

Investigation Report

Investigation of a complaint against the Belfast Health & Social Care Trust

NIPSO Reference: 201917352 / 23643

The Northern Ireland Public Services Ombudsman

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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 care and treatment the complainant received from the Belfast Health and Social Care Trust (the Trust) while an inpatient in the RVH in 2020. The complainant requested a spinal MRI and a referral to a spinal consultant. The complainant said that the Trust failed to assess her properly and sought to discharge her prematurely without any treatment.

I accepted two issues of complaint for investigation as follows:

1. Whether the care and treatment provided on general medical ward was appropriate?
2. Whether the Speech and language therapist's (SLT's) assessment was carried out appropriately?

I obtained the complainant's medical records and sought advice from independent professional advisors.

I considered that the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 28 July 2020 to 4 August 2020 were appropriate and reasonable and I did not uphold issue one of the complaint.

I also concluded that the SLT assessed the complainant appropriately on 30 July 2020. I did not find any failings and I did not uphold issue two of the complaint.

The Trust accepted my findings.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) about the complainant's care and treatment on two occasions when she attended the Royal Victoria Hospital (RVH) in Belfast.

Background

2. The complainant developed symptoms following ENT surgery in 2014. She had surgery to remove her thyroid on 16 June 2016. Her symptoms worsened and continue to trouble her. The symptoms are diverse and include a weight sensation, loss of swallow reflex, metallic taste in mouth and a crawling sensation round her body.
3. She had been under the care of a consultant neurologist as an outpatient at Craigavon Area Hospital (CAH) since August 2016. He made a referral to the RVH neurology department on 4 April 2017. The complainant attended the ED of the RVH on 17 May 2017. She was admitted and was an inpatient until 8 June 2017. She was diagnosed with a functional neurological illness.
4. The consultant Neurologist at CAH referred her to the University College London Hospitals (UCLH) National Hospital for Neurology and Neurosurgery in London for an independent assessment. She was admitted on 22 October 2018 and discharged on 9 November 2018. The discharge summary supported the diagnosis of a functional neurological illness.
5. Another Consultant Neurologist at the RVH reviewed her on 22 January 2019 and explained to her that he could not find '*any organic pathology to count for her symptoms*' and that she might benefit from neuropsychology and neuropsychiatry.

6. The complainant went by ambulance to the RVH ED on 19 March 2019 seeking admission for further review. The ED doctor sought an opinion from a neurology consultant and she was discharged.
7. She attended the RVH by ambulance on 28 July 2020 seeking a spinal MRI
Her accompanying GP letter requested assessment with regards to longstanding worsening symptoms of abnormal sensations that started in her mouth and throat and moved over her body. Her chief complaint to the ambulance crew was recorded as chronic deterioration. Her ED record documented her presenting complaint as reduced oral intake and weight loss.
8. She was placed on a waiting list on 27 October 2020 to see a spinal surgeon following referrals from her GP to Musgrave Park Hospital Belfast. She was given an appointment to see the surgeon in September 2021.

Issues of complaint

9. The issues of complaint accepted for investigation were:

Issue one

Whether the care and treatment provided to the complainant on general medical ward 7a from 28 July 2020 until discharge on 4 August 2020 was appropriate?

This will include:

- i. Whether there was appropriate consultation with the Neurology team?
- ii. Whether the Consultant Physician's assessment on 29 July 2020 and conclusion that the complainant did not need an urgent MRI or acute spinal referral was reasonable and appropriate?
- iii. Whether the complainant's concern regarding cerebral fluid leaking from her nose was adequately considered?
- iv. Whether the lump on her neck, identified on examination on 31 July 2020 as a possible lipoma or sebaceous cyst, was adequately assessed?
- v. Whether discharge on 4 August 2020 was appropriate?

Issue two

Whether the Speech and language therapist's (SLT's) assessment on 30 July 2020 was carried out appropriately?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

11. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor(s) (IPA):
 - Dr (BA Hons, Post Grad Diploma Clin Comm Studs, MSc, PhD) Post Grad diploma vocational qualification in Speech & Language Therapy and MsC in Speech/Swallowing
 - DR MBiochem (Oxon), BMBCCh (Oxon), FRCP(Edin), MMedSci(ClinEd) a consultant in Acute internal medicine, regularly managing patients with both acute neurological symptoms and those with somatising disorder.

I enclosed the clinical advice received at appendix three to this report.

12. I included the information and advice that informed my findings and conclusions within the body of this report. The IPAs provided 'advice'; however, how I weigh this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

13. 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 refer to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles¹:

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

14. The specific standards and guidance I refer 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:

- The General Medical Council's (GMC) Good Medical Practice 2013, as updated April 2014 (the GMC Guidance);
- Functional Neurological Symptoms A guide to understanding, managing & seeking help for Functional Neurological Symptom Clinical Neuropsychology Regional Neurosciences Royal Hospitals, Belfast August 2018 (The FNS Guide).

I enclose relevant sections of the guidance considered at appendices four and seven.

15. 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 took into account everything I considered to be relevant and important.

16. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant provided her comments which were fully considered when finalising the report.

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

THE INVESTIGATION

Issue one

Whether the care and treatment provided on general medical ward 7a from 28 July 2020 until discharge on 4 August 2020 was appropriate?

Detail of Complaint

17. The complainant presented to the ED of the RVH on 28 July 2020. She said she was admitted by a registrar. Based on extensive clinical examination, she said she felt she needed to be seen by spinal and neurology. She was sent to an outlying medical ward 7A to be seen the following morning. She complained she was never examined again. No MRI was performed and she was not referred to a spinal consultant. She said there was a lump, located 4cm from the nape of her neck and 1cm to the left of her spine, which was not properly assessed. She felt she had been leaking cerebral spinal fluid (nasal) and had a salty, metallic taste in her mouth which was not investigated.
18. She was continually asked to go home. She was verbally threatened with legal action and physical removal from ward, by the locum consultant and a senior member of the hospital's administrative team.

Evidence Considered

19. I considered the following guidance:
 - The GMC Guidance (extracts at appendix four)
 - The FN Guide (appendix seven)

The Trust's response to investigation enquiries

20. The Trust provided written responses to the complaint. The Trust explained that following her ED assessment, the treatment plan was as follows:
 1. *'Speech and Language assessment.*
 2. *Neurology review in AM*
 3. *? MRI brain and spine*

4. ? OGD – patient reports previously done in “352” and would not go through again.
5. ? auto-antibodies for sjogrens
6. ? spinal review – patient requesting spinal consultant in AM, believes has spinal fluid leaking into nose and mouth.
7. Liaison psychiatry input- expresses suicidal ideation.’

21. The Trust explained that the patient was then moved to ward 7A at 20:07 hours and the neurology team discussed her case overnight. The Trust explained:

‘The Neurology advice at this time was that the patient should be reviewed by gastroenterology as may require an OGD (Oesophago-Gastro-Duodenoscopy) as reason for admission was difficulty swallowing. Neurology would review patient if clinically indicated but noted that her current symptoms had been extensively investigated in the past and they had little else to suggest at this stage. They did document that further review by psychiatry may be of benefit.’

22. With regard to test results, the Trust stated:

‘Urea & Electrolytes and Complete Blood Count were sent from ED on 28/07/2020. All major components were within normal limits. One of the parameters measured in the complete blood count is the MCH (Mean Corpuscular Haemoglobin). This was mildly elevated, as it has been from at least May 2017. This likely reflects low folate levels which is why the patient is prescribed folic acid.’

23. The Trust stated that on 29 July 2020, the complainant was assessed by the Acute Medical Consultant. He reviewed all the documentation relating to the current admission as well as all results and correspondence on the patient’s electronic care record (ECR). After speaking to the patient, he determined there was no indication for a Spinal Consultant review or MRI as an inpatient. The patient stated she was not leaving hospital until she had these assessments. He apologised but explained there was no indication for inpatient acute spinal consultant review or MRI based on her current symptoms. He confirmed that she was medically fit for discharge and that she was on the waiting list for outpatient MRI and Spinal review following assessment in the Southern Health & Social Care Trust (SHSCT) earlier that month.

24. The Trust explained:

'[The patient] underwent psychiatric assessment by a Psychiatric Consultant on 31/7/2020 and 4/8/2020 who agreed with the diagnosis of somatisation² disorder made by a Consultant Psychiatrist, SHCT. There were no clinical signs or symptoms that she was leaking cerebral spinal fluid and therefore no indication to send a sample of this fluid for analysis.'

25. The Trust also stated:

'The Trust acknowledges the ongoing distress [the patient] experiences and has endeavoured to manage and address her concerns with empathy. However, the Trust regrets that she cannot accept the outcome of the medical assessments completed or the Trust's response to her complaint. The Trust is truly sorry we have not been able to resolve her concerns to her satisfaction.'

Relevant Trust records

26. The independent professional advisors reviewed the relevant clinical notes and records and referred to them in their advice where appropriate.

27. I attach the clinic record from the consultation with the Consultant physician acute medicine and gastroenterology on 29 July 2020 at appendix five.

28. I attach a copy of the discharge note dated 4 August 2020 at appendix six.

Relevant Independent Professional Advice

General Medicine IPA (GM IPA)

29. The Investigating Officer asked the GM IPA's opinion about the tests performed on 28 July 2020. He advised that the results were normal. The Mean Cell

² When physical symptoms are caused by mental or emotional factors

Haemoglobin of 34 was slightly high but *'On its own it is of no relevance or clinical importance'*.

30. In relation to the complaint of leaking cerebral fluid, the GM IPA advised:
'The risk would be rapid infection of the brain and the fluid surrounding it, symptoms of meningitis (Headache, neck stiffness, rash, high fever, coma and potentially death), and a history that explained how it could have happened – usually either trauma or a tumour.'
He advised that the complainant did not present with these symptoms and no action was required.
31. Referring to the medical consultant's assessment on 29 July 2020, the GM IPA advised:
'The medical consultant's assessment was sufficient. The diagnosis is easily obtainable from the clinical notes and the history that he obtains from talking to the patient. The patient attempts to manipulate the consultant into performing unnecessary and potentially harmful investigations which is rightly resisted. An examination has already been performed by more junior doctors and there is no need for the consultant to repeat this... Her symptoms had already been put down to somatising disorder and as such there was no indication for a MRI scan or acute spinal referral. The rationale was communicated to the patient appropriately however disappointed they might have found this.'
32. The Investigating Officer asked the GM IPA if the lump on her neck, identified on examination on 31 July 2020 as a possible lipoma or sebaceous cyst on her back, was adequately assessed. He advised:
'There is no need to assess the lump further, and certainly not as a hospital inpatient. It is an incidental finding of no relevant clinical significance and likely to have been present from many months if not years.'
33. The GM IPA advised that no further examination or assessments were required as the diagnosis was documented in the history of previous attendances at the RVH. He advised referral for psychiatric review was made appropriately.

34. The Investigating Officer asked the GM IPA if appropriate pain relief was administered. He advised:

'There is evidence and documentation of painkillers being given on multiple occasions, including extra painkillers when requested due to increased pain. It is not always possible to give medication the instant it is requested or required due to the competing demands on nursing staff's time, however it would appear that all requests were met in a sensible time frame, and this is borne out by the medication charts which show no missed doses, and short periods of time between those doses written up by a doctor and the time when administered by nursing staff.'

35. The Investigating Officer asked the GM IPA to what extent the decision that the patient was ready for discharge was documented and communicated to the patient on 30 July 2020. He advised:

'MFFD is standard abbreviation for 'medically fit for discharge' and so this was documented appropriately. Nurses and doctors reading the notes would know what this meant. The decision was communicated to the patient appropriately and the rationale given.'

36. In relation to the circumstances of her discharge, the GM IPA advised:

'She had already been in a hospital bed unnecessarily for 6 days refusing to leave or engage with discharge planning. It seems that efforts were made during this time to change her mind which were to no avail. Action to release the bed to someone that needed it were entirely reasonable by the stage she left.'

Analysis and Findings

Whether there was appropriate consultation with the Neurology team?

37. Standard 15 of the GMC Guidance states *'refer a patient to another practitioner when this serves the patient's needs'*. During the complainant's admission, the ED doctor referred the patient to neurology and an appointment was also made for the complainant to see a psychiatrist. I consider this met the GMC standard. Therefore I do not consider there was a failure in the complainant's care and treatment.

Whether the medical consultant's assessment on 29 July 2020 and conclusion that the complainant did not need an urgent MRI or acute spinal referral was reasonable and appropriate.

38. The Trust explained that the medical consultant reviewed all the documentation relating to the current admission as well as all results and correspondence on the patient's electronic care record (ECR). After speaking to the patient, he determined there was no indication for a Spinal Consultant review or MRI as an inpatient.

39. I accept the GM IPA's advice that '*Her symptoms had already been put down to somatising disorder and as such there was no indication for a MRI scan or acute spinal referral.*' The ED doctor had already examined the complainant thoroughly and her previous attendances and diagnosis were evident from reviewing the extensive clinical notes. The complainant was well known to the neurologists at the RVH who carried out investigations during an admission on 17 May 2017 and reviews as an outpatient on 22 January 2019 and 19 March 2019. The Trust also had access to the complainant's clinical records from the CAH where a consultant neurologist saw her as an outpatient.

40. The medical consultant was aware that the complainant's GP had already referred the complainant for review by a spinal consultant and she was on a routine waiting list. I am satisfied that this decision not to perform an MRI or make a further spinal referral at that time was reasonable. Therefore I do not uphold this element of the complaint.

Whether the concern regarding cerebral fluid leaking from her nose was adequately considered?

41. The Trust stated there were no clinical signs or symptoms that the complainant was leaking cerebral spinal fluid and therefore no indication to send a sample of this fluid for analysis. The IPA agreed, advising that her symptoms were not consistent with leaking cerebral fluid and most likely to be due to a somatising disorder. I am satisfied that there was no failing in care or treatment.

Whether the lump on her neck, identified on examination on 31 July 2020 as a possible lipoma or sebaceous cyst, was adequately assessed?

42. I considered the clinic letter from 31 July 2020 which records 'a small sebaceous cyst or lipoma in her mid thoracic area'. I accept the advice of the GM IPA that the lump was of longstanding and there was no need for urgent investigation as an inpatient. The complainant had already been referred by her GP for spinal assessment. I am satisfied that no further investigation was appropriate at that time. Therefore I do not uphold this element of the complaint.

Whether discharge on 4 August 2020 was appropriate?

43. I note that the blood test results were normal and that the complainant's history was considered. I accept the advice of the IPA that there were 'no deficits in care' and the complainant had been fit for discharge from 29 July 2020. By 4 August 2020 she had undergone psychiatric assessment and received a diagnosis of somatisation disorder. There was therefore no medical reason for the complaint to remain in the ward and I consider that her refusal to leave was unreasonable.
44. I therefore conclude that the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 28 July 2020 to 4 August 2020 were appropriate and reasonable. I do not uphold this issue of complaint.

Issue two

Whether the Speech and language therapist's (SLT's) assessment on 30 July 2020 was carried out appropriately?

Detail of Complaint

45. The complainant said, in her letter of complaint to the Trust dated 5 August 2020, that the Speech and Language Therapist (SLT) gave her approximately 1/3 pancake, some juice and a few spoonful of yoghurt. She believed this was not an appropriate test to determine her swallow reflex.

Evidence Considered

The Trust's response to investigation enquiries

46. The Trust stated *'As the complainant was complaining of dysphagia (difficulty swallowing); the treatment plan following this assessment was to refer her for speech and language swallow assessment.'*
47. The Trust also stated that the SLT record states that, to assess her swallow, she was given ½ pancake, spoonful's of yoghurt and 100 mls of fluids and that she declined to take any more food or fluids during this assessment. The Trust stated that the outcome of this assessment was that the patient's swallow was grossly intact with no physiological evidence of impairment and there was no indication for further investigation by SLT.

Relevant Trust's records

48. The independent professional advisor reviewed the relevant clinical notes and records and referred to them in her advice where appropriate

Relevant Independent Professional Advice

Speech and Language Therapist IPA (SLT IPA)

49. The SLT IPA advised that the SLT noted the patient's past history and discussed it with the patient. In relation to the 'cranial nerves' examination the SLT IPA advised
- 'It is not clear what the SLT did to assess the cranial nerves but she is able to record their function. This information may not routinely be included in notes. From this the reviewer concludes that it was performed appropriately. Cranial nerve examination is not always assessed at every initial dysphagia assessment dependent on the individual's presentation so this suggests the SLT conducted a thorough assessment.'*

50. The Investigating Officer asked if the food chosen for the swallow trials was suitable. She advised:
- 'Swallow trials are most effective when they make use of food and drinks that the patient is like to eat in everyday life. From review of the notes the SLT records the patient was "agreeable to thin fluids <100mls, ½ pancake (refused further), & spoonful's of yoghurt – declined further". This language suggests that the SLT engaged in negotiation with the patient about what she would be prepared to eat and drink as part of the assessment. While this is only an impression gleaned by the reviewer it is the reviewer's opinion that the foods used for assessment were appropriate.'*
51. The SLT IPA advised the findings were:
- 'That the "oropharyngeal swallow function was grossly intact with nil physiological evidence of impairment. Nil indication at present further investigation warranted by SLT" ie that there was no evidence of physiological swallowing impairment...In the opinion of the reviewer, on consideration of the evidence presented, the conclusions and recommendations were appropriate. The SLT agreed to liaise with the treating team to address any queries.'*

Analysis and Findings

52. The complainant attended the ED of the RVH on 28 July 2020. Her ED record documented her presenting complaint as reduced oral intake and weight loss and she reported difficulty swallowing. I consider that it was appropriate to refer her to a SLT.
53. In the opinion of the SLT IPA, the SLT conducted a thorough assessment, including an assessment of the cranial nerves. The SLT IPA advised that the SLT discussed the foods used for assessment with the complainant and that these were appropriate.
54. The SLT IPA advised that there was no evidence of physiological swallowing impairment. I accept the advice of the SLT IPA *'on consideration of the evidence*

presented, the conclusions and recommendations were appropriate. Therefore, I do not uphold this issue of complaint.

CONCLUSION

55. I received a complaint about the care and treatment the complainant received from the Belfast Health and Social Care Trust while an inpatient in the RVH during the period 28 July 2020 to 4 August 2020. On arrival she complained about difficulty swallowing and weight loss. The complainant requested a spinal MRI and a referral to a spinal consultant. The complainant said that the Trust failed to assess her properly and sought to discharge her prematurely without any treatment.
56. The Trust was aware that the complainant's GP had already made a referral for her to see a spinal consultant at Musgrave Park hospital. I note that this GP referral was eventually accepted after a number of refusals following triage. She was placed on a waiting list on 27 October 2020 and was seen in September 2021.
57. I accepted two issues of complaint for investigation as follows:
- i. **Whether the care and treatment provided on general medical ward 7a from 28 July 2020 until discharge on 4 August 2020 were appropriate?**
 - ii. **Whether the Speech and language therapist's (SLT's) assessment on 30 July 2020 was carried out appropriately?**
58. I considered that the care and treatment afforded to the complainant, while an inpatient in the RVH during the period 28 July 2020 to 4 August 2020 were appropriate and reasonable and I did not uphold issue one of the complaint.
59. I also concluded that the SLT assessed the complainant appropriately on 30 July 2020 and I did not uphold issue two of the complaint.
60. I note that the complainant had been previously diagnosed with Functional Neurological Disorder or Functional Neurological Symptoms (FNS), a condition where no known cause can be found for physical symptoms. Her history was well known to the neurology team at the RVH. On this occasion, the diagnosis was of

a somatisation disorder, where physical symptoms are caused by psychological or emotional factors. It must be confusing for the complainant that clinicians have used different adjectives to describe her illness. I thought it might be helpful to include the full FNS guidance.. This provides a detailed and comprehensive guide to FNS. It reinforces that the complainant's symptoms, though without an identifiable physical cause, are real, not imagined and must be extremely distressing for her.

61. I welcome the Trust's acknowledgement of the ongoing distress the complainant is experiencing and its regret that the Trust was not able to resolve her concerns to her satisfaction. I sincerely hope that the complainant will achieve a satisfactory outcome from her consultation with the Spinal consultant and with the help of her GP and other allied professionals, find some relief from her symptoms.

**Margaret Kelly
Ombudsman**

24 January 2022

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Taking responsibility for its actions.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

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.