Patients Association

Good practice standards for NHS Complaints Handling

September 2013

The Patients Association
listening to patients, speaking up for change

Background

Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of care at NHS organisations. It provides a tangible and measurable reflection of the organisation's commitment to an open and responsive safety culture. Numerous national reports have found that complaints are often handled poorly by the NHS. As long ago as 2004, the Shipman Inquiry stated that "… *there is an urgent need for standards which can be applied…in dealing with complaints…These should be established as a matter of urgency..."*

In November 2008, the Parliamentary and Health Service Ombudsman published the "Principles of Good Complaint Handling." The report states:

> "*Good complaint handling should be led from the top, focused on outcomes, fair and proportionate, and sensitive to complainants' needs. The process should be clear and straightforward, and readily accessible to customers. It should be well managed throughout so that decisions are taken quickly, things put right where necessary and lessons learnt for service improvement*."

The Patients Association considers that these key principles should be used as the guiding framework for determining whether a complaint was handled well or badly. The Patients Association also believes that a uniform approach to complaint management is required across the healthcare sector as a whole if it is to maintain the confidence of the public at large.

As part of the Health Foundation funded 'Speaking Up' project, the Patients Association has been developing tools aimed at improving the quality of complaints handling at Mid Staffordshire NHS Foundation Trust and elsewhere. This included developing a set of good practice standards for complaints handling. These were refined over a two year period by a group including clinicians, lay people and complaint managers.

The work and the standards on complaint handling which we developed as part of this project were commended by Robert Francis, QC, in his recent public inquiry into the problems at Mid Staffordshire NHS FT (MSFT).

Recommendation 113 of the Public Inquiry report published in February 2013 states:

"Trusts should consider the recommendations and standards

developed by the Patients Association in its work with Mid Staffs Hospital…"

This document details those standards. The first eight standards relate to the handling of an individual complaint case. They can be used by any NHS organisation which has to handle formal complaints. The last four standards are organisational standards.

This document is not intended to include all inclusive standards for every complaint investigation as each complaint received and the subsequent investigation that follows is unique. Neither should it be construed as legal advice. However, the standards should allow individuals and organisations to assess their practice, approach complaints handling in a robust and rigorous way and make adjustments to their systems and processes where necessary. Finally, we believe that organisations have a responsibility to learn from each other as much as they can and also agree to share what they know.

Overarching Principles

When managing a complaint, all those involved (the complainant, staff members etc.) should be treated with respect, tact, compassion and concern for their wellbeing. It is important to listen carefully to what people say and to conduct the investigation in a fair and objective manner.

The Patients Association also believes that organisations should be able to demonstrate to all stakeholders that the investigation and the decision making processes has been:

- Open and transparent;
- Evidence based;
- Logical and rational;
- Comprehensive and with a level of detail appropriate to the seriousness of the complaint;
- Timely and expeditious;
- Proportionate to the seriousness of the complaint(s) raised.

What is a complaint?

The Patients Association define a complaint as:

“An expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a response. There is no difference between a ‘formal’ and an ‘informal’ complaint. Both are expressions of dissatisfaction.”

The Patients Association Good Practice Standards

Standard 1. The Complainant has a single point of contact in the Organisation and is placed at the centre of the process. The nature of their complaint and the outcome they are seeking is established at the outset.

Complainants are provided with a named individual, a single point of contact with whom they can liaise. There is equality of access for all complainants, with particular consideration for those people who may find it more difficult to use the process.

1.1 The complainant is given contact details for a named person with whom they can liaise with throughout the process.

Best thought of as a 'case worker', complainants should be able to establish a working relationship with a named person who can act as their liaison throughout the process. References to "on behalf of the team" or similar would not constitute a named person. If an assigned case worker is away, ideally, complainants should be informed of an alternative point of contact.

1.2a. Sufficient attempts are made to contact the complainant verbally.

Unless explicitly asked not to, it is good practice to try and establish verbal communication even if just at the outset. This is typically carried out by phone. We would define 'sufficient' as a minimum of three attempts.

1.2b. If there is verbal contact, the person making the call should accurately establish the aspects of the complaint and the solutions the complainant wants in order to resolve the complaint.

If a complainant is contacted verbally, whoever speaks to them should record the details of their complaint and the outcome they are seeking to achieve.

1.3. The complainant's preferred method of communication should be established at the earliest opportunity.

The legislation requires that the complainants preferred method of communication be established ***(Regulation 13 (1) – complaints may be made orally, in writing or electronically).*** *Complainants may wish to communicate in writing, over the phone, by email or through face to face meetings. At the point of initial contact the preferred method of communication should be established. It may be that the complainant states at the outset how they wish to communicate e.g. stating in a complaint letter that they wish to communicate by writing.*

1.4 An explanation of how the complaints process at the organisation works should be provided.

Explaining how the complaints process works is the first step in ensuring the complainant is well informed about what to expect and how typically complaints are handled.

1.5 The complainant should be offered a face to face meeting to discuss the issues raised early on in the process.

It is good practice to offer face to face meetings, especially when complaints relate to more serious issues or complex circumstances. It may be that it was explicitly raised by the complainant that they would not like a face to face meeting, in which case select 'not applicable'. In addition, you may judge that, for some reason, offering a meeting was inappropriate.

1.6 Third party consent should be obtained, where the complaint was made on behalf of the patient.

Consent is required when communicating to the complainant about the details of a third party and the Trust should have a written record from the third party giving their consent. This includes MPs writing on behalf of constituents.

1.7 Where the complainant is communicating through a third party (e.g. an independent advocacy service provider, Member of Parliament or a solicitor), the organisation establishes the boundaries of communication e.g. does the complainant wish to be copied into correspondence? Would they still be interested in a face to face meeting? What amount of clinical information can be released to the third party?

A letter from a solicitor does not prevent an organisation from attempting to establish good relationships with a complainant, including offering to meet still and copy in correspondence.

1.8 A written acknowledgement is sent to the complainant in the three day time frame.

*Written acknowledgement within three days of receipt is one of the few specific requirements of the law regarding complaints handling (***Regulation 13 (3)).** *Unless explicitly asked not to, this should be a hard copy letter posted to the complainant.*

1.9 The complainant is informed of the availability of third party support to help them during the complaint process.

The legislation requires that complainants are informed of the existence of third party support to help them make their complaint ***(Regulation 3 (2) (d))****, namely the Department of Health funded Independent Complaints Advocacy Service - ICAS. This should be done in either writing or verbally at the outset of the complaints process i.e. first conversation with the complainant or in the acknowledgement letter.*

1.10 The outcome the complainant is seeking should be clearly established.

Complainants may be seeking information, an apology, a second opinion on their treatment, the retraining or disciplining of staff and changes to practice amongst other things. The organisation should be clear what outcome is expected.

1.11The manner in which the complaint is to be handled should be discussed with the complainant.

The legislation requires that the manner in which the complaint is to be handled is discussed with the complainant ***(Regulation 13 (7) (a)).*** *This is in addition to a general explanation of the process covered earlier and might include who will investigate the complaint, how they propose to do it and what evidence they might be considering. There should be evidence of a record of a call or meeting with the complainant or through reference to a conversation in a letter to a complainant.*

1.12a A timeframe for responding should be discussed with the complainant.

The legislation requires the organisation to discuss the timeframe for handling a complaint. Where such an offer is refused, the complainant should be informed of the organisation's decisions on both these issues **(Regulation 13 (7) (b)).**

1.12b The complainant should be informed if the investigation may be taking more time than originally planned.

After setting a timeframe, the organisation should try its up most to stick to it. Where this proves difficult, the complainant should be informed in good time **(Regulation 14 (1) (b) keep the complainant informed …….as to the progress of the investigation).**

1.13 If yes, a new date for a response should be agreed with the complainant.

Whilst not required by legislation, it is good practice to agree a new timeframe when there is a delay.

Standard 2. The complaint undergoes initial assessment and any necessary immediate action is taken. A lead investigator is identified.

The complexity and seriousness of the complaint should influence the extent of any investigations. The level of seniority of the person leading any investigation must match the level of severity of the complaint i.e. the more serious the complaint, the more senior the investigating officer. Where conflict of interest issues arise, it is good practice to engage the services of a person who is external to the Organisation.

2.1 The complaint is recorded and initially assessed and categorised as low, moderate, high or extreme.

The organisation must make a record of the complaint **(Regulation 13 (2) (a)).** *The organisation should have a risk rating scheme that looks at both severity of impact and the likelihood of repetition. Typically these classify complaints as low, moderate, high or extreme.*

2.2 Categorisation is appropriate.

Correct grading of a complaint is important as it often determines the nature and quality of an investigation. It may be that the complaint has different distinct aspects of different severity, but the grading must relate to the highest area e.g. if any aspect could be rated as extreme, the complaint as a whole is rated as extreme.

2.3 Complaints relating to clinical care are risk assessed by a clinician of appropriate seniority.

Whilst non-clinical staff may provide an initial risk assessment, where the complaint is about clinical care, clinical staff must be involved in reviewing this risk assessment if not involved in the initial assessment.

2.4 Members of the executive team are alerted to a serious complaint.

In most instances when a complaint is major and always when extreme, there should be evidence of this being communicated to a Board level executive

(e.g. Director of Nursing, Medical director, Chief Executive). Use your judgement as to whether an executive should be informed based on the detail of the complaint.

2.5 The complaint is communicated to external Organisations e.g. the Police, Care Quality Commission, Strategic Health Authority as appropriate.

In exceptional circumstances, the issues raised in a complaint may warrant communication to an external organisation. For example, the police may be contacted when a criminal offence is suspected.

2.6 Where serious misconduct is suspected, the individual(s) is suspended, pending further investigation.

Suspension is warranted when the content of a complaint suggests an individual(s) poses a significant risk to others at the time the complaint is made. Suspending that individual reduces that risk while the organisation investigates further.

2.7 A lead investigator is identified.

The lead investigator is responsible for planning the investigation and gathering all the evidence together and its conclusion. Complaints that cross departments may have a number of 'investigators' but a lead investigator should have oversight. Coordination and administration does not constitute investigation. The person might be identified on a complaint case file or in the response letter to the complainant but you must be satisfied that this individual played an investigative role - not that they were simply a senior member of staff in the relevant area who is associated with responsibility for the response.

Standard 3. Investigations are thorough (Regulation 3 (2) (b) and Regulation 14 (1)), where appropriate obtain independent evidence and opinion, and are carried out in accordance with local procedures, national guidance and within legal frameworks.

After the initial assessment, the nature and scope of the investigation is determined and the approach to it planned. Statements, interviews, reviews of notes and site visits will usually constitute the bulk of an investigation but third party sources of independent evidence to evaluate findings against will also be obtained. If the investigation should be based solely on a review of entries into the health record, this is usually inadequate. The investigator is chosen and sufficient evidence should be gathered.

3.1 There is evidence of a clear management plan for the investigation.

It is critical that one person be responsible for the conduct of the investigation and thus for establishing the framework for the investigation. This is particularly important where the complaint spans more than one division or even more than one health care facility. Ensuring that the planning stage is performed well will have a major influence on the ultimate success of the investigation. Has the investigator identified what questions need to be answered? What information is required to answer those questions and the best way to obtain that information? It is not best practice simply to have one individual dividing up the complaint and requesting responses from the relevant departments or individuals (for example through internal emails or proforma).

3.2 There is sufficient evidence to show, where necessary, patient records (e.g. clinical notes, booking system records, lab results) were reviewed.

Reviewing the records of a patient's treatment will often form the starting point of an investigation and will be a key (though not infallible) source of evidence. Frequently, reference to the notes being reviewed is made in a letter to the complainant, or internal communication or proforma. Records held at another Trust can be accessed in cooperation with the complainant and so this is not a viable reason for not being able to review all relevant parts of the record

where important.

3.3a. There is sufficient evidence to show that statements were obtained from relevant members of staff involved with (or witnessing) the complaint.

Statements will form a key part of an investigation and are relatively easy to obtain in comparison to interviews. They may include accounts of events but also opinions on the appropriateness of treatment provided or conduct of an individual. Collecting statements from those involved or able to act as witnesses is particularly important where there is an apparent dispute over events. Accounts may be provided on behalf of a junior (e.g. Consultant giving a view on behalf their registrar who gave treatment) but only when the statement is complete and comprehensive and has no apparent need for further clarification. If the investigator was unable to obtain a statement from a key member of staff, this should be recorded with reasons why. A staff member being on night duty is not an acceptable reason for not obtaining a statement. Where they are a crucial witness, the organisation should evidence they have made efforts to contact ex-employees. Where they are regulated professionals (e.g. nurses and doctors) they have a duty to cooperate.

3.3b There is sufficient evidence to show that statements were obtained from other individuals involved with (or witnessing) the complaint individuals (e.g. friends, relatives, the complainant).

If there is an important third party witness, for example a relative or carer, the organisation should seek permission from the complainant to obtain a statement from them. In some cases it may be that a detailed separate statement is sought from the complainant if there is a specific issue for which a detailed account is required. These will obviously have a weight of credibility ascribed to a biased witness but each statement should be assessed on its merits rather than not being collected at all.

3.4 Where necessary, there is sufficient evidence to show that relevant members of staff involved with (or witnessing) the complaint were interviewed.

In certain circumstances, an interview may be warranted. This may be because of a serious complaint with conflicting accounts being provided by

staff or third party witnesses.

3.5 Where necessary, there is sufficient evidence to show that other individuals (e.g. friends, relatives, the complainant) were interviewed.

As described in relation to staff, in certain circumstances statements are insufficient. Other people beside organisation staff may be useful witnesses who can be interviewed with the complainants consent.

3.6 The organisation uses a standardised template for recording interview notes.

A good practice point. A well designed template document ensures a standardised approach to conducting investigations is taken throughout the organisation; it should prompt the investigator to collect the relevant information/evidence. A standardised approach makes it easier for staff to review the information.

3.7 The date, time, venue and duration of any interview are recorded.

This is to ensure that a full and transparent record of the investigation process is made.

3.8 The notes identify the name(s) and job title of those who conducted the interview.

Recording the names(s) of the interviewers shows who was accountable for conducting the interviews; it will also help panel members determine whether the interviewer was a person of sufficient seniority.

3.9 The interview notes give a clear and concise account of the interview.

A clear and concise account will make it easier for the decision maker to draw their conclusions.

3.10 A “site visit” to areas concerned is conducted.

A site visit may be appropriate in order to examine the scene of a complaint (where the condition of the site, or something at the site, is an issue), possibly taking photographs to refer to at a later date.

3.11 Relevant copies of any organisation policies/protocols are obtained along with other documentary evidence e.g. NICE guidelines to support judgements on clinical practice.

If the decision was made on the basis of hospital policy and/ or professional/NICE guidelines, this should be referred to and available on file, ideally, with the specific part of the guidance highlighted.

3. 12 Appropriate further independent opinion is secured on complaints relating to clinical issues

This sub standard relates specifically to independent opinion from those divorced from the handling of the complaint and the issues complained about. In most cases seeking only the opinion of clinical staff actually complained about would does not constitute best practice unless the issue is minor or clear cut and easily verified e.g. guidelines/records reviewed. The degree of involvement will depend on the severity of the complaint. For lower level concerns, a simple review may suffice. For others, detailed opinions may be required. Where the complaint relates to serious harm or death, opinions from clinicians from outside the Trust (e.g. another Trust, a medico legal review, a Royal College review) will likely be required.

Standard 4. The investigator reviews, organises and evaluates the investigative findings.

The role of the investigator is also to gather and analyse all the relevant facts and opinions pertaining to the complaint and at the end of the fact finding exercise, report back and, if appropriate, make relevant recommendations. Their role is to provisionally prove or disprove any matter of fact raised by the complainant and to highlight key points for the decision maker to consider.

4.1a The investigator identifies any dispute of facts (e.g. different accounts of events).

The points of agreement and disagreement should be clearly laid out as the response to the complainant will need to highlight what facts are in dispute (if any). Examples of disputed facts include what was said by a healthcare professional to a patient before, during or after treatment (for example if risks of an operation and chances of success were explained), whether a healthcare professional did something (e.g. ignored a patient asking for help on a ward), whether a treatment was or was not given (e.g. given medicine to take home at discharge) or when a letter for an appointment was or wasn't posted. There may be different views of what happened but there must be a right or wrong answer. There is some degree of overlap with disputes of opinion, for example whether a healthcare professionals tone was rude rather than complaining about what they actually said.

4.1b Where there is a dispute of facts, the investigator identifies any evidence which indicates the more likely version of events.

This might include highlighting the relevant aspects of the health record (e.g. the consent form or record of an outpatient appointment in notes) or highlighting corroborating elements from different statements of interviews which indicate a more likely version of events. It may also include highlighting the credibility of witnesses (e.g. a healthcare professional about whom there have been a number of previous complaints or a complainant who has complained frequently and no grounds for the complaint have been found).

4.2a The investigator identifies any difference of opinion (e.g. views

from different clinicians on appropriateness of patient treatment).

Differences of opinion will typically be over whether a treatment was appropriate as there may not be an exact or clear answer. It might also be over something like a waiting time for an appointment where a department or member of staff has given an appointment date they consider reasonable but the complainant does not. As mentioned above, there can be some overlap where the complaint is about how somebody said something, rather than what they said.

4.2b Where there is a difference of opinion, the investigator highlights any evidence which suggest one opinion to be more reasonable.

For disputed clinical care issues, the investigator should highlight key aspects of best practice guidance or independent opinion that has been obtained. There might be other sources of evidence to support, on balance, whose opinion is more reasonable, for example NHS Constitution rights for patients waiting times or organisation policies. As with matters of fact, credibility of witnesses, particularly in relation to complaints about the manner/attitude of staff, will be important to highlight.

4.3 The investigator indicates the preliminary conclusion(s) they have reached on each key complaint aspect.

For the key complaint aspects, the investigator will detail their conclusions. This is best thought of as the prosecution in court; the prosecution is pressing the case for guilty but they don't decide, the judge does. In this instance, they are not attempting to prove guilt or innocence, rather reviewing the evidence and pressing the case for the version of events they support in light of their investigation.

4.4 The investigation report clearly and concisely summarises the investigation, evidence and preliminary conclusions reached.

There should be a succinct but comprehensive report or proforma highlighting the key aspects of the above to enable the decision maker to make good quality well informed decisions without needing to go back through the entire investigation in detail.

Standard 5. The judgement reached by the decision maker is transparent, reasonable and based on the evidence available.

Ideally the investigator and decision maker should not be the same person. The quality of any decision will depend on the decision maker's knowledge, experience and integrity. After evaluating the findings, the decision maker will exercise their discretion in deciding whether the complaint can be upheld or not. This decision will be based on the civil standard (proof on the balance of probabilities).

5.1 An identifiable individual with appropriate seniority has reviewed the findings of the investigation and the provisional recommendations.

Typically, a divisional lead will authorise the response which has been drafted for them. It is insufficient to simply review a draft letter; it must evidence (for example through a proforma) that the person has properly considered the underlying issues of a complaint.

5.2 The decision maker decides which aspects of the complaint are justified and which are not, detailing why they have reached their view.

After reviewing the investigation or draft letter, the decision maker must decide whether or not they uphold the complaint. There must be evidence of the decision maker highlighting the key aspects they took into account when making their decision.

5.3 The decision maker decides which (if any) issues could not be resolved in the investigation and records why.

When there is an issue that cannot be resolved, it is particularly important for the decision maker to explain why they have been unable to reach a conclusion. A typical example will be a dispute between a complainant and a member of staff about what was said during a consultation or a complainant reporting inappropriate behaviour of staff on a ward. The explanation is particularly important as, very often, complainants perceive that when a conclusion is not reached in their favour, the organisation is denying their version of events is true. In fact, they are stating there is no clear evidence that they are right or wrong.

5.4 Any decisions reached are correct on the balance of probabilities.

It should be clear that information is collected and thoroughly evaluated; and that the right policies, procedures and clinical guidelines were followed. It should be clear that the decision maker reached his or her decision based on the balance of probabilities.

5.5 The decision maker classified the complaint as fully, partly or not upheld.

An essential stage when finalising a complaint is to determine whether it is upheld or not. This provides clarity for the complainant and for the person complained about. This should complement the narrative findings. A complaint should be upheld where the findings show that the service provided did not reach the appropriate standard. Any facts on which the judgement to uphold the complaint is based must be proven on the balance of probabilities. A complaint should not be upheld where the facts are clearly established and it is determined that what the complainant claims happened did not occur or their views on what they should expect are unreasonable. A complaint will also not be upheld where there is insufficient evidence to conclude, on the balance of probabilities, that the complainant's allegation is true. Commonly, this will arise where there is a conflict of accounts that cannot be reconciled on the evidence available and the investigator cannot establish the facts.

Standard 6. The complaint documentation is accurate and complete. The investigation is formally recorded, the level of detail appropriate to the nature and seriousness of the complaint.

Good documentation is fundamental to effective complaints handling. All information should be maintained centrally as there are risks to effective record keeping and decision making if statements and other material pertinent to the complaint are kept in a number of different locations. Documentation should be such that it permits evaluation of the conduct of an investigation and would enable an independent observer to draw the same conclusion as the decision maker.

6.1 The file should include all relevant documents. This should include:

- The initial complaint correspondence;
- The initial assessment of the complaint severity and the details of the person making the assessment;
- Dates, identities and positions of all parties involved in the investigation;
- Copies of all correspondence (patients, staff and other opinions sought);
- Interview notes and emails in relation to the investigation;
- Extracts from the patient record where appropriate;
- Records of oral communications – face to face and telephone conversations;
- Photographic evidence where appropriate- a hard copy should be available which is signed on the back "as taken and not modified". A copy of the original digital photograph should be stored on CD;
- Copies of organisation policies or protocols that have been referred to or at least a reference made to it in the file;
- Cleaning schedules if there are infection controls concerns;
- Staffing rotas may be included to determine interviewees or possible staff shortages;
- Any previous complaints about the same persons or situation or process;
- Any previous complaints from the complainant, where appropriate;
- Other supporting information obtained to help formulate a judgement;
- The final investigation report should be included, detailing the author, the decision making process, conclusions and recommendations i.e. a summary of the key facts relied upon in reaching the final decision;
- The response letter to the complainant;
- Evidence of support offered to staff involved in the complaint;
- A chronology of the investigation process.

Good record keeping assists in improving accountability and provides for transparent decision-making. Care Quality Commission Essential Standards of Quality and Safety also state "A documented audit trail of the steps taken and the decisions reached is kept – 17A(4)".

6.2 The documentation should be clear, legible and non erasable.

Internal documentation must be legible, clear and in a format where it cannot be altered (e.g. not written in pencil).

6.3 The documentation should be professional and non-judgemental.

Internal documentation must be professional; it shouldn't contain off hand derogatory remarks or indicate prejudice to the outcome of the complaint (outside of the formal process of reaching a conclusion).

Standard 7. Both the complainant and those complained about are responded to adequately. (Regulation 14, investigation and response).

Many complaints are resolved through the provision of an explanation, detailed information and an apology where needed. Responses to complainants are often incomplete and do not offer adequate explanation. Some letters contain factual errors; others make no acknowledgement of a mistake being made. It is important that the response letter addresses all the matters arising from the complaint.

7.1 The response letter is sent from the Chief Executive.

The Complaints Regulations **(Regulation 14 (2))** *state that the organisation must send the complainant in writing a response, signed by the responsible person. This is the CEO of the organisation although the functions of the responsible person may be performed by any person authorised by the responsible body to act on behalf of the responsible person. It is widely recognised as good practice that letters come from the Chief Executive. A cover letter from the Chief Executive explaining they have read and reviewed an enclosed letter or report from another member of staff would be acceptable.*

7.2 The response letter is sent within the planned time.

The timeframe for the investigation should have been communicated to the complainant, ideally after discussion as highlighted earlier in the scorecard.

7.3 The timeframe is reasonable.

25-28 days has been the historical target for delivering responses and for some Clinical Commissioning Groups, remains a contractual requirement. This should be used as a starting point but complex complaints will reasonably take longer. Also, some simpler complaints could be answered much more quickly. You should take into account the urgency of the issues raised, the complexity of the case and the reasonable expectations of the complainant.

7.4 The response letter is personalised and the tone courteous.

Complaints Regulations state that "complainants are treated with respect and courtesy" paragraph 3c (2). The letter should demonstrate sincerity and where appropriate, compassion. It should never contain any rude or dismissive comments. Importantly, the tone should match the seriousness of the complaint. The letter should not contain effusive apologies for a minor complaint or a lack of appreciation of the gravity of the situation in a major one.

7.5 The style and language of the response letter is appropriate.

The letter should be written in a style that can be easily understood by the person receiving it so that they understand the reasons for the decision and why the decision was made. The language should not be overly formal or overly casual and again should indicate some consideration of the style and language used by the complainant.

7.6 Technical or specialist terminology is explained.

Plain English is the key here. The organisation should take care if using technical language; that it is explained unless used by the complainant first. Specialist terminology and hospital speak (e.g. consultant on take, hospital on red alert, winter pressures, discharge plan etc.) should be avoided where possible if the words are not likely to be understood by the complainant.

7.7 There is a summary or statement of the complaint that mirrored the complainant's original complaint in the letter.

This assumes that all key aspects of the complaint have been correctly

identified at the outset.

7.8 The response letter could reasonably be considered by the organisation to constitute a full and honest account of events.

Answers should be forthcoming and not skirt around the issues. There should be no unsatisfactory events or findings uncovered in the investigation that are deliberately not shared with the complainant e.g. inadequate staffing levels not communicated to the complainant. In extreme cases, a wholly inadequate investigation might impair the organisation's ability to argue that their response is full and honest as well as adequate/sufficient.

7.9 The letter contains a response to each of the specific issues raised by the complainant.

All too often, key issues raised by the complainant are not discussed in the final response letter.

7.10 The letter contained an explanation of the findings in a level of detail that the complainant wanted.

Clear and relevant reasons should be given for the decisions. The 2009 Complaint Regulations state that:
"clear and relevant reasons should be given for the decisions…..must send a response which includes the following matters:

- *an explanation of how the complaint has been considered; and*
- *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."*
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7.11 An acknowledgment of responsibility and an apology is given where appropriate.

If errors have occurred, then the response should first admit fault i.e. accept responsibility. This is a necessary precondition for a sincere apology. It is not good practice to include apologies which are non-specific or an apology but no acceptance of responsibility.

7.12 The complainant is notified if a firm conclusion could not be drawn and an explanation given as to why.

If the decision maker could not make a firm conclusion based on the available evidence, then he or she should say so and give the reasons why not. These reasons should be explained clearly and be objectively sound.

7.13 Appropriate remedies are given including financial compensation where appropriate.

An organisation that values openness and accountability should be willing to admit and make good its errors. Redress should be proportional to the detriment suffered. Generally, when a person suffers a detriment wholly or partly as a result of the inappropriate actions of an organisation, that person should, wherever possible, be restored to their original position. When this is not possible, fair and reasonable alternatives should be offered. As examples, the PHSO often secures awards of around £250-£500 for patients that have experienced particularly poor complaints handling about a serious matter. A further appointment and a refund of car parking charges might be other examples.

7.14 A sufficient explanation of next steps, including any remedial action, changes in policy or clinical practice is given (Regulation 3(2) (g)).

Did the response letter say how the hospital was going to rectify the issue(s)? Was a promise made to take certain actions to ensure that the problem will not be allowed to happen again? The more specific, personalised and timed the plans for improvement, the more credible they will be. General promises to talk to staff are often not seen as credible by complainants. Action plans may be included to detail timescales and lead individuals for thorough responses.

7.15 The complainant is offered the opportunity to discuss the outcome of the hospital's findings.

The letter should make it clear who the complainant should contact if they would like to discuss the matter further. A specific offer means a named individual with their contact details e.g. a divisional manager or the Consultant in charge of a person's care. A general offer could be "please contact the

complaints department".

7.16 The complainant is advised in writing of their right to ask for an independent review by the Parliamentary and Health Service Ombudsman.

Care Quality Commission Essential Standards 17e(10) state that the people using the services:

"...know the steps they can take if they are not satisfied with the findings or outcome once the complaint has been responded to, and are advised of their right to refer the matter to the next stage of the complaints system, including the Health Service Ombudsman."

7.17 Staff members involved in the complaint are informed of the outcome.

It is important that staff are made aware of the conclusions of the investigation. They are entitled to know the outcome (for example whether the complaint was upheld and/or it was accepted that the care they delivered was inadequate). This also allows staff to be informed about the reasons being given by their organisation for things going wrong. For example a complainant might have been told short staffing on a ward was a one off when the staff themselves know that short staffing is in fact a repeated occurrence. This gives staff the opportunity to raise this issue with their managers and/or union representatives.

Standard 8. The investigation of the complaint is complete, impartial and fair.

Complaints need to be examined in a fair, impartial and objective manner. Investigators should approach people and issues with tolerance and an open mind, listening to and taking account of what they say. They should respect people as individuals and ensure that anti-discrimination, fairness and equity principles are applied throughout the process. All the relevant evidence should be gathered as the investigator has a fundamental obligation to ascertain all the facts. The investigation must be conducted by someone who has not been involved in the events giving rise to the complaint. They must not have, or be perceive to have any conflict of interests. Unbiased decisions should be made based upon sufficient evidence.

8.1 As a whole, the investigation strategy and process is planned thoroughly and well executed.

As a whole, you must ensure that reasonable effort is made to conduct a sufficient investigation; records checked, witnesses interviewed, statements critically reviewed and independent evidence gathered. It can be difficult to consider an investigation as impartial or fair if evidence gathering was so minimal as to be unable to provide the necessary information to make a judgement.

8.2 The complaint process is managed fairly for the complainant.

Was procedural fairness followed? Was a fair and proper procedure followed when reaching a decision? In particular you should ensure that information is not held back from the complainant and that there were no witnesses that were not interviewed who might have corroborated a complainant's version of events.

8.3 The complaint process is managed fairly for the complained about.

Any decision affecting an individual must make sure that the rules of procedural fairness are followed. Fairness demands that a person be told the case to be met and given the chance to reply before any decision is made. In other words, hearing the other side of the story is critical. In particular if apologies for misconduct are given on behalf of staff that they are aware this is being done and have been given an opportunity to comment.

8.4 The organisation should be able to successfully defend the quality and fairness of its investigative process for the complaint.
Was the right information collected and thoroughly evaluated? Were the right policies, procedures and clinical guidelines followed? Did the decision maker reach their decision based on the balance of probabilities?

Organisational Standards

In addition to ensuring that each complaint is handled according to best practice, we would recommend that NHS organisations adopt the following organisation wide standards.

Standard 9

The organisation records, analyses and reports complaints information throughout the organisation and to external audiences.

Standard 10

Learning lessons from complaints occurs throughout the organisation.

Standard 11

Governance arrangements regarding complaints handling are robust.

Standard 12

Individuals assigned to play a part in a complaint investigation have the necessary competencies.