‘Putting Things Right’ Management and Resolution of Concerns Policy (Incidents, Complaints and Claims)

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Brief Summary of Document:	This Policy sets out the arrangements, under Putting Things Right, by which Hywel Dda University Health Board (the Health Board) will manage, respond and resolve concerns in order to meet the requirements of the NHS Welsh Government legislation: Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and subsequent guidance documents. This policy is also compliant with the Public Services Ombudsman for Wales Act (2019) and the Complaints Standards Authority Principles for Complaint Handling.
Scope:	This policy applies to all staff who have a responsibility to report, manage and / or formally review concerns or be engage in the formal review of a concern. The Policy covers concerns about: • Health Board services; • Services provided by Health Board employed staff; and • Services provided by the independent or voluntary sector which are funded by the Health Board. The Health Board recognises that independent contractors are under no obligation to adhere to this policy. However, the Health Board expects its independent contractors to have processes in place that meet the requirements of the Putting Things Right Regulations.

HYWEL DDA UNIVERSITY HEALTH BOARD

To be read in conjunction with:	244 - Being Open/Duty of Candour Guidance 514 Incident Reporting Procedure Management of Patient Safety Incidents and Serious Concerns Procedure 004 Policy for Claims Management 018 - Staff Attending Inquests/Court and Assisting with Police Investigations Guideline 558 Management of Nursing and Midwifery Medication Errors/Near Miss Policy
Patient information:	Putting Things Right: Raising a Concern about the NHS in Wales HDUHB Procedure for Raising a Concern (website page)

Owning Committee/ Group	Nursing Directorate Listening and Learning from Events Sub Committee

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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New Policy for approval	9.6.2020
2	Updated policy for approval.	

Keywords	Putting Things Right, Incident, Complaint, Claim, Concern, Duty of Candour, Being Open

CONTENTS

1. Introduction

Whilst modern health care is undoubtedly beneficial, it also has the potential of having harmful effects on patients. Estimates show that in high-income countries, as many as one in 10 patients is harmed while receiving hospital care. The harm can be caused by a range of adverse events, with nearly 50% of them considered preventable. (WHO, September 2019).

However, the provision of safe services is extremely important across all levels of health care, including in primary and out-patient care, where the bulk of services are offered. Globally, as many as four out of 10 patients are harmed while receiving health care in these settings, with up to 80% of harm considered to have been preventable. The most detrimental errors are related to diagnosis, prescription and the use of medicines (WHO, September 2019).

Therefore the organisation has a responsibility to ensure systematic measures are in place to safeguard people, property, NHS resources and its reputation. This also extends to ensuring that when a concern is raised (incident, complaint or claim) it is appropriately reviewed and an understanding of why the event occurred is established and ultimately, to ensure steps are taken to reduce the chance of either a similar concern happening again in a single organisation or, if appropriate, across the NHS as a whole.

This policy incorporates the arrangements required for the management of concerns in line with NHS (Concerns, Complaints and Redress) (Wales) Regulations 2011 (the regulations) and subsequent guidance documents. These regulations place a statutory responsibility upon NHS organisations in Wales to manage all concerns consistently and as set out in the Regulations. This includes where potential safeguarding concerns are identified, they are referred to child or adult protection procedures as appropriate in accordance with the duty to report an adult or child at risk in the Social Services and Wellbeing (Wales) Act 2014.

The Public Services Ombudsman (Wales) Act 2019 (the Act) created a new Complaints Standards Authority for Wales. In December 2020, all public sector providers received notification that in accordance with Section 36 of the Act, they were responsible for ensuring their complaint handling procedures were compliant with the following principles:

a) Complainant Focused
b) Simple
c) Fair & Objective
d) Timely & Effective
e) Accountable
f) Committed to Continuous Improvement.

This policy and all procedures related to the management of concerns will adhere to these principles and the Regulations referred to above.

2. Policy Statement

It is the Health Boards aspiration that no patient should come to avoidable harm whilst under its care. Therefore, the Health Board shall ensure a systematic approach to the management, review and resolution of concerns to reduce the likelihood of recurrence and to improve future patient outcomes and experience as well as services and the environment.

In doing so, the Health Board will promote a learning culture which focusses on identifying causal factors rather than blaming individuals, by sharing and implementing the lessons learned.

This policy, and associated written control documents, do not take precedence where there is a child or adult identified as being at risk, or who is experiencing or is at risk of abuse or neglect. In such instances these cases must be reported to the relevant Local Authority Safeguarding Team or Police in line with the Social Services and Well-Being (Wales) Act 2014, All Wales Child Protection Procedures and the Health Board Safeguarding Adults at Risk Policy. The reporting and escalation of safeguarding concerns should run in parallel to this policy, however incidents must not be investigated via this process unless authorised by Police or the Local Authority Safeguarding Team. Advice in relation to safeguarding incidents can be sought from the Health Board Corporate Safeguarding team.

3. Scope

This policy applies to all staff who have a responsibility to report, manage and / or formally review concerns or be engaged in the formal review of a concern.

The Policy covers concerns about:

- Health Board services;
- Services provided by Health Board employed staff; and
- Services provided by the independent or voluntary sector which are funded by the Health Board.

The Health Board recognises that independent contractors are under no obligation to adhere to this policy. However, the Health Board expects its independent contractors to have processes in place that meet the requirements of the Concerns, Complaints and Redress regulations.

4. Aim

The aim of this policy is to ensure that there is a systematic person centred approach to the management, review and resolution of concerns which reduces the likelihood of recurrence and to improve future outcomes and patient experience as well as services and the environment

5. Objectives

The aim of the policy will be achieved by:

- Developing an organisational culture, which allows concerns to be reported in an open and fair environment
- Analysing and learning from when things go wrong
- Development of a learning culture throughout the organisation; and
- Resolving system failures and improving service delivery.

6. Principles

In terms of the effective management, formal review and resolution of concerns, with an approach that is person centred, the Health Board is committed to the principles of openness, accessibility, transparency, responsiveness, fairness and confidentiality. In line with national equality and diversity legislation, the Board takes all reasonable steps to enable patients, their representatives and our staff to raise a concern in the most appropriate format to them. It also offers the support of advocacy services where necessary, working collaboratively with Hywel Dda Community Health Council.

The general principles are:

- Concerns are dealt with efficiently, openly, sympathetically, in a timely manner and with a person centred approach;
- The person raising the concern will be treated with respect and courtesy, with confidentiality maintained if requested;
- The formal review (investigation) will be proportionate to the severity of the concern raised (see appendix 1 for levels of harm which is equally applicable to complaints and incidents);
- The person raising the concern will be guided to independent support or advocacy, if required, for example Community Health Council and Public Services Ombudsman for Wales.
- A named Health Board contact will be allocated, usually the Reviewing Officer, who will make early and regular personal contact with the person raising the concern;
- Action will be taken to address any areas for improvement and learning;
- The concern will be managed in line with Welsh Government regulations and the Statement of Principles (Appendix 4).
- Consideration will be given to of an offer of Redress, in accordance with the Regulations, where investigation or formal review into the matters raised reveal that there is a qualifying liability in tort.

7. Definitions

7.1 Concern

A “concern means any complaint; notification of an incident or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation” (Welsh Government 2011).

7.2 Complaint

A “complaint means any expression of dissatisfaction”. (Welsh Government 2011)

7.3 Never Events

“Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.” (NHS Improvement, 2018).

The current Never Event List can be found at https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Occurrence of a never event, triggers the Management of Patient Safety Incidents and Serious Concerns Procedure. Advice can be sought from the Quality, Assurance and Safety Team, if there is any doubt as to whether an incident is a never event.

7.4 Patient Safety Incident

A patient safety incident "means any unexpected or unintended incident which did lead to or could have led to harm for a patient" (Welsh Government 2011).

7.5 Adverse Event

Any event that has given or may give rise to actual or possible personal injury, patient dissatisfaction, or to property loss or damage.

7.6 Near Miss

Any event or omission that could have potentially caused harm, but due to prompt action by a member of staff, or simply because of good fortune was prevented.

7.7 Redress

Under the The NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011, the Health Board is required to consider when investigating a concern whether there is a qualifying liability in tort i.e. whether there has been a breach of our duty of care and whether that breach of duty is causative or any harm or loss to that person. Where this is indicated there is a qualifying liability in tort and a consideration of an offer of redress is necessary.

Redress can take the form:

- An Apology
- Remedial Action
- Investigation or formal review and explanation
- Financial compensation up to £25,000

Where redress is being considered or a claim for compensation made the Health Board's Policy for Claims Management will be followed.

8. Primary considerations of practice

8.1 Who can raise a concern

Almost anyone can raise a concern. However, it might not always be possible to share the full details of the formal review with the person raising the concern, for instance, if they are not the patient or person that the patient has consented as acting on their behalf.

Concerns can be raised by:

- People who are receiving or who have received services from the Health Board;
- People affected or likely to be affected by the actions, errors or decisions of the Health Board;
- Staff members of the Health Board;
- Independent members (non-executive director or non-officer) of a NHS body;
- Partners, e.g. a partner in a GP practice;
- A third party acting on behalf of a person who is unable to raise a concern e.g. a young child or someone who lacks capacity to act on their own behalf; or because that person wants someone else to represent them;

- A third party on behalf of a person who has died.

8.2 Single Point of Entry

People can raise concerns in a variety of ways:

Phone: 0300 0200 159
Email: hdhb.patientsupportservices@wales.nhs.uk
Letter: FREEPOST FEEDBACK@HYWEL DDA
Text: 07891 142240

The Health Board considers each of the above to be a single point of entry e.g. if a concern is raised by phone, the person will not be expected to formally write to the Health Board.

Staff can also raise concerns through the Health Board's Incident Reporting Procedure or through the All Wales Procedure for NHS Staff to Raise Concerns which should be considered before using the details provided above.

8.3 Acknowledgement

All concerns (incidents, complaints and claims) will be logged on a central system and an acknowledgement of receipt sent to the person raising the concern (where contact details have been provided). In line with the Putting Things Right Regulations, the acknowledgement must be sent within two working days of first receipt. Any person raising a concerns will be treated with compassion and understanding.

8.4 Being Open/Duty of Candour

When a concern has occurred, it is essential that all staff comply with Hywel Dda UHB Being Open/Duty of Candour Guidance and ensure that the person is offered an apology and given an explanation (wherever possible) of any actions taken. It is important to note that saying sorry is not an admission of liability.

An appropriately nominated person will provide, in a truthful and open manner, information about the formal review to the person raising the concern. The offer of a face to face meeting should be considered and where appropriate made.

The principles of the regulations are that when a concern has been raised the patient affected will be informed. When a formal review is being undertaken the patient affected should be notified. However, for incidents only, where it is felt that it would not be in the best interests of the patient to inform or involve them in the formal review:

- The rationale for that decision must be recorded; and
- As circumstances may change, the decision not to involve the patient must be kept under review throughout the investigation or formal review.

8.5 Multidisciplinary Responsibility

Most healthcare provision is through multidisciplinary teams. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the Putting Things Right process is consistent with the philosophy that concerns usually result from system failures and rarely from the actions of an individual.

8.6 Continuity of care

Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their

healthcare needs to be taken over by another team, where possible, alternative arrangements should be made.

8.7 Proportionate and Appropriate Formal Review

Identifying the root cause of the concern will focus the formal review and help to improve the systems of care. The principle of conducting a thorough and proportionate formal review into a concern and reassuring the person that lessons have been learned will help to prevent the event recurring.

Information about the formal review must be given to the staff involved in a truthful and open manner although if imparting this information may jeopardise the formal review, then it is advised not to inform the member of staff.

Information given to patients and staff is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as the investigation or formal review is undertaken and that patients, their families and carers will be kept up to date with the progress of the investigation or formal review.

8.8 Support for Staff Involved in Concerns

Being the subject of a concern or even reporting a concern as a member of staff can be very stressful. In terms of being the subject of a concern, when an issue is raised, whether by a patient or through a report from a member of staff, the details should be shared with the staff member involved wherever appropriate. This should be done supportively and staff may want to have a member of their professional association or Trade Union representative present in any meetings.

The Directorate Senior Management Team, Redress Team, Patient Support Team and/or Assurance, Safety and Improvement Team will provide support for those involved with the formal review of a concern in accordance with the 'assist me' good practice model for supporting staff involved in adverse events.

Consideration should also be given under the workforce and organisational development policies as to whether a staff member may need more proactive support such as counselling. In terms of staff who report concerns, consideration should also be given as to whether they may require specific support. For any member of staff involved in a concern, their line manager should be involved in any decisions that are taken.

9. Governance Framework

All concerns with significant learning will be reported to the Listening and Learning from Events Sub-Committee and/or the Operational Quality, Safety and Experience Sub Committee. The concerns raised will form part of the regular assurance reports to the Quality, Safety, and Experience Assurance Committee. Details of the subject and nature of the concern together with the outcome of the investigation must be recorded.

Compliance with the stated time periods for response are monitored and reported. The Board are made aware of concerns which may adversely affect the reputation of Board by the Chair of the Quality, Safety and Experience Assurance Committee.

The time periods set in the Putting Things Right Regulations are:
Complaints (concerns considered under Regulation 24)

- Final responses should be issued within working 30 days of first receipt of the concern, but if this is not possible the person raising the concern must be informed of the reason for delay.
- When a response cannot be issued within 30 days, the response must then be sent as soon as possible and within 6 months of the date the concern was received.
- If, in very exceptional circumstances, the response cannot be issued within 6 months, then the person raising the concern must be informed of the reason for delay and given an expected date for response.

Patient Safety Incidents

- The principle of timely and proportionate investigation is paramount.
- For the majority of incidents, the investigation should be completed within 60 days.
- This policy will ensure that the Health Board complies with the requirements of the All Wales National Incident Reporting Policy (Appendix 2).

10. Roles and Responsibilities

10.1 Chief Executive

The Chief Executive Officer has overall responsibility for dealing with concerns. This responsibility has been delegated to the Director of Nursing, Quality and Experience with day-to-day responsibility delegated to the Assistant Director of Nursing (Assurance, Safeguarding, Quality and Professional Regulation) and the Assistant Director (Patient Experience/ Legal Services).

10.2 Non-Officer Lead

The delegated non officer for the Health Board is the Chair of the Quality, Safety, Experience and Assurance Committee who is responsible for maintaining a strategic overview of the Policy (Regulation 2.6). This person is responsible, in particular for:

- Ensuring that the organisation complies with the arrangements it has in place for ensuring that the details of concerns received and investigated are considered so that lessons may be learned in order to seek to avoid such deficiencies recurring;
- Ensuring that an annual report is prepared which summarises the organisation's activities under the regulations (NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2010. (Regulation 10.2); and
- Ensuring that arrangements for dealing with concerns are published in a variety of media, formats and languages and that a copy of the arrangements is given free of charge to any person who requests it, in the format requested.

10.3 Director of Nursing, Quality and Patient Experience (Responsible Officer)

The Director of Nursing, Quality and Patient Experience is the Responsible Officer for overseeing the day to day management of these arrangements and ensuring that the Health Board operates in an integrated manner to:

- Deal with concerns in line with the Regulations;
- Allow for the consideration of qualifying liability; and
- Provide for concerns to be dealt with under a single governance arrangement.

The responsibilities of the Director of Nursing, Quality and Experience are delegated to the Assistant Director of Nursing (Assurance, Safeguarding, Quality and Professional Regulation) and the Assistant Director (Patient Experience/ Legal Services), but remain under the direct control and supervision of the executive lead.

10.4 Other Directors

All Executive Directors and Directors are responsible for supporting the Chief Executive in their responsibility and supporting the directorate managers, clinical directors and medical staff in implementing this policy across the organisation.

10.5 Senior Investigations Manager

The handling and consideration of concerns in accordance with the Regulations will be the responsibility of the Senior Investigations Manager. As well as the handling and consideration of concerns under the Regulations, part of the Senior Investigations Manager's role will require them to undertake other functions in relation to dealing with concerns and to co-operate with other persons or responsible bodies, e.g. primary care providers, to facilitate the handling and investigation or formal review of concerns. The Senior Investigations Managers provide leadership and advice to the Board, clinicians and managers on patient safety and on the handling and management of concerns. This includes implementing a system across the Health Board which ensures remedial actions are taken to avoid recurrence of concerns and the sharing of lessons learnt across the organisation and beyond. This role is supported by additional suitably trained staff as part of the integrated arrangements.

The Senior Investigations Managers are the Assistant Director of Nursing (Assurance, Safeguarding, Quality and Professional Regulation) and the Assistant Director (Patient Experience/ Legal Services).

10.6 Directorate Managers/Triumvirate Teams

The directorate managers/triumvirate teams have responsibility to make sure that the principles outlined within this policy are implemented within their directorate/hospital including fostering a culture for learning from experience and sharing lessons learned.

They are responsible for disseminating lessons learned to colleagues within their directorate, providing opportunities for learning through team meetings and with colleagues in other directorates where appropriate.

It is the responsibility of the Heads of Nursing to escalate any fitness to practice concerns to the Director of Nursing, Quality and Patient Experience.

It is the responsibility of the Hospital Clinical Director to escalate any fitness to practice concerns to the Executive Medical Director or Executive Director of Therapies and Health Science.

10.7 Heads of Service/Departmental Managers

Heads of service/departmental managers have a responsibility to foster a culture or learning from concerns.

They are responsible for disseminating lessons learned to colleagues within their directorate/hospital, providing opportunities for learning through team meetings and with colleagues in other divisions where appropriate.

10.8 Responsibility of All Staff

All staff are responsible for ensuring that they:

- Work to the principles outlined in this policy, and associated written control documents;
- Learn from concerns; and

- Co-operate fully and openly in the investigation or formal review of a concern.

11. Culture

The Health Board is committed to ensuring that the action and learning from all concerns will be incorporated within the whole organisation to ensure the safety of patients and staff.

In order to promote this philosophy and ensure staff feel confident **whether they are the subject of a concern or are** the reporter or witness of an incident, we will ensure managers take a fair, equitable and consistent approach when they review concerns. Most concerns including serious incidents will not lead to individuals being managed under a workforce policy. Within the spirit of being, "Open and Fair" a workforce process will only be considered when information highlights potential issues of alleged personal/professional misconduct. To support this process the Health Board will follow the principles laid out in "a just culture guide" published by NHS Improvement.

12. References

Welsh Government (2013) Putting Things Right Guidance (version 3)
Welsh Government (2011) The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
NHS Improvement (undated) A Just Culture Guide
NHS Improvement (2018) Never Events Policy and Framework (revised January 2018)
NHS Improvement (2018) Never Events list 2018 (revised 31 January 2018)
NHS Wales Delivery Unit (2021) National Incident Reporting Policy (appendix 2)

Supporting written control documents

Being Open/Duty of Candour Guidance (244)
Incident Reporting Procedure (tba)
Management of Patient Safety Incidents and Serious Concerns Procedure (tba)
Policy for Claims Management (004)
Staff Attending Inquests/Court and Assisting with Police Investigations Guideline (018)
Management of Nursing and Midwifery Medication Errors/Near Miss Policy (558)

Other supporting written control documents

Safeguarding Adults at Risk Interim Policy (098)
All Wales Child Protection Procedures
Procedural Response for Unexpected Deaths in Childhood Procedure (PRUDIC) (563)
Safeguarding Children & Young People in Emergency and Out of Hours Service Procedure (405)
Allegations against Employees of Hywel Dda University Health Board of Harm/Abuse Involving Children or Adults (246)
All Wales Disciplinary Policy & Procedure (201)
All Wales Capability Policy (203)
All Wales NHS Staff to Raise Concerns Procedure (435)

13. Appendix 1: Grading framework for dealing with all concerns

Level of Harm	Examples of concerns
Level 1 No harm	a) Concerns which normally involve issues that can be easily / speedily addressed; b) Potential to cause harm but impact resulted in no harm having arisen; c) Outpatient appointment delayed, but no consequences in terms of health;, d) Difficulty in car parking; e) Patient fall – no harm or time of work; f) Concerns which have impacted on a positive patient experience.
Level 2 Minor Harm	a) Concerns regarding care and treatment which span a number of different aspects/specialties b) Increase in length of stay by 1 – 3 days c) Patient fall – requiring minor treatment d) Requiring time off work – 3 days e) Concern involves a single failure to meet internal standards but with minor implications for patient safety f) Return for minor treatment, e.g. requiring local anaesthetic further treatment/monitoring by GP g) Samples taken from the wrong patient – not acted upon but require repeat venepuncture. h) Pathology labelling error detected post analytically before further intervention
Level 3 Moderate harm	a) Clinical / process issues that have resulted in avoidable, semi-permanent injury or impairment of health or damage that requires intervention b) Additional interventions required or treatment / appointments needed to be cancelled c) Readmission or return to surgery, e.g. requiring general anaesthetic d) Necessity for transfer to another centre for treatment / care (e.g. for an incident in a GP Practice, admission to hospital) e) Increase in length of stay by 4 – 15 days f) RIDDOR reportable incident (moderate harm) g) Requiring time off work 4 – 14 days h) Concerns that outline more than one failure to meet internal standards i) Moderate patient safety implication j) Concerns that involve more than one organisation (e.g. cross border incidents that may involve English providers or other Health Boards, incidents involving interface with Local Authority, or Ambulance Trusts)
Level 4 Major Harm	a) Clinical process issues that have resulted in avoidable, semi-permanent harm or impairment of health or damage leading to incapacity or disability b) Additional interventions required or treatment needed to be cancelled c) Unexpected readmission or unplanned return to surgery d) Increase in length of stay by >15 days

	e) Necessity for transfer to another centre for treatment / care f) Requiring time off work >14 days g) A concern outlining non-compliance with national standards with significant risk to patient safety h) RIDDOR reportable incident (significant harm)
Level 5 Catastrophic Harm	a) Concern leading to unexpected death, multiple harm or irreversible health effects b) Concern outlining gross failure to meet national standards c) Normally clinical/process issues that have resulted in avoidable, irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well being d) Clinical or process issues that have resulted in avoidable loss of life e) RIDDOR reportable incident (catastrophic harm) f) Significant / consistent reporting errors i.e. malignant as benign.

14. Appendix 2:

The attached document replaces the previous guidance outlines in the (2013) Putting Things Right Guidance (version 3)

(Link to National Incident Reporting Policy)

15. Appendix 3: List of Never Events 2018/19

Extract from NHS Improvement (2018) Never Events list 2018 (revised 31 January 2018)

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post procedure
4. Mis-selection of a strong potassium containing solution
5. Administration of medication by the wrong route.
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter
16. Undetected oesophageal intubation

16. Appendix 4 - Public Services Ombudsman for Wales - Complaint Handling Processes statement of Principles

Effective complaints handling processes should be:
1) Complainant Focused
2) Simple
3) Fair & Objective
4) Timely & Effective
5) Accountable
6) Committed to Continuous Improvement

1) Complainant Focused

The complainant should always be at the centre of the complaints process.

Service providers need to be flexible when responding to complainants' differing needs.

2) Simple

Complaints processes should be well-publicised, have easy-to-follow instructions and have no more than two stages.

Information on advocacy services and support should be available.

Complaints responses should set out clearly the next stage and the right to approach the Ombudsman.

3) Fair & Objective

Complainants should receive a complete and appropriate response to their concerns.

Complainants and staff complained about should be treated equally and with dignity.

4) Timely & Effective

Complaints should be resolved promptly, when possible

Investigations should be thorough, yet prompt.

Complainants should be kept informed throughout of the progress of a lengthy investigation.

5) Accountable

Complainants should receive an honest and clear explanation of the findings of an investigation.

Service providers should explain to complainants what changes will be made if their complaint is upheld, whenever possible.

6) Committed to Continuous Improvement

Information from complaints should be collated and analysed.

Data should be shared with the organisation's senior leaders and the Ombudsman to support improvement in complaint handling and in service delivery.

Decision makers should regularly review the information gathered from complaints when planning service delivery.