Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Lurgan Medical Practice

NIPSO Reference: 20583

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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 regarding the actions of the Lurgan Medical Practice (the Practice). The complaint concerns the care and treatment a GP from the Practice provided to the complainant's late mother (the patient), following a home visit on 14 March 2018. The patient continued to remain unwell after the home visit on 14 March 2018 and was reviewed by an out of hours (OOH)[1] GP on 17 March 2018 and again by the Practice GP on 21 March 2018 when she was advised to attend the emergency department (ED). The patient was subsequently admitted to hospital and diagnosed with a severe urinary tract infection[2] (UTI). The complainant was concerned that the care and treatment the GP provided to the patient during the home visit on 14 March 2018 was not adequate.

The investigation established that during the visit on 14 March 2018 the GP took a history and performed an assessment of the patient in accordance with good medical practice. The patient's observations were normal and the GP prescribed magnesium oral supplements as this had helped previously and could account for the patient's lethargy. The GP also stopped diuretic and blood pressure medication and checked blood test results regarding kidney function. However, the investigation established that the records created by the GP did not indicate that the complainant and the patient were advised what to do should symptoms not improve or get worse, what the patient's plan of care and follow up was or what he had discussed with the patient and her family. I therefore upheld the complaint.

I am satisfied the failure I have identified caused an injustice to the complainant due to the uncertainty the lack of advice may have created.

I recommended the Practice bring the failure identified to the attention of the GP and that the GP should discuss the findings from this report with their appraiser as part of his next appraisal.

[1] Outside normal hours you can still phone your GP surgery but you will usually be directed to an out of hour's (OOH) service. This OOH GP service provided to the patient on 17 March 2018 was not part of the GP Practice but was a service provided by the Health and Social Care Trust.

[2] A **urinary tract infection** (UTI) is an **infection** from microbes. These are organisms that are too small to be seen without a microscope. Most UTIs are caused by bacteria,

THE COMPLAINT

1. I received a complaint about the actions of the Lurgan Medical Practice (the Practice). The complainant said his mother (the patient) did not receive appropriate care and treatment on 14 March 2018. In particular, he believed that the GP home visit to his mother on 14 March 2018 was inadequate.

Background

2. The patient had been admitted to hospital on 13 February 2018, where she was treated for diverticulitis[3] and colitis[4] until 23 February 2018 when she was discharged to her home. The patient continued to feel unwell following discharge from hospital and on 13 March 2018 the complainant felt that she deteriorated and he requested a GP home visit on 14 March 2018. The complainant confirmed the GP attended the patient's home on 14 March 2018 and he carried out an assessment of her. The complainant said his mother's health continued to deteriorate and she became incontinent. The complainant confirmed that after an out of hours (OOH)[5] GP home visit on 17 March 2018 and a further Practice GP home visit on 21 March 2018, his mother was admitted to hospital where she was diagnosed with a severe urinary tract infection.

Issues of complaint

3. The issue of the complaint which I accepted for investigation were:

Issue 1: Was the Care and Treatment provided by the Practice on 14 March 2018 in accordance with good medical practice?

[3] **Diverticulosis** occurs when small, bulging pouches (**diverticula**) develop in your digestive tract. When one or more of these pouches become inflamed or infected, the condition is called **diverticulitis**.
[4] **Colitis** is a chronic digestive disease characterized by inflammation of the inner lining of the colon. Infection, loss of blood supply in the colon, Inflammatory Bowel Disease (IBD) and invasion of the colon wall with collagen or lymphocytic white blood cells are all possible causes of an inflamed colon.
[5] Outside normal hours you can still phone your GP surgery but you will usually be directed to an out of hour's (OOH) service. This OOH GP service provided to the patient on 17 March 2018 was not part of the GP Practice.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Practice all relevant documentation relating to the patients clinical records together with the Practice's comments on the issues raised by the complainant. This documentation included information relating to the Practice's handling of the complaint.

Independent Professional Advice Sought

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

- General Practitioner (GP IPA), Mb ChB FRCGP, GP for 33 years

6. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has provided me with 'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

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

8. The general standards are the Ombudsman's Principles[6]:

- The Principles of Good Administration
- The Principles of Good Complaint's Handling
- The Public Services Ombudsman's Principles for Remedy

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

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Practice and individuals whose actions are the subject of this complaint.

10. The specific standards relevant to this complaint are:

- British Journal General Practice (BJGP) Diagnostic Safety Netting 2009 (Diagnostic Safety Netting Guidance); and
- General Medical Council (GMC) Good Medical Practice Guidance 2013 (GMC Guidance)

11. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings. I have included information from the patient's GP records.

12. A draft copy of this report was shared with the Practice and the complainant for comments on factual accuracy and the reasonableness of the findings and recommendations. The Practice and the complainant have both made comments on the draft report and the report has been amended to reflect this.

THE INVESTIGATION

Issue 1 Was the care and treatment provided by the Practice on 14 March 2018 in accordance with Good Medical Practice?

Detail of Complaint

13. The complainant said his mother had remained unwell after being discharged from Craigavon Area Hospital (CAH) on 23 February 2018. In particular, he believed his mother's level of alertness had deteriorated on 13 March 2018. Therefore, he requested a GP home visit. The patient's GP carried out a home visit on 14 March

2018. The complainant said that as his mother was elderly changes in her condition were to be expected and that she would be back to her normal self in a few days. The complainant said the GP prescribed magnesium oral supplements, however his mother's condition did not improve. The complainant confirmed his mother had an OOH GP home visit on 17 March 2018 and a further Practice GP home visit on 21 March 2018. She subsequently attended the ED and was admitted to hospital where she was diagnosed with a UTI on 21 March 2018. The complainant believed his mother's GP visit assessment on 14 March was inadequate.

Evidence Considered

Guidance

14. I examined the Diagnostic Safety Netting Guidance and considered the following relevant extracts:

Recommendations:

1. The existence of uncertainty. If the diagnosis is uncertain, that uncertainty should be communicated to the patient (or parent/carer) so that they are empowered to re-consult if necessary.
2. What exactly to look out for. If there is a recognised risk of deterioration or complications developing then the safety-net advice should include the specific clinical features (including red flags) that the patient (or parent/carer) should look out for.
3. How exactly to seek further help. Safety-net advice should give specific guidance on how and where to seek further help if needed
4. What to expect about time course. Where information about the likely time course of illness is known, safety-net advice should include this information. However, it should be made clear that if a patient (parent/carer) has concerns they should not delay seeking further medical advice'.

What should be recorded:

5. Safety-net advice should be documented in the medical notes
6. There was no consensus on when and whether safety-net advice should be given

in written format rather than verbally'.

15. I considered standards of the GMC Guidance.

The Practice's response to investigation enquiries

16. In response to investigation enquiries regarding the GP home visit of 14 March 2018, the Practice stated '*At the time of the home visit the GP took a history from the patient and her family who were present and then conducted a clinical examination including blood pressure, pulse and temperature observations along with chest auscultation[7] and assessment for peripheral odema[8]. The patient did not report any pain and did not appear to be in pain when examined. The GP did consider infection as possible but in view of the normal temperature, pulse rate and blood pressure as well as the absence of significant pain, they felt this was less likely at that point in time'.*

17. The Practice further stated '*the GP's plan of care following his visit on the 14 March 2018 was to stop diuretic[9] and blood pressure lowering medications that could cause a decline in kidney function as well as potentially contributing to lethargy. He made arrangements to continue to monitor the kidney function with a repeat blood test to ensure that this was improving following these changes and if further decline was noted then review as needed. The GP also advised restarting magnesium supplements[10] as during a previous hospital admission these had been noted to be low and can contribute to lethargy. As [the patient's] care needs at home had increased the GP also made contact with Access and Care services so that a renewed assessment could be made. Further review of the situation was pending blood test results and if there was acute deterioration in the interim further assessment could be requested by the family'.*

[7] **Auscultation** of the **lung** is an important part of the respiratory examination and is helpful in diagnosing various respiratory disorders.
[8] **Peripheral edema** is **edema** (accumulation of fluid causing swelling) in tissues perfused by the **peripheral** vascular system, usually in the lower limbs.
[9] A diuretic is any substance that promotes diuresis, the increased production of urine. This includes forced diuresis. There are several categories of diuretics. All diuretics increase the excretion of water from bodies, although each class does so in a distinct way.
[10] **Magnesium supplements** may improve a number of health markers, such as blood pressure and blood sugar control. It may also reduce your risk of health conditions such as heart disease, migraine, and depression.

18. In response to investigation enquiries regarding the patient's blood tests results and the possibility of her having had an infection, the Practice stated '*The (patient's) blood sample taken on 12 March 2018 was to check the blood levels of urea and electrolytes*[11] *(U&E) to assess kidney function. This type of test would not be used to check for a urinary tract infection. The sample in this case was taken on 12 March 2018 and the result was available on 15 March 2018. This demonstrated a decrease in kidney function from the previous test. The GP had suspected that this may be the case and as the fluid overload appeared to have been treated he had already advised to stop the diuretic at the home visit the previous day. This is because diuretic medication can cause kidney function to decrease'.*

19. In response to investigation enquiries regarding home visits, the Practice stated '*with regard to home visit requests in the practice, reception staff will add home visit requests to the clinical diary for that day for review by the medical staff on duty that day. Visits are allocated between medical staff and are generally carried out at lunch time following surgeries. If reception staff are made aware of any acute issues that need addressing then the request will be forwarded immediately to medical staff for their attention'.*

Clinical Records

20. I examined the patient's clinical records and considered the following relevant extracts:

14 March 2018: 'T*/C, History: Spoke with son* [the complainant]*, chest improved but not quite weak, in bed, agreed see later, also repeat U&E tomorrow* [15 March 2018]*, hold of diuretics for now*. *Home Visit GP; History in bed in front room, struggling to make it out to toilet which is on ground floor, chest is better but lethargic and sleepy, not in any pain. Examination; chest is clear, ankles have no sign of odema, temperature 36.5, On examination (O/E) blood pressure reading 118/61 mm Hg pulse 76 irregular. Comments: have started magnesium supplements as has been*

[11] **Urea and electrolytes** are the most commonly requested biochemistry tests. They provide essential information on renal function, principally in excretion and homoeostasis. Creatinine levels are a major factor in determining the estimated glomerular filtration rate, which is the gold standard marker of kidney health.

low in past, cause of lethargy[12], also hold anti hypertensives – lercanidipine[13] and lisinopril'[14]

15 March 2018: '*U&E report results received 15 March 2018 at 15.27 Dr says – satisfactory, diuretic and other nephrotoxic[15] meds stopped at present'.* T/C '*Medication requested and protect plus sheets for bed and incontinence pads for overnight cannot prescribe'. GP Information No Patient Contact, spoke with Access and Information Services. OT Assessment being arranged and assessment for care needs'.*

17 March 2018: '*Home visit arranged with OOH service'.* OOH GP clinical notes state '*No fever, nil to the chest. Vitals are normal but feels the need to sleep all the time. Heart rate is 60 bpm, regular'.*

21 March 2018: '*Home visit arranged with Practice GP'*.

30 July 2018: I also considered in this part of the clinical records correspondence from the Practice to the complainant; '*on the night of the 13 March 2018,* you *noted some deterioration and requested a home visit on 14 March 2018. The GP called to see your mother around lunchtime and it was noted that she was in bed downstairs. Her chest was examined and it was recorded that the auscultation was much improved and the leg swelling had settled. She did not report that was in any pain and her blood pressure was normal albeit on the lower side. Her heart rate and temperature were normal also. However it was apparent that she had difficulty mobilising to the toilet and she was lethargic. Nevertheless, the GP felt that her observations and clinical examination were reassuring and that her continued use of blood pressure medication combined with her recent ill health could be contributing to the lethargy and it was advised holding administration of these medications for time being. Magnesium levels had been noted to be low in the past and as this can*

[12] a lack of energy and enthusiasm.
[13] **Lercanidipine** is a type of medicine called a calcium channel blocker. Like other calcium channel blockers, **lercanidipine** works by blocking calcium going into muscles in the heart and blood vessels.
[14] Lisinopril is a medication of the angiotensin-converting enzyme inhibitor class used to treat high blood pressure, heart failure, and after heart attacks.
[15] damaging or destructive to the kidneys.

contribute to tiredness he advised restarting this medication with a view to repeated blood tests the following week to monitor both the kidney function and magnesium.

At the time of the home visit as the observations had improved and the fluid retention had resolved, he felt that hospital admission could potentially be avoided. It may be helpful if I explain that the response to the treatment of any acute deterioration in the health of an elderly person can be prolonged. This was the issue the GP was attempting to convey at the time of the home visit. Nevertheless, he would like to apologise if this came across as treating her condition as trivial. I assure you this was not the case and the further follow up was arranged. The following day the GP contacted the access and care services helpdesk requesting a renewed assessment of your mothers care needs as these were likely to increase. He also noted that the recent kidney function tests showed that there had been a decline and that cessation of the diuretic medication for the moment was appropriate'.

Independent Professional Advice

21. In response to the home visit made by the GP on 14 March 2018, the GP IPA advised '*the notes show that the GP took a history and made an examination. The records of both are rather brief'.*

22. In response to the patient's symptoms on 14 March 2018, the GP IPA advised '*The patient had been treated for a chest infection and the findings suggested this had cleared. He (the GP) did not record any new symptoms. His (the GP) examination showed her chest was clear and she had normal observations i.e. pulse, BP and temperature. Therefore, there was no indication of any infection'.* The GP IPA further advised that '*it is not possible to state from the limited medical record (taken by the GP)'*, *if the GP considered the patient had an infection….. Reviewing the records there was no indication of a urinary tract infection either in the history or the examination. Therefore, no further assessment would be indicated at that time'.*

23. The GP IPA also advised there was nothing recorded in the notes regarding *'follow up, safety netting*[16] *nor repeat blood tests'*. In response to the patient's plan of

[16] **Safety netting** is a management strategy of patients, tests and referrals used in the context of diagnostic

care, the GP IPA advised '*His* (the GP) *notes are lacking in information on what he planned or indeed discussed with the family. No advice is detailed other than "hold" some medication. It is not clear what that meant.*

24. In response to the patient's overall care and treatment during the GP home visit on 14 March 2018, the GP IPA advised *'The failing here is that the records are very concise and so it is difficult to fully assess the level of care, especially as there is no mention of what the family were told or what plan was made. The notes are in this respect lacking but he did visit, take a history and perform an appropriate examination which allowed him to make an assessment of her condition as per good medical practice. I feel that better more detailed records need to be kept. In particular, more of details of the history and then what was discussed, what advice was given to the patient and family and a plan if relevant…..there is no safety netting recorded….the deficiency here appears to be the record keeping'.*

25. In relation to the impact a lack of safety netting would have had on the patient, the GP IPA advised '*It is good practice to safety net consultations, and this should detail what the patient and/or carers were told in respect of diagnosis and prognosis. Some advice on when to seek further assistance is usually given. A plan might include details of any follow up. None was given in the GP notes. As she was not seen again for some time it is not clear when she deteriorated. GP saw her three days later and I am not aware of their findings. Lack of safety netting might have delayed the family seeking further medical attention as they were unaware of her situation.*

26. In response to information the GP had in advance of his home visit with the patient, the GP IPA could not confirm if he had accessed the Northern Ireland Electronic Care Record (NIECR) system in advance of the home visit. However, the GP IPA confirmed the patient's GP was '*aware of the blood results, in particular the low serum magnesium which he treated and so must have accessed some records. Presumably this was the practice notes'.*

uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.

The Practice's response to IPA

27. The Practice confirmed it had no comments to make on the GP IPA advice received.

The Complainant's response to Draft Report

28. 'I am satisfied with your analysis, conclusion and recommendation's. However, you report that my mother did not suffer any injustice as a result of the failings you identified. I'm not sure what the term injustice means but I do know that my mother continued to have bouts of urinary incontinence after recovering from her UTI. The persistence of her incontinence may have been avoided had she received the proper treatment sooner than she did but perhaps that is conjecture on my part rather than anything factual'.

The Practice's response to Draft Report

29. Upon receipt of the draft report the Practice stated '*The Practice accept the findings and recommendations in the draft report'.*

Analysis and Findings

28. The investigation established the patient had a GP home visit assessment carried out on 14 March 2018. I note the Practice stated the GP performed a clinical examination on the patient and '*the patient did not report any pain and did not appear to be in pain when examined'.* The Practice also stated that in the GP's consideration of whether the patient had an infection her vitals had been normal during the examination. Therefore the GP considered it '*was less likely at that point in time'.* I note the Practice stated the GP put in place a plan of care to '*stop diuretic and blood pressure lowering medications that could cause a decline in kidney function as well as potentially contributing to lethargy….arrangements were made to continue to monitor the kidney function with a repeat blood test to ensure that this was improving following these changes and if further decline was noted then review as needed.* I note that in response to the patient's care needs increasing, the GP contacted the access and care services within the Trust on 15 March 2018, the day after his home visit, so that a renewed assessment could be carried out. I further note that the patient had an OOH GP home visit on the 17 March 2018 and a Practice GP home visit on 21 March 2018 after which the patient attended ED and

was admitted to hospital. I reviewed the clinical notes from the OOH GP home visit on 17 March 2018 and established the OOH GP recorded the patient's '*vitals are normal'*. The records of the 17 March OOH GP do not indicate that an infection was diagnosed and no antibiotics were prescribed though a urine sample was to be arranged.

29. In relation to any indication the patient may have had an infection, the GP IPA advised that upon '*reviewing the records there was no indication of a urinary tract infection either in the history or the examination'.* I have also considered and I accept the GP IPA advice that '*he* [the GP] *did visit, take a history and perform an appropriate examination which allowed him to make an assessment of her condition as per good medical practice'.*

30. However, I note the GP IPA advised '*his* [the GP] *notes are lacking in information on what was planned or indeed discussed with the family….there is no mention of follow up, safety netting nor repeat blood tests'.* The Investigating Officer established that neither the complainant nor his sister who was also present during the GP home visit on 14 March 2018, had any recollection of advice being given concerning the ongoing care of their mother. I refer to the Diagnostic Safety Netting Guidance which recommends '*safety-net advice should give specific guidance on how and where to seek further help if needed'* and *'safety-net advice should be documented in the medical notes'.*

31. I have considered and I accept the GP IPA advice that '*the failing here is that the records are very concise and so it is difficult to fully assess the level of care especially as there is no mention of what the family were told or what plan of care was made…better more detailed records need to be kept….more details of history, what was discussed, what advice was given to the patient and family and a plan if relevant'.* I refer to Standard 21 of the GMC Guidelines which states that '*clinical records should include (a) relevant clinical findings, (b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions and (c) the information given to patients'.*

32. I considered and I accept the GP IPA advice that '*It is good practice to safety net consultations and this should detail what the patient and/or carer's were told in respect of diagnosis and prognosis….a plan might include details of any follow up…none was given in the GP notes'.* I further accept the GP IPA advice that '*a lack of safety netting might have delayed the family seeking further medical attention as they were unaware of her situation'.* I have been presented with no evidence that the GP provided safety net advice. I consider the absence of any safety netting is not in accordance with relevant guidance.

33. I have reviewed the GMC guidance, the GP IPA advice and the diagnostic safety netting guidance. I consider the GP's failure to record any safety net advice, what the patient's plan of care and follow up was and what he had discussed with the patient and her family to be inadequate and to constitute a failure in care and treatment. I, therefore uphold the complaint. However, I note the complainant without the benefit of safety netting advice by the GP did seek further review of the patient on 17 March 2018, three days after the home visit. I do not consider the patient to have suffered an injustice as a result of this failing. I note the patient was not advised to attend hospital on 17 March 2018 by the OOH GP, no infection was diagnosed, no antibiotics were prescribed though a urine sample was to be arranged and it was only as a result of a further Practice GP visit on 21 March 2018 that the patient attended hospital and was diagnosed with a UTI. I do however consider that the lack of safety net advice and explanation of the plan of care caused an injustice to the complainant due to the uncertainty the lack of advice may have created.

CONCLUSION

34. The complainant submitted a complaint to me about the actions of the Practice.

The investigation of the complaint found the GP assessment performed on 14 March 2018 was carried out in accordance with good medical practice.

However, the investigation of the complaint found a failure in care and treatment in relation to the following matters:

I. Failure to provide safety netting advice, and a failure to record what the patient's plan of care and follow up was and what was discussed with the patient and her family.

I am satisfied the failure I have identified in this report did not cause the patient any injustice. I am also satisfied the failure I have identified caused an injustice to the complainant due to the uncertainty the lack of advice may have created.

Recommendations

I recommend:

i. The Practice apologise to the complainant for the failure to provide safety net advice and explain the GP's plan of care. This should be completed within one month of the date of the final report.

ii. I recommend the Practice bring the failure identified in this report regarding the lack of safety netting advice and explanation of the plan of care, to the attention of the GP with a view of improving practice and remind the GP of the Diagnostic Safety Netting, within one month of the date of my final report.

iii. I recommend the GP should discuss the findings from this report with their appraiser as part of their next appraisal.

I am pleased to note the Practice accepted my findings and recommendations.

PAUL MCFADDEN
Acting Ombudsman **July 2020**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.

- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

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

- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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