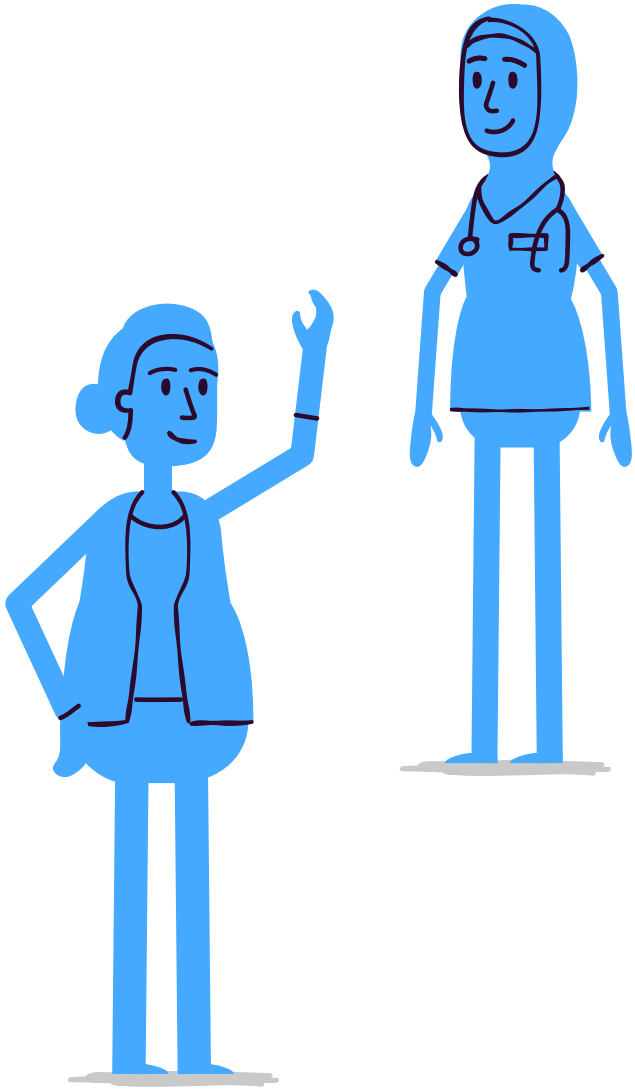
A closer look: providing a remedy



Complaint Standards NHS

Parliamentary and Health Service Ombudsman

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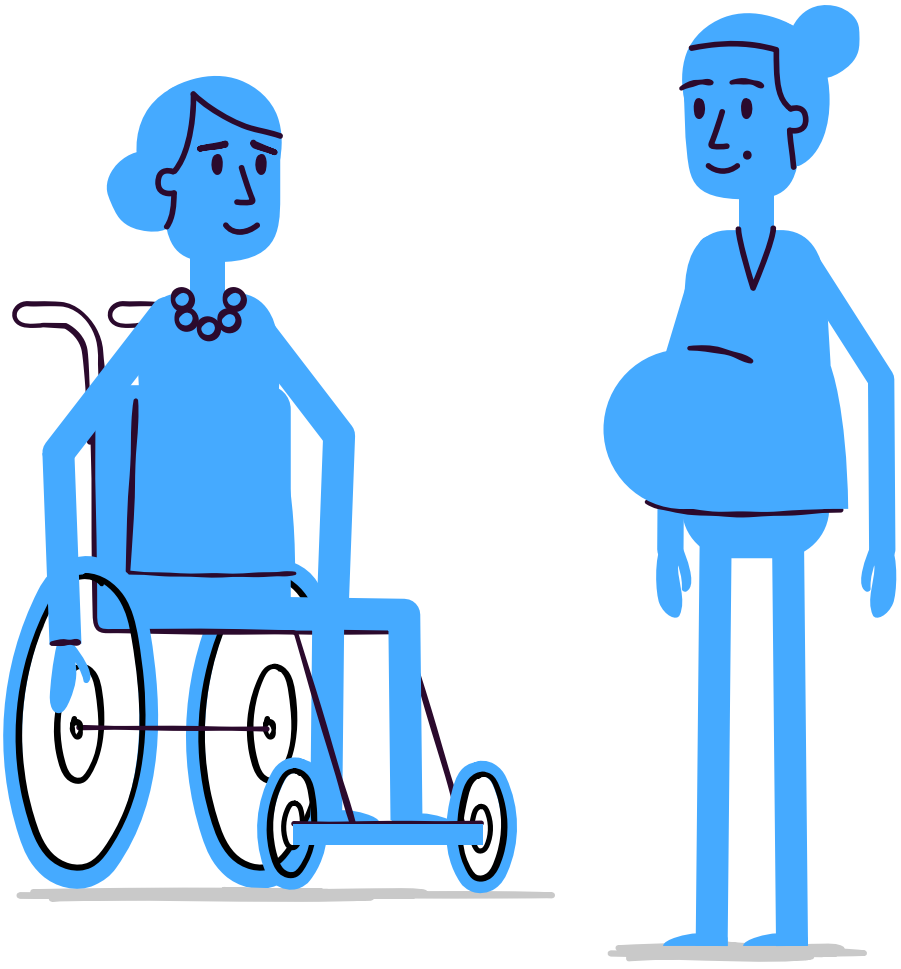

Welcome to this guide

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 how to identify and provide an appropriate remedy when something has gone wrong. It will also help you make consistent decisions. It explains how to:

- establish the impact of any failings you have found
- provide an appropriate remedy to put things right
- make a meaningful apology.

Read this module 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

Welcoming complaints in a positive way

- Organisations make sure staff can identify when issues raised in a complaint should be addressed (or are being addressed) via another route at the earliest opportunity, so a co-ordinated approach can be taken. Other possible routes include inquest processes, a local disciplinary process, legal claims or referrals to regulators. Staff know when and how to seek guidance and support from colleagues on such matters so they can give people information on the relevant process and explain where they can get support.

Giving fair and accountable responses

- 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 people concerned.
- Organisations empower staff to identify suitable and appropriate ways to put things right for people who raise a complaint. They provide guidance and resources to make sure any proposed action to put things right is consistent.

What the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 says

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (Section 14) say:

As soon as reasonably practicable after completing the investigation, the responsible body must send the complainant in writing a response, signed by the responsible person, which includes—

a. a report which includes the following matters -

   (i) an explanation of how the complaint has been considered; and

   (ii) the conclusions reached in relation to the complaint, including any matters for which the complaint specifies, or the responsible body considers, that remedial action is needed; and

b. (b) confirmation as to whether the responsible body is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken.

What to do

At the start of an investigation, it is essential to understand the impact of events and the outcome the person is looking for. When you think through how best to put things right, you need to bear this in mind – treating each person fairly and as an individual.

Understand what people want

When you ask people what they want to achieve by raising a complaint, most say:

- they want an apology
- they want things put right
- they want to understand what happened
- they want to make sure what happened to them (or a loved one) does not happen to anyone else.

A meaningful apology and explanation are more likely to resolve a complaint early than any other action you might take. An open and honest apology may be the only practical way of restoring trust and repairing a broken relationship.

A remedy is any action that puts things right for the person who has complained. But you also need to gather and share wider learning for your organisation, to help improve services for everyone.

Find out more

See the guidance A closer look - clarifying the complaint.

Understanding the impact of any failings

When you discover that something has gone wrong, you need to find out what impact that failing has had on:

- the person who made the complaint
- other service users or services your organisation provides – now or in the future.

This will help you understand what you need to put right with your remedy.

Tip: You will already have spoken to the person who has raised the complaint about the impact on them. But remember, you can ask for more detail at any point of the investigation, if you need to. This is especially important if the failings you have found are slightly different to those they first complained about.

You should also consider the:

- impact from the failing itself
- impact of making the complaint.
- **Impact from the failing itself** Look at the failings and ask yourself what would have been different if they had not taken place. For example:


Did a delay in diagnosis affect the prognosis in some way?


Did an error in the decision-making process have a negative impact on the person's treatment?


Did a medication error or a cancelled procedure, cause the person to suffer in any way?


Did a failure to explain what was happening cause unnecessary anxiety and frustration?

- **Impact from making the complaint** Now, think about the impact on the person of having to take the time and trouble to complain.


Were there any errors or unreasonable delays in your response to the complaint?


If so, did these worsen the person's distress or frustration?


Again, if so, take this impact into account too, when you decide on a remedy.

As you think about the impact, use the prompts in the box below to make sure you capture all the detail.

Checklist: Identifying impact

Inconvenience and distress could be 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, being denied the chance to make an informed choice because of not being given the full facts, or not having the risks explained (for example, when consenting to surgery or making decisions about care).

This could result in a lost opportunity for a better outcome, recovery or prognosis, or it could cause unnecessary or extra surgery or treatment.

Physiological injustice may include minor pain, permanent or serious injury, or harm.

Bereavement could include avoidable death. It could also be a poor standard of care, or poor communication with family, when a patient died.

Loss through actual costs incurred might include care fees, private healthcare or loss of benefits.

Other financial loss includes loss of a financial or physical asset (such as loss of, or damage to, possessions), reduction in an asset's value, or loss of financial opportunity.

Financial remedy and possible legal claims

If the issue you are investigating could reveal a serious failing or impact, think about whether the person might have a potential legal claim.

The complaints process is not a court of law. It cannot decide:

- who is legally liable for something
- whether an action is negligent
- whether someone has broken the law.

Nor is it responsible for providing compensation that might be awarded by a court.

But when you are resolving a complaint, you can make a payment that acknowledges pain, distress and inconvenience as part of the complaints procedure. Even if you uncover a possible legal claim during your investigation, your organisation should still give approval for you to offer a financial remedy. This would form part of your response to the complaint and would not need legal action.

In a case like this, discuss the matter with your legal team or defence organisation and NHS Resolution.

Refer to the joint NHS Resolution/PHSO guidance on resolving NHS complaints and claims.

If the person making the complaint says they are seeking compensation, or would like to, signpost them to, independent advice from organisations such as the charity Action against Medical Accidents (AvMA) or from solicitors specialising in the relevant field.

Putting things right: the remedy

If the failings you have found have had an impact of any kind, your first step is to provide a meaningful apology (see below) and then, where possible, put things right for the person(s) directly affected.

Aim for the remedy to return anyone affected to the position they would have been in, had the failing not happened. If this is not possible, provide a remedy that compensates them appropriately.

Where appropriate, you also need to offer remedies to others who have suffered an impact as a result of the same failing or poor service.

What counts as a remedy?

Remedies may include:

- a meaningful apology, explanation, and acceptance of responsibility
- remedial action including any combination of things like:
    - correcting an error
    - reviewing or changing a decision
    - reviewing or changing the service someone receives
    - speeding up an action
    - waiving or reimbursing a fee or penalty
    - issuing a payment or refund
    - revising published material
    - revising policies and procedures to stop the same thing happening again
    - training or supervising staff
- financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, distress, or any combination of these.

The remedy you offer must take into account the outcomes you discussed at the start of the complaint. Usually, the person who has made the complaint will want an individual remedy to put things right and to recognise the impact of the failing on them. This could include:

- apologising
- acknowledging the error
- providing reassurance that you have taken action to make sure the same mistakes do not happen to others.

When you share your initial views with the person who made the complaint, discuss your proposed remedy with them. This will help them understand what action has been (or will be) taken as a result of their complaint. It also gives them the chance to comment on your ideas before you reach a final decision.

Find out more

The Ombudsman's Principles for Remedy: https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy

The Ombudsman's guidance on financial remedy:/www.ombudsman.org.uk/organisations-we-investigate/putting- things-right/financial-remedy

See also A closer look - carrying out the investigation guidance

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Complaints involving issues that may give rise to other procedures

The complaints procedure is not a disciplinary procedure. When you look into the complaint, you may find issues that could lead to remedial or disciplinary procedures for a member of staff.

If this happens:

discuss the situation with relevant colleagues.

- Take legal advice about how much information you are allowed to disclose.
- If the complaint relates to the same issues, tell the person who made the complaint (in broad terms) that this action is being taken.
- If the person making the complaint has already referred the matter to a health professional regulator (or wherever they choose to) do not let this affect the way their you investigate or respond to their complaint.
- Signpost the person making the complaint to sources of independent advice.

Find out more

See guidance on Complaints and other procedures.

Showing that lessons have been learnt

Always offer to involve the person making the complaint in any action you take to improve services as a result of their complaint. This will help them see that your organisation has listened and learnt from their complaint.

This could involve:

- inviting them in to see any changes you have made
- sharing drafts of any changes to policies and procedures
- sharing the outline and objectives of any training sessions and even involving the person in that training, if appropriate.

Once the organisation has taken the actions, ask the person to tell their story, as part of wider learning for staff or board members. This is a compelling way to help staff understand how their work affects people's lives and the importance of the recommended changes.

These actions help people see that their speaking up was worthwhile and has resulted in positive change for the organisation and service users.

Making a meaningful apology

Saying sorry is always the right thing to do when something has gone wrong. It is not an admission of legal liability. NHS Resolution confirms that it has never, and will never, refuse cover on a claim because an apology has been given. Saying sorry should incorporate the three R's.

Saying sorry: the 3 R's

- Regret. Say sorry and accept responsibility for the mistake and the impact it has had on the person.
- Reason. Provide a reason for the mistake. This may simply be what you know so far. If there is no valid explanation, be open and honest and say there is no excuse for the action or behaviour.
- Remedy. Say what you will do to find out more and/or how you will put things right. Provide assurance that the mistake will not be repeated.

Apologising when things go wrong should be straightforward. But even for the most experienced person, it can be filled with difficulties and emotion. If this is something you find hard, try using the tips below.

Make your apology at the earliest opportunity, as soon as you know that something has gone wrong (but it's never too late to say sorry).

If something has gone wrong, always include an apology in your final written response.

Where possible, say sorry in person (in person or by phone or video call).

When you apologise, show sincere regret that something went wrong.

Involve the relevant members of the healthcare team – ideally, somebody senior.

At the same time as the apology, explain what you know so far, and what you are doing to find out more.

The dos and don'ts of making a meaningful apology

Don't say
'I'm sorry you feel like that.' 'We're sorry if you're offended.' 'I'm sorry you took it that way.' 'We're sorry, but...'
Do say
'I'm sorry X happened.' 'We're truly sorry for the distress caused.' 'We apologise.'

Find out more

NHS Resolution guidance on saying sorry: https://resolution.nhs.uk/resources/saying-sorry/

SPSO guidance on apologies: https://www.spso.org.uk/sites/spso/files/csa/ApologyGuide.pdf

Find out more

Ombudsman's action plan guidance and template: www.ombudsman.org.uk/organisations-we-investigate/putting- things-right/writing-action-plans

AvMA leaflet on the duty of candour: www.cqc.org.uk/sites/default/files/Duty-of-Candour-2016-CQC- joint-branded.pdf

Information for NHS trusts on the roles of PHSO and NHS Resolution in resolving complaints and claims: The joint NHS Resolution/PHSO guidance

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

Let's make complaints count!