediately and explain why.

Always focus on providing a response as quickly as possible. The longer it takes to deal with a complaint, the more stressful it can be for everyone involved.

Keep track of the complaint

It is important to track the complaint, so you know where things are at any time.

- When you first receive the complaint, record it on your complaint handling system.
- Keep track of (and record) progress against the plan.
- Take responsibility for monitoring the smooth running of the investigation.
- Provide regular updates as agreed and meet the timescales.
- Explain the reasons for any delay.

Identify and gather evidence

- Once you've established the specific points of the complaint and what outcomes the person is hoping for, use these to focus the scope of your investigation.
- You can delegate the investigation, or any part of it, to any complaints leads in your organisation who have specific knowledge of the service area you are investigating. But you are responsible for overseeing the overall investigation.

Asking the right questions

A good investigation starts with a thorough review of the circumstances complained about. Your aim is to answer these questions:

- What happened?
- What should have happened?
- If there is a gap between these, why was this?
- What can be done to put any failings right?
- What impact the failings had on the person making the complaint?
- How might that impact be put right for the person and others who may be similarly affected?

Base your conclusion on an objective analysis of the evidence and explain this analysis clearly.

To find out what happened, the evidence you gather could include:

- evidence from the person making the complaint to support what they say
- evidence from witnesses to the events
- staff interviews, statements and evidence to support what they say
- information from relevant clinical records
- information from other sources if necessary (for example, CCTV or phone records).

Using the ideas in this list as a starting point, think through what evidence could help you in your investigation. Whenever you share and update your plan (and any updates), talk to everyone involved about what evidence you are looking at and ask if they think anything is missing.

To find out what should have happened, gather evidence such as:

- national policies, standards, procedures and guidance
- local policies, standards, procedures and guidance
- if the complaint involves clinical matters, your organisation's view of whether the care or service provided was appropriate and in keeping with the relevant standards, procedures, policies and guidance. (This should be provided by someone who is suitably qualified and has not been directly involved in the person's care.)

Act fairly during the investigation

Make sure the person who made the complaint, and anyone they have complained about, has the opportunity to:

- say what they believe happened in relation to the complaint
- provide evidence to support what they say
- say whether they agree with any initial findings before you reach a conclusion.

Try not to prejudge the outcome or favour the complainant or anyone they have complained about.

As the person investigating the complaint, you should not have been involved previously in the issues being complained about, as far as possible. If this is not possible, you need to be open about this from the start.

Explain to the person making the complaint that you will:

- investigate fairly
- make sure you provide a balanced account of what happened
- reach conclusions based only on the evidence.

The Francis Report recommends that hospitals (and ideally, other organisations) always use an independent investigator – in other words, someone from outside their organisation – in the following circumstances:

- where a complaint amounts to an allegation of a serious untoward incident
- where questions involving clinically related issues cannot be resolved without expert clinical opinion
- where a complaint raises substantive issues around professional misconduct or the performance of senior managers
- where a complaint raises issues about the nature and extent of the services commissioned.

Tip

Finding an independent investigator can take time to arrange. That's why it is a good idea to put in place agreements with other organisations so you can provide support and independent investigations for each other if the need arises.

Checklist: Keeping people updated

Give anyone who has made a complaint, and anyone who has been complained about, the chance to submit relevant information and evidence.

Keep them informed and updated throughout the process.

Before you issue a final response, give them the opportunity to comment on any initial findings.Consider their comments before you reach a conclusion.

Make sure the person making the complaint, and anyone they complain about, knows how to get help and support during the process if they need it.

Make sure the person making the complaint is aware of your local independent NHS complaints advocacy provider (or any relevant national support organisations).

Make sure anyone complained about is supported through the process and has access to a named contact who can help them, if they need this. This may be their line manager but should not be the person who is responsible for investigating or making decisions about the complaint outcome.

How to reach your conclusion

Your conclusion needs to set out the following information:

What happened (and did something go wrong)?
You can usually determine what happened using the evidence you gather during your investigation.

If there is conflicting evidence or uncertainty about what happened, consider whether something is more likely than not to have happened, based on the balance of probability.

If there is not enough evidence, or the evidence is so equally balanced that you cannot reach a view, explain clearly why this is the case, setting out all the evidence you have considered.

What should have happened?

It is not enough just to explain what happened. You also need to determine what should have happened in the situation.

Then, compare the two, to see whether there is a difference and whether anything went wrong. (You need to base this on evidence, not opinion.)

To determine what should have happened, you will probably be looking at things like:

- legislation, statutory powers and duties
- nationally recognised policy, guidance or standards
- local policies and procedures
- relevant professional standards
- any other recognised standards that were in place at the time of the events being complained about.

Identify whether there was a gap between what happened and what should have happened. This is done by comparing what happened against the standards that relate to the case.

Tip:

In cases involving clinical care, you will probably need to seek a view on the matter from a suitably qualified clinician who has not been directly involved in the care provided. Any advice must be based on relevant standards, policies and procedures. To find out more, go to The Ombudsman's Clinical Standard.

Assess the impact

If your investigation has found that something went wrong, you need to consider how this affected the person complaining.

Assess what impact the event had on the person making the complaint. This will help clarify what you are seeking to put right.

Think about whether the failings you have found could affect other service users, or services that your organisation provides, in the future.

At the beginning of your investigation, you will have discussed the impact with the person who made the complaint, and they will have told you how they feel they have been affected.

Now consider if their view is accurate or whether there are wider issues that they are not aware of.

The impact of something going wrong could include:

- **inconvenience and distress** – possibly caused by:
    - cancellations
    - failures or delays in service provision or decision making
    - failures in communication
    - unreasonably prolonged complaint handling
- **being denied an opportunity** – for example, to make an informed choice because they were not given the full facts or did not have the risks explained to them (such as when consenting to surgery or making decisions about care). This could lead to a lost opportunity for a better outcome, recovery or prognosis, or cause unnecessary or additional surgery or treatment
- **physiological injustice** – for example, minor pain, harm, or permanent or serious injury
- **bereavement** – including avoidable death, a poor standard of care, or poor communication with family when a patient died
- **loss through actual costs incurred** – for example, care fees, private healthcare or loss of benefits
- **other financial loss** – for example, loss of a financial or physical asset (such as loss or damage to possessions), reduction in an asset's value, or loss of financial opportunity.

Tip

Treat this list as a starting point. If you need to, talk further with the person making the complaint (or the person representing them) to make sure you have understood the impact fully.

Consider whether to share your initial views

By this point, you should have identified whether something has gone wrong. If it has, you will have a good idea of what impact it has had. You will now be thinking about what you need to do to put that right.

Before you reach a conclusion, consider giving the person making the complaint, and anyone who has been complained about, a chance to comment on your initial findings. This helps ensure you have acted fairly.

In making this decision, it is important to be proportionate. Tip: When to share initial findings

In more complex cases (such as cases with multiple issues or covering complex clinical matters) or where the claimed (or identified) impact is significant, you should always share your initial views.

For more straightforward cases (for example, complaints covering single issues, or where the impact is minor) it may not be necessary.

Always consider the best approach for each case, in the interests of fairness and transparency. Remember, the reason for doing this is to make sure:

- you have not missed anything
- you consider any final thoughts and comments before you issue a final response.

Tip

If you decide to share your initial views, do it by phone, email or meeting, in line with the person's communication preferences. You may also want to share a draft of your final response letter.

Checklist: How to share your initial views

- Tell the person making the complaint that you are nearing the end of your investigation.
- Explain that before you make a final decision, you would like to share what you have found so far, in case you have misunderstood anything or have missed something.
- Tell them you will be sending them a draft letter and would like to receive any final comments.
- If they ask what you have found, depending on your findings, say either:
  - you have not found that anything went wrong and you hope that your letter will clearly explain what happened
  - you have found that something went wrong, what it was, and apologise.
- When you are deciding how to share your initial views, and before you have the discussion, you should always consider:
  - the sensitivity of the information to be shared
  - the likely impact on the person making the complaint.
- Show empathy and offer apologies for any failings.
- In the most serious cases, arrange to meet face to face with the person who has complained, their family, any representative and relevant members of staff to explain what you have found so far. This is a good opportunity to discuss the issues and identify any unanswered questions before you give your final written response.

Manage the final stages

Once you have shared your initial views, you can move on to the final steps:

- Consider any comments that arise from these discussions.
- Carry out any further investigation needed.
- Conclude your investigation.
- Issue a final response letter, signed and issued by your responsible person or their delegate.

Managing complaints that may lead to disciplinary or professional procedures

The complaints procedure itself is not a disciplinary procedure. But when you are considering or investigating a complaint, you may come across issues that might require remedial or disciplinary procedures for a member of staff. If this happens:

- discuss it with the relevant colleagues, such as your manager or someone in HR
- advise the person making the complaint, in broad terms, that your organisation is taking this action
- seek legal advice about how much information you are allowed to disclose.
- if the person making the complaint has already referred the matter to a health profession regulator, or if they later choose to, make sure this does not affect the way you investigate and respond to their complaint.

Good investigation record keeping

It is important to keep a record of the complaint and all relevant evidence. This will provide a full audit trail of what you have done and how you have reached a conclusion.

You will need this if the complaint is referred to the Ombudsman or a regulator, or if there is a legal claim. Store this record centrally, in a complaint or investigation file (either electronic or hard copy).

Key documents you will need to include

You will need to include:

- a copy of the original complaint or complaint statement
- the investigation plan
- all telephone, meeting and interview notes or recordings, with the date and time and names of everyone present
- any statements from staff
- any statements from witnesses
- copies of any relevant extracts from clinical records
- notes of any updates provided or discussions about the case
- copies of all evidence reviewed in the course of the investigation
- a copy of any advice received, including reference to any relevant standards, policy and guidance
- a statement about any action taken, or to be taken, in response to the complaint or specific resolution reached on the matter, including clear reasons for decisions made
- details of any comments received from the parties on your initial findings and how these have been addressed
- the final written response
- if relevant, any action plans for delivering agreed actions
- if relevant, details of how the person making the complaint will be involved and updated until all necessary actions are completed.

Overlap with other investigations or reviews, such as patient safety investigations

Everyone has a right to make a complaint and to have it investigated and responded to in a full and timely manner. This is true regardless of what other reviews or investigations are taking place into an incident or death.

As you consider a complaint, you may find that another process is needed, such as a patient safety investigation. In these cases, it is good practice to discuss the matter with relevant colleagues and agree on how best to work together.

If the issues you are considering overlap with issues already being investigated or reviewed elsewhere, ask the person who has made the complaint what concerns and questions they want to be answered.

If possible, work with colleagues to incorporate these into their investigation or review, to provide a comprehensive response that meets the needs of both processes.

Either way, the person making the complaint needs a single point of contact who can keep them updated and informed about both processes. Always provide them with details of independent NHS complaints advocacy services to support them through the process.

Consider financial or other redress and legal claims

The complaints process is not designed to determine legal liability, negligence or breach of statutory duty, or to provide compensation that might be awarded by a court. But if you identify a serious failing or impact, you need to consider whether the person has a potential legal claim.

As part of the complaints procedure, you can make a payment that acknowledges pain, distress and inconvenience when resolving a complaint.

Even if you identify a potential legal claim during the course of your investigation, you should still be able to offer a financial remedy as part of your response to the complaint without the need for legal action.

In these cases, discuss the issue with your legal team or defence organisation and NHS Resolution.

If the person making the complaint says they are seeking compensation or would like to make a legal claim for compensation, signpost them to independent advice from an organisation such as the charity Action against Medical Accidents (AvMA) or from solicitors who specialise in the relevant field.

Find out more See the Joint NHS Resolution/PHSO guidance on resolving NHS complaints and claims.

If you would like this document in a different format, such as Daisy or large print, please contact us.

Let's make complaints count!