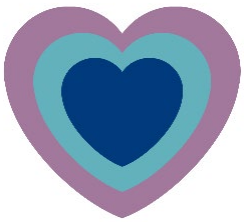
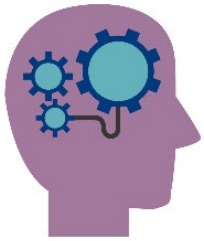
Decision Making Tool for Complaint Investigators

Are you Decision Ready ?

Heart



Head



Heal

STEP 1:
What questions are you answering?

STEP 2:
Planning and information gathering

STEP 3:

Evaluating the evidence

STEP 4:

Reaching a decision

STEP 5:
Communicating the decision

STEP 6:

Remedy, learning and improving

Heart & Head & Heal

Complaint investigators need multiple skills to carry out their role effectively. They need to be good listeners, project planners, critical thinkers, reasoned decision makers, effective communicators and change managers. Investigators within an organisation also act as critical friend to their own organisation similar to the work of internal auditors. This can be a difficult balance to achieve and even harder to demonstrate.

This tool has been designed to help guide investigators through this challenging process.

Different steps in an investigation require a different emphasis and balance. The *Heart, Head and Heal* approach can be used as a prompt to consider what is appropriate at each step.

- An investigation starts with an empathetic approach to understanding the problems experienced by the complainant and the impact these are having on their lives. This is *Heart*
- Next steps involve careful planning and information gathering and evaluation. This is *Head*
- Finally, action is needed to fix any problems, prevent reoccurrence if possible and repair any on-going relationship with the complainant. This is *Heal*

This resource is intended mainly for use by people with an interest in the investigation stage of a complaint (also referred to as Stage 2). Sections of it will be also be useful to people dealing with Early Resolution (Stage 1) complaints and Step 6 will be of particular relevance to anyone interested in learning and improvement. It will also be helpful to anyone considering Quality Assurance mechanisms for complaints handling.

Each step contains guidance and a number of key questions or action points. All of these are summarised in the tool (p20) which can be used to review each stage of the process.

The document has been written assuming one person is carrying out all the tasks. In practice, the process may be carried out by more than one person and only certain steps may be relevant to each person.

Throughout the document, there are links to other resources that you may find useful. These, and other tools, are available on https://www.spso.org.uk/spso. We may periodically update this tool or the resources contained within it. Please check https://www.spso.org.uk/spso for the most up to date version of this document.

Are you decision ready?

Before you start

As a complaint handler you need make fair, quick accurate and effective decisions about complaints. As a decision maker you do more than just apply a set of rules to solve a problem. You evaluate information and use your judgement to arrive at the best decision you can make in the particular circumstances. To do this you need to be decision ready. This means that you are comfortable about making a decision and confident about the decision you are making.

Being decision ready includes being as sure as you can be that:

- you have the right knowledge to make the decision;
- your decision is impartial;
- you have no direct conflicts of interest;
- your decision is free from bias; and
- you are making your decision under the best possible thinking conditions.

Knowledge

Good decision makers know themselves and their limitations. They understand their own decision making strengths and weaknesses. In particular, they understand their own circle of competence in relation to decision making. This means that they know what they know, as opposed to what they think they know. It is very easy to mistake familiarity for knowledge – “I’ve seen one of these before, so I already know the answer”. Pride can get in the way here sometimes – not wanting to admit that you don’t know something, or feeling that people will think less of you if you ask for help. Good decision makers aren’t afraid to admit what they don’t know and they recognise when they need to ask someone else who may have greater knowledge or expertise. Seeking expert advice does not mean that you are handing over responsibility for reaching a decision – it means that you are gaining additional evidence to help you reach a sound decision.

- Do you have the right experience and where can you get help otherwise.

Independence of mind

Good decision makers are impartial. To achieve this you will need to have independence of mind. Where you are investigating your own organisation’s action it will be very difficult for you to be fully independent - you can, however, take steps to ensure and demonstrate that your thinking isn’t unreasonably influenced in any way or by anyone when you are making your decision. It can be difficult to make an independent decision for example if

you work in a small organisation or team, or are being asked to make decisions where those involved are more senior to you. Often you will need to make tough decisions about issues involving people you know. You need to be scrupulous about making your decision based on the evidence, and be able to recognise if you are being swayed or influenced by something or someone else.

- Are you able to make your decision freely and without undue influence from others

Conflict of Interest

Good decision makers have no direct conflicts of interest. A **direct** conflict of interest exists when you have, or appear to have, a personal interest in the decision. For example, where you review a decision which you yourself originally made. You should make known immediately, usually to a more senior person, any personal interest that you have in the complaint, and if needs be, ask for someone else to make the decision. An **indirect** conflict of interest might arise from a perceived or assumed interest. For example, because you know the people involved in the original decision even though you didn't make the decision yourself. In these situations it may not be practical for anyone else to investigate. Instead you should ensure that your investigation and decision making demonstrate that you are free from a direct conflict of interest.

- Check for and declare or manage any conflicts of interest

Bias

Good decision makers make decisions with as few biases and assumptions as possible. They also know and understand their own biases. **Implicit bias** is when you discriminate for or against a person in some way. We all make unconscious assumptions which influence our judgements. For example, we may have expectations or assumptions about characteristics associated with age, status or gender. We often apply generalisations which may not be accurate. You may also be biased by your experience of a complainant – it can be hard not to be affected by behaviour you find particularly challenging or difficult. We all also have **cognitive biases** which affect the way we think. For example, we tend to give more weight to information that is more recent or readily available, we put too much emphasis on one piece of information when making a decision and we tend to prefer information which confirms what we want to believe. You can minimise the risk of bias by adopting rational, logical approaches to investigation. You will find more information about biases and how to achieve a rational and logical approach in Steps 2 and 3.

- Reflect on your thinking throughout the investigation to check for biases

Thinking conditions

Good decision makers know what's needed to allow them to make their best decision. Unfortunately our judgement can be influenced by factors unconnected with the decision. These include how hungry you are, what the weather is like and what mood you are in. Time pressure can result in a rushed or hasty decision, rather than a measured one when you had the opportunity to weigh up the pros and cons.

Self-reflection can help here – look back on your past decisions, good and bad, and think about what helped. Recreating the right conditions and avoiding the problems will help you make better decisions in the future. It can also be useful to receive feedback about your decisions – are they seen to be accurate and consistent?

Ideally you should build in time to deliberate so that you can set aside your initial conclusions and come back to review them later. Practically, there will often be deadlines to meet and you will need to balance competing demands.

- Give yourself ample time and opportunity to reach your decision

STEP 1: What questions are you answering?

This is arguably the most important step in ensuring an effective investigation and a robust decision. You need to be very clear in your own mind about the exact questions you are setting out to answer. You need to check that you and the complainant have the same understanding of those questions.

1. What complaints do you think the complainant wants answered? Make a list, but make sure this list is manageable. If there seem to be numerous issues, try to find common themes (for example, say 'staff were rude' rather than listing five separate complaints about attitude).

   - Read through (or listen to) the complaint and write down a list of all the issues you found

2. Have you checked with the complainant that you have properly understood these? In many of the complaints that escalate to SPSO, there is a misunderstanding about the issue being complained about. At other times the investigator has assumed they know what the issue is when they don't, often because it is similar to another complaint they have dealt with before or an issue they looked at recently. It is also helpful to find out about the impact that the problem has had on the complainant.

   - Contact the complainant in person. Share your list of questions and check if you have properly understood the issues. Ask if there are any other issues they haven't mentioned already and check what impact all this has had for them

3. Can you deal with all the issues? If not, you need to explain why not and, if relevant and you know, who else can look at these issues. Typically the reasons for this might be:

- Timescales - how long ago did the complaint happen?
- Jurisdiction - is (some of) the complaint about another organisation?
- Consent - if this is a complaint on behalf of another living person, do you have/need their consent to share the information with the person bringing the complaint?
- Alternative Process - is there another process to deal with (some of) the issues? For example, an appeal.

   - Explain to the complainant in person any limitations on what you can look at and why

4. Do you know what the complainant wants to achieve? Does the complainant know what they want to achieve? Unless you both know what this is then you will struggle to reach a resolution to the problem. If they want to achieve something you cannot ever achieve for them then you need to manage their expectations from the beginning. Sometimes people want something much more simple and achievable than you might have thought and a quick solution can be found.

- Ask the complainant what outcome they are looking for
- Explain what outcomes are possible and what is not
- If the complainant doesn't know you can make some suggestions: for example "when we find problems we might arrange staff training or an apology or a change of policy"

5. Does the complainant share your understanding of the issues to be considered and the potential outcomes?

- Summarise your understanding on the phone/ in the meeting
- Send a written summary to the complainant confirming your discussion
- If you can't make personal contact, send a written summary and ask the complainant to let you know if they have queries

STEP 2: Planning information gathering

Now you are clear about the questions you are going to answer, you need to think about the information that will let you decide those answers. It is very tempting to dive headlong into the issues and immediately look for solutions but this approach will often lead an investigation astray. Sometimes investigators concentrate on one part of the problem (often the piece they find most interesting or know most about) and may forget to answer all the questions. At other times investigators waste time looking into issues where there isn't a disagreement or which are irrelevant. Finally, some investigators keep investigating long after they have enough information and should reach a conclusion. Planning is the best way to prevent all of these problems. It may take an extra 20 minutes to do this in the beginning but it will save a lot of time later.

6. What information do you need

For every issue you need to answer two basic questions: **What did happen?** and **What should have happened?** If what did happen is the same as what should have happened then the complaint is unlikely to be justified but if there is a difference between the two answers then there is likely to have been a problem that needs fixed. The information you need to answer these two questions can be broken down further **for each issue.**

- decide what relevant information you already have and make a note of it
- decide what information you need and how you are going to find it

Here's an example of what this might look like: (You can also find a blank template on our SPSO website)

Complaint Issue	Information we have about **what did happen**	Information we need about **what did happen**	Info we have about **what should have happened**	Information we need about **what should have happened**	Comments
Mrs Smith was told that there was a six week wait for the service but she waited for 10 weeks	Mrs Smith's account of the telephone call with staff at the service centre who told her there was a six week wait	The recording of the telephone call if this is still available (may not be) Customer Service note on Mrs Smith's file Comments from staff member involved in the call	Internal all-staff email from July 2016 explaining the current waiting time was between 9 and 12 weeks	Policy and staff guidance on processing service requests – especially what information should be given and what should be recorded	

7. Revise your investigation plan

   Once you have a plan you can start to add in the information gathered, moving from information needed to information you have. Sometimes a piece of information will create more questions and these can be added to the plan but always check first if the question is relevant to the original problem. Don't allow yourself to become distracted by more interesting but irrelevant issues. If the information doesn't give you all the answers you need you may need to think about other sources of information and add these to your plan. Again, think carefully about whether the other information would ever answer the question or whether it is reasonable to try and follow every possible source of information. If you don't think it will help make the situation clearer or it will be very expensive or time consuming to find out, you should note down why you decided not to look any further.

- keep checking back with your plan and revise it as you get new information

STEP 3: Evaluating the evidence

We said in Step 2 that there are two key questions which need to be answered in an investigation. These are: **What did happen?** and **What should have happened?**
Step 2 identified the information needed to answer these questions. At Step 3 the information gathered needs to be evaluated to decide if it provides the necessary evidence to answer those two key questions. There are a number of ways this information should be analysed. Not every test will apply to every case.

Types of Evidence

Official or personal: Official documents are generally those produced by organisations, while personally produced documents are those produced by individuals. It **should not** be assumed that official documents are more reliable than personally produced ones or that computer records are more accurate than hand written or manual records.

Documentary or Narrative: Evidence will be either documentary (a letter or computer file record for example) or it will be narrative (the account provided to you verbally or in writing by the complainant or a staff member, for example). It is often assumed that documentary evidence is more reliable than personal recollection.

However, the people directly involved may have had more and better reason to notice what was happening at the time than the member of staff who created the documentary record.

8. All the information you have gathered, whatever its source of type, needs to be evaluated. This well help you decide how useful any piece of information is to you as evidence of what did or should have happened.
   - **Relevance:** Is the information relevant to the issue being investigated? Does it help in either proving or disproving a fact at issue?
   - **Time**: When was the information created and how close was it to the events in question? Is the information (for example a Policy) the one that was in place at time of the events being looked at?
   - **Expertise**: Who created the information? Is it the opinion of someone who has up to date specialist knowledge of the issues? If you are relying on one of your own experts, were they directly involved in the events and

if so do you need to seek an independent view? If statements or other communications show signs of defensiveness then it will be especially important to consider getting a 'second opinion'. *(see the Decision Ready section)*

- **Direct or Indirect**: Is it the recollection of someone who was there at the time of the event or is it relying on 'usual' practice and what someone expects to have happened? Is the information second-hand and does it rely on what someone else told someone or on records made by a third party?
- **Credibility**: Does the document contain obvious errors which makes the whole document less reliable? If something is stated as a fact in one document but this fact isn't supported by other information it may make the document less credible. What is the source of the information? Is it a well referenced or researched guideline or is it an unchecked internet article?
- **Representativeness**: Is a single document representative of all the relevant documents? For example, if one letter suggests that an individual wasn't given an important piece of information is that true of all the letters sent to them? Sometimes, records or correspondence may have been destroyed – in such cases you must decide whether the information that remains available is going to be enough to draw a conclusion.
- **Meaning**: Is the evidence understandable? In some cases, a document will be useless, for example, if it is defaced or written in such a way that it is impossible to read or to make any sense of. Can you ask for a transcript?
- **Authenticity**: Is the document genuine and are you sure of its source? It may be that a document that seems to be from a certain source (to make it more credible) is not what it seems to be at first glance. If there is doubt as to the authenticity of a document, you will need to resolve the doubt before relying on the information it contains.
- **Proportionality**: Do you have enough evidence to answer the core questions raised in the investigation? A lot of time can be wasted on over investigating an issue about which you already have enough information to answer the question or on an issue which isn't actually in dispute. What will it add if you interview 10 people if you already have 4 broadly similar statements or 4 very different ones?

If it won't ever be clear then you may need to reach a conclusion based on another factor rather than continuing to gather more contradictory statements.

9. Biases

- **Availability Bias** occurs when we prefer information which is more

recent or more readily available over information about more distant or less memorable events which may in fact be more relevant. “This is just like the case I saw last week.”

- **Anchoring Bias** occurs when we put too much emphasis on one piece of information when making a decision simply because it formed part of our initial thinking.
- **Confirmation Bias** happens when we prefer information which confirms what we want to believe. Remember this may also impact of the information you are given by others.
- **Hindsight Bias** exists where we judge a situation by what we now know to be the case rather than what we should reasonably have known at the time.
- **Overconfidence Bias** occurs when a person overestimates the reliability of their judgements. This can include the certainty one feels in one’s own ability, performance, level of control, or chance of success – 80% of drivers think they are better than average.
- **Fundamental Attribution Error & Actor-Observer Bias** we all have a tendency to blame others’ personalities when things go wrong. Instead of looking objectively at the situation, we excuse ourselves from blame because of external events.
- **Information Bias** occurs when we keep seeking out more information which won’t actually make any difference to our decision. If you have enough information to reach a reasonable decision you can stop.
- **Clustering Illusion** happens when we string together randomly occurring events to make a cohesive story. This is a strong human tendency and again you may see examples of it from those providing you with information.
- **Blind Spot Bias** is the failure to recognise your own biases.

STEP 4: Reaching a decision

We said in Step 2 that there are two questions which need to be answered to ensure any conclusion you reach is properly thought through. These are: **What did happen?** and **What should have happened?** Sometimes the dispute is about exactly what did happen, sometimes the dispute is about what should have happened; for example the complainant expected a particular outcome or action to occur but staff considered that the policy required a different outcome or action. In many cases there are disagreements about both. Follow these three steps and you will be in the best possible position to reach a decision.
Importantly, if you have followed all these steps you must then reach a decision. Difficult decisions are most often difficult precisely because we put off making them.

At SPSO our decisions are classified as 'upheld' or 'not upheld'.
Your organisation may use different descriptions.

10. Reach a conclusion based on the balance of the evidence
Law Courts have standards of proof: Beyond Reasonable Doubt or Balance of Probabilities. These standards don't apply to complaint investigations. 'On balance' is generally the standard that complaint investigators will use. The information gathered should be able to demonstrate whether it is more likely that events happened or that they didn't happen.
The balance can be very clear cut (80/20) but more often it is a very fine balance (49/51). It is these fine balance cases that can be particularly hard to judge and where you need to be especially careful to explain your final decision. This may include explaining to the complainant that it is a very close decision. Investigators often make statements such as 'there is no evidence' when the complainant has given them a lot of information or even just their own recollection. All of that *IS* evidence, it is just not *enough* evidence to reach the conclusion they want. In such cases it is better to explain that the decision has been reached 'on balance' of all the evidence considered. A good decision will demonstrate that it has taken account of any contrary evidence as well as the evidence that supports it.
Also remember, the importance of not reaching a decision based on hindsight - you are considering what was known or should reasonably have been known at the time the events of the complaint happened.

- **Decide on balance what did happen and what should have happened**

11. In any event, once you have answers to those two key questions you

can compare the answers. If what did happen is the same as what should have happened then it is likely you will not agree with the complainant (SPSO describe this as 'not upheld'). If there is a difference between what did happen and what should have happened then it is likely that there has been a problem that needs to be resolved (SPSO describe this as 'upheld').

For example:

What complainant said happened	**What staff said happened**	**What the complainant said should have happened**	**What the Policy, guidance, usual practice says should have happened**
Waited 10 weeks for operation	Waited 6 weeks from consultant agreement for operation	Waiting Time Guarantee means operation should be in six weeks of GP referral	Waiting Time Guarantee only applies from time of consultant agreement not GP referral
Conclusion: Operation happened within six weeks of consultant agreement. Complaint not upheld			

- **Compare what did happen to what should have happened**

12. Responsibility
If you have identified a difference between what did happen and what should have happened you may need to consider who or what is responsible for the difference before reaching a conclusion. Was your organisation responsible for the difference or was it outside of your organisation's control?

- **Determine where you are responsible for the difference**

13. Partially upheld decisions
If you find that some aspects of the complaint are upheld but that others are not you can manage this in a number of ways. You might partially uphold the complaint or you might break the complaint down into two separate complaints with one an uphold and another not-upheld. If you do opt to partially uphold it is important to be very clear which aspects of the complaint you supported and which you didn't.

STEP 5: Communicating the decision

As important as it is to reach a properly thought through decision, all that good work can rapidly come undone if your decision isn't properly explained to the complainant and it does not show an understanding of their particular circumstances and the issues they have faced. It is an essential part of making your decision that you give clear reasons for reaching that decision. It will also be helpful in explaining your decision to those involved in your own organisation.
Here are some keys points to consider in explaining your decision.

14. Many organisations have a structured template for staff to use to make sure they include all relevant information and to help make sure explanations are consistent (an investigation plan template is on our website). It can also be very helpful to have a Quality Assurance process to explain what standard your organisation expects and check for consistency. (See an example of a QA tool)

- **Use a structured template letter to ensure consistency in communicating decisions**

15. Having a structured template is NOT the same as using standardised phrases or language. It is very important that decision letters / communications are personalised to every complainant and every complaint. Here are a number of tips to help ensure your response is as clear, personalised and effective as it can be.

- **Review your letter using the tips for good communication (see next page)**

16. Ensure you acknowledge the circumstances that led to the complaint, and the issues the complainant has faced and ideally the outcomes that they were seeking. Showing empathy for the complainant's circumstances does not mean that you are not being impartial in your decision making. It shows that you have properly considered the impact the circumstances have had on the individual.

- **Reflect the impact of the situation on the complainant and the outcomes they were seeking**

Tips for good communication

- Check all names are spelled correctly and that any dates are properly detailed and correct (double check years)
- Include specific reference to every aspect of the complaint you agreed to investigate at stage 1
- Set out a brief summary of how you have investigated; for example reading electronic or paper files, interviewing staff, researching policies or guidance, seeking expert advice
- Set out the information provided to you by the complainant as well as the internal information
- Set out clearly any relevant law, standard, guidance or procedure which applies
- Explain how you have evaluated the information against any standard or other rule
- Include a clear and easily identifiable decision; a number of complaints escalate to SPSO that have been upheld by the organisation but this fact isn't clear in their communications
- If there have been errors, make a clear and easily identifiable apology (SPSO guidance apology)
- If you are taking action to sort the problem then include appropriate details about this
- Include details on any next steps open to the complainant, not forgetting any referral to SPSO or any other appeal or review body
- Acknowledge the impact events have had on the complainant and the outcomes they were seeking
- If there is an element of difficult or problematic behaviour by the complainant that is relevant to your decision you can take that into account but you must clearly explain it. If the behaviour has no direct bearing on your decision then it should not be mentioned as part of your decision. Not should any other irrelevant information – two wrongs don't make a right and (for example) the
- fact that the complainant is behind in their rent doesn't mean that an organisation can ignore their obligations to carry out repairs
- Consider asking someone to review your letter to give it a sense check / proof read. Or leave it overnight and look at it with fresh eyes the next day.

STEP 6: Remedy, Learning and Improving

If you identified failings or issues that need to be put right you will need to decide how best to fix these. Putting things right can broadly fall into two categories: putting things right for the individual affected, or learning / improvement that goes beyond an individual fix. You will need to consider what fixes are appropriate for each case and also how you ensure the fix is completed. Finally you will need to make sure that the fix worked as you intended.

17. In many complaints what is needed is a solution for the individual(s) immediately affected by the problem. There are several different types of remedy available. From Step 1 you should have a clear sense of what the complainant was looking for and have managed their expectations about what is achievable. This will be your starting point. If you have identified additional fixes that are needed during your investigation you will want to add these too. Finally you should add apologies for any errors you identified.

- **Check for any relevant remedy the complainant was seeking, any further fixes identified in your investigation and also whether any apologies are due**

18. Some complaints may also require a longer term, more widespread, solution to ensure there is no repeat failing. If you are not sure whether more action is necessary then it can be helpful to assess the likelihood of a recurrence or the potential impact of any recurrence (See an example)

- **Assess whether there are learning / improvement actions which need to be addressed**

19. If you decide that there is wider learning or improvement opportunities from a complaint, you need to consider what the appropriate actions will be. At SPSO, we have developed a simple three-level categorisation of people, policy or process level change. *People* level changes are typically staff reminders and training; *policy* level fixes include revising, amending or adding to existing policies or staff guidance or the introduction of a new policy or guidance; *process* level changes can include revising or amending existing systems (including physical resources) or introducing a new process (including physical changes such as IT solutions for previously manual activity). (See website under making improvements)

- **Decide what learning / improvement action is / are needed**

20. Once you have scoped all the fixes needed, decide which issues cannot be implemented immediately and create an action plan for these. The action plan should include who is responsible for the implementation, a timescale for implementation and what evidence is needed to demonstrate completion. Responsibility for checking action plan completion should be included in an appropriate management process. (See the SPSO website for a template improvement plan)

- **Create an action plan including a process for management review of completion**

21. Complaints can have a very negative perception in organisations. One of the most effective ways of enabling a positive attitude to complaints and encouraging a positive complaints culture in any organisation is to share the learning from complaints. This helps people see what improvements have been brought and also enables them to consider whether a similar problem could arise elsewhere in the organisation which they could take steps to prevent happening. (A template learning note is available to download)

- **Maximise the improvements from a complaint by sharing the learning across your organisation**

22. SPSO come across a number of complaints where a previous fix was implemented but either no action plan was created or no one checked the action had been taken. Following the previous steps should ensure this doesn't happen. It is best practice to also review any fixes that are implemented to check that they have worked and also that there haven't been unintended adverse consequences. It can also be extremely helpful to demonstrate to your colleagues the value of complaints if you are able to demonstrate to them the improvements and benefits that have happened as a result of complaints.

- **Check whether you have achieved the desired outcomes and share information about the improvements achieved**

Decision Making Checklist	
Are You Decision Ready?	
Are you able to make your decision freely and without undue influence from others	
Check for and declare any conflicts of interest	
Reflect on your thinking throughout the investigation to check for biases	
Do you have the right experience and where can you get help otherwise	
Give yourself ample time and opportunity to reach your decision	
STEP 1: What questions are you answering	
Read through (or listen to) the complaint and write down a list of all the issues you found	
Contact the complainant in person • Share your list of questions and check if you have properly understood the issues. Ask if there are any other issues they haven't mentioned already • Check what impact all this has had for them • Explain to the complainant in person any limitations on what you can look at and why • Ask the complainant what outcome they are looking for. Explain what outcomes are possible and what is not. If the complainant doesn't know, you can make some suggestions: for example "when we find problems we might arrange staff training or an apology or a change of policy" • Summarise your understanding on the phone / in the meeting	
Explain what outcomes are possible and what is not	
Summarise your understanding on the phone/ in the meeting	
Send a written summary to the complainant confirming your discussion	
If you can't make personal contact, send a written summary and ask the complainant to let you know if they have queries	
STEP 2: Planning and Information Gathering	
For each issue decide what information you already have and make a note of it	
For each issue decide what information you need and how to find it	
Keep checking back with your plan and revise it as you get in new information	
STEP 3: Evaluating the evidence	
Test the information to evaluate how useful it is to you as evidence	
Step 4 Reaching a decision	
Decide on balance what did happen and what should have happened	
Compare what did happen to what should have happened	

Determine where you are responsible for the difference	
Step 5 Communicate your decision	
Use a structured template letter to ensure consistency in communicating decisions	
Review your letter using the tips for good communication	
Reflect the impact of the situation on the complainant and the outcomes they were seeking	
Step 6: Remedy Learning and Improving	
Check for any relevant remedy the complainant was seeking, any further fixes identified in your investigation and also whether any apologies are	
due	
Assess whether there are systemic issues which need to be addressed	
Decide what systemic changes are needed	
Create an action plan including a process for management review of completion	
Check whether you have achieved the desired outcomes and share information about the improvements achieved	
Maximise the improvements from a complaint by sharing the learning across your organisation	