Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust

NIPSO Reference: 201916957

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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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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

The complaint concerned the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's (the patient) eye condition.

The patient said that the Trust failed to treat his eye condition, epiretinal membrane (ERM), in a timely manner which has left him with a permanent vision loss. He also said that Trust Consultant Ophthalmic Surgeon continued to maintain that the vision loss was due to an injury caused during the patient's surgery when evidence from scans indicated that this was not the case and the Trust failed to record this surgical injury, as required under its Adverse Incident Policy.

The complaint was partially upheld. The investigation established that there were failures in care and treatment. These included failure to appropriately monitor the stability of the patient's condition; failure to escalate pre-operative assessment results to medical staff; and failure to consider the atypical aspects of the patient's case both when originally scheduling his surgery and in rearranging the operation when the Trust postponed it. The investigation also identified that the Trust failed to act in accordance with both the General Medical Council's Good Medical Practice Guidance and its Professional Duty of Candour Guidance in relation to advice and information provided to the patient which were not based on relevant evidence. The investigation found that, on the balance of probabilities, both the ERM caused the patient's loss of visual acuity and earlier surgery may have prevented the patient's present vision loss. The investigation also identified maladministration in relation to a failure to report and manage the patient's case under its Adverse Incident Policy.

The investigation established that, as a result of the failings identified, the patient lost the opportunity both for earlier intervention and treatment, with the potential for a better chance of recovery. The patient also experienced anger, frustration, uncertainty and was unable to move on.

I made five recommendations, including providing the complainant with both an apology for the failings identified and an explanation of the Trust's initial and ongoing diagnosis of the patient which was contrary to the presenting evidence. I also recommended that the relevant staff in the Trust are given the opportunity to reflect on the advice provided by the Consultant Vitreoretinal Surgeon IPA about the management of cases which present as unusual and that the Trust implements a process to highlight any unusual cases to ensure appropriate monitoring of the progression of the condition and therefore the associated scheduling of treatment. I also recommended that the Trust ensures that all relevant staff are reminded of the importance of both the General Medical Council's Good Medical Practice Guidance and its Professional Duty of Candour Guidance. I recommended that the Trust ensures that relevant staff are made aware of the importance of identifying and reporting issues which require corrective and preventative improvement actions. Evidence of these recommendations are to include details of any revised processes, records of information sharing and sample audits.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complaint related to the care and treatment provided to the complainant (the patient) for an eye condition, epiretinal membrane[1] (ERM).

Issues of complaint

2. The issues of complaint accepted for investigation were:

   Whether the care and treatment for the patient's eye condition, provided by the Trust during the period 7 October 2013 to 22 November 2016, was appropriate, reasonable and in accordance with relevant procedures, guidance and standards.

   In particular this will include consideration of:

   - Monitoring of the patient's condition prior to surgery;
   - Escalation of the patient's pre-operative assessment results to medical staff;
   - Timing of the patient's surgery; and
   - Information provided to, and communication with, the patient during the period of care and treatment.

INVESTIGATION METHODOLOGY

3. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation, together with its comments on the complainant's issues.

Independent Professional Advice Sought

[1] Epiretinal membrane is a thin sheet of fibrous tissue that develops on the surface of the macula and can cause problems with central vision. Sometimes, scar tissue forms which grows across the macula. As the membrane contracts, it causes distortion of the retinal tissue. If this happens, the macula cannot work normally. This affects the vision, particularly for reading and other visually demanding tasks, but it does not cause total blindness. This most commonly happens to people over the age of 50. While the scar tissue is developing, it does not appear to affect vision. However, when it stops growing, it contracts and causes distortion of central vision – for example, straight lines appear wavy or crooked in appearance, and reading is difficult. Depending on the severity of this distortion, a substantial loss of central vision may occur.

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

- Consultant Ophthalmologist, Vitreoretinal Surgeon (Consultant Vitreoretinal Surgeon) MD FRCS FRCOphth, a Consultant Ophthalmologist for five years

The professional advice received is enclosed at Appendix six.

5. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however, how I weighed this advice, 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[2]:

- 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:

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

- General Medical Council, '*Good Medical Practice'*, April 2013 (GMC Good Practice Guidance);
- General Medical Council, '*Openness and honesty when things go wrong: the professional duty of candour*', June 2015 (GMC Professional Duty of Candour Guidance);
- Belfast Health and Social Care Trust Adverse Incident Reporting and Management Policy, April 2014 (Trust Adverse Incident Policy);
- Belfast Health and Social Care Trust Vitrectomy Patient Advice Leaflet (Trust Vitrectomy Advice Leaflet); and
- Integrated Care Pathway for Ophthalmic Surgery, June 2014.

Where appropriate, relevant extracts from the guidance considered are enclosed at Appendices four and five to this report.

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

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

THE INVESTIGATION

Detail of Complaint

10. The patient said that the Trust failed to provide him with treatment for an ERM in a timely manner which resulted in his present loss of vision. The patient said that the Trust did not accurately assess the stability of his ERM condition, and therefore, while the patient waited for surgery, the condition deteriorated significantly, causing '*serious permanent vision loss and visual dysfunction'*. The patient said that the deterioration was evident at his pre-operative assessment in February 2014 but there was no intervention, and indeed, the surgery originally planned for early May 2014 was postponed until June 2014.

11. The patient also said he believed that the Trust Consultant Ophthalmic Surgeon failed to give an '*open and honest'* account of the situation. The patient said that the Trust Consultant Ophthalmic Surgeon maintained for more than two years that the vision loss was caused by an intraoperative (phototoxic) injury[3] sustained during his surgery. The patient said that, on a number of occasions, he disputed this with the Trust Consultant Ophthalmic Surgeon and also that the Trust Consultant Ophthalmic Surgeon reviewed scans in the period after the surgery which clearly indicated that there was no phototoxic injury. The patient also said that another Trust Ophthalmologist (Trust Ophthalmologist B) informed him that there was no phototoxic injury. The patient also said that the Trust Consultant Ophthalmic Surgeon '*directed'* Trust Ophthalmologist B to change his view on this. The patient said that when he made his complaint to the Trust, the Trust Consultant Ophthalmic Surgeon changed his view that the vision loss was caused by a phototoxic injury.

12. The patient said that, although the Trust Adverse Incident Policy requires all intraoperative injuries as well as loss and harm to be reported, neither the phototoxic injury, to which the Trust Consultant Ophthalmic Surgeon ascribed the patient's vision loss, nor the loss of vision were reported.

13. The patient said that he feels completely *'betrayed … angry and frustrated'* and *'appalled'* by the Trust's failure to be honest about what happened. He also said he has had to '*devote an inordinate amount of time pursuing this complaint'.*

Evidence Considered

Legislation/Policies/Guidance

[3] Retinal injury caused by light exposure from the operating microscope and endoillumination during ophthalmic surgery.

14. I considered the Trust Adverse Incident Policy and the Trust Vitrectomy Advice Leaflet. These documents are provided in full, together with relevant key extracts at Appendices four and five.

The Trust's response to investigation enquiries

15. As part of investigation enquiries, the Trust was provided with an opportunity to respond to the complaint. The Trust's response to these enquiries is at Appendix three to this report.

Relevant records

16. I considered all the patient's ophthalmic medical records from the period 7 October 2013 to 22 November 2016. I also considered the Independent Review Report of the patient's case which was commissioned by the Trust.

Relevant Independent Professional Advice

17. As part of investigation enquiries, I received independent professional advice from a Consultant Vitreoretinal Surgeon IPA (CV IPA). The substantive advice the CV IPA provided to me is at Appendix six. A summary of the significant key points from the advice is provided in paragraphs 18 to 36 below.

Management of the patient's care and treatment

18. The investigation into the complaint examined whether the stability of the patient's ERM condition was appropriately assessed and monitored, with consideration of the timescales in providing the patient with surgery. The complaint investigation also considered the Trust's actions when the reduction in the patient's Visual Acuity (VA[4]) was identified at the pre-surgery assessment. The investigation also sought to determine what impact the care and treatment provided by the Trust had on the patient's resulting loss of vision.

Monitoring of the patient's condition prior to surgery

[4] Visual acuity is the clarity or sharpness of vision.

19. The CV IPA advised that, as an Optical Coherence Tomography (OCT)[5] was not carried out after the patient's first appointment on 16 October 2013 until 24 June 2014, which was after his surgery, it is '*difficult to say if the ERM got worse in the meantime'.* The CV IPA further advised, however, that the patient's VA decreased from 6/6 in October 2013 to 6/9-2 in December 2013 and to 6/18 in February 2014. The CV IPA advised that this '*is an extremely fast progression for an ERM'* and, although the absence of an '*associated OCT makes it difficult to state 100% that the speed of progression in decreased VA is due to the ERM, … given the young [patient's] age and lack of any other eye issue, on balance it is fair to say the ERM was the culprit for the VA reduction between the first assessment and surgery day'.* The CV IPA also advised, however, that it is '*impossible to comment on the reason for the final VA loss.'*

20. The CV IPA advised that he would have repeated the OCT at each appointment. He also advised that '*it is becoming more and more standard to repeat OCT, but … it is not standard practice everywhere … It is absolutely NOT mandatory to do so, but it is a helpful piece of information to have especially in light of a VA reduction.'* The CV IPA further advised, however, that if a patient's VA reduces from *'6/6 to 6/18 this should trigger an alert to repeat the OCT'.* He also advised that, as this was *'a non-standard presentation (young with progressive VA worsening)',* he would have requested an OCT at each appointment. The CV IPA advised that if, at the pre-operative assessment, the worsening in VA had been flagged as it should, *'it would be expected that an OCT would have then been requested by the consultant'.*

21. The CV IPA advised that there was evidence that the patient's VA '*was declining quickly, and this is indeed a sign the condition may not be stable'*. He further advised, however, that because there are no OCTs for 31 December 2013 or 11 February 2014, he could not '*say for sure the final reduction in VA was due to a worsening of the ERM'* but that if there were OCTs for these

[5]An OCT is a non-invasive medical imaging technique, using light waves, to produce images of the eye. OCT imaging systems are used to provide details of the back of the eye (the retina), and with the addition of extra lens an OCT can also provide detailed images of the front surface of the eye (the cornea). OCTs assist in early detection and monitoring of various diseases such as Glaucoma, Diabetic Retinopathy and Age Related Macular Degeneration.

appointments, '*this could have been picked up'.* The CV IPA advised that it was '*very difficult to say'* what impact the timescales for the patient's treatment had on his condition as '*sometimes even straightforward ERM operated on very quickly do not recover or do this only partially'* and '*this is not a typical presentation, and young PTs tend to heal better'.* He advised that '*it is possible a delay had a long term effect, but again there is no way to actually demonstrate this is the case'.*

22. The CV IPA concluded that the presentation of the ERM '*was non-standard and it should have been considered as such'.*

Escalation of the patient's pre-operative assessment VA results to medical staff

23. The CV IPA advised that the Trust Consultant Ophthalmic Surgeon '*should have been made aware of the VA decrease and an OCT should have been repeated to be certain the ERM was causing the reduction in VA'.* He further advised that '*VA dropping 4 lines in 4 months should be escalated. The department did not appear to have a process in place for this at the time of this incident, but this should be implemented.'* The CV IPA advised that, if the reduction in VA had been escalated to medical staff, '*the surgery could have been done sooner, say Feb-March 2014 instead of being booked for May and then postponed to June 14'.*

24. The CV IPA advised that the *'original referral and listing time was appropriate, but it should have been flagged up at pre-assessment that the VA was getting worse and worse rapidly. This is true as a general rule, and not in relation to this case specifically. Any case where VA deteriorates at a speed which is not normal should be flagged.'*

Timing of the patient's surgery

25. The CV IPA advised that '*ERM progress very slowly, if at all'* but also advised that it normally occurs later in life. He advised that '*an ERM in a 31yo is by definition unusual*'. The CV IPA advised that a four to six month delay between diagnosis and treatment is '*acceptable'* practice but also that '*given the young age of the [patient] and the progression it would have been sensible to at least*

consider the option of treating him sooner rather than later'. The CV IPA advised, therefore, that in the patient's '*specific case'* the timescale for treatment was not appropriate. He advised that a VA reduction of 6/6 to 6/18 in four months *'is very unusual and should have been flagged up'.* The CV IPA advised that '*the quick progression'* would have '*justified'* performing the surgery in February 2014, following the pre-operative assessment.

26. The CV IPA advised that it appeared that the Trust Consultant Ophthalmic Surgeon was not *'aware of the rapid deterioration of the VA'.* The CV IPA advised that '*it is not clear why the surgery was postponed'* but it was likely to have been because of an emergency which the CV IPA advised '*is standard practice everywhere'.*

27. The CV IPA concluded that it is *'acceptable'* to postpone surgery because of emergencies, for example, a retinal detachment; however, *'given the very quick progression of this case everything should have been done to book the PT again into the following list yet the surgery listed for early May '14 did not take place until June '14.'*

The patient's resulting loss of vision

28. The CV IPA also advised that it is *'impossible to comment on the reason for the final VA loss'.* He further advised, however, that '*surgery was uneventful so I would exclude any standard surgical complication. It is possible the retina never recovered from the epiretinal membrane, and vision remained poor'.* The CV IPA advised that it was '*very difficult to say'* what impact the timescales for the patient's treatment had on his condition and that in the absence of any OCTs from October 2013 to June 2014, that *'it is possible a delay had a long term effect, but … there is no way to actually demonstrate this is the case'.*

Information provided to and communication with the patient during the period of care and treatment about his vision loss

29. The investigation into the complaint considered whether the Trust's communication with the patient about his loss of vision, following his surgery, was reasonable and accurate.

Communication with the patient about the cause of his vision loss

30. The CV IPA advised that a phototoxic injury is a *'phototoxic maculopathy caused by endoillumination during macular surgery which occurs through photothermal as well as photochemical damage.*' He advised that it '*is very uncommon'* and '*has a quite specific presentation'*. The CV IPA advised that, as OCT results were available on 24 June 2014, which corresponds to the patient's first review appointment with the Trust Consultant Ophthalmic Surgeon, and these do *'not show any feature typical of a phototoxic injury … it does not seem there is any justification for the [the Trust Consultant Ophthalmic Surgeon] to assert there was any phototoxic injury'* and that '*the opinion of a phototoxic injury continued after'* the OCT results. He advised that, based on the clinical records, the Trust Consultant Ophthalmic Surgeon definitively continued to state that it was a phototoxic injury up to and including the review of the patient in January 2015. The CV IPA further advised, however, that based on a combination of references in the clinical records for the appointment in August 2016 and the follow-up letter to the patient's GP, it was likely that the Trust Consultant Ophthalmic Surgeon also held this view in August 2016.

31. The CV IPA advised that on 23 August 2016 a Registrar (a ST7) '*noted discussion about phototoxicity as an option, saying "…option 1 [phototoxicity] more likely…"*'. The CV IPA further advised, however, that in the context of his advice in paragraph 30 above, this opinion appeared to have been '*put forward by the [Trust Consultant Ophthalmic Surgeon] not ST7'.* The CV IPA also advised that '*it does not appear from the notes that anything has been amended'.*

32. The CV IPA advised that tests were undertaken after the patient's surgery, including OCT scans and a Fluorescein angiography[6] '*with no obvious result'.* He further advised, however, that he would also have *'requested electrodiagnostic exams'* which he said could have been helpful in identifying

[6] Fluorescein Angiography is a diagnostic procedure that uses a special camera to record the blood flow in the retina – the light sensitive tissue at the back of the eye. The test does not involve any direct contact with the eyes.

the cause of the permanent vision loss. The CV IPA further advised, however, that there are no guidelines about this and that these are '*very complex tests, done and reported by few ophthalmologists'* and not requested as standard practice. He advised that he would have '*requested them in this case for the simple reason I could not find any obvious explanation for the VA loss, in the hope that I would get a lead.'* The CV IPA concluded that the tests to ascertain the cause of the *'poor vision (6/36 to 6/60) were appropriate but could have been integrated with electrodiagnostics'.*

33. The CV IPA concluded that the patient's surgery '*was uneventful (a retinal tear happened and was treated with no consequences) and the post-op apparently had no complications'.* He further concluded that '*phototoxicity was a rare but conceivable option'* but, as the OCT scans of 24 June 2014 which were available at the patient's first review do '*not show any feature typical of a phototoxic injury. It does not seem therefore there is any justification for the Consultant to assert there is any phototoxic injury'.*

Application of the Trust Adverse Incident Policy

34. The investigation sought to determine if the Trust adhered to its Adverse Incident Policy in relation to reporting the patient's loss of vision post-surgery.

35. The CV IPA advised that the cause and fact of the patient's permanent vision loss should have been recorded as an adverse incident under the Trust Adverse Incident Policy. He advised that '*if the VA loss was considered permanent, in my opinion, it falls under this 2.2, hence it should have been reported. The reason for reporting an incident is not blaming or shaming, but is an opportunity to discuss, create pathways and make sure that it does not happen again. Policy apart, it would just have been sensible to do so'.* The CV IPA emphasised the reference to '*did lead to … loss'* under paragraph 2.2 of the policy.

The Trust Vitrectomy Advice Leaflet

36. The CV IPA advised that, in the Trust Vitrectomy Advice Leaflet given to the patient, '*there is no mention of vision loss'*. The CV IPA further advised that

'*vision loss, total or partial, is indeed a complication for any VR procedure, in fact probably the worst. In my opinion a leaflet which does not report this as a possible complication is inadequate.'*

Responses to the Draft Investigation Report

37. Both the patient and the Trust 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 in paragraphs 39 and 39 below.

Patient's Response

38. The patient drew attention to the OCT scans of 24 June 2014, which were available at his initial post-operative review and requested that the CV IPA provide advice about whether these scans provided the same information as those performed in August 2014 and, therefore, the Trust Consultant Ophthalmic Surgeon had no basis at any point to inform the patient that there was a phototoxic injury.

39. The patient said that to describe his experience and the series of events as demonstrating a 'lack of candour' did not adequately reflect the gravity of the 'serious dishonesty' he faced. The patient said that the term 'lack of candour' could mean that the Trust Consultant Ophthalmic Surgeon, and the other Trust's medical professionals involved, merely withheld information. The patient said that the Trust Consultant Ophthalmic Surgeon, however, repeatedly tried to deceive him by saying that he had suffered a phototoxic injury that clearly did not exist with the purpose of avoiding accountability for the failures in the patient's care and treatment. The patient also said that since his initial complaint in 2017, multiple ophthalmologists at the Trust were involved in the case and that they failed in their professional duty to be honest about both the failings in care and treatment and the Trust Consultant Ophthalmic Surgeon's deception.

Further Independent Professional Advice following Draft Investigation Report Responses

40. Following the patient's comments on the Draft Investigation Report, I sought further advice from the CV IPA. The key extract is included at paragraph 30 above. The complete additional advice is at Appendix seven.

Analysis and Findings

41. I carefully examined the care and treatment the Trust provided to the patient in the period between 7 October 2013 to 22 November 2016.

Management of the patient's care and treatment

Monitoring of the patient's condition prior to surgery

42. The Trust stated that there is no formal guidance about undertaking pre-operative ERM monitoring whilst awaiting surgery and that it is not common practice to monitor patients with ERM in the time from the decision to carry out surgery and the surgery itself.

43. The CV IPA advised that an OCT was not carried out in the period from 16 October 2013 to 24 June 2014, which was after the patient's surgery. I note that the CV IPA advised that the patient's VA decreased from 6/6 in October 2013 to 6/9-2 in December 2013 and to 6/18 in February 2014 and that this '*is an extremely fast progression for an ERM*'. The CV IPA advised that, as this was 'a *non-standard presentation (young with progressive VA worsening)',* he would have requested an OCT at each appointment. He further advised that, although not mandatory, *'it is becoming more and more standard to repeat OCT'* as *'it is a helpful piece of information to have especially in light of a VA reduction.*' I note that the CV IPA also advised that if a patient's VA reduces from *'6/6 to 6/18 this should trigger an alert to repeat the OCT'.*

44. The CV IPA advised that there was evidence that the patient's VA '*was declining quickly, and this is indeed a sign the condition may not be stable'.* The CV IPA concluded that the presentation of the ERM *'was non-standard and it should have been considered as such'.* The report of the Independent Review of the patient's case stated that the '*relatively rapid progression is*

atypical of ERM, and should prompt reconsideration of the urgency of treatment'.

45. The CV IPA advised that in the absence of any OCTs for 31 December 2013 or 11 February 2014, he could not '*say for sure the final reduction in VA was due to a worsening of the ERM'* and that it was *'very difficult to say'* what impact the timescales for the patient's treatment had on his condition as *'sometimes even straightforward ERM operated on very quickly do not recover or do this only partially'.* I note, however, that the CV IPA advised that *'given the young [patient's] age and lack of any other eye issue, on balance it is fair to say the ERM was the culprit for the VA reduction between the first assessment and surgery day*' but that it is also *'impossible to comment on the reason for the final VA loss.'*

46. I accept the CV IPA's advice that the patient's case was non-standard, the patient's VA was quickly decreasing and that this indicated that the condition may not be stable. I also consider that the view of the independent reviewer on this accords with the CV IPA's advice. I also accept the CV IPA's advice that, given the particular features of this patient's case, an OCT should have been carried out at each appointment and, particularly that, when the VA reduced from 6/6 to 6/18, this should have instigated an OCT.

47. I note the CV IPA's advice that, whilst the final reduction in VA cannot be definitively attributed to a worsening of the ERM, because sometimes even when ERM conditions which are operated on very quickly do not recover or only partially recover, it is reasonable to conclude that the ERM was the culprit for the VA reduction between the patient's first assessment and his surgery. Whilst the cause of the loss of patient's VA loss cannot be definitively identified, in consideration of the CV IPA's advice and in the absence of any other explanation, I find that, on the balance of probabilities, the loss of VA was as a result of the ERM. I consider, therefore, that the Trust failed to appropriately monitor the stability of the patient's condition. I consider that this is a failure in care and treatment.

Escalation of the patient's pre-operative VA results to medical staff

48. The Trust stated that the Trust Consultant Ophthalmic Surgeon was not informed of the VA findings identified at the pre-operative assessment on 11 February 2014 and that the Independent Review Report confirms this. The Trust stated that it would not be the role of the pre-operative assessment nurse to evaluate the VA results and draw clinical conclusion from them. I note that the Trust stated that there is no formal guidance for pre-operative assessment nursing staff to escalate issues of concern to the consultant surgeon, but rather that referral to medical staff would be based on individual case findings. The Trust also stated that, had the further reduction in VA noted on 11 February 2014 been communicated to the Trust Consultant Ophthalmic Surgeon, surgery may have been expedited. I note that the Trust stated that it has since introduced additional measures where pre-operative assessment findings are communicated to medical staff to provide them with an up-to-date report on the patient's condition.

49. The CV IPA advised that the Trust Consultant Ophthalmic Surgeon '*should have been made aware of the VA decrease'*, as '*VA dropping 4 lines in 4 months should be escalated'* and that, although the Trust did not have a process in place for this, '*this should be implemented.*' I note that the CV IPA advised that if medical staff had been made aware of the reduction in VA at the pre-operative assessment, surgery could have been carried out sooner in February/March 2014 *'instead of being booked for May and then postponed to June 14'.* I also note that the CV IPA advised that the *'original referral and listing time was appropriate'* but that the rapid deterioration in a patient's VA should be flagged up '*as a general rule'* and not just in this specific case.

50. I note and accept the CV IPA's advice that the Trust should have had a process in place to ensure that medical staff were alerted when patients had a rapid reduction in VA. I consider that, although the Trust stated that the Trust Consultant Ophthalmic Surgeon was not made aware of the four-line loss in VA over a period of four months and that the purpose of the pre-operative assessment was not to identify information about the status of the patient's level of vision, the dramatic loss in VA should have been brought to the

attention of the Trust Consultant Ophthalmic Surgeon so that a decision could have been made about the optimum time for the surgery to be carried out. I consider that the Trust's subsequent introduction of a process to communicate pre-operative assessment findings to medical staff represents recognition by the Trust of this requirement. I consider that the Trust's failure to make the Trust Consultant Ophthalmic Surgeon aware of the pre-operative findings constitutes a failure in care and treatment. I note that the Trust stated that it has since introduced additional measures where pre-operative assessment findings are communicated to medical staff to provide them with an up-to-date report on the patient's condition.

Timing of the patient's surgery

51. The Trust stated that a consultant ophthalmic surgeon's clinical consideration determines the scheduling of surgery with the risk to sight as the primary consideration. I note that the Trust stated that, amongst other factors, condition progression, unusual case features and age, are also part of the decision in scheduling surgery. The Trust stated that clinical emergencies are prioritised over electively scheduled cases. The Trust stated that in the period October 2013 to June 2014, the standard waiting time for eye surgeries of this type was six to nine months and that there are no targets for *'a routine case, such as the patient's*'. I note that the Trust referenced the Independent Review Report's view that a six-month waiting time would be expected to have little effect on prognosis in normal circumstances but also that the Independent Review Report stated that the patient's case had unusual features, given his relatively young age and the progression of his specific condition. The Trust stated that the degree of vision loss noted between the patient's first presentation on 7 October 2013 and 31 December 2013, when his surgery was scheduled, was in keeping with scheduling to the routine surgical list for ERM. The Trust stated that, therefore, the care provided to the patient *'was in line with available evidence of 2013/14 and commensurate with an appropriate standard of care and treatment for epiretinal membrane'.* The Trust also stated that the surgery might have been scheduled as urgent, if the Trust Consultant Ophthalmic Surgeon had been aware of the patient's deteriorating eye condition.

52. The Trust stated that, at the pre-operative assessment on 11 February 2014, the patient was advised of the possibility of a short notice cancellation of the surgery and that this is standard advice for pre-operative patients as urgent cases will be given priority. I note that the Trust stated that the reason for the cancellation of the patient's surgery in May 2014 is not recorded. The Trust also stated that, as the patient was a cancelled case, he would have been given priority for rescheduling.

53. I note that the Trust stated that there '*is no evidence to suggest that [the Trust Consultant Ophthalmic Surgeon] denied that [the patient's] surgery was left too long'.*

54. I note that the Independent Review Report stated that '*given the unusual course of [the patient's] progressively deteriorating vision, it would have been sensible to consider expediting his operation'.*

55. The CV IPA advised that normally ERM progresses slowly but it also normally occurs later in life and therefore '*an ERM in a 31yo is by definition unusual'.* The CV IPA advised that a waiting time of four to six months for surgery is '*acceptable*' but also that, because of the patient's youth and the progression of his condition, *'it would have been sensible to at least consider the option of treating him sooner rather than later'*. I note that the CV IPA advised, therefore, that in the patient's 'specific *case'* the timescale for treatment was not appropriate.

56. The CV IPA advised that it is both acceptable and standard practice that scheduled surgery is postponed if an emergency, such as a retinal detachment, presents. He advised that in this case, although this was the likely cause, *'it is not clear why the surgery was postponed'* as the rationale for the decision was not recorded. I note that the CV IPA concluded, however, that *'given the very quick progression of this case everything should have been done to book the PT again into the following list yet the surgery listed for early May '14 did not take place until June '14.'*

57. I consider that the Trust's actions in relation to the timing of the patient's surgery is contrary to its statement that the progression of the condition, unusual case features and age are taken into consideration when scheduling surgery. I also consider that the Trust's position, in relation to its references to the statements in the Independent Review Report that the planned waiting time for the surgery would normally have little effect on prognosis and the patient's case had unusual features of age and progression, are contradictory.

58. I note and accept the CV IPA's advice that the patient's age and condition progression made the case '*unusual*' and that because of these factors, the timescale for treating the patient was not appropriate. I also consider that the independent reviewer's opinion that earlier surgery should have been considered because of the unusual presentation of the case reflects the CV IPA's advice. I also accept the CV IPA's advice that, when the original surgery was postponed, the patient should have been rescheduled as soon as possible but that this did not happen for approximately one month.

59. I consider that the Trust's failure to take the unusual aspects of the patient's case into account when scheduling his surgery and the further delay in carrying out the operation, following the cancellation of the planned procedure, represent failure in care and treatment.

The patient's resulting loss of vision

60. The Trust referenced the independent reviewer's opinion that the cause of the patient's poor post-operative vision remained '*obscure*'. I note that the Trust stated that *'it is therefore difficult to state conclusively that the waiting time on the surgical list was the cause of [the patient's] vision loss given the lack of clinical evidence to support this'.*

61. The CV IPA advised that the patient's *'surgery was uneventful so I would exclude any standard surgical complication. It is possible the retina never recovered from the epiretinal membrane, and vision remained poor'*. I note, however, that he also advised that *'sometimes even straightforward ERM operated on very quickly do not recover or do this only partially'* and that in the

absence of any OCTs from October 2013 to June 2014, *'it is possible a delay had a long term effect, but … there is no way to actually demonstrate this is the case'.* I note that the CV IPA advised it is '*impossible to comment on the reason for the final VA loss'.*

62. I refer both to my finding at paragraph 47, that the VA reduction between the patient's first assessment and his surgery was due to the ERM and my finding at paragraph 50, that if the patient's pre-operative assessment findings had been communicated to medical staff, earlier surgery would have been considered. I also refer to paragraph 21 about the Consultant Surgeon IPA's advice that, if OCTs had been carried out at each appointment and which was identified in paragraph 46 as a failing, any relationship between the ERM and the vision loss could have been identified.

63. I consider that, although the reason for the delay in surgery is not recorded, it is reasonable to assume that the information on the patient's unusual presentation of the condition and his significant VA loss would have led to earlier surgery and most certainly would have prevented the surgery being delayed by approximately one month. I consider, therefore, that whilst it is not certain that the operation would have halted the patient's loss of VA, I am satisfied that as the procedure is generally successful, on the balance of probabilities the patient's present loss of VA may not have occurred if the operation had been carried out sooner.

64. I refer to my findings at paragraphs 46, 49, 58 and 62. I therefore uphold the elements of the complaint related to the management of the patient's care and treatment.

Injustice

65. I find that because of the failures identified in paragraphs 46, 49, 58 and the finding noted in paragraph 62, the patient lost the opportunity both for earlier intervention and treatment, with the potential for a better chance of recovery. The complainant also experienced anger and frustration.

Information provided to and communication with the patient during the period of care and treatment about his vision loss

66. As outlined in paragraph 29 above, consideration was given to whether the Trust communicated appropriate and accurate information to the patient about his loss of vision and its cause. This included how the vision loss was managed under the Trust's reporting system for adverse incidents.

Communication with the patient about the cause of his vision loss

67. I refer to the GMC Good Medical Practice Guidance and the GMC Professional Duty of Candour Guidance. I note that the guidance states that doctors must respond honestly to patient's questions. This guidance also states that doctors must be open and honest with patients if things go wrong and, if a patient has suffered harm or distress, if possible, doctors should put matters right, offer an apology and explain fully and promptly what has happened and the likely short-term and long-term effects. The GMC Good Medical Practice Guidance also states that doctors must be honest and trustworthy in all communications with patients and make reasonable checks to make sure any information given is accurate, including any written information and that any written information is neither false nor misleading and that relevant information is not deliberately omitted.

68. Review of the patient's medical records indicate that the patient's surgery was on 6 June 2014. The patient's initial post-surgery review, by the Trust Consultant Ophthalmic Surgeon, was on 24 June 2014 and a further review took place on 5 August 2014. I note that OCT scans were undertaken at the first review in June 2014 and then, at the review on 5 August 2014, the Trust Consultant Ophthalmic Surgeon requested additional OCT scans to investigate the patient's vision loss. This took place on 6 August 2014 and the patient was seen again on 12 August 2014 by the Trust Consultant Ophthalmic Surgeon. The patient was again reviewed by the Trust Consultant Ophthalmic Surgeon on 13 January 2015 and then, on 23 August 2016, the patient was reviewed by the Trust Consultant Ophthalmic Surgeon with Trust Ophthalmologist B.

69. In the clinical records of the patient's appointments both on 12 August 2014 and 13 January 2015, the Trust Consultant Ophthalmic Surgeon recorded '*?phototonic injury'*. In the Trust's letter to the patient's GP dated 18 August 2014, following the patient's appointment on 12 August 2014, the Trust Consultant Ophthalmic Surgeon stated *'it is possible that [the patient] suffered a photonic injury'.* I note that in the Trust's letter dated 16 January 2015, after the patient's appointment on 13 January 2015, the Trust Consultant Ophthalmic Surgeon stated that it was his '*impression that [the patient] has suffered photonic injury during vitrectomy surgery.'* The clinical records indicate that, on 23 August 2016, phototoxic injury was again noted. This record was completed and signed by Trust Ophthalmologist B. The record states, however, that the patient was *'s/b (seen by) [the Trust Consultant Ophthalmic Surgeon]: long d/w (discussion with) patient re: possible diagnoses (1) phototoxic damage … (2) cystic spaces …'.* I also note that in the Trust's letter to the patient's GP about the appointment on 23 August 2016, dated 21 September 2016 and signed by Trust Ophthalmologist B, states, '[*the patient] was also seen by [the Trust Consultant Ophthalmic Surgeon] today and he had a long discussion with the patient regarding possible diagnosis'.*

70. The Trust stated that, on 5 August 2014, the Trust Consultant Ophthalmic Surgeon told the patient that his reduced vision after his surgery required investigation and a range of investigations were carried out. The Trust stated that there '*was no indication to carry out an electro diagnostic testing to investigate this retinal condition'*. I note that the Trust stated that the Trust Consultant Ophthalmic Surgeon *'suggested phototoxity as one possible cause of the patient's poor vision post operatively'* and that cystoid macular oedema and pre-operative vision distortion were also noted in discussions with the patient. The Trust stated that the Independent Review Report stated that an intraoperative photoxic injury was unlikely but that it was reasonable to consider it as a possible cause of poor vision post-operatively and that the cause of the patient's poor post-operative vision remained obscure. The Trust stated that no definitive cause for the patient's visual loss was determined between his surgery in June 2014 and 22 November 2016, when the patient was discharged from the care of the Trust Consultant Ophthalmic Surgeon.

71. The Trust stated that the question of whether Trust Ophthalmologist B had suggested a different cause of the patient's vision loss, other than a phototoxic injury, and if he had then been asked to change his opinion by the Trust Consultant Ophthalmic Surgeon was discussed with Trust Ophthalmologist B. The Trust stated that following reference to his contemporaneous notes of the appointment on 23 August 2016, Trust Ophthalmologist B confirmed both he and the Trust Consultant Ophthalmic Surgeon reviewed the patient that day. I note that the Trust stated that Trust Ophthalmologist B had noted that a range of possible diagnoses were considered at that time and that Trust Ophthalmologist B did not recall being asked to amend a diagnosis. The Trust also stated that there is no record of this within the medical records.

72. I note that the Trust Independent Review Report stated that electrodiagnostic tests '*might be helpful to pinpoint the site of any retinal dysfunction'.*

73. The CV IPA advised that a phototoxic injury '*is very uncommon'* and '*has a quite specific presentation'*. I note, however, that the CV IPA further advised that the OCT of 24 June 2014 *'does not show any feature typical of a phototoxic injury'* and, therefore, as this was at the time of the patient's first review appointment, there did not appear to be '*any justification for the [the Trust Consultant Ophthalmic Surgeon] to assert there was any phototoxic injury'* but also that the Trust Consultant Ophthalmic Surgeon's '*opinion of a phototoxic injury continued'.* The CV IPA advised that the clinical records indicate that the Trust Consultant Ophthalmic Surgeon definitively continued in his opinion of a phototoxic injury up to and including the review of the patient in January 2015. The CV IPA's advised that records also indicate that it was likely that the Trust Consultant Ophthalmic Surgeon also held this view in August 2016.

74. The CV IPA advised that, following the patient's surgery, tests were carried out to identify the cause of the '*poor vision (6/36 to 6/60)'.* I note that he advised that these tests were appropriate but they could have been integrated with electrodiagnostics. He further advised that electrodiagnostics are '*very complex tests, done and reported by few ophthalmologists'* and are not

requested as standard practice but that he would have '*requested them in this case [as] I could not find any obvious explanation for the VA loss, in the hope that I would get a lead.*'

75. I note that the CV IPA advised that it did not appear that anything was amended in the notes, including, as purported by the patient, the opinion of the Trust Ophthalmologist B.

76. I consider that the records clearly document that the Trust Consultant Ophthalmic Surgeon put forward that phototoxic injury was the reason for the patient's loss of vision until January 2015 and that, in that period of time, no other reason was recorded. I note that this opinion continued through four appointments after the OCT scan results which, the CV IPA advised, indicated that there was no phototoxic injury.
77. The rationale for the continuation of the Trust Consultant Ophthalmic Surgeon's stated view that the patient's vision loss was due to a phototoxic injury for a prolonged period is not documented and therefore remains unclear. I consider that, in informing the patient that the loss of VA was due to a phototoxic injury in the context of evidence to the contrary does not accord with the GMC Good Medical Practice Guidance. I also consider that, in continuing to convey this opinion and information to the patient, in clinical records and in correspondence with the patient's GP across a period involving several consultations, as well as during the Trust's complaints process, the Trust demonstrated a lack of candour which is contrary to both the GMC Good Medical Practice and, during the period from June 2015, the GMC Professional Duty of Candour Guidance and which I find concerning. I therefore uphold this element of the complaint.

Injustice

78. I find that as a result of the failures, the patient experienced frustration, uncertainty and was unable to move on.

79. In relation to the patient's belief that Trust Ophthalmologist B had offered a different view on the cause of the patient's loss of vision but then was told by the Trust Consultant Ophthalmic Surgeon to change this opinion, I accept the

CV IPA's advice that there were no apparent amendments. This has also been confirmed by my own review of the records. Therefore, I do not uphold this element of the complaint.

Application of the Trust Adverse Incident Policy

80. I note that the Trust Adverse Incident Policy defines an adverse incident as an instance that '*could have or did lead to harm, loss or damage to people …'* with harm defined as '*injury … disability …..'* I note that the Trust stated that both because the reason for the patient's vision loss could not be determined and there was no evidence that earlier surgery would have changed the outcome for the patient, the patient's loss of vision did not need to be reported as an adverse incident.

81. I note that the GMC Good Medical Practice Guidance states that doctors must contribute to adverse event recognition.

82. The CV IPA advised that if the VA loss was considered to be a permanent loss, it should have been recorded as an adverse incident. The CV IPA emphasised the reference to '*did lead to … loss'* under paragraph 2.2 of the Trust Adverse Incident Policy. I note that the CV IPA advised that '*the reason for reporting an incident is not blaming or shaming, but is an opportunity to discuss, create pathways and make sure that it does not happen again. Policy apart, it would just have been sensible to do so'.*

83. I consider that the patient did experience a VA loss during the period of his care and treatment from the Trust and therefore that this circumstance lies within the parameters of the Trust Adverse Incident Policy. I accept the CV IPA's advice both that the patient's case met the policy's criteria and that, as the purpose of reporting incidents is to make improvements, it would have been beneficial and reasonable to report the case. I consider that a patient lost his sight who would not have reasonably been expected to do so. I consider that the Trust was aware of the patient's significant VA loss and yet surgery was not expedited but rather was delayed. In these circumstances, I consider that the Trust should have recognised the necessity to report and manage the case under the Trust

Adverse Incident Policy. It is also reasonable to conclude that, without the submission of the patient's complaint, the Independent Review Report would not have been commissioned. Therefore, the important learning about the significance of sharing the pre-operative assessment findings would not have been identified. I consider that the failure to report an adverse incident in relation to the patient's case does not accord with either the GMC Good Medical Practice Guidance or the Trust's own policy. I consider that this represents a failure to act in accordance with the first, third and sixth Principles of Good Administration. Specifically, '*Getting it right'* by acting in accordance with established good practice and the body's own policy; '*Being open and accountable'* through taking responsibility for its actions; and *'Seeking continuous improvement'* by ensuring that the Trust learns lessons from problems and uses these to improve services and performance. I consider that this is maladministration and therefore uphold this element of the complaint.

Injustice

84. I find that as a result of the maladministration, the patient experienced frustration and uncertainty as there was no investigation or accountability for the loss of vision.

CONCLUSION

85. I investigated the complaint and found failures in care and treatment in relation to the Trust's actions. I also identified that information and advice provided by the Trust was not accurate and complete.

- The Trust failed to appropriately monitor the stability of the patient's condition.

- The Trust failed to escalate the patient's pre-operative assessment results to medical staff.

- The Trust failed to consider the unusual aspects of the patient's case both when originally scheduling his surgery and in rearranging the surgery after the Trust postponed it.

    - I am satisfied that as a result of the failings identified, the patient , experienced anger, frustration and lost the opportunity both for earlier intervention and treatment, with the potential for a better chance of recovery.

- The Trust failed to act in accordance with the GMC's Good Medical Practice Guidance and Professional Duty of Candour Guidance in communicating with the patient about the cause of the vision loss as the information and advice provided was inaccurate and unsupported by evidence.

    - I am satisfied that as a result of the failure, the patient experienced frustration, uncertainty and was unable to move on.

- The Trust failed to act in accordance with either the GMC Good Medical Practice Guidance or the Trust's own policy in relation to reporting an Adverse Incident. The Trust's actions were therefore not in accordance with the first, third and sixth Principles of Good Administration. This is because the Trust did not comply with the requirements of established good practice or its own policy and failed both to take responsibility for its actions and ensure that lessons were learned and improvements made as a result of the case.

    - I am satisfied that as a result of the maladministration, the patient experienced frustration and uncertainty.

Recommendations

1. I recommend that the Trust provides the complainant 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 and maladministration identified (within **one month** of the date of this report).

2. I recommend that the Trust also provides the patient with an explanation of why the Trust offered a diagnosis of a photo-toxic injury in the context of evidence to the contrary (within **one month** of the date of this report).

3. I refer the Trust to the CV IPA's advice, in relation to how unusual presentation of cases should be considered both in terms of the monitoring of the condition and carrying out treatment. I recommend that the Trust provides relevant staff with the opportunity to reflect on this advice in relation to the staff's own practice. This should be evidenced by records of information sharing.

4. I also recommend that the Trust implements a process which will ensure that atypical cases are flagged within the system to facilitate appropriate monitoring of the progression a patient's condition and associated scheduling of treatment.

5. I refer the Trust both to the GMC Good Medical Practice Guidance and the GMC Professional Duty of Candour Guidance and recommend that all relevant staff are reminded of the importance of these, particularly in relation to always being open and candid with patients, ensuring that decisions and information provided to patients take all relevant evidence into account to ensure reasonableness and accuracy. This should be evidenced by records of information sharing.

6. I refer the Trust to both its Adverse Incident Policy and the GMC Good Medical Practice Guidance and recommend that it ensures that all relevant staff are made aware of the importance of identifying and reporting issues which require corrective and preventative improvement actions. This should be evidenced by records of information sharing and a sample audit.

7. I recommend that the Trust implements an action plan to incorporate these recommendations and 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 records and/or self-declaration forms which indicate that staff have read and understood any related policies).

8. I refer to the additional measures which the Trust stated it has introduced and which is detailed at paragraph 3 in the '*Observations'* section below. In addition to the evidence of actions taken in response to the recommendations outlined at one to five above, I also recommend that the Trust provides evidence of this improvement.

Observations

1. The Trust Vitrectomy Advice Leaflet details seven risks associated with the surgical procedure; however, none of these refer to any degree of loss of vision. The CV IPA advised that '*vision loss, total or partial, is indeed a complication for any VR procedure, in fact probably the worst. In my opinion a leaflet which does not report this as a possible complication is inadequate.'* The Trust may wish to give consideration to revising its Vitrectomy Advice Leaflet to include the risks of partial or total loss of vision.

2. Although, electrodiagnostic tests are not considered standard practice, I note both the CV IPA's advice and the Independent Review Report's position that, as no cause for the patient's VA loss could be identified, these tests may been helpful which in turn may have supported the Trust Consultant Ophthalmic Surgeon in relinquishing his opinion of a phototoxic injury. I note that a cause for the patient's loss of VA has yet to be identified.

3. The Trust stated that it has implemented a new process to provide consultants with pre-operative assessment findings to ensure that consultants are cognisant of the current status of the patient's condition. I welcome the learning and commitment to service improvement already identified and progressed by the Trust and commend the Trust for this developments.

MARGARET KELLY **21 September 2022**

Ombudsman

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. **Getting it right**

- Acting in accordance with the law 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 learned from complaints.

- Including complaint management as an integral part of service design.

- Ensuring staff are equipped and empowered to act decisively to resolve complaints.

- Focusing 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.

2. **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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. 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.

4. 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 and actions 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

5. 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.

6. 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 learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.