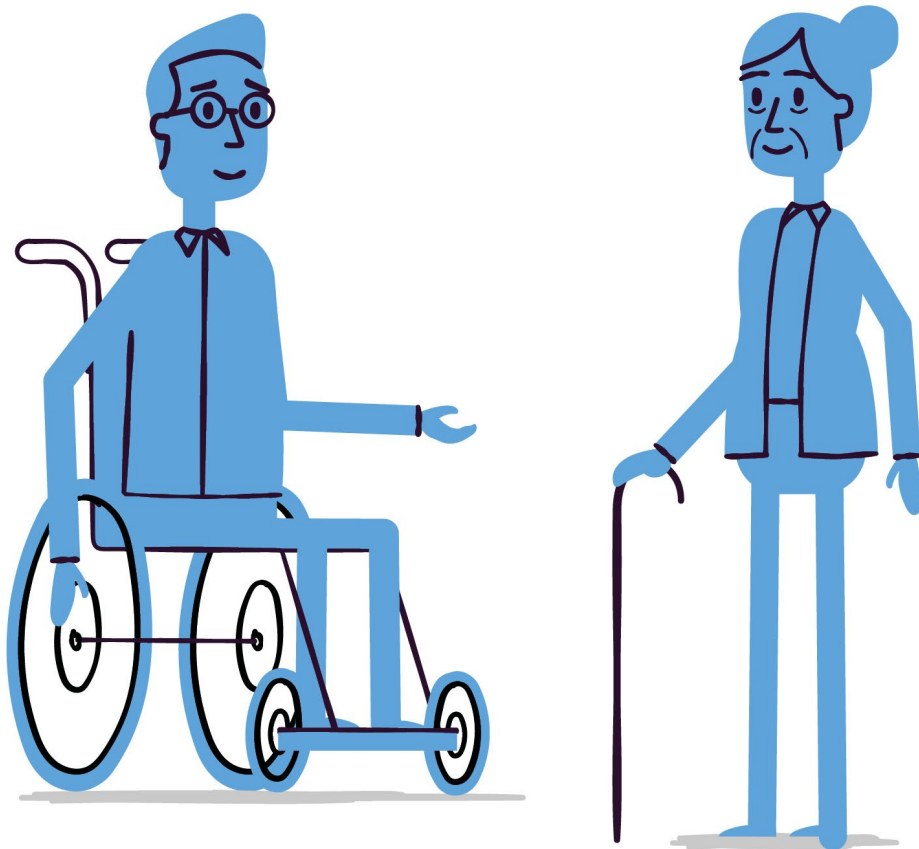


# A closer look - providing a remedy



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# 1. Introduction

- 1.1 This is part of a series of guidance modules that will help you implement and deliver the expectations set out in the [NHS Complaint Standards](#).
- 1.2 This module sets out 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.
- 1.3 You should read this module alongside the [Model Complaint Handling Procedure](#) and the following modules:
  - Early resolution
  - A closer look - clarifying the complaint and explaining the process
  - A closer look - the investigation
  - A closer look - writing and communicating your final written response
  - Referring people to the Ombudsman
  - Complaints and other procedures.

The guidance modules are available on the Ombudsman's [website](#).

## 2. The Complaint Standards and relevant legislation

### 2.1 The relevant Complaint Standards expectations are:

#### **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.

### 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 they:

- want an apology
- want things to be put right
- want to understand what happened
- do not want what happened to them (or a loved one) to 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.

3.2 At the start of an investigation, it is important to understand the impact of events and the outcome the person is looking for. You should bear this in mind when you identify how best to put things right, treating each person fairly and as an individual. For more information see the guidance [A closer look - clarifying the complaint](#).

3.3 When you provide a remedy, you are not only putting things right for the person or people concerned. You should 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 about what you will put right with your remedy. This should 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 who has raised the complaint about the impact any failings have had on them. You need to take this into consideration when you think 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 they 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 an error in the decision making process have a negative impact 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 think about the impact on the person of having to take the time and trouble to complain. Did any unreasonable delays in responding to the complaint worsen the distress or frustration the person experienced? If they did, you should take that impact into account when you decide on a remedy.
- 3.8 When thinking about impact, it may be helpful to consider the following categories:
- 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, 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, or caused 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 what may be a serious failing or impact, you will need to consider whether the person might have a potential legal claim. 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. 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 says they are seeking compensation or would like to make a legal claim for compensation, they 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 failings you have identified have 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 had not happened. If this is not possible, any remedy should compensate them appropriately. Where appropriate, you should also offer remedies 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 any combination of things like:
    - correcting an error
    - reviewing or changing a decision or the service given to an individual
    - 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.
- 3.13 The remedy you offer should take into account the outcomes you discussed at the start of the complaint. In most cases, 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, and providing reassurance that you have taken action to make sure the same mistakes do not 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 the [A closer look - carrying out the investigation](#) guidance. This will help them 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 practice procedures**

- 3.15 The complaints procedure itself is not a disciplinary procedure. While you consider or investigate the complaint, you may identify issues that require a member of staff to be subject to remedial or disciplinary procedures. If this happens, you will need to discuss it with relevant colleagues. If the complaint includes those issues, you should tell the person who made 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. If the person making the complaint has already referred the matter to a health professional regulator, or wherever they subsequently choose to, this 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 procedures](#).

### **Demonstrating that lessons have been learnt**

- 3.16 You should 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.

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 legal liability. NHS Resolution confirms that it has 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.
- 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. It is best to give an apology at the earliest opportunity, as soon as you know



that something has gone wrong. It should show sincere regret that something went wrong. Where possible, you should say sorry in person and involve the right members of the healthcare team, ideally somebody senior. 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 it is best to apologise soon after the failing has happened, it is never too late to apologise. You should always include an apology in your final written response if something has gone wrong. You may also want to have a separate phone call or meeting with the person so you can apologise in person.

## 4. Examples

4.1 The dos and don'ts of making a meaningful apology

Don't say
<ul style="list-style-type: none"><li>✗ I'm sorry you feel like that</li><li>✗ We're sorry if you're offended</li><li>✗ I'm sorry you took it that way</li><li>✗ We're sorry, but...</li></ul>
Do say
<ul style="list-style-type: none"><li>✓ I'm sorry X happened</li><li>✓ We're truly sorry for the distress caused</li><li>✓ We apologise</li></ul>

## 5. Practical tools

- 5.1 The Ombudsman's Principles for Remedy:  
<https://www.ombudsman.org.uk/about-us/our-principles/principles-remedy>
- 5.2 The Ombudsman's guidance on financial remedy:  
[/www.ombudsman.org.uk/organisations-we-investigate/putting- things-right/financial-remedy](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/spso/files/csa/ApologyGuide.pdf>
- 5.5 Ombudsman's action plan guidance and template:  
[/www.ombudsman.org.uk/organisations-we-investigate/putting- things-right/writing-action-plans](https://www.ombudsman.org.uk/organisations-we-investigate/putting-things-right/writing-action-plans)
- 5.6 AvMA leaflet on the Duty of Candour:  
[//www.cqc.org.uk/sites/default/files/Duty-of-Candour-2016-CQC- joint-branded.pdf](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 PHSO and NHS Resolution in resolving complaints and claims: [the joint NHS Resolution/PHSO guidance](#)

## 6. Version control

- 6.1 Final - December 2022