Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 16809

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities. She may also investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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EXECUTIVE SUMMARY

I received a complaint about the actions of the Western Health and Social Care Trust concerning how it dealt with the complainant's request for a carer's assessment and her subsequent complaint.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- The Trust's response to the request for a carer's assessment made in November 2012.
- The Trust's handling of the complaint.

Findings and Conclusion

I investigated the complaint and found failures amounting to maladministration in relation to the following matters:

- Failure to provide a carer's assessment following a request
- Failures in complaints handling by the Trust

I am satisfied that the maladministration I identified caused the complainant to experience the injustice of distress, frustration, loss of opportunity to obtain support and time and trouble taken to pursue her complaint to my office.

Recommendations

I recommended:

- an apology from the Chief Executive of the Trust
- a payment of £500 as a solatium
- a review of Trust carer's policy and procedure to ensure consistent information and capture of requests
- a review of Trust complaints policy and procedure to ensure full investigation of issues, meeting a person with a complaint where appropriate and avoidance of unnecessary delays.

THE COMPLAINT

1. I received a complaint about the actions of the Trust in failing to offer the complainant a carer's assessment, and the Trust's handling of her subsequent complaint.

2. The complainant alleged that she had been acting as a carer over a period of time within her family. I do not intend to detail the individual circumstances of the complainant's family, including the nature of any medical issues concerned, for reasons of patient confidentiality. It is sufficient that I have had access to records recording details of the engagement with the Trust over a period of time and involved contact with various Trust services and staff. The complainant stated that she had requested a carer's assessment in an email to a Trust social worker dated 30 November 2012. A subsequent note by Trust staff dated 14 December 2012 records that a carer's assessment was to be completed. The complainant believes this lack of assessment and access to support led to significant additional distress for her and her family.

ISSUES OF COMPLAINT

3. I accepted the following issues of complaint for investigation:

    - The Trust's response to the request for a carer's assessment from the complainant made in November 2012.
    - The Trust's investigation of the complaint.

INVESTIGATION METHODOLOGY

4. The Investigating Officer obtained from the Trust all complaint documentation together with the Trust's comments on the issues raised by the complaint.

5. All documentation from the Trust relevant to the issue of carer's assessments was also obtained, including information and guidance on Carer's Assessments and carer's rights. My investigating officer discussed the case with a Clinical Psychologist and an Assistant Director from the Trust, to seek further information

in relation to the complaint on 31 August 2018.

6. The complainant clarified that her complaint related to how her request for a carer's assessment was handled from 2012, and her subsequent complaint to the Trust.

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

8. The general standards are the Ombudsman's Principles[1]:
   (i) The Principles of Good Administration
   (ii) The Principles of Good Complaints Handling
   (iii) The Public Services Ombudsmen Principles for Remedy

10. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgment of the individuals whose actions are the subject of this complaint and the administrative policies of the Trust. The specific professional and regulatory standards relevant to this complaint are:

    (i) The Carer's and Direct Payments Act (Northern Ireland) 2002[2]

    (ii) DHSSPS Circular "Implementation of Carer Strategy" HSS (ECCU) 4/2006[3]

    (iii) WHSCT "Working in Partnership with Carer's" – Carer Strategy document January 2009[4]

    (iv) DHSSPS Regional Complaints in Health and Social Care: (2013)

    (vii) WHSCT Trust Policy for the Management of Complaints (2011)

    (viii) WHSCT Trust Carer Handbook (2015)

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[2] https://www.legislation.gov.uk/nia/2002/6/contents
[3] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-eccu-4.pdf
[4] http://www.westerntrust.hscni.net/pdf/WHSST._Carer's_Strategy.Working_in_Partnership.final.pdf

(ix) WHSCT Information and Guidance notes on completing carer assessments (2011)

11. I have not included in this report every detail identified during my investigation. However, I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings and conclusions in this case. I have shared the draft report with the complainant and the Trust.

THE INVESTIGATION

12. The complainant stated that she performed a number of roles as a carer within her family. She believes that the Trust would have been aware of this as it had some ongoing involvement with her family. I note that more than one Trust service was involved with the family. In any event the complainant informed a Social Worker from the Trust in an email of 30 November 2012, among other matters, that a carer's assessment was sought by her. In December 2012 a Trust Social Worker recorded that a carer's assessment was to be completed. The complainant stated that no such assessment took place at that time.

13. The complainant had further contact with Trust staff from a number of disciplines over the next number of months. However, she was not provided with a carer's assessment.

14. In October 2013 the complainant wrote to the Trust to outline her dissatisfaction with a number of aspects of the Trust engagement with her family. The correspondence provided a detailed chronology of engagement with Trust services by the family and responses to a number of areas of complaint. It also raised the non-completion of a carer's assessment. Considerable communication by telephone, email and letter ensued over the following months between the complainant and Trust staff. For the purposes of this investigation and report I am dealing solely with the complainant's request for a carer's assessment. I will consider the handling of the complaint about the carer's assessment under the

second issue in this report.

Evidence considered

15. The complainant provided an email dated 30 November 2012 which she forwarded to a Trust social worker, which indicated, among other matters: "…I need…a Carer's Assessment". She also provided a copy of a diary note which recorded that an assessment was to be completed.

16. During initial assessment of the complaint, relating to the Trust handling of this matter, a Trust response of 4 December 2017 highlighted that: the service dealing with the family was in its "initial developmental phase"; the service had no Clinical Lead at that time; the family were engaged with a number of Trust services; and the Trust considered there were issues regarding consent to sharing patient information.

17. The Trust provided copies of the internal communications between staff related to the complaint. I note the following internal trust communications as significant:

    i - email: 10 December 2013: "…undertaking was given at the first meeting…that a carer's assessment would be provided"

    ii - email: 11 December 2013 "…I don't think [the complainant] could be classed as…carer?"

    iii - email 12 December 2013 "…WHSCT Carer's Assessment Guidance stated there should be an holistic approach. Where two teams are involved, negotiation should take place to agree who is best placed to carry out the assessment…"

    iv - email 18 April 2014:"…she has not been given a reason why a carer's assessment has not been carried out…"

    v - email: 13 May 2014 "[complainant] sent carer's assessment guidance

    vi - letter: 23 May 2014 "[complainant]…received an email …would be happy to complete a carer's assessment"

    vii - visit: 19 August 2014 carer's assessment carried out

    viii - email: 15 September 2014 carer's assessment shared with the complainant

18. During the investigation the Trust, by letter from the Chief Executive dated 17 April 2018, confirmed that there was no specific Trust carer's assessment policy during the period being reviewed. The Trust provided copies of "Information and Guidance" for staff on completion of the carer's assessments from 2011, 2013 and 2016. The Trust informed the Investigating Officer that while there was no specific policy on carer's assessments, the Trust guidance and the Health and Social Care Board (HSCB) guidance sets out the legislative context and relevant guidance in practice.

19. I consider the following provision of the Carer's and Direct Payments Act (Northern Ireland) 2002 (the 2002 Act) to be of particular significance:

> *"Rights of carer's to assessment*
>
> *4. (1) Where –*
>
> *(a) The carer of an adult requests an authority to carry out an assessment of the carer's ability to provide and to continue to provide care for the person cared for; and*
>
> *(b) The authority is satisfied that the person cared for is someone for whom it may provide personal social services*
>
> *The authority shall carry out such an assessment."*

20. As part of this investigation, I examined the WHSCT "Carer Strategy" (2009) document. This sets out the context and background to the development of carer support regionally and commits the Trust as accepting and embracing the principles of the regional strategy. It provides:

> *"Key principles of Caring for Carer's*
>
> *1. Carer's are real and equal partners in the provision of care*
>
> *Carer's must be recognised and involved in every level of planning and service delivery. Carer's views are taken into account in all aspects of the care planning process."*

21. I note the Trust's own "Information and Guidance" (2011) provided to its staff to assist with completing the carer support needs assessment. I note that it does not

directly refer to initiation by the carer by a request for assessment. However the guidance focuses on the Trust legal requirement to inform carer's of their right to request an assessment and targeting carer's from within existing service provision.

22. I refer to the Trust Carer's Handbook (2013) which states:

"Help for you - Carer's Support Needs Assessments

If you regularly provide or intend to provide a substantial amount of care for a friend or relative, or you have a disabled child, you have a legal right to ask the Western Trust for a carer's support needs assessment. This assessment will consider your caring role and responsibilities and willingness to continue caring. The assessment is not a test of your ability to care but aims to make caring easier for you by finding out and providing the support you need, even if the person you are looking after is not receiving services from the Trust."

Analysis and findings

23. The complainant has stated that the Trust failed in its statutory obligation to undertake a carer's assessment under the 2002 Act. I am satisfied based on available evidence that the complainant raised the issue of a carer's assessment with the Trust, including in her email of 30 November 2012 and orally in records made by Trust staff of discussions with her.

24. There is no evidence of the Trust undertaking a carer's assessment from December 2012 until the issue was raised again by the complainant in October 2013 as part of her complaint. Trust records evidence that the Trust was discussing the issue of providing a carer's assessment in late 2013 and the first half of 2014. I conclude on the evidence available that the complainant did request a carer's assessment in December 2012. There is no record of direct communication with her to acknowledge her request, explain the delay, or to propose how the assessment would be provided, until May 2014. The carer's assessment was completed by the Trust in August 2014. This was a delay of some 20 months.

25. In considering this issue I have had regard to the First Principle of Good Administration which requires public bodies to 'get it right', which includes acting in accordance with the law and relevant policies and guidelines. The 2002 Act specifies that a carer can request the relevant authority (the Trust) to carry out an assessment. The Trust's explanation for the delay in carrying out the assessment that this service involved was relatively new and did not have a clinical lead practitioner. I consider this explanation is inaccurate. From the available evidence I conclude that the Trust was aware of the policy and legislative moves to recognise the roles of carer's regionally certainly from 2002. The Third Principle of Good Administration requires public bodies to be open and accountable.

26. I am therefore satisfied that the Trust failed in its statutory duty to act on a request for a carer's assessment from December 2012 to August 2014. It therefore failed to meet the requirements of the First and Third Principles of Good Administration. I consider this to be maladministration. I uphold this element of the complaint. I consider that the complainant sustained the injustice of distress and frustration as a result of the failure to provide a carer's assessment in a timely manner. I am satisfied that she sustained the injustice of a lost opportunity during that time to obtain additional support in her role as a carer. I will deal with the remedy in the conclusion of this report.

The Trust's investigation of the complaint.

27. In October 2013 the complainant made a complaint to the Trust about its failure to undertake a carer's assessment. This complaint was detailed in a lengthy document, setting out a number of issues regarding Trust services dealing with her family. In October 2017 she complained to my office that she was dissatisfied with the outcome of her complaint to the Trust. My investigation into the Trust's complaint handling deals with the issue of the carer's assessment only.

28. The Trust acknowledged the complaint by letter dated 17 October 2013, but progress was delayed due to patient consent issues. Those issues did not directly relate to the carer's assessment. The Trust partially responded to the complaint in June 2014, August 2014 and January 2015. When the complainant

specifically drew the Trust's attention to the lack of acknowledgement of a carer's assessment for her and the delay in provision, the Trust responded by letter of 6 July 2015 and the Assistant Director of the service apologised for the lack of provision of a carer's assessment. The complainant was not satisfied with the Trust's apology and response on the carer's assessment issue, including details of staff training on carer's assessment and action to prevent a recurrence. Despite further correspondence in November 2015 and a Trust response in May 2016 she remained dissatisfied. Trust attempts to organise a meeting between the complainant failed and it responded finally in June 2017 by letter to say that it had exhausted the complaints process

29. As part of the investigation, the Investigating Officer obtained copies of: all complaint correspondence, the Trust complaint file, and internal communications between Trust staff involved with the complaint.

30. The Trust complaint policy document clearly indicates it is intended to comply with the DHSSPSNI Regional Complaints guidance document generally and sets out specific guidance to be followed. This includes, where relevant to this complaint:

"…14.4 Those wishing to make third party complaints who want to pursue their own concerns can bring these to the attention of the organisation without compromising the identity of the service user. Any identified concerns will be considered, investigated and addressed as fully as possible. A response will be provided to the third party on any issues it is possible to address without breaching the service user's confidentiality.

…21.2.2 The complaint will be forwarded to the relevant Investigating Officer with a copy to the relevant Director and Assistant Director. The Investigating Officer undertakes and completes an investigation which will be forwarded by complaints staff along with a copy of the complaint. An Investigation Template for Investigating Officers is provided in Appendix 6.

…21.2.3 Where the complaint involves more than one area of service or

Directorate the relevant Director/s will be asked to identify which Investigating Officer will be responsible for coordinating the investigation and drafting the response. Those complaints covering more than two areas of service or Directorates will be co-ordinated by complaints staff who will request reports via the relevant Investigating Officer/s and collate the draft response.

21.2.4 The Investigating Officer either during or on completion of his/her investigation should consider whether there is a need to contact or meet with the person making the complaint before the written response is issued. This decision should be reached through consultation with the relevant Assistant Director and/or Director and include identification of those staff members requiring to be present at the meeting….

21.2.5 It is the responsibility of the relevant Investigating Officer to prepare the draft response from the information obtained from the investigation…The response should be clear, accurate, balanced, simple and easy to understand. The draft response should aim to answer all the issues raised in the complaint, be open and honest explaining the situation, why it occurred and reporting the action taken or proposed. The draft response should also include an apology where things have gone wrong with the aim of assuring the person making the complaint, that we have taken their concerns seriously.

…21.2.9 As required by the Department of Health, Social Services and Public Safety complaints must be investigated and the person making the complaint issued with a written response from the Trust within 20 working days. A holding letter will be issued, if necessary explaining that the response will be delayed and providing a reason for the delay. Any additional delays should be notified to complaints/ staff to allow them to keep the person making the complaint informed of progress. Any delay in issuing the written response should not normally exceed an additional 20 working days. "

31. I refer to the DHSPSNI Regional complaints guidance which states at section 1.7:

"Learning

…Effective complaints handling is an important aspect of clinical and social

care governance arrangements and, as such, will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of complaints handling by highlighting the added value of complaints within health and social care and making the process more acceptable/amenable to all."

Analysis and findings

32. I consider that the full written complaint made by the complainant in October 2013 was detailed and complex involving a number of services and Trust Staff. A method of analysing the complaint would undoubtedly have been to seek to contact the complainant to go through the complaint and isolate individual services, provision or individual interactions that were the subject of the complaint. This is outlined in the investigation template referred to in paragraph 21.1.2 and the possible need for the complaint Investigating Officer to meet the person making the complaint at paragraph 21.2.4. In the records supplied by the Trust there is no record of the use of the investigation template or of consideration being given to meeting the complainant at that stage.

33. I note that despite the Trust's delay in dealing with her request that the complainant received a carer's assessment in August 2014.

34. I conclude that the issue of a carer's assessment did not feature in the Trust's investigation of the complaint due to the failure to adequately analyse all the elements of the complaint. This caused delay in providing a full response to the complainant on this issue from October 2013 to July 2015, a period of some 21 months.

35. Where an issue such as consent or patient confidentiality arises the Trust complaints policy sets out at paragraph 14.4 the actions the Trust should take to deal with the issue. It is clear that the Trust identified that there may be a consent issue in addressing elements of the complaint, however, it took a considerable time to deal with the matter from October 2013 to March 2014. During that time the complaints file records that limited information about the delay was provided to

the complainant. The Trust did not attempt to arrange to meet her to discuss the consent matter, or other matters, were made.

36. When the complainant specifically raised the failure by the Trust to respond on the carer's assessment issue in her correspondence of November 2014 and February 2015, the Trust responded in July 2015 - a further delay on that specific issue of some eight months. I note the Trust complaint policy, in keeping with the DHSSPS NI Regional guidance, sets a 20 working day response time, with a possible extension "not normally exceeding" an additional 20 working days. The complaint file contains a considerable volume of material, however, there is no clearly recorded explanation for almost all of the considerable delays, save for routine issues of leave or staff moving posts.

37. The complainant received an apology from the Assistant Director of the service in a Trust letter in July 2015. I note that the Chief Executive of the Trust "supported" him in that apology. I consider that apology was inadequate as it should have been made by the Chief Executive in accordance with the complaints policy. It should have clearly indicated after the full investigation what was found to have gone wrong in actioning the complainant's carer's assessment request. The apology did not full contain details on actions taken to address the identified failures and to prevent a recurrence. The DHSSPS NI Regional guidance on complaints emphasises the role of learning from complaints at paragraph 1.7 outlined in paragraph 31 in my report. There is no evidence that the Trust took steps to learn adequate lessons from this complaint.

38. I consider that the Trust failed to follow its complaints policy in relation to the investigation template analysis, considering meeting with the complainant and the extended delay in its response. The First Principle of Good Complaint Handling: "Getting it Right" requires a public body to act in accordance with published guidance. I consider these failings to amount to maladministration. I uphold this element of the complaint. I consider that the complainant sustained the injustice of distress and frustration as a consequence of the delays in addressing the carer's assessment element of her complaint in a timely manner. I also consider that there was an element of time and trouble in the complainant bringing her

complaint to my office. I will deal with the remedy in the conclusion of my report.

39. I observe in dealing with this complaint with the Trust that my office has faced a considerable delay in obtaining responses to letters and email communications on a number of occasions. I was compelled to write to the Chief Executive of the Trust personally about the delay in obtaining responses. I was appreciative of her personal contact and commitment to improving the timing of Trust responses.

CONCLUSION

40. The complainant submitted a complaint to me about the actions of the Western Health and Social Care Trust. I have investigated the complaint and found failures amounting to maladministration in relation to the following matters:
    - Failure to provide a carer's assessment following a request
    - Failures in complaints handling by the Trust

    I am satisfied that the maladministration I identified caused the complainant to experience the injustice of distress, frustration, lost opportunity to obtain support and time and trouble taken to pursue her complaint to my office.

Recommendations for Remedy

41. I recommend that the complainant receives a written apology from the Chief Executive of the Trust, in the terms of my guidance on Apology, for the failures identified in this report. I also recommend a payment of £500 should be made by way of solatium for the injustices of delay, frustration, loss of opportunity and time and trouble I have identified in this report within one month from the date of this report.

42. I recommend that the Trust should review its carer's policy and procedure to ensure capturing requests for carer's assessments. It should also review all literature, carer's handbooks, leaflets and online materials to ensure clarity on what action the Trust will take when a carer's assessment is requested (where appropriate) within three months of the date of my report. I also recommend that the Trust review appropriate staff training to ensure clarity on action to be taken

on a request for a carer's assessment following the issues highlighted in this report. The reviewed procedures should be cascaded to all staff with an implementation/action plan to incorporate any recommendations of the review and the Trust should provide me with an update within six months of the date of my final report, supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any revised procedures).

43. I recommend that the Trust should conduct a review of the operation of the Trust complaints process. This should consider my findings, to ensure full investigation of issues, meeting a person with a complaint where appropriate in accordance with DHSSPS NI Guidance and avoiding unnecessary delays. It should report the outcome to me within **three** months, and implement an action plan to incorporate any recommendations of that review. It should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

The Trust have accepted my recommendations.

MARIE ANDERSON
Ombudsman **June 2019**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.