Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a Dental Practice in County Tyrone

NIPSO Reference: 201917148

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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, and 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.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

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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SUMMARY

I received a complaint about the actions of a Dental Practice (the Practice) in relation to its decision to de-registrate a patient.

I obtained all relevant information, including practice records, correspondence and relevant guidelines and policies. I also sought advice from a Dental Independent Professional Advisor (D IPA).

The investigation upheld the complaint. The investigation concluded that, although it was appropriate for the Practice to make the decision to de-register the patient, the Practice failed to evidence its decision to invoke de-registration without the standard three months' notice, to adhere to relevant regulations in enacting the immediate de-registration process and to adhere to the requirements of the Practice's Health and Safety Policy.

The investigation established that, as a result of the failings identified, the patient suffered the injustice of upset and loss of opportunity.

I made a number of recommendations, including an apology to the patient for the failings identified. I also recommended that the Practice ensures that relevant staff are made aware of relevant standards, guidance and policies.

THE COMPLAINT

Background

1. The patient was de-registered by the Practice. The Practice stated that this was because of her behaviour towards team members. This behaviour was cited as being '*abusive*'. According to the Practice, the decision was taken to de-register the patient following two phone calls between the patient and the Practice on 7 August 2020.

Issues of complaint

2. The issue of complaint accepted for investigation was:

   Whether the removal of the patient from the Practice was carried out in accordance with relevant policies and procedures.

   In particular, this included;

   (a) Whether the alleged behaviour was addressed in line with policies; and

   (b) Whether records were made at the time of the alleged abuse.

INVESTIGATION METHODOLOGY

3. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues raised by the patient. This documentation included information relating to the Practice's handling of the complaint.

Independent Professional Advice Sought

4. After further consideration of the issues, I obtained independent professional advice from the following dental independent professional advisor (D IPA):

   - A Director of Dentistry with over 30 years' experience in primary care dentistry. This has included 15 years in General Dental Practice, and 16 Years in the Public Dental Service. He has been active as a clinician, throughout this period, and continues to see patients in a Primary and Secondary Care setting.

5. The information and advice which informed the findings and conclusions are included within the body of this report. The D IPA provided 'advice'; however how this advice

was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

6. 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. I also make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[1]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

7. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - Bupa Dental Care Health and Safety Policy, December 2017 (Bupa H&S Policy);
   - Bupa Dental Care Zero Tolerance for Abusive Patients Policy, 12 August 2020 (Bupa Abusive Patients Policy);
   - Bupa Dental Care Complaints Procedure (Bupa Complaints Procedure);
   - General Dental Services Regulations (Northern Ireland) 1993 (GDS Regulations); and
   - Department of Health Zero Tolerance on Abuse of Staff, 2000 (DoH Zero Tolerance Guidance).

8. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the administrative actions of the Practice. It is not my role to

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

question the merits of a discretionary decision taken unless that decision was attended by maladministration.

9. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

10. A draft copy of this report was shared with the patient and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Evidence Considered

Legislation/Policies/Guidance

11. I considered the Bupa H&S Policy, the Bupa Abusive Patients Policy, the Bupa Complaints Procedure, the GDS Regulations and the DoH Zero Tolerance Guidance.

The Practice's response to investigation enquiries

12. In correspondence to the complainant dated 30 September 2020, the Practice stated that the decision to de-register the patient arose due to her behaviour towards team members. The Practice stated that this decision was made with the support of the Practice Manager, who in turn sought the advice of the Patient Liaison Team. The Practice referenced the GDS Regulations, 1.7.8 concerning a breakdown in the relationship between the dentist and the patient.

13. In correspondence dated 8 October 2020, the Practice apologised to the patient that the letter informing her of her de-registration did not reach her. In this correspondence, the Practice also stated that the Practice had sent a copy of the de-registration letter to the Business Services Organisation (BSO) on 23 September 2020, together with the de-registration letters for the patient's children. The Practice subsequently issued an apology for the de-registration of the patient's children and reversed the decision to de-register them. The Practice stated that the Practice had sent three forms for de-registration (for the patient and her two children) to BSO on 12

August 2020 and then followed this up with another copy on 23 September 2020 once the Practice became aware that it had not been received.

14. The Practice stated that the relevant policy in place at the time was *"Violent patients cited within previous version of H&S policy".* This is cited within the overarching Bupa H&S Policy. In terms of industry-wide guidance, the Practice referred to the GDS Regulations, Schedule two, part two, sections 11 and 11A which outline how general dental practitioners (GDPs) should deal with abusive behaviour.

15. In response to further queries during the investigation, the Practice stated that, after the *'incident on the 7/8/20'* the relevant staff members who recalled relevant incidents were spoken to and that the evidence of these staff supported the allegation that the patient's behaviour was abusive and aggressive. The Practice stated that, whilst there were no documented statements taken at the time of these instances, the relevant staff members were able to recall these, and statements were subsequently documented. The Practice stated that these are written representations of the verbal statements given to the Practice Manager at the time. The Practice stated that there was no advice in the Bupa policy available at the time about de-registration. The Practice stated that it referred to the information about de-registration within the GDS Regulations, Schedule 2, part 2, section 11A.

16. The Practice stated that it had not informed the Police as per the GDS Regulations because *'the latest instance was not physical but conveyed over the phone and therefore no imminent physical danger. We also believed that this would not warrant use of police time and that it could be dealt with at practice level.'*

17. The Practice stated that it was a culmination of events that ultimately led to the decision to de-register the patient. The Practice also stated that, during a worldwide pandemic, incidents such as this are magnified. The Practice provided additional comments from the dentist concerned. The dentist further stated; '*I have a responsibility to protect staff from all types of abuse, particularly verbal abuse and take action when appropriate. I feel that in this case I have acted with care and consideration. A satisfactory professional relationship has deteriorated to the extent that it is in nobody's interest for it to continue'*. Along with the additional comments,

the Practice provided a list of incidents which the Practice stated led to the decision to de-register the patient.

Relevant Practice records

18. The records reviewed are cited within the D IPA's advice.

19. The Practice listed ten alleged incidents which it stated led to the patient's de-registration. There are no contemporaneous records of any of these incidents. The records include statements and comments by Practice Staff obtained following the complaint, four months after the immediate de-registration of the patient.

Relevant Independent Professional Advice

20. The D IPA referred to Section 11 of the GDS Regulations which covers the de-registration of a patient from a practice. He noted that these are defined as *'Termination of a continuing care arrangement or capitation arrangement'.* The D IPA advised that, under the GDS Regulations, a dentist can *'electively'* de-register a patient under set criteria which is *'to advise them of their decision, and give them 3 months' notice in writing.'*

21. The D IPA also advised, however, that where a practice wishes to de-register a patient in a period of less than three months, the GDS Regulations, Section 11, paragraph 4 becomes relevant. This regulation states that '*where a dentist wishes a continuing care arrangement or a capitation arrangement to be terminated on less than 3 months' notice, he shall apply in writing to the Agency'* (BSO);
    (a) asking that it terminate the arrangement;
    (b) setting out the reasons why he wishes the arrangement to be terminated; and
    (c) giving details of any care and treatment which he has agreed to provide for the patient and which is outstanding including any arrangements made for completion of that care and treatment.

22. The D IPA summarised the GDS Regulations, Section 11A as follows;
    '*If they wish to terminate the registration earlier than 3 months, the dentist should contact [BSO], explaining the reasons why, and how any remaining treatment is to be completed. If the dentist wishes immediate deregistration, due to, for example, a*

patient's aggressive behaviour that has required the involvement of the police, then the dentist should contact [BSO] forthwith, while ensuring that written notification is given, and [BSO] will then take responsibility for contact with the patient.' The D IPA advised that in this case, the Practice wished to de-register the patient immediately, due to "*verbally abusive*" behaviour.

23. The D IPA provided advice in relation to whether the criteria for de-registration was appropriately applied and followed in this case. The D IPA referenced the GDS Regulations, Section 11 paragraph 4, subsections (a) to (c). He advised that, *'the dentist having ticked box 4, and entering the reason for withdrawal in that section satisfies requirements '(a) asking that it terminate the arrangement', and '(b) setting out the reasons why he wishes the arrangement to be terminated'.*

24. The D IPA then considered the requirements of the GDS Regulations, Section 11A. He advised that the reason the Practice gave for the de-registration was that the patient was *'verbally abusive to staff members over a number of years' (as per the withdrawal document sent by the Practice to the Agency)'* and that this reason was applicable to the *'criteria in Section 11A.1.(i); a person, with whom a dentist has a continuing care arrangement, or a capitation arrangement, has committed an act of violence against the dentist or an employee of the dentist or has behaved in such a way that such dentist or employee has feared for his safety'.* The D IPA also advised, however, that the actions of the Practice did not satisfy the second part of the GDS Regulations, Section 11A.1.(ii), '*the dentist has reported the incident to the police, the dentist may notify the Agency that he wishes the arrangement to be terminated immediately'.*

25. The D IPA advised that there is no record of any communication from the Practice to the patient about her behaviour prior to de-registration. The D IPA also advised that no records of the alleged abusive behaviour were made at the time these occurred.

Responses to the Draft Investigation Report

26. Both the patient and the Practice were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been reflected in changes to the report. Other comments are outlined below in paragraphs 28 to 31.

The patient's response

27. The patient referred to Appendix five in which the Practice listed a number of instances that the patient was allegedly '*rude, extremely rude or difficult'*. The patient made specific reference to four of the alleged instances. The patient said that, as her daughter was only 12 when she allegedly left her at the Practice alone, she would not have left her there unattended. The patient said that she requested '*lab work'* be posted to her but that she had paid for both the treatment and the postage and she considered that this was a reasonable customer request. Referring to the incident on 7 August 2020, which the Practice stated led to the patient's de-registration, the patient said that the corresponding Practice staff's statement has '*no mention … of …being abusive, nor of a staff member being in tears as noted in the appendix [five]*' and that even if accurate, this '*'worst incident to date' [has] nothing abusive or threatening in it and by implication there was nothing abusive nor threatening in any of the previous calls either.'*

28. The patient said that the experience of de-registration has caused significant upset in her family, including how her children have been treated.

The Practice's response

29. The Practice referred to the D IPA's advice that the Practice failed to act in accordance with Section 11A of the GDS Regulations by not providing the details of any outstanding care and treatment. The Practice stated that there was no outstanding treatment required for any of the three patients who were de-registered and, therefore, this was not included in the forms sent to BSO.

30. The Practice stated that it accepted that, under the GDS Regulations, the police should have been informed. The Practice also stated that the dentist did not feel that informing the police was necessary as the abuse was verbal only. The Practice stated that the dentist only became aware of the other most recent incident after the

patient had ‘exited’ the Practice and therefore the dentist was unable to involve the police at the time of the event.

Analysis and Findings

Process of de-registration

31. I investigated the complaint by carefully examining the records available, the relevant guidance, the patient’s account, the Practice’s responses and the D IPA’s advice.

32. I note that the patient indicated that she and her family were upset by their experience of being removed by the Practice.

33. I have considered the information provided by the Practice about the alleged behaviour of the patient. This includes the non-contemporaneous statements provided by members of staff and the list of alleged incidents culminating in the incident on 7 August 2020.

34. The patient referred to the list of alleged incidents provided by the Practice in her response to the Draft Investigation Report. I note that the patient refuted that she had ever left her 12 year old daughter unattended at the Practice. The patient said that her request for ‘*lab work’* to be posted to her home was a reasonable customer request for which she made payment. The patient also pointed out that the statement made by the member of the Practice staff about 7 August 2020 contained no reference to the patient being abusive or threatening. The patient also highlighted that, as this was cited by the Practice as being the ‘*worst incident to date’*, this implied that previous interactions were neither abusive nor threatening.

35. I refer to the DoH Zero Tolerance Guidance. I note that in this ‘violence’ is defined as ‘*any incident where staff, are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, wellbeing or health.’* I also refer to the GDS Regulations Section 11A which outlines circumstances for ‘violent patients’. I note that it states that a ‘violent patient’ is ‘*where a person … has committed an act of violence against the dentist or an employee of the dentist or has behaved in such a way that such dentist or employee has feared for his safety’*. I further refer to the Bupa H&S Policy which was the applicable policy at

the time of the patient's de-registration. I note that under the section for violent patients it stated *'threatening or aggressive behaviour towards any team member'*.

36. The investigation has not identified any contemporaneous records of the incidents in which the Practice alleges the patient exhibited violent behaviour. I am satisfied that all the records pertaining to the allegations were prepared in response to the complaint, several months after the alleged incident on 7 August 2020 which prompted the de-registration of the patient without notice. In considering the information provided by the Practice, I note that none of the statements contain any references or descriptions of behaviour which constitute 'violence' or a 'violent patient' under the relevant policies and guidance referred to in paragraph 36 above; specifically, there are no references to 'abuse', 'threat', 'assault', 'wellbeing', 'safety', 'health', 'violence' or 'aggression'. Of the list of alleged incidents, only one references a specific incident which was on 7 August 2020. This was described as '*the worst incident to date*' and prompted the patient's de-registration without the standard notice period. The statement related to this incident on the 7 August 2020 describes the patient as '*tutting*' at the member of staff twice, with no reference to any abuse, threat, aggression or upset. As with the other statements, there is no reference to any of the criteria for violence or abuse, verbal or otherwise.

37. In the Practice's response to investigation enquiries, the dentist stated that, on 16 September 2020 during a call with the patient, the patient was *'aggressive*' and that the incident was *'upsetting'* for the dentist. I consider that staff should not be subjected to aggression in any form and should be treated with respect and courtesy; however, notwithstanding this entitlement, I note that this incident took place after the patient was de-registered without notice and therefore was not material to the Practice's decision to de-register the patient without notice.

38. I also refer to the Bupa Abusive Patients Policy. Although this policy was not formally implemented until 12 August 2020, three working days after the patient's de-registration, I note that this policy categorises abusive behaviours with descriptors for each of the three categories and outlines the process to be followed for each category of abuse. I note that, based on the records provided by the Practice of the alleged incidents, including any related to the period after the patient was de-registered, under this policy the patient's behaviour would have been categorised as 'mild' or

'moderate' behaviour. I note that the policy stipulates that for each of these categories, a warning should be issued to the patient; in the former case, a verbal warning and in the latter a written warning. I note that in neither category of behaviour would the patient be removed from the Practice.

39. I consider that the GDS Regulations state that a dentist can electively de-register a patient. This was also confirmed by the D IPA who advised that under, *'Section 11, a dentist may deregister any NHS patient, having given them 3 months' notice.'* I particularly note that the GDS Regulations, Section 1.7.8 state that '*trust between [the dentist] and a patient may break down, and [the dentist] may find it necessary to end the professional relationship.'* I therefore consider that in deciding to de-register the patient, the Practice was operating within the parameters of the GDS Regulations. Therefore, I do not uphold the complaint that the patient should not have been de-registered.

40. I also consider, however, that under the GDS Regulations and in acceptance of the D IPA's advice, the Practice was required to provide the patient with three months' notice of the de-registration. I consider that in reference to the criteria for 'violent' under the policies and guidance detailed in paragraph 36, the Practice failed to evidence its decision to de-register the patient on 7 August 2020 as a 'violent patient' without notice under the GDS Regulations Section 11A. I further refer to the GDS Regulations and the D IPA's advice that the Practice should have contacted the police if the patient's behaviour warranted immediate removal. I therefore uphold the complaint that the patient's de-registration without the required notice period of three months was not in accordance with relevant standards.

Injustice

41. I find that, as a result of the Practice's immediate de-registration of the patient out-with the criteria of the GDS Regulations, the patient suffered the injustice of upset and loss of opportunity for potential continuity of care.

Compliance with the Practice's Policies

42. I note that in the Bupa H&S Policy under 'violent patients', it stated that when there is a violent or aggressive patient, written, signed and dated statements should be taken and a written statement submitted to the area manager. I note that the Practice did

not comply with any of these requirements for any of the incidents which were alleged to have taken place prior to the patient's de-registration. I also consider, therefore, that the Practice failed to comply with the Bupa H&S Policy in not taking appropriate statements at any of the alleged incidents and in not submitting statements to the area manager.

43. I consider that the Practice's failures detailed in paragraph 43 above constitute maladministration in failing to act in accordance with the first Principle of Good Administration. Specifically, 'Getting it right' by acting in accordance with the public body's policy and guidance and taking account of established good practice.

44. The D IPA also advised that the Practice failed to act in accordance with the GDS Regulations, Section 11A by not providing BSO with the details of any outstanding care and treatment. I note, however, that in its response to the Draft Investigation report, the Practice stated that there was no outstanding treatment at the time of de-registration. I note that review of the records confirms that there was no outstanding treatment for the patient. I therefore consider that there was no omission in relation to this in how the Practice transferred the patient to BSO.

Record Keeping

45. I note that the Practice failed to make contemporaneous records of the alleged incidents and that the statements provided by members of Practice staff were not taken at the time of the relevant alleged incidents. I consider that this is a failure by the Practice to adhere to the Principles of Good Administration, in particular, the third principle, 'Being Open and Accountable'. I consider that the Practice should have kept proper and appropriate records of each incident which ultimately related to the decision to de-register the patient.

46. I also note that there is no evidence that the Practice issued any warning to the patient about her behaviour prior to the decision to de-register. I note that the D IPA also advised that, '*there is no record ... of any contact with the patient, regarding her behaviour, prior to her deregistration*.' I consider that the information provided by the Practice about the patient's behaviour over a period of time and the Bupa Abusive Patients Policy, which was implemented three working days after the patient's de-registration, indicate that the Practice should have warned the patient about the unacceptability of her behaviour prior to the incident on 7 August 2020. I consider that

this would have provided the patient with an opportunity to amend her behaviour. I consider that the Practice's failure to do so constitutes maladministration as it does not accord with the second and third Principles of Good Administration, 'Being Customer-focused' and Being Open and Accountable'.

Injustice

47. I find that as a result of the failure identified in paragraph 47 above, the patient suffered the injustice of the loss of opportunity to improve her relationship with the Practice which may have prevented the de-registration.

CONCLUSION

48. I investigated the complaint and found failures in actions taken by the Practice.

i. The Practice de-registered the patient without the required three months' notice and failed to evidence its decision to do so.

I am satisfied that the failure identified caused the patient to suffer the injustice of upset and loss of opportunity for potential continuity of care.

ii. The Practice failed to comply with the Bupa H&S Policy as it failed to take appropriate statements at any of the incidents at which the patient was alleged to be violent and it did not submit written statements about these incidents to the area manager.

iii. The Practice did not meet the standards of the Principles of Good Administration as it failed to issue the patient with any warning about her behaviour prior to de-registration and did not maintain contemporaneous records of alleged incidents on which the decision to de-register the patient was based.

I am satisfied that as a result of the failures, the patient suffered the injustice of the loss of opportunity to improve her relationship with the Practice which may have prevented the de-registration.

Recommendations

1. I recommend that the Practice provides the patient with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustices caused as a result of the failures identified (within **one month** of the date of this report).

2. I refer the Practice to the GDS Regulations and the complete advice provided by the D IPA in relation to de-registration. I recommend that the Practice reviews it policies to ensure they are complaint with the GDS Regulations and that the Practice ensures that any updated policies are brought to the attention of staff. I also refer the Practice to the Principles of Good Administration, in particular Principles one to three. I recommend that relevant staff should be made aware that where patients' behaviour is not acceptable, in the interests of openness, transparency and fairness, these patients should be advised of this and the potential consequences of continued unacceptable behaviour. These actions should be evidenced by a record of the information-sharing and confirmation that the policies have been reviewed.

3. I recommend that the Practice takes steps to ensure that adequate records of any issues with patients' behaviours are maintained. This should include training for the relevant staff in good record-keeping, with particular reference to the published standard: '*Records Matter, a view from regulating and oversight bodies on the importance of good record keeping'* (The Public Services Ombudsman, the NI Audit Office and the Information Commissioner's Office, January 2020.) This should be evidenced by a record of the training.

4. I recommend that the Practice implements an action plan to incorporate these recommendations and should provide me with an update within **three** 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 records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY

Ombudsman **14 March 2022**

Appendix 1

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.