Parliamentary and Health Service Ombudsman

Investigation Manual 6.0

Version: 6.0
Version date: 29/01/15

Version control and sign off

Date	Version	Details
6 June 2014	0.1	Draft by Neil Armstrong
24 July 2014	0.2	Revised draft by Russell Barr
2 September 2014	0.3	Final draft by Russell Barr
17/12/14	1.1	Revised draft by Sophie Grant

Sign off

Date	Version	Details
10/9/14	1.0	Final version agreed by Russell Barr and Chris Morgan.
24/12/14	2.0	Revisions agreed by Russell Barr and Chris Morgan. Milestones, planning template, letter templates and report checklist and template added in. Amendments to Confirming the Investigation and further detail added to Reaching a Decision.
08/01/15	3.0	Minor corrections to milestones.
12/01/15	4.0	Added table (Annex E) explaining where to send health reports and action plans.
23/01/15	5.0	Minor amendments to Annex E – CQC and TDA she be sent ANON reports where systemic

		recommendations are made and NHS Local Area Teams should be sent an ANON report for all GP/Dentist and independent provider cases.
29/01/2015	6.0	Added requirement to anonymise reports sent to Responsible Officers to Annex E and paragraph 150.

Contents

INTRODUCTION

This document is to be used by staff undertaking investigations that are currently operating in the Investigations Directorate.

It is intended to provide clear guidance on the considerations that must be made at each of the 5 steps set out in the Investigations Directorate Investigation Process document.

Whilst there are some actions that must be undertaken due to legal and policy requirements it remains that large parts of the investigative process rely on discretion and good judgement. This is still the case.

One document cannot provide the answer to every investigative question but the guidance here should assist in the majority of situations as we work through our 5 step process.

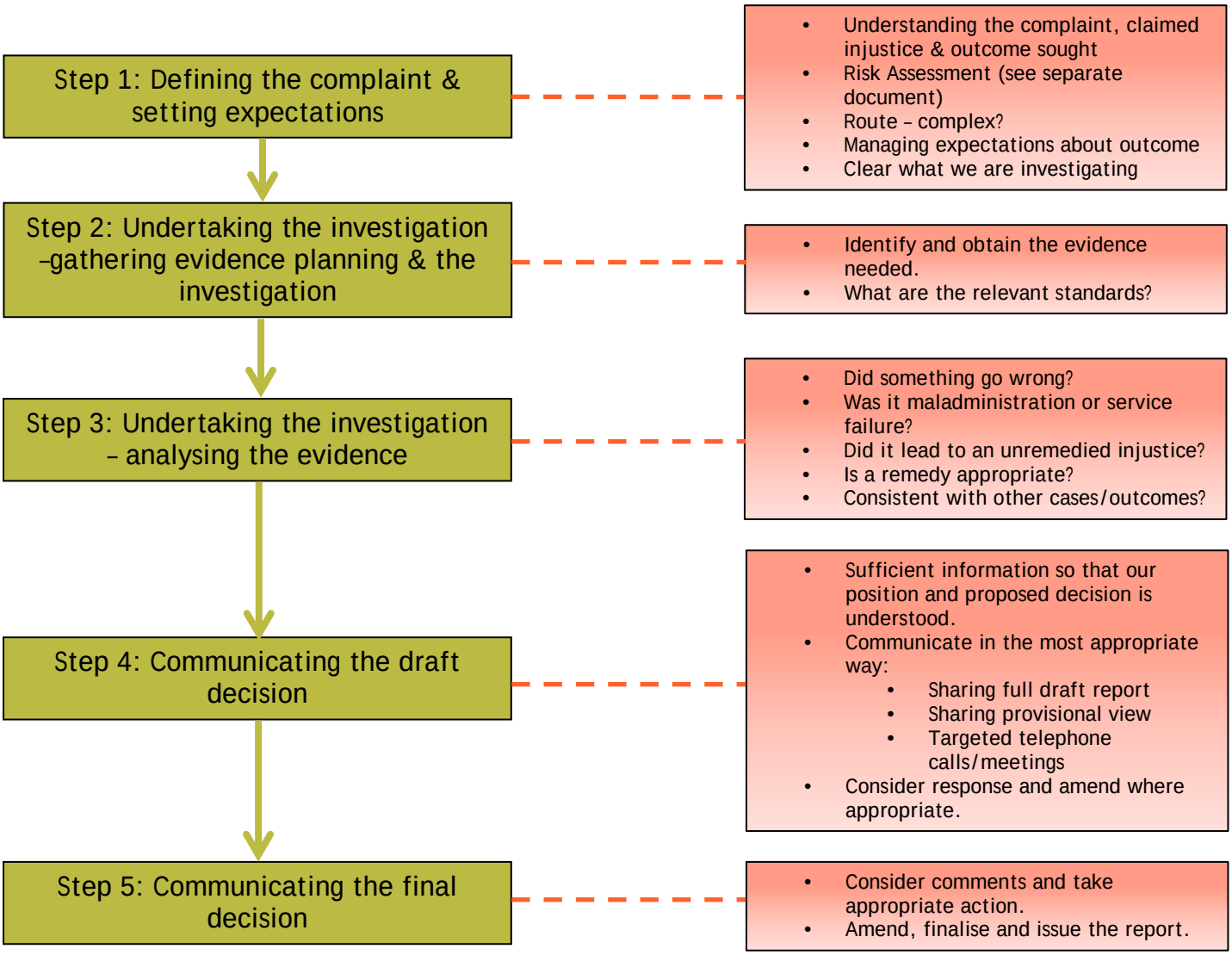
The 5 steps of the process are:

- Defining the complaint and setting expectations
- Gathering the evidence and planning the investigation
- Analysing the evidence
- Communicating the draft decision
- Communicating the final decision

Additionally, there are 7 investigation milestones which detail the key stages of an investigation. Each milestone should be actioned and marked on VF as completed, by the case worker. The 7 milestones are:

- Milestone 1: Investigation Allocated
- Milestone 2: Investigation Confirmed
- Milestone 3: Evidence/Advice requested
- Milestone 4: Ready for analysis
- Milestone 5: Draft report issued to body
- Milestone 5: Draft report issued to complainant
- Milestone 6: Receipt of draft report comments
- Milestone 7: Final Report issued

PROCESS FLOWCHART



STEP 1: DEFINING THE COMPLAINT AND SETTING EXPECTATIONS

1. Key objective of this step: to properly understand the complaint, the claimed injustice and desired outcome

2. The main actions in this stage will be:

    - Initial review of the case file
    - Contact the complainant
    - Confirm the investigation and its scope
    - Contact the organisation
    - Review case risk

    (Note: some of these actions may happen in a different order, depending on the circumstances of the case.)

o ***Milestone 1 - Investigation Allocated. Check relevant button has been pressed on VF.***

Initial review of the case file

3. Review the case file to find out:

    - What has happened so far.
    - Reasons for investigating.
    - What was in the proposal to investigate.
    - Whether replies have been received to the proposal to investigate.
    - Previous risk assessment.
    - Any diversity issues.
    - Any communication preferences.

Contact the complainant

4. Contact with the complainant should take place in all cases and, ideally this should be done by phone. However, the complainant's preferences and availability may mean that email or letter contact needs to be used instead. The following should be covered:

    - Introducing the Investigator and their role.
    - Confirm our understanding of the complaint and what the claimed injustice and desired outcome are. (Note: this is not intended as an opportunity to add in additional heads of complaint but re-scoping may be needed in some cases)
    - Be clear about any parts of the complaint not being investigated

- Manage expectations about outcome if the complainant appears to be seeking an unrealistic remedy and explain what we can realistically achieve.
- Identify whether they have further evidence that may be useful.
- Explain our procedures and the route we think the investigation will follow (including that the complainant will have the opportunity to comment on the proposed outcome of the investigation).
- Establish whether the complainant has any particular needs (e.g. communication preferences or other adjustments needed).
- Discuss and agree how, and how often, you will update the complainant and when the next point of contact is likely to be.

Confirm the investigation and its scope

5. As the law requires us to give organisations and individuals an opportunity to comment on the **proposed** investigation, we need to take a decision on whether to go ahead with the investigation, having seen any comments made.

6. There is no requirement to follow up with the organisation to get a response and we may confirm the investigation without having had the response. If there is delay at this stage or a suggestion of non-cooperation then that should be taken into account in the risk assessment.

7. If an organisation challenges our jurisdiction then the risk rating should be reviewed and advice sought from the Legal Team.

8. Any response to the proposal to investigate should be looked at by the Investigator and a decision taken on whether to go ahead, based upon what the organisation has said:

    - **Organisation declines to comment or there is nothing in the reply that casts doubt on the proposed investigation**. Case accepted and investigation proceeds.

    - **Organisation's comments cast doubt on the proposed investigation or suggest that it would be inappropriate or unnecessary to proceed (including where the organisation offers an appropriate resolution).** Case declined for investigation if we accept the organisation's response.

9. If an investigation is not confirmed then it must be dealt with as if it was being declined, with the decision letter including a full reply to the whole complaint. This will not be an investigation report and will not make formal findings or say if a complaint was upheld. The case will revert back to an enquiry on the case management system.

10. Examples of where we might not confirm the investigation:

    - Organisation provides a full remedy
    - Organisation provides clear evidence that there is no injustice, maladministration or service failure
    - Organisation shows that the complaint is still premature and it agrees to complete, or do further work on, the complaint

11. In some cases, other factors may result in the investigation not being confirmed. For example, if a complainant decides to take legal action on the complaint we were proposing to investigate.

12. The scope (what we are investigating and the perceived injustice) should also be defined and confirmed with all parties to the complaint. In some cases this may be the same as the statement of complaint that was issued with the proposal to investigate. However, in some cases, we may need to refine the detail of what we are looking at (for example, being specific about periods of care or the involvement of particular individuals). We should be clear about any parts of the original complaint which are not being investigated.

13. We do not have to confirm the investigation in writing, unless it has been specifically requested that we do so or the scope of the complaint has changed significantly. For all other cases, we can confirm to both the complainant and organisation by phone, email or other means. We must ensure that there is an accurate record on VF explaining that we have confirmed the investigation, how we have confirmed and any other comments or feedback we have received about the scope.

Contact the organisation complained about

14. Contact the organisation complained about which could include:

    - Introducing the Investigator and their role.
    - Confirm the scope of the investigation and the outcome the complainant is seeking.
    - Give relevant information about how we will conduct the investigation (enquiries, interviews).
    - Request any further evidence.
    - Explain our procedures (including that the organisation will have the opportunity to comment on a draft of any investigation report).
    - Discuss and agree how, and how often, you will update the organisation.

15. In family health service provider cases we should also consider whether we should tell the NHS organisation with which they are contracted about the investigation at this stage. The main reason for doing so is to make them aware of the investigation as they will receive an anonymised copy of the final report. Such notifications should be anonymised (that is, they do not identify the complainant or, generally, any other individual). For example, we would identify the organisation complained about but not the complainant.

16. Where an independent health provider is being investigated, we should also consider whether we should tell the health service organisation for which the independent provider was acting about the investigation at this stage. Again, the main reason for doing so is to make them aware of the investigation as they will receive an anonymised copy of the final report. Such notifications should be anonymised (that is, they do not identify the complainant or, generally, any other individual). For example, we would identify the organisation complained about but not the complainant.

17. In cases where we are investigating a second tier complaint handler we will also have sent the proposal to investigate to the original organisation. The original organisation should also be notified of the confirmation of the investigation.

Review case risk

18. Cases should be reviewed in line with the Assessing risk in casework guidance.

    - ***Milestone 2 - (Investigation Confirmed). Ensure button pressed on VF.***

STEP 2: GATHERING THE EVIDENCE AND PLANNING THE INVESTIGATION

19. Key objective of this step: to obtain the information we need to enable us to make a correct decision in the most efficient and effective way.

20. The main actions in this stage will be:

    - Identifying the evidence needed and where it will be obtained from.
    - Planning the investigation.
    - Gathering the evidence.

Identifying the evidence needed and where it will be obtained from

21. Decide whether we have enough evidence to reach a decision on the case. If not, decide what evidence is needed and how we will get it.

22. We may need to obtain the following:

    - Organisation's original records (or copies where appropriate).
    - Answers to specific enquiries from the organisation.
    - Further evidence from the complainant
    - Evidence from third parties.
    - Relevant standards (that is, the professional, administrative and legal standards that cover what is being complained about).
    - Professional advice.

Planning the investigation

23. The documenting of a plan is required on standard cases; deciding what must done and by when in order to conclude the investigation. If there is a reason why a plan is not needed (for example, on very simple, straightforward cases), then this should be clearly documented. There is a standard plan template at Annex B (available on Visualfiles). This can be adapted to each individual case.

24. The plan should reflect the agreed scope of the investigation and also take into account the complainant's desired outcome.

25. Think about whether there are reasons for obtaining additional information on the case, possible reasons for this may include:

    - A significant injustice.
    - A potential systemic issue.
    - Likely resistance to findings or recommendations.
    - To assist with a disputed/unclear fact or element of the case.

26. Investigators should ensure they record the predicted case closure date on Visualfiles.

Gathering the evidence

27. We can obtain evidence in writing, by telephone, in person, at interviews, during telephone conferences or in case conferences.

28. We should obtain copies of original papers although there may be some occasions where the originals will be required (if we have reason to doubt the provenance of the copy). We normally accept as primary evidence the files/papers of second tier or other complaint handling bodies (which will include within them copies of an original organisation's papers).

29. We should ensure that the method we are using to obtain evidence is proportionate to the importance of the evidence we are trying to obtain, and to the potential outcome of the investigation. For example, interviews or visits should not be used to obtain evidence that can be more effectively and efficiently obtained by other means (telephone, email or correspondence). Where information or evidence is unavailable or difficult to obtain then we should take into account the importance of that evidence when deciding if and how to pursue it.

30. We have wide-ranging powers to request information or documents relevant to an investigation from any person[1]**.** It may be necessary when undertaking certain enquiries to cite the Ombudsman's legal powers. If we experience difficulties at any stage of an investigation in obtaining documents or evidence from any party then the case should be escalated via line management and, where necessary, advice sought from the Legal Team. A Legal Team briefing note is available on our power to obtain information.

31. The amount or format (for example, computer files) of evidence may make it difficult for it to be sent to us. Where it is more practical or efficient to do so consider arranging to visit the premises where the evidence is held.

32. Consider whether it would be beneficial to conduct interviews, particularly in cases where the documentary evidence does not provide a clear picture of events or where we need to look into a particular area of concern.

33. We may not always need to make an enquiry of the organisation within jurisdiction to obtain guidance and legislation as we may be able to obtain details through our own information sources, external sources or by using the Learning and Resource Centre (LRC).

34. Seek appropriate professional advice (legal, clinical, other specialist) and in doing so be specific about the advice we want from advisers. If we are involving several advisers consider whether a case conference would be helpful.

    - ***Milestone 3 - Evidence/Advice requested. Ensure button pressed on VF.***

STEP 3: ANALYSING THE EVIDENCE

- ***Milestone 4 - Ready for analysis. Ensure button pressed on VF.***

35. Key objective of this step: to balance the evidence appropriately to reach a robust, evidence based, impartial decision.

[1] 1967 Act, section 8. 1993 Act, section 12

36. The main feature of this stage will be considering the evidence in order to reach a decision. It is the evidence that dictates the outcome of the investigation. There is no set point at which it is possible to reach a decision, but we are likely to be able to do so when the following questions can, as far as possible (and where relevant), be answered:

    - Did something go wrong?
    - Was it serious enough to be maladministration or service failure?
    - Did it lead to an unremedied injustice or hardship?
    - Is a remedy appropriate?
    - Is the outcome consistent with other cases and any remedy proportionate to the injustice or hardship?

37. This stage may also involve:

    - Escalation
    - Discontinuation

Considering the evidence

38. Consider and weigh up all of the evidence that is available, ensuring that the decision is based on all the relevant evidence, is consistent with the facts and ignores irrelevant information.

39. Take account of any professional advice received, but remember that we make the decision; professional advice should only inform it. Record clearly the view we have taken on any advice, including where we have decided not to follow it and why.

40. Address any problems arising from contradictory evidence, the unavailability of important evidence or the reliability of oral evidence.

Reaching a decision

What should have happened?

41. We must refer to the relevant standards to find out what should have happened. As explained in the Principles of Good Administration (under 'Getting it right') these include the law, statutory powers and duties, other rules governing the service provided, local policy and procedure and other recognised quality standards in place at the time of the events complained about.

42. In health cases there are not always clear standards for all situations and so we ask our clinical advisers to tell us what was 'established good practice' at the time of the events complained about. It's important to stick with

'established good practice' (not 'accepted practice' or 'best practice' or 'reasonable practice' or 'what could be expected' or any other formulation) because that is our test. In health cases we must avoid the Bolam[2] and Bolitho[3] tests which refers to the reasonable body of clinical opinion because this is the test courts use in negligence cases and we are not making determinations about negligence.[4]

What did happen?

43. This will be established using the evidence gathered during the investigation (for example, complaint papers, witness statements, interviews, clinical records, chronologies, explanations from clinical advisers etc) depending on the type of case and the nature of the issues complained about.

Was there a gap between what happened and what should have happened?

44. We consider what did happen against what should have happened. The Ombudsman's Principles say '*We will apply a broad test of fairness and reasonableness, taking into account the circumstances of each particular case, not a test of perfection.'* When we need to apply a test to help us decide what did happen (when there is a degree of uncertainty or conflicting evidence) our test is the balance of probability. In lay terms, that test is whether something is more likely or not to have happened. It may be that there is not enough evidence or evidence is equally balanced and in that circumstance, even on the balance of probability, we cannot come to a judgment.

45. We should be wary of making findings about complaints that have not been brought to us[5], although we can make factual comments about such matters. For example, we should not make findings about clinical records if they have not been complained about, but we could say that poorly completed records make it difficult to establish what happened, as a fact.

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[2] *Bolam v Friern Barnet Hospital Management Committee* (1957) ruled that a doctor "is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."

[3] *Bolitho v City and Hackney Health Authority* (1997) ruled that, in applying the *Bolam* test, "if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible."

[4] *R (Attwood) v Health Service Commissioner* [2008] EWHC 2315

[5] *R (Redmond) v Health Service Commissioner* [2004] EWHC 1847

46. We also need to ensure that we do not make legal determinations, for example, about reasonable adjustments or human rights. It is not the role of the Ombudsman to adjudicate on matters of law or to determine whether the law has been breached: that is a matter for the courts.

47. The Principles of Good Administration do, however, say that the Principle of 'Getting it right' includes acting in accordance with the law and with regard for the rights of those concerned, and taking reasonable decisions based on all relevant considerations. If it appears, for example, that someone's disability rights are relevant in relation to the events complained about, we will expect the organisation to have had regard to those rights in the way it has carried out its functions, and to have taken account of those rights as a relevant consideration in its decision making.

If there was a gap between what should have happened and what did happen, was this so far below the relevant standard that it amounted to maladministration or service failure?

48. Our decision about whether a failing or shortcoming (where something that happened was not in line with the relevant standard) amounted to maladministration/service failure requires a judgment about how serious the failing was. Not every fault will be maladministration or service failure.

49. We do not have to make a finding of maladministration/service failure on every point of the complaint. We can do that, but more often we make an 'in the round' decision. This is a good way of ensuring our decision is fair and balanced. An example is nursing care. We might find that there were shortcomings in the way that nurses recorded what someone ate but that their assessments of nutritional need, their plan to meet the identified need and their attention to implementing the plan was in line with the relevant standard. A likely decision would be that although there was a shortcoming in what they did the nurses got most things right and on balance the nutritional care did not fall so far below the relevant standard that it was service failure.

50. However, we need to be careful not to lose sight of something which was such a serious failing on its own that it tips the scales towards service failure. Using the same example we might find that the assessment of nutritional need, the plan to meet that need and the recording of what the person ate was all in line with the relevant standard but on several occasions the person was given inappropriate food which they were not able to eat. Here we might decide that although the assessment, planning and recording were in line with relevant standards the fact that the person was given inappropriate food on several occasions was such a serious failing that the nutritional care he received amounted to service failure.

51. Another possibility is that a series of minor failings mean that on balance we make a finding of service failure.

Did it lead to an unremedied injustice or hardship? (What was the impact of the maladministration/service failure on the people involved: the complainant and/or the aggrieved?)

52. Where we find maladministration or service failure we then need to decide whether it led to an injustice. An error may have happened that did not lead to an injustice or someone could have suffered an injustice but it did not actually happen because of the maladministration or service failure. There are some cases in which it can never be known (even on the balance of probabilities) if there is a link between what went wrong and the claimed injustice (for example, some cases which revolve around the outcome of court proceedings had circumstances been different) and there are other cases where we will find that the link between maladministration and the claimed injustice is not established.

53. The impact and injustice are part of our findings. This is not just what the complainant/aggrieved says. We need to analyse the evidence and come to a finding. The key question is 'did the injustice claimed occur in consequence of the maladministration/service failure we have found' (not other things that may or may not have gone wrong). In health cases we are often guided on this by our clinical advisers, for example in relation to chances of survival, or impact of delay in treatment.

54. We can make findings of injustice which relate to the claimed injustice. For example we may find that death was not avoidable but that there was a missed opportunity to provide treatment which may have prolonged life. This has left the complainant in a position where they will never know whether, had that opportunity not been missed, the person would have survived and this has caused an injustice.

55. We cannot invent injustice. If we think that an injustice flows from the maladministration/service failure but the complainant has not raised this with us, we can ask them if they want us to consider it during our investigation.

56. Injustice could include:

- loss through actual costs incurred. For example care fees, private healthcare and 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, and loss of financial opportunity;

- being denied an opportunity. For example, to make a choice in the light of the full facts or risks (such as an informed consent decision in relation to a surgical procedure); and
- inconvenience and distress as a result of failures in service provision (for example, delay in receiving a benefit, worry over the effect of misinformation, cancelled operations, misdiagnosis) or where the handling of the complaint in itself has been prolonged or inadequate.

57. The typology of injustice contains definitions of the injustice types that have been identified from our casework.

58. If the injustice did happen because of the maladministration or service failure then we need to look at whether the injustice is still unremedied because, in some cases, the organisation complained about may have provided an appropriate remedy.

What can the organisation do to remedy any injustice or hardship?

Remedy for the individual and those similarly affected

59. The Principles for Remedy are our guide in our approach to securing remedy for injustice which we have found to flow from maladministration/service failure we have identified. As the Principles say, some remedies are straightforward and others require very careful consideration. A key point is that remedy should be appropriate and proportionate to the injustice sustained. When an injustice is unremedied, our general approach is that we seek to place people back in the position they would have been in had the maladministration or poor service not occurred. The Principles say that where the injustice cannot be put right compensation may be appropriate. Most often this is where we recommend payments related to personal impact such as distress, frustration, pain and inconvenience. The Typology of Injustice and casework discussion helps us determine appropriate amounts by referring to our precedents and considering the circumstances of the individual case. Please note that remedies will be determined by the impact on the individual (or individuals) concerned

60. If an investigation has found maladministration or poor service and if we have found that an unremedied injustice flowed from that, then we will need to consider what type and level of remedy it is appropriate to pursue.

61. The types of remedy that we might seek to obtain will be tailored to the individual circumstances of the case (while taking account of similar cases). Appropriate remedies can include:

    - apologies, explanations or acknowledging responsibility;

- remedial action such as reviewing or changing a decision; revising published material or revising procedures to prevent a recurrence; or

- financial compensation.

62. Decide if redress is appropriate and, if so, identify a remedy which flows from, and is proportionate to, the injustice that has been identified. We need to be aware that it is for us to determine whether a remedy offered or proposed is appropriate, not the complainant.

63. Please note that an apology should always be by personal communication from a suitably senior person within the organisation in jurisdiction to the aggrieved or his or her representatives. The apology should be specific in what it is addressing rather than general. Expressions of regret and apology made through this Office rather than direct to the aggrieved are not an appropriate form of remedy.

Specific considerations in respect of financial remedy

64. Consider the following when looking at questions of financial remedy:

- Both the final amount that is paid and the way this amount is calculated should be proportionate to the injustice resulting from the maladministration.

- Calculations of financial loss incurred by an individual should be based on evidenced and quantified loss. We may need to obtain an appropriate independent opinion, for example, legal or financial advice to check our understanding of the loss.

- Any delay between when the financial loss was incurred and the compensation payment date should be recognised by the payment of appropriate interest.

- Compensation should be appropriately linked to other forms of redress - for example, an apology.

- Some organisations within jurisdiction may have their own compensation schemes by which they judge levels of financial remedy in respect of maladministration or poor service. In recommending a level of financial remedy we are not bound by the rules or limits of such schemes.

- When considering the level of financial redress, we should also consider factors such as the impact on the complainant (were they

particularly vulnerable; was ill-health compounded, hardship aggravated or injustice prolonged?); the length of time taken to resolve the complaint and the trouble that the individual was put to in pursuing the complaint. When considering awards for distress or inconvenience we should also take into account the level of awards made to others who have suffered a similar injustice.

- Financial compensation may be appropriate, additionally, for injustice or hardship deriving from the pursuit of the complaint (as well as the original dispute). For example, costs in pursuing the complaint or additional inconvenience or distress caused.

- Is the outcome consistent with other cases we have looked at and any remedy proportionate to the injustice or hardship?

65. The typology of injustice contains a searchable database of a range of upheld or partly upheld investigations. This is intended to help caseworkers identify relevant precedent cases when thinking about recommendations for financial redress. Advice on proposed levels of recommendations for financial remedy can be sought from the Outcomes and Compliance caseworker.

Escalation

66. When reaching a decision on an investigation it is particularly important to think about whether any of the provisional findings suggest that there might be a wider systemic problem (outside of the individual complaint) either in relation to a particular issue (for example, are we seeing similar complaints about a range of health organisations) or a particular organisation (for example, are we seeing a range of similar complaints).

67. If the case has evidence of systemic issues then you should escalate the case to your Manager so that a decision can be taken on what action should be taken.

Systemic remedy

68. We may also make recommendations for systemic remedy: to prevent a recurrence of the failings that we have found. Generally this should take the form of asking the body to propose their own solutions to the systemic problems we have identified in our report. Usually we do not make specific systemic recommendations. Our general approach is that it is for the individual or organisation to decide how to achieve the required changes and improvements. Most often systemic remedy is in the form of an action plan which asks the individual or organisation to set out what they will do and by when to address the failings identified in the report.

69. It may be appropriate to bring the need for a systemic remedy to the attention of the organisation at draft report stage with a view to opening a dialogue, which may also bring out the extent to which the body is aware of the problem and are taking/have taken steps to deal with it. It is not our role to direct the body as to the changes that they should make, although it is appropriate for us to guide the body if we consider that a specific form of remedy is merited.

Recommendations

70. Recommendations in a report are used normally to obtain a remedy for injustice arising from maladministration or poor service. The basis for our recommendations is normally the unremedied injustice arising as a consequence of maladministration or service failure. In those circumstances, recommendations must be relevant to the injustice found: whether this is to the complainant concerned; to others who have been affected or to those who might be so affected in the future.

71. The remedy is to put right the injustice resulting from maladministration. It is not compensation for the maladministration.

72. All remedies must be SMART (specific, measurable, achievable and realistic, with a timescale).

73. Discuss the proposed or requested remedy with the complainant and manage their expectations if they are seeking a remedy that would be unachievable or disproportionate.

Payments where the aggrieved has died

74. In cases where the aggrieved has died we will not automatically recommend that any financial remedy (which would have been payable to the aggrieved if they were alive) be paid to their family or to their estate. These cases should be considered on their individual merits, but the following should be considered:

- In cases of actual financial loss we can consider asking for payments that would have been due to the deceased to be made to their estate (for example, a special payment for loss of benefit that should have been paid while they were alive). However, we would need to be certain that any payment would have been payable to the deceased, were it not for the failings identified.

- We would normally only recommend compensation for non-financial loss for the family members of the deceased if they have suffered a specific

injustice themselves (for example, emotional injustice as a result of witnessing the poor care given to their relative). This should be explored as part of the investigation.

Compliance

75. When making recommendations we should also think about how the organisation under investigation will comply with them, what evidence we will need to see to satisfy ourselves that compliance has been achieved and how we will monitor compliance.

When is an investigation upheld?

76. Where we have found that an unremedied injustice (or hardship) arose in consequence of maladministration or service failure then a complaint will be upheld (fully or partly as applicable). A decision about whether one of these cases is fully or partly upheld should be based on the circumstances of the case but a decision to partly uphold a complaint will normally result from a multi-strand complaint where we have only upheld some parts or a case where we found a lesser injustice than that claimed.

77. We will uphold (or partly uphold) complaints if we find that the injustice (or hardship) was remedied after the complaint was received by the Ombudsman but either before the start of, or during, an investigation. However, there may be some cases of this type where the organisation offers a full remedy and we do not make formal findings:

    - If the full remedy is offered immediately in reply to the proposal to investigate. In these cases we may revert the case to an enquiry and close it as a resolution.

    - The organisation offers a remedy during the investigation which is accepted by all parties and we close the case as a mediated outcome.

78. Where we have found that an injustice (or hardship) arose in consequence of maladministration or service failure but that it was fully remedied before the complaint was received by the Ombudsman then a complaint will not be upheld.

79. If we find that there was maladministration or service failure but that an injustice did not flow from it, then the complaint will be partly upheld. In some cases we may decide that, even though we have identified potential failings, the organisation should review the complaint and consider how it might be resolved.

80. A full list of investigation closure codes is at Annex A.

Precedent Checks

81. These are electronic checks carried out on the records we hold about the organisation/s we are investigating. We look to identify recurring issues about these organisations dating back over the past two years. The purpose is to identify possible trends and give the caseworker some context about the organisation. If appropriate, we might also identify other cases with the same complainant and check if named person(s) had been previously complained about.

82. Precedent checks should be completed on all partly or fully upheld cases. They do not have to be carried out at the start of a case or on not upheld cases. However, if the investigator has particular concerns for any reason, for example about poor standard of medical records, or the case is high risk / profile, the investigator can request a check if they feel it is appropriate for their case.

83. The investigator should request a check from Business Support. They will complete the check, but it is the investigator's responsibility to look at the results to see if we have made similar recommendations to the organisation in the past. This is to avoid us repeating recommendations or to alert us to ongoing problems despite previous recommendations.

84. Investigators should also raise any concerns about repeated mistakes by an organisation with their manager, for example, if the check shows we have several investigations that are upheld on complaint handling. Investigation managers can then pass this information to relevant staff, such as liaison and/or strategic investigations managers;

85. Where we are making systemic recommendations we should check the outcome of any recent Care Quality Commission (CQC) inspections in the area of the organisation or aspect of care we are investigating. For example CQC may have done an inspection after the events complained about which found satisfactory standards (or not). Our recommendations can be tailored to join up with CQC results where appropriate

Discontinuing an investigation

86. There are a number of circumstances in which we might consider discontinuing an investigation (this list is not exhaustive):

    - when the complainant requests it;
    - where the complainant has obtained or resorted to an alternative legal remedy on the same facts;
    - where the complainant fails to co-operate;
    - where the complainant has died; or

- where the unreasonable behaviour policy has been applied.

87. The decision on whether to discontinue an investigation rests with PHSO and not any of the other parties to the complaint. If an investigation is discontinued then we must provide the relevant parties to the complaint with our reasons for doing so, because we are in effect taking a decision not to investigate a complaint.[6]

88. Any case in which we are proposing to discontinue, should be referred first for an internal 'in principle' approval for the discontinuation to be given. The level for this approval is given in the Delegation Scheme.

89. In all cases (with the exception of those where the complainant is requesting discontinuance) the complainant needs to be told what we are proposing to do and why, and to be given an opportunity to give their views before the final decision is made. In some circumstances it may also be appropriate to seek the views of the organisation under investigation. Once comments have been obtained from the parties to the complaint (as appropriate) the final decision to discontinue must be taken in line with the Delegation Scheme.

STEP 4: COMMUNICATING THE DRAFT DECISION

90. Key objective of this step: to reach a decision that is correct, and evidence based, and to communicate this clearly and appropriately. To conclude our investigation at the earliest possible stage.

91. The main features of this stage are:

- Sharing sufficient information so that our position and proposed decision are understood.
- The draft decision is communicated in the most appropriate way.
- Obtaining and considering the responses to the draft decision and making amendments where appropriate.

Why we share drafts and who receives them

92. The law does not require the sharing of draft decisions but we do so because:

a. If we are criticising an organisation or individual within jurisdiction, it is fair to allow them to have the opportunity to respond to that criticism; and

[6] 1967 Act, Section 10(1). 1993 Act, Section 14(1)-(2)

b. It allows the parties to the complaint to comment upon and raise concerns about the factual accuracy, findings and any proposed recommendations; and enables us to take those comments into account before the report is finalised.

93. The draft decision must be shared with both parties, that is, the complainant and the organisation complained about (if we have investigated a second-tier handler only, then this includes sending the report to the original organisation).

94. The draft decision must also be shared with any person specifically named in the complaint[7].

    a. For health complaints, if a complaint is made against a sole practitioner (who will have been recorded as a named person) then we share the draft decision directly with them. In all other cases (for example, if a Practice has more than one Practitioner) then the draft decision should be shared with both the organisation/provider and the named individual.

95. Draft decisions can also be shared with advocates or other representatives, providing we have appropriate authorisation from the complainant for them to act on their behalf.

96. The draft decision should be shared with the organisation complained about by contacting the person who we wrote to originally asking for comments on the proposal to investigate. In Parliamentary cases this will normally be the Permanent Secretary or Chief Executive of the organisation in jurisdiction. In Health cases this will normally be the Chief Executive of the organisation in jurisdiction. Draft decisions can be shared simultaneously to other parties within the organisation in jurisdiction as appropriate (for example, Agency Chief Executives if the report was sent to the Permanent Secretary of a Department, focal points or local complaint handlers).

97. The draft report should be signed off in line with the Delegation Scheme

Review case risk

98. At the draft report stage, cases should be reviewed in line with the Assessing risk in casework guidance.

[7] These individuals will have been notified previously of the complaint and our investigation, normally at the 'proposal to investigate' stage.

Content of draft decisions

99. Receipt of the draft decision is likely to be the first time that the parties to the investigation become aware of the proposed outcome of the investigation and the impact it will have on them. It is therefore important that our decision and the reasons for it are clear.

100. Annex C contains a checklist of points that should be considered when writing a draft report. The below links also set out a template report for both Health and Parliamentary cases. Both the checklist and template can be tailored accordingly.

101. In some cases we may decide to share a provisional view. This means that we share our early thinking about the complaint or some particular aspect of it in order to make quicker progress towards concluding the case. For example:

- If we obtain early and very clear clinical advice which indicates that there was service failure we could share that advice with the organisation, under a brief covering note, in order to flush out objections or arguments at an early stage or to get agreement to further work on the complaint.

- If we have clear indications of an unremedied injustice flowing from maladministration we could share the key arguments and supporting evidence with the organisation to try and obtain early agreement to an appropriate remedy.

How to share draft decisions

102. A decision needs to be taken on how the draft decision will be shared. In many cases we will share a copy of all or part of the draft decision and ask for comments in writing. However, we can share by other means (or a combination of them). Other options are:

    a. Sending the report and asking for comments by phone.
    b. A phone call in advance of the report being sent.
    c. A meeting to share the draft report.
    d. Sending the report and then meeting to discuss it.
    e. Sharing the decision by phone only.

103. The circumstances of the case should determine which method is used. For example, a meeting might be used for particularly sensitive cases or

where we are likely to face a challenge. Sharing by phone is likely to be appropriate for straightforward cases.

104. A decision on whether to share the decision sequentially (for example, with the organisation first and then the complainant) or simultaneously should be taken on a case-by-case basis. However, the fact that an organisation or individual is being criticised does not prevent us from sharing simultaneously with them and with the complainant.

105. If third parties have provided information or been referred to in other evidence that we are going to include in our draft decision (for example, other family members, Social Services employees, banks or building societies) then we must consider if it is necessary to check with them that we have the facts correct. We would probably only share the relevant sections of any decision. Contact the complainant first if you are going to contact someone known to them.

106. In some cases it may be appropriate (for example, where the report is particularly lengthy or complex, or where the events are in dispute) to share the draft report in stages. This would normally mean sharing the draft factual sections of the report first (in order to obtain comments on that and reach a view on what actually happened). But could also involve sharing clinical advice separately, particularly where that may be controversial or we anticipate the organisation challenging it. After we have received comments on those sections of the draft report we should share the full draft report, including our findings and recommendations.

107. In some cases it may be inappropriate to share the entire draft report with every person involved. In these circumstances, the relevant portions of the report should be sent to the individuals concerned. For example, if a report criticises both a GP and a hospital consultant and it is not necessary for them to see the entire report to understand our findings and recommendations relating to them as individuals. In those circumstances we should consider excluding the criticism of the other individual from the decision being shared with each named person, until they have both had an opportunity to comment and/or provide further evidence.

108. To help the process of the sharing and receiving of comments on draft reports run as smoothly as possible it is good practice to consider telephoning recipients of the decision:

a. In advance to let them know that it will be sent shortly.
b. After it has been issued, to confirm that they have received the report and are aware of the deadline for comments.
c. In advance of the deadline to remind them when comments are due.

109. Below are links to our template covering letters which should accompany the draft report to the complainant and organisation. The covering letters should be tailored accordingly. These can be accessed on VF through **'Investigator' > 'General Action' > 'Letter Templates'.**

- Standard Letters - 4a - Cover letter for Draft report - to customer
- Standard Letters - 4b - Cover letter for draft report - to organisation

  - ***Milestone 5 mandatory - Draft report issued to body. Ensure button pressed on VF.***

Requests for extensions and failure to respond

110. We expect parties to the investigation to respond to draft decisions within a reasonable timescale and to contact us promptly if they are unable to meet the deadline. Any request for an extension should be considered on its individual merits and discussed with line management if necessary. Factors that might lead us to grant an extension include:

- That the respondent notified us promptly of the delay (rather than a 'last minute' request).
- Where there is good reason for the delay: for example, if a complainant has been away from home or unwell or if we are satisfied that an organisation is making genuine efforts to respond fully to the report (that may include circumstances where the organisation is developing a response to a recommendation for remedy).

111. If the organisation in jurisdiction fails to respond at all to the draft decision by the date set, then we should chase progress by telephone and, if appropriate, agree a new date (in these circumstances we would not normally allow more than a further 7 calendar days unless there is a good reason to). If no response is received by the revised date then we should decide whether to proceed without their comments. In such cases, the risk assessment of the case should be reviewed and a decision taken on whether the case should be escalated.

112. If the complainant fails to respond at all by the date that was set when the draft decision was shared it may be that they do not want to comment. Do not issue a final report on the day that responses are due to be received back from the complainant. Wait **at least** until the following day and check to see if correspondence has been received. In those circumstances we will proceed to the next stage without comments.

113. The issuing of a draft decision may sometimes prompt an information request for the material evidence we have relied upon to reach our decision. Material evidence is the information we used to arrive at a decision on that complaint. This evidence should be described in our analysis and reports and also be identified on the case file. If a request is received you will have to decide what that information is and (usually) give it. If the request is at draft decision stage and the volume of papers given is large then you may, in the interest of fairness, need to extend the deadline for comments. If there is any concern about releasing any of the information (for example, due to its potential to cause harm or because it contains third party information) then please contact the FOI/DP team for advice.

Considering the response

114. Ensure that you consider the comments received following the sharing of the draft decision and decide what impact those comments have on the decision. Be robust in the assessment of comments received on the draft. Remember that it is the Ombudsman's investigation and that we are independent. If a complainant or organisation in jurisdiction disagrees with elements of the report then we can reflect those views when we issue the final report (in a covering letter if necessary), even if we are not persuaded by them. A note should be placed on Visualfiles to show that we have considered the comments and that contains a proportionate analysis of the view we have taken on them:

- This note should contain enough information so that anyone coming new to the case could understand the view we took on the comments made on the draft decision and why.
- It is not enough to say simply that the comments have been considered and there is no basis to change the decision.
- The note must acknowledge (even if only in summary form) the key points made in response to the draft decision and any related analysis (that is, why we decided to make changes or not).
- In some cases the complainant may simply restate their complaint. If that happens and they have not provided any new evidence, new facts nor highlighted any inaccuracies or omissions then the analysis should say so clearly and give that as the reason for not changing the decision.

115. If appropriate, undertake further investigation or analysis of the evidence provided and consider whether further evidence gathering (for example, clinical advice in health cases) is necessary in the light of the comments received

116. Generally, we should not treat a complainant's challenge or unhappiness with our provisional findings as a complaint about us or as a reason for reallocating the case. The key reason for sharing our emerging findings in draft form is to give the parties to the complaint the opportunity to comment on those provisional findings. However, if you are uncertain about whether comments in response to a draft report should be treated as a complaint then speak to you manager in the first instance.

117. If the organisation challenges a provisional finding then we should review the risk rating on the case and ensure that the case is escalated appropriately.

- ***Milestone 6 - Receipt of draft report comments. Ensure button pressed on VF.***

Refusal to accept recommendations

118. Where an organisation or individual refuses to accept a recommendation for remedy made in a draft investigation decision, the following process should be followed.

119. Review the reasons given for refusing to accept the recommendation, seeking advice if necessary, and decide whether the recommendation should be retained or amended/removed.

120. If the recommendation is to be amended/removed then the decision should be updated and consideration given to whether the whole decision needs to be re-shared with the parties. If it is not re-shared in full then the parties should be told about the amended/removed recommendation before the report is finalised.

121. If the recommendation is to be retained then the case risk should be reviewed and should be escalated to Assistant Director level in order to decide how to proceed. We should consider what action we will take if the organisation/ individual maintain their refusal and who will take that action. This may include:

- Referral to professional body (for example, GMC or GDC).
- Referral to appropriate regulator.
- Publication of a report (liaise with the Publications Steering Group, through EA&S/Operations).

122. The normal process will be to contact the organisation/individual, explain that we intend to proceed with issuing the final report with the recommendation unchanged, set out any other action we propose to take and to give the organisation/ individual a final opportunity to

accept the recommendation. That contact should ideally take place by telephone but it may be necessary to follow this up with email or written contact.

123. If the organisation/individual maintains their refusal then we should proceed to finalise and issue the investigation report supported by whatever additional action has been agreed.

Further draft reports

124. In circumstances where the comments on a draft decision result in further substantive investigation work being undertaken or significant changes to the decision, then we should consider whether it is appropriate to reshare the decision in draft. Decisions to reshare should be taken on the individual circumstances of the case and discussed with line management in the first instance.

STEP 5: COMMUNICATING THE FINAL DECISION

125. Key objective of this step: to ensure that our decision and rationale are clear and easy to understand.

126. The main features of this stage are:

- Communicating the final decision clearly and effectively
- Closing the case and ensuring that arrangements for compliance monitoring are in place.

What the law says

127. In **parliamentary** cases the Ombudsman must issue the final report to the referring MP, the 'principal officer' of the organisation complained about, to any person specifically complained about and (in Victims' Code cases only) to the complainant. We do send a separate copy of the final report to the complainant in all other cases as well, but this is not a legal requirement[8].

128. In health cases the Ombudsman must issue the final report to a list of people which changes depending upon the section under which the investigation has been conducted. However, in all cases a report must be sent to the complainant, the person or organisation specifically complained about, any other person specifically complained about and any MP who assisted in the making of the complaint.[9] We also have the

[8] 1967 Act, section 10(1)-(3)
[9] 1993 Act, section 14(1)-(2)

power to share a health report with any other person we think appropriate. Such decisions will be taken on a case by case basis.

Case summaries

129. Separate guidance is available on what caseworkers need to do to write case summaries for publication and to notify the relevant parties of potential publication.

Naming clinical advisers

130. In reports or decisions we will not name clinicians. This includes: drafts, final investigations and decisions not to investigate.

131. Requests for the names of individual clinicians should be treated as individual Freedom of Information requests and advice sought as appropriate from the Freedom of Information/Data protection team in Legal Services.

132. Any investigation report that refers to clinical advice must explain that the clinical advice is only one part of the evidence that has been considered in reaching our decision (all investigation reports should include reference to the material evidence we have relied upon).

Approving final reports

133. Final investigation reports should be approved in line with the levels set out in the Delegation Scheme. The need for escalation of a case above those levels should be determined by the individual circumstances of the case.

134. A member of staff approving a final report should only do so having seen the draft report supported by any necessary separate analysis (for example, analysis of comments on the draft report).

Reports for the Ombudsman's signature

135. Reports relating to investigations of complaints referred by the Speaker of the House of Commons, the Chairman and Members of the Public Administration Select Committee, the Chairman of the Health Select Committee, the Chairman of the Public Accounts Committee and leaders of the three main parties must be signed by the Ombudsman or Managing Director.

136. In cases for the Ombudsman's signature, it is generally the case that the decision will be shared and all relevant feedback taken into account

before sending the file to the Ombudsman's Casework Manager. However, there may be cases (for example, high risk cases) where the Ombudsman should be consulted or sighted at an earlier stage. Investigators should keep their Managers and Directors sighted on any cases that are likely to require the Ombudsman's signature.

137. The case file, with appropriate final drafts (of both the report and covering letters) for the Ombudsman's signature, should be referred via line management and sent to the Ombudsman's Casework Team. Any queries regarding cases to be signed by the Ombudsman should be directed to the Ombudsman's Casework Team.

Process for issuing reports

138. The final investigation report should be issued simultaneously to all the parties to the complaint. Reports will be sent to all parties under a covering letter. Letter reports will be addressed directly to the complainant and sent to other parties under a covering letter. In some circumstances a covering letter to the complainant may be used with a letter report to address issues outside of the final report (for example, if the complainant had raised issues about our handling of the complaint or to respond to comments about the draft report).

139. A template for the final covering letters can be accessed on VF through **'Investigator' > 'General Action' > 'Letter Templates'.** and linked to here:

- Standard letters - 5a - Cover letter for final report - to customer
- Standard Letters - 5b - Covering letter for final report - to organisation
- Standard Letters - 5c - Covering letter for final report - to MP

140. In all cases where the complainant has been represented by an advocate or other professional representative we should (providing we have written authorisation from the complainant for the representative to act on their behalf or to receive copies of all correspondence) also send them a copy of the final report.

141. If we have investigated the actions **only** of a second tier complaint handler and were, at the start of the investigation, required to notify the original organisation of the complaint and give them the opportunity to comment then we should send the original organisation the final report. If we notified the original organisation of the investigation (but did so at our discretion) then they should be notified of the outcome, although it will not generally be necessary to send them the final report.

142. The parties to the complaint should be sent a hard copy of the signed report.

o ***Milestone 7 - Final report issued. Ensure button pressed on VF.***

Additional requirements: parliamentary cases

143. The signed report is sent to:

- the referring MP[10]
- the complainant
- the Permanent Secretary/Chief Executive of the organisation in jurisdiction[11] (we would also copy the report to any focal point or complaints lead with whom we had been dealing during the investigation)
- any person specifically complained about[12]

144. A signed copy of the final report should also be retained on the case file

Additional requirements: health cases

145. The signed report is sent to:

- any MP involved[13]
- the complainant[14]
- the organisation complained about[15] (addressing the report to the person to whom we addressed the original letter seeking comments on the proposed investigation: normally a Chief Executive but copying to other parties as appropriate). In family health service provider cases we should write direct to that organisation (for example, a GP practice). Where an independent provider is to be investigated, we should write to the Chief Executive (or equivalent) of the provider.
- the relevant commissioning organisation (where the law requires us to do so or there is another specific reason to do so).
    - We are required by law to send reports to clinical commissioning groups (CCGs) and to NHS England when they have commissioned the service complained about from an independent provider or a family health service provider. The law does not require us to do so when a CCG or NHS England

[10] 1967 Act, section 10 (1)
[11] 1967 Act, section 10 (2)
[12] ibid
[13] 1993 Act, section 14(1)- (2)
[14] ibid
[15] ibid

have commissioned the service from a health body (for example, a Trust).
    - Reports sent to commissioners should be an anonymised version of the final report (which does not identify the complainant or, generally, any other individual).
    - In a case which involves multiple CCGs we can consider identifying the single most appropriate CCG to share the report with (for example, the 'home' CCG where the patient lives).
- any person specifically complained about[16] (Note: if a complaint is made against a family health service provider who is a sole practitioner then we should send only one copy of the report, but, in the covering letter, should explain that this meets the statutory requirement to notify both the provider and the 'person specifically named in the complaint'. In all other cases, (for example, where a Practice has more than one Practitioner) the final report should be sent to both the organisation/provider and the person specifically named in the complaint.

146. The above information is also set out in a table at Annex E.

147. A signed copy of the final report should also be retained on the case file.

148. We have a power[17] to share the report with other people we consider appropriate. Such decisions will be taken on a case by case basis. Where we do share a report with another party we need to consider whether any personal data in the report needs to be redacted from it in order to comply with the requirements of the Data Protection Act. A common redaction would be to anonymise the report so that the complainant cannot be identified. If you are unsure about how to proceed in dealing with such issues then discuss with your line manager and, where necessary, seek further advice from the Head of FOI/DPA or the Legal Team.

Sending reports to responsible officers in complaints about named doctors

149. Where we uphold or partly uphold a complaint against a named doctor we must consider whether to send the final report to that doctor's responsible officer[18]. The purpose of sending the report to the responsible

[16] ibid
[17] ibid
[18] A responsible officer's role is (broadly) to ensure that doctors are regularly appraised and where there are concerns about a doctor's fitness to practise they are investigated and, where appropriate, referred to the General Medical Council (GMC). Each doctor will have a responsible officer who will make a recommendation to the GMC (normally every 5 years) as to whether that doctor's license to practice should be revalidated.

officer is to make them aware of the finding about the doctor so that they can consider it as part of their ongoing appraisal of the doctor and as part of the revalidation process.

150. Our normal approach is to send an anonymised report in these circumstances, unless there is good reason not to do so. If we decide not to do so then the reasons should be recorded on Visualfiles. Reasons for not sending a report could include:

- Where the overall complaint has been upheld or partly upheld but the service failures lie with another individual (or organisation).

- If the doctor has retired since the events complained about and/or has been removed from the General Medical Council's List of Registered Medical Practitioners.

151. In most circumstance, we will be sending reports to responsible officers using our powers under Section 14 of the Health Service Commissioners Act 1993. Although in some cases, responsible officers may be recipients of reports or other information if we are making a disclosure in the interests of the health and safety of patients.

152. A final report should be sent to a responsible officer under a brief covering letter.

Monitor and the NHS Trust Development Authority

153. In any health investigation report where we have made a recommendation for systemic remedy to prevent recurrence we should also send an anonymised copy of the investigation summary (or if there is no summary a copy of the anonymised report) to:
    - Monitor (if the NHS organisation is a foundation trust)(summaries for Monitor are sent individually under a brief covering letter at the point that the report is issued.)
    - NHS Trust Development Authority (if the NHS organisation is a non-foundation trust) (summaries for the authority are sent individually under a brief covering letter at the point that the report is issued.)

Refusal to accept recommendations

154. A refusal to accept a recommendation will normally have been identified when an organisation or individual responds to a draft report and a decision taken on how to respond. If we have retained the disputed recommendation in our final report then we should ensure that any additional action that has been agreed takes place (for example, referral to professional body or appropriate regulator).

Closing the investigation

155. Under the 'Investigator' tab on Visualfiles select 'Investigation outcome' and then record whether the complaint was fully, partly or not upheld. A full list of investigation closure codes is at Annex A.

156. If the complaint has not been upheld then the case can be closed (on the day the final report is issued) by selecting (under the 'Investigator' tab) 'Case closure' and then the 'Issue final report' option.

157. Any recommendations contained in the final report will need to be noted on Visualfiles (under the 'Investigator' tab select 'Compliance').If we have not upheld the complaint then we cannot normally make any recommendations. It is a requirement to add at least one compliance item to Visualfiles on any fully or partly upheld complaint. Once relevant compliance items have been added then the case can be closed (on the day the final report is issued) by selecting (under the 'Investigator' tab) 'Case closure' and then the 'Issue final report' option.

158. Where we have found that an unremedied injustice (or hardship) arose in consequence of maladministration or service failure then a complaint will be upheld (fully or partly as applicable). A decision about whether one of these cases is fully or partly upheld should be based on the circumstances of the case but a decision to partly uphold a complaint will normally result from a multi-strand complaint where we have only upheld some parts or a case where we found a lesser injustice than that claimed.

159. We will uphold (or partly uphold) complaints if our final report finds that the injustice (or hardship) was remedied after the complaint was received by the Ombudsman but either before the start of, or during, an investigation.

160. Where we have found that an injustice (or hardship) arose in consequence of maladministration or service failure but that it was fully remedied before the complaint was received by the Ombudsman then a complaint will not be upheld.

161. If we find that there was maladministration or service failure but that an injustice did not flow from it, then the complaint will be partly upheld. In some cases we may decide that, even though we have identified potential failings, the organisation should review the complaint and consider how it might be resolved.

Compliance

162. Where we find maladministration or service failure which has led to an injustice or hardship we make recommendations about how the relevant organisation should remedy that injustice. Where the recommendation is delivered, that represents the outcome for the aggrieved person (and other persons on whom the recommendation may impact, which could include all of the relevant organisation's customer base or the wider public). The process by which we assure ourselves that the recommendation has secured the outcome is by monitoring the relevant organisation's compliance.

163. Any completed investigation which involves a recommendation for remedy, for example an apology, financial redress, a change in procedure or other recommendation, must be recorded in Visualfiles as a compliance item. This applies to items proposed or agreed by the organisation investigated even if the issues are resolved before the final decision is issued. When issues have already been resolved before the final decision is issued then a compliance item should be opened as normal – but it will be closed immediately as compliance has, in effect, already been achieved.

164. We consider compliance to have been achieved when we are satisfied that the relevant organisation has taken reasonable steps to implement our recommendations. Once we are satisfied that all of our recommendations have been complied with, we should write to inform the complainant and the relevant organisation that our action is complete More detailed information is available on the compliance process in Annex D.

Annex A: Investigation closure codes

Further work required by organisation
Potential failings identified but we decide that the organisation should review the complaint and consider how it might be resolved.

Mediated outcome – Complaint remedied without findings being made
Where we have mediated a resolution with the organisation and the complainant which means we can close the investigation without making findings or recommendations.

Not upheld - No maladministration or service failure
No maladministration or service failure identified.

Not upheld – Failings found but already accepted and remedied by organisation
Failings identified but we are satisfied that the organisation has taken appropriate and reasonable steps to put things right before our involvement.

Partly upheld – Failings found but no injustice
Failings identified but they have not led to any injustice or hardship. If the organisation has already accepted and acknowledged the same failings we have identified, the appropriate closure code might be 'Not upheld – Failings found but already accepted and remedied by organisation', as above.

Partly upheld – Failings found but not injustice claimed
Failings identified but the injustice is not as great as that claimed.

Partly upheld – Multi-strand complaint
To be used where there are a number of different strands to the complaint and we have upheld some but not all.

Upheld – Failings found leading to an unremedied injustice
Failings identified leading to an injustice or hardship that has not been suitably remedied by the organisation.

Discontinued
Where there is a reason not to carry on with the investigation.

Other
To be used where none of the other closure codes are relevant. For example, Cafcass cases where there might have been failings and an injustice but we decide that it was more appropriate for those issues to have been raised and resolved in Court.

Annex B Investigation plan template

Case ref	
Complainant	

Action	Proposed date
Read through case file	
Contact complainant and organisation and confirm scope of investigation	
All initial evidence requested	
All initial evidence received	
Share draft report (separate dates if sharing sequentially)	
Comments received	
Further evidence requested (if needed)	
Further evidence received	
Issue final report	

Further details/planning considerations

Reason(s) if plan not needed

Annex C Investigation report template and checklist

Section heading	Content	Explanation
Summary	• Statement that this is our report of the investigation. • Concise summary of complaint investigated (and injustice claimed and outcome sought). • Complainant/aggrieved. • Organisation/individuals complained about. • Clear statement of the overall outcome.	Where we have made findings say clearly if a complaint is upheld, partly upheld or not upheld.
Background	Essential information to put the decision in context which could include: • How we investigated the complaint. • Role of organisation complained about. • What we are basing our judgments on (e.g. law, policy, guidance, procedures, our Principles). • Background to the complaint. For example, the complainant's personal circumstances and events leading up to the complaint. • Key events. The overall story including the complaint to the body and their response.	Case by case decision (can be woven into other parts of the report if appropriate): • Only include information that contributes to an understanding of the decision and any recommendations. • Use annexes for information that is not key to understanding the complaint and the decision. • Use plain and clear sub-headings for different types of information. • Keep this as short and focused as possible. • Use the minimum necessary to justify the decision.
Evidence we considered	Refer to or include the evidence that we have considered, including any advice, in reaching our decision.	Can be woven into other parts of the report. Where applicable: • Explain that advice is only part of the evidence considered. • Say how we have

		considered and balanced evidence from different sources (including conflicting evidence).
Section heading	**Content**	**Explanation**
Evidence we considered	Acknowledge/summarise/respond to comments received on the draft decision.	Comments received should be considered and addressed as appropriate in the final report and/or covering letter.
What we found	Clear statement of whether there was a failing (did what happened differ from what should have happened) and be clear about what went right.	We must be clear why we have reached our findings, based on the available evidence and the test of balance of probability.
What we found	Clear statement of whether any failings were serious enough to be maladministration/service failure and, if so: • whether they led to an injustice or hardship, • whether it remained unremedied; and • what the specific effect of the injustice was.	Be clear about the links between any maladministration/service failure and injustice If appropriate, identify (and explain why) any claimed hardship or injustice did not flow from the failings identified.
Recommend actions	Set out any recommendations or agreed actions (ensuring they are SMART) and how they link to unremedied injustice or hardship (including the basis for the recommendations/actions).	We make recommendations to remedy injustice (not failings) or prevent recurrence.
Conclusion	Conclusion giving the overall decision.	

Other points
Normal approach is to use a formal 3rd person formal report under a covering letter. Letter format can be used if appropriate.
Paragraph and page numbers used in all reports.
It is not a requirement to use legal terms (e.g. maladministration, service failure) in reports but our internal analysis must be clear about these points and any alternative terms used in reports must be unambiguous.
Plain English sub-headings which say accurately what is in each section can be added as necessary.
Annexes, where used, should be in plain English and clear about purpose.
Draft reports should be marked clearly as such on every page using a watermark or footer.
Final reports should be signed and dated.

Annex D Compliance process

a) The aim of our compliance process is to ensure that all remedies that we recommend or request for complainants/aggrieved are secured in full, without undue delay. We should not close compliance action until the remedy has been secured or until an Assistant Director or above agrees that action should be closed.

b) Compliance action starts at the point where we submit the recommendation or request for remedy to the organisation. For recommendations, this will be the date of the final report issue; for other remedies it will be the date we submit the request to the organisation in writing.

c) Prior to compliance action, we will agree recommendations and remedies with the organisation concerned, agree an appropriate and achievable target date, and record the compliance item on Visualfiles. In all cases each remedy must be recorded on Visualfiles as a separate compliance item. Where a financial remedy involves financial and non-financial loss, these should be recorded as separate compliance items wherever possible.

On receipt of a new case for compliance action

d) The member of staff monitoring compliance on the case should ensure that remedies have been recorded correctly, paying particular attention to the type of remedy, the date of submission to the organisation, and the target date. Items which have been recorded incorrectly should be referred to the Outcomes and Compliance Caseworker for amendment.

e) With the exception of those cases where the organisation complies 'up front' (i.e. before or shortly after final report issue) we should send initial compliance letters, separate to the final report/covering letter, setting out:

- The remedies they are expected to provide, referring to the recommendations in the final report/decision letter
- The evidence that we need to see, for example proof of payment, copies of apology letters; copies of action plans.
- The compliance target date (or dates) clearly and ask the organisation to let us know if they cannot comply by the target date.

f) The initial compliance letter should be sent to the head of the organisation and copied to the complaints team, focal point etc. where one exists.

g) We should also tell the complainant explaining that we are now monitoring the organisation's compliance with the recommendations set out in our investigation report.

h) We should only amend target dates where the original target date was input wrongly or was not properly considered/agreed. Any other change must be agreed with the Outcomes and Compliance Caseworker. We should not change target dates just because an organisation says that they are unable to comply on time with a target date that they have previously agreed. Where we do change a target date for any reason we must notify the complainant that we have done so and explain why.

i) A week before the target date for each item, check whether evidence has been received; if not, issue a reminder, usually to the complaints team. This need not be by letter; where we have an established contact it may be more effective to use telephone or email.

j) Where evidence of compliance is received, this should be evaluated to ensure that the remedy delivered was the remedy we asked for. For many remedies such as apologies, compensation payments and other straightforward actions, this can normally be done by the member of staff monitoring compliance. However, some more detailed or complex issues may need to be referred for advice (for example, to the Investigator).

k) Checks to be considered include:

- Compensation payments: check the amount, and that it has been paid to the complainant/aggrieved.
- Apologies: make sure that these are appropriately worded and are not conditional (i.e. that they do not contain wording such as "we are sorry if you felt that…").
- Systemic remedies including action plans: do they address all of the failings identified? On health investigations involving clinical failings it may be appropriate to refer to a clinical adviser.
- Action to remedy: has the organisation carried out the specific action we have asked for?

l) Where we are satisfied that a remedy has been provided, details should be recorded on Visualfiles, and compliance should be recorded as closed. The 'date complied' means the date the organisation took the required action – that is the date an apology letter, payment or action plan was sent to the aggrieved; this may be different to the date PHSO were notified.

m) If evidence of compliance is unsatisfactory, notify the organisation at once and ask them to put matters right. We should also let the complainant know that we have done so.

n) Where an organisation has provided some evidence of remedy but we decide that a further work is required (for example, for additional detail to be added to a systemic action plan), it may be appropriate to extend the target

date. We should do so where we are satisfied that the organisation has made a genuine attempt to provide the remedy AND they do so before the compliance target date.

o) If an organisation complies with some remedies but others remain outstanding, we should update the complainant and assure them that we are still monitoring compliance with the other remedies.

p) If an organisation attempts to provide a remedy but are unable to do so because the complainant fails to provide required information (for example, bank details to facilitate payment; details of expenditure required to calculate a financial loss) then we should ask the complainant to send the information to us within two weeks and warn them that we may close compliance action if they fail to do so. If the required information, or an explanation, is not received by the requested date we should issue one further reminder. If, following that reminder the required information is not received then the compliance item should be closed as complied with. We should tell the organisation that we have done so, but say that we would still expect them to provide a remedy if the complainant provides the information in the future.

q) If the complainant refuses to accept a remedy we should close the compliance item as complied with.

r) Once an organisation has complied with all remedies, we should write to the organisation and the complainant to let them know that our compliance action is complete and the complaint is now closed.

s) Each compliance item should be closed on Visualfiles, paying particular care to record the date the organisation complied – i.e. the date that the remedy was provided. This will usually be the date action was taken – e.g. the date an apology letter was sent to the complainant, the date a payment was made

t) If, in response to a compliance closure letter as above, the complainant says that they do not agree that the remedy has been provided, check again that we have evidence of compliance. If we are satisfied that the organisation has complied we should reply saying that we have considered the points raised but remain satisfied that the remedy has been delivered; we should also let the complainant know how to complain about us if they are unhappy. If the issue involves a failure to comply by the target date we should explain that whilst we actively monitor compliance to obtain closure, we have no formal power to require the organisation to comply, or to do so by a specific date.

u) If the complainant raises issues involving the substance of the complaint or our findings, or expresses dissatisfaction with the recommended remedies,

these should be referred to the investigator as they fall outside of the compliance process.

Cases where compliance action has been overlooked

v) If we find that a compliance item has not been pursued by PHSO in line with our compliance policy, for example because it was overlooked or archived before compliance was secured, we are still required to attempt to secure compliance.

- Examine the Visualfiles record and paper file to see whether there is any evidence of compliance.
- Check whether we are holding any later complaint from the same aggrieved on the same issues (particularly for 'premature further work' items).
- If we are unable to close compliance action, contact the organisation to explain that compliance is still showing as outstanding and ask them to submit any evidence that they have complied.
- If the organisation say that they have not yet complied then ask them to do so within one month.
- If the organisation fails or refuses to do so, implement the escalation process.
- Update the complainant as appropriate.

Escalation process

w) No later than a week after the target date the member of staff monitoring compliance should check that if evidence has been received, then make one last contact (ideally by telephone) to confirm that the remedy is not in transit or imminent. If after a further week (i.e. 2 weeks after the target date) we have not received evidence of compliance, the following escalation process should be initiated:

- Stage 1: In all cases we should send a formal letter from the E1 Manager, usually to the organisation's complaints team, saying that we are concerned by the organisations failure to comply and asking for immediate compliance, otherwise we will escalate the matter to the head of the organisation. If no response or an inadequate response is received within two weeks:

- Stage 2: A letter from the Assistant Director to the head of the organisation, expressing concern about the failure to comply and setting out the possible actions that we may take. If no response or an inadequate response is received within two weeks, proceed to stage 3: All cases where stage 2 action is taken should be notified to the Outcomes and Compliance Caseworker.

- Stage 3: A final warning letter signed by the Director (with escalation to the Managing Director or Ombudsman if the circumstances of the case require

it. For example, in high risk cases). This should usually advise the specific action we propose to take unless the organisation provides the agreed remedy within two weeks.

Where an organisation has indicated that they do not intend to comply, move straight to stage 2.

The actions that we take if an organisation fails to comply will be discussed as part of the management of the individual case, but could include the publication of a report or (in health cases) the wider sharing of the report or making a referral because of a concern about the health and safety of patients.

Annex E - Where to send health reports and action plans

Type of Case	If UPHELD / PARTLY UPHELD	If NOT UPHELD	Action Plans
GP/DENTIST (a.k.a. Family Health Service Provider)	• Complainant / Representative[i] • the Practice • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor)[ii] • **ANON Report** to NHS England Local Area Team	• Complainant / Representative • the Practice • any Named Person • **ANON Report** to NHS England Local Area Team	• Complainant • Ombudsman • NHS England (Local Area Team) • CQC
Trust (Foundation)	• Complainant /Representative • the Trust • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor) • Monitor (if systemic recommendations made)	• Complainant / Representative • the Trust • any Named Person	• Complainant • Ombudsman • CQC • Monitor
Trust (Not / not yet Foundation)	• Complainant / Representative • the Trust • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor) • NHS Trust Development Authority (if systemic recommendations made)	• Complainant / Representative • the Trust • any Named Person	• Complainant • Ombudsman • CQC • NHS Trust Development Authority

CCGs (inherited all the abolished PCTs and SHAs secondary care liabilities)	• Complainant / Representative • the CCG • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor) • **ANON Report** NHS England (Local Area Team)	• Complainant / Representative • the CCG • any Named Person • **ANON Report** NHS England (Local Area team)	• Complainant • Ombudsman • NHS England (Local Area Team)
NHS England (inherited all abolished PCTs and SHAs primary care liabilities)	• Complainant / Representative • NHS England • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor)	• Complainant / Representative • the CCG • any Named Person	• Complainant • Ombudsman
Independent Provider	• Complainant / Representative • the Provider • any Named Person • **ANON Report** to Responsible Officer (if any Named Person is a doctor) • **ANON Report** to the Commissioning Body (e.g. CCG or NHS England)	• Complainant / Representative • the Provider • any Named Person • **ANON Report** to Commissioning Body (e.g. CCG or NHS England)	• Complainant • Ombudsman • Commissioning Body • CQC

GENERAL POINTS TO NOTE

[i] Only send to a representative if we have written authorisation from the complainant for the representative to act on their behalf or to receive copies of all correspondence.

[ii] Where we uphold or partly uphold a complaint against a named doctor our normal approach is to send the final report to the Responsible Officer, unless there is good reason not to do so. We should anonymise the complainant's details in the report.