

A closer look - Providing a remedy

This is draft material and is not live guidance. It is shared for information and will be tested with organisations who have agreed to pilot the new Complaint Standards.

1. Introduction

1.1 This guidance is part of a range of guidance modules produced to help you implement and deliver the expectations set out in the Complaint Standards. [Insert link](#)

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

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

1.3 This guidance should be read alongside:

- Early Resolution [Insert link](#)
- A closer look - clarifying the complaint and explaining the process [Insert link](#)
- A closer look - the investigation [Insert link](#)
- A closer look - writing and communicating your final written response [Insert link](#)
- Referring people to the Ombudsman [Insert link](#)
- Complaints and other procedures [Insert link](#)

2. Standards and relevant legislation

2.1 The relevant Complaint Standards expectations are:

Welcoming complaints in a positive way

- Organisations make sure staff are able to identify when issues raised in a complaint are likely to be addressed (or are being addressed) via

another route, 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 and are able to provide people with information on 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 make sure the apologies and explanations they give are meaningful, sincere, and openly reflect the impact on the individual or individuals concerned.
- Organisations empower staff to identify suitable ways to put things right for people who raise a complaint. Organisations provide guidance and resources to make sure any proposed action to put things right is consistent.

2.2 The relevant Regulations that apply are:

[The Local Authority Social Services and National Health Service Complaints \(England\) Regulations 2009](#)

At section 14 the 2009 Regulations 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) 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.

3. What you should do

- ### **3.1**
- When you ask people what they want to achieve by raising a complaint, most say that they want an apology, to understand what happened or, perhaps most commonly, that they do not want what happened to them (or a loved one) to happen to anyone else. A meaningful apology is 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.

- 3.2 It is important at the outset of an investigation to understand the impact of events and what outcome the person is looking for. You should bear this in mind when identifying how best to put things right, treating each person fairly and as an individual. For more information see clarifying the complaint [[insert link](#)].
- 3.3 When providing a remedy, your aim is not only to put things right for the person or people concerned, but to also think about any wider learning for your organisation so that you can help improve services for everyone.

Establishing and understanding the impact of any failings

- 3.4 When you have identified that something has gone wrong, you need to determine what impact that failing has had on the individual(s) so you are clear on what you are putting right with your remedy. This should also include thinking about whether the failings(s) you have found could affect other service users, or services your organisation provides in the future.
- 3.5 By this stage, you will already have spoken to the person raising the complaint about the impact they say any failings have had on them. You need to take this into consideration when thinking about a suitable remedy. Remember you can go back and discuss this in more detail with them at any point during your investigation if you need to - particularly if the failings you have found are not quite those that were first complained about.
- 3.6 You should look at any failings you have found and consider what would have been different if they had not happened. For example:
 - did a delay in diagnosis affect the prognosis in some way?
 - did a failure/delay in providing treatment/medication 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?
- 3.7 You should also consider the impact on the person of having to take the time and trouble to complain, and whether any unreasonable delays in responding to the complaint have exacerbated the distress or frustration the person has experienced. If they have, you should also take that impact into account when deciding on a remedy.
- 3.8 When thinking about impact, it may be helpful to think about the following categories:
 - Inconvenience and distress. Possibly caused as a result of cancellations, failures, or delays in service provision, as a result of failures in communication, or where the handling of the complaint has been unreasonably prolonged.

- Being denied an opportunity. For example, being denied the opportunity to make an informed choice because the person was not given the full facts or did not have the risks explained to them (for example, when obtaining consent for surgery or when making decisions about care). This may have led to a lost opportunity for a better outcome, recovery or prognosis, unnecessary or additional surgery or treatment.
- Physiological injustice. For example, minor pain, permanent or serious injury or harm.
- Bereavement. Such as avoidable death, or a where a poor standard of care or poor communication with family occurred 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.

Considering financial or other redress and possible legal claims

- 3.9 If you identify a potentially serious failing or impact you will need to consider if the person may have a potential legal claim. The complaints process is not designed to determine legal liability or to provide compensation which might be awarded by a court. When resolving a complaint you can make a payment that acknowledges pain, distress and inconvenience as part of the complaints procedure. 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 you should discuss the matter with your legal team or defence organisation and NHS Resolution. You should also refer to [the joint NHS Resolution/PHSO guidance](#) on resolving NHS complaints and claims.
- 3.10 If the person making the complaint indicates that they are seeking compensation or would like to make a legal claim for compensation, the person making the complaint should be informed and advised of the availability of 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

- 3.11 If the failing(s) you have identified has had an impact of any kind, you should first provide a meaningful apology (see below) and then, where possible, put things right for the person(s) directly affected. The remedy should aim to return anyone affected to the position they would have been in if the failing hadn't happened. If this is not possible, any remedy should compensate them appropriately. Where appropriate, remedies should also be offered to others who have suffered an impact as a result of the same failing or poor service.

3.12 Remedies can include:

- a meaningful apology, explanation, and acceptance of responsibility
- remedial action, which may include reviewing or changing a decision on the service given to an individual, revising published material, revising policies and procedures to prevent the same thing happening again, training or supervising staff, or any combination of these
- financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, distress, or any combination of these.

3.13 The remedy you offer should take into account the desired outcomes discussed at the outset of the complaint. In most cases, the person making the complaint will want an individual remedy to recognise the impact of the failing on them, such as an apology and acknowledgement of error, alongside reassurance that action has been or will be taken to make sure the same mistakes don't happen to others.

3.14 When you share your initial views with the person who made the complaint, you should discuss your proposed remedy with them (see carrying out the investigation [Insert Link](#)). This will help make sure they understand what action has been taken (or will be taken) as a result of their complaint, and that they have an opportunity to comment on this before you reach a final view.

Complaints involving issues that may give rise to disciplinary or health professional fitness to practise procedures

3.15 The complaints procedure itself is not a disciplinary procedure. However, while considering or investigating the complaint you may identify issues that require a member of staff to be subject to remedial or disciplinary procedures. If that happens, you will need to discuss this with relevant colleagues. If the complaint includes those issues, you should advise the person making the complaint in broad terms that such action is being taken. You should take legal advice about how much information you are allowed to disclose. Where the person making the complaint has already referred the matter to a health professional regulator, or where they subsequently choose to, it should not affect the way their complaint is investigated and responded to. They should be signposted to sources of independent advice. See guidance on complaints and other processes [[insert link](#)]

Demonstrating that lessons have been learnt

3.16 You should always offer to involve the person making the complaint in any action taken to improve services as a result of the complaint. This will help them see that your organisation has truly 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. It can also be useful, once the actions have

been taken, for the person making the complaint to tell their story, as part of any wider learning for staff and Board members. These actions will help them see that speaking up and making their complaint really was worthwhile and has resulted in positive change for your organisation and the people who use your services.

Making a meaningful apology

3.17 Saying sorry is always the right thing to do when something has gone wrong. It is not an admission of liability. NHS Resolution confirms that they have never, and will never, refuse cover on a claim because an apology has been given. You can find more information on making a meaningful apology in the NHS Resolution and Scottish Public Services Ombudsman leaflets in the practical tools section below. [Insert Links](#).

3.18 Apologising when things go wrong should be straightforward but, even for the most experienced person, it can be filled with difficulties and emotion. An apology is best given at the earliest opportunity, as soon as you know that something has gone wrong. It should demonstrate sincere regret that something has gone wrong. Where possible, you should say sorry in person and involve the right members of the healthcare team. At the same time as you apologise, you should explain what you know so far and what you are doing to find out more.

3.19 One technique is to use the three Rs:

- **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.

3.20 While an apology is best made soon after the failing has occurred, it is never too late to apologise. You should always include an apology in your final written response. You may want to also have a separate phone call or meeting with the person so you can apologise in person.

4. Examples and case studies

4.1 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 unreservedly for the distress this has caused you and your family

4.2 Case examples - **to follow**

4.3 Example of paragraph explaining disciplinary procedures or referral to a regulator - **To follow**

5. Practical Tools

5.1 The Ombudsman's Principles for Remedy can be found here:

<https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy>

5.2 The Ombudsman's guidance on financial remedy can be found here:

<https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right/financial-remedy>

5.3 NHS Resolution guidance on saying sorry

<https://resolution.nhs.uk/resources/saying-sorry/>

5.4 SPSO guidance on apologies

<https://www.spsso.org.uk/sites/spsso/files/csa/ApologyGuide.pdf>

5.5 Ombudsman's action plan guidance and template

<https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right/writing-action-plans>

5.6 AvMA leaflet on Duty of Candour

<https://www.cqc.org.uk/sites/default/files/Duty-of-Candour-2016-CQC-joint-branded.pdf>

5.7 Information for NHS Trusts on the roles of the PHSO and NHS Resolution in resolving complaints and claims: [the joint NHS Resolution/PHSO guidance](#)

5.8 Guidance on financial remedy - **To follow**

6. Version control

6.1 Pilot draft - March 2021