



Northern Ireland

Public Services
Ombudsman

Investigation of a complaint against a GP Practice

Report Reference: 202005762

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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

This complaint was about the care and treatment the Practice provided the complainant's late husband. It was also about how it handled the subsequent complaint.

The investigation established that the Practice failed in the care and treatment it provided the patient. I found that the patient should have been offered urgent investigative tests or a suspected cancer pathway referral for the symptoms he presented to the Practice with over a period of three years.

The investigation also identified maladministration in the Practice's handling of the complaint. The Practice failed to fully investigate and address each of the issues of complaint, keep full and accurate records of its investigation and have the complaint reviewed by someone not involved in the events leading to the complaint. It also failed to consider the use of the Strategic Planning Performance Group during local resolution of the complaint. The Practice's final response failed to signpost the complainant to this office, something which it is statutorily obliged to do.

I recommended that the Practice apologise to the complainant for the failings identified. I also recommended service improvements to ensure the failings do not recur.

THE COMPLAINT

1. This complaint was about care and treatment the Practice provided to the patient. It was also about how the Practice handled the subsequent complaint. The complainant was made by the patient's stepson on behalf of his mother, the patient's wife.

Background

2. The patient was registered with the Practice from 1999 until 10 May 2022.
3. The patient attended the Practice raising concerns regarding his weight loss – as follows:
 - 26 January 2016 – the Practice conducted blood tests. It recorded the patient's weight as 72.8kg.
 - A Consultant Cardiologist from St Bartholomew's Hospital wrote to the Practice on 30 June 2016 requesting they investigate the cause of recent unexplained weight loss.
 - 4 July 2016 – the Practice conducted blood tests. It recorded the patient's weight as 67.2kg. The Southern Trust diagnosed the patient with a hiatus hernia¹ on 23 August 2016.
 - 16 November 2016 – the Practice documented the patient had "*no new symptoms*". It recorded the patient's weight as 66.8kg.
 - 26 October 2017 – the Practice was concerned about the patient's half stone weight loss. A referral was made to the Southern Trust's community dietician on 13 November 2017.
 - 13 February 2018 – the Practice recorded the patient's weight as 66.2kg. It prescribed the patient with nutritional supplemental drinks.
 - 1 October 2018 - the Practice recorded the patient's weight as 64.1kg. It prescribed the patient with nutritional supplemental drinks.

¹ A hiatus hernia is a condition in which the upper part of the stomach bulges through an opening in the diaphragm.

4. The patient registered with a different GP Practice in early August 2022. A GP examined the patient and referred him for an urgent gastroscopy² in January 2023.
5. The Southern Trust completed a CT scan on 1 April 2023 and took biopsies on 28 April 2023. It diagnosed the patient with squamous cell carcinoma which had spread to his liver and lymph nodes (Metastatic Oesophageal Cancer³).
6. The oncologist met with the patient on 18 May 2023. The oncologist advised the patient he was too unwell to undergo chemotherapy due to extreme weight loss. The oncologist prescribed the patient Dexamethasone⁴ to increase the patient's appetite and scheduled a review in 4 weeks.
7. The patient's appetite initially improved in the first week before deteriorating once more. He sadly passed away on 1 June 2023.

Issues of complaint

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

Issue 1: Whether the care and treatment the Practice provided the patient was appropriate, reasonable and in accordance with relevant policies and standards.

Issue 2: Whether the Practice handled the complaint in accordance with relevant guidance.

INVESTIGATION METHODOLOGY

9. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Practice's complaints process.

² The procedure called gastroscopy involves the placing of an endoscope (a small flexible tube with a camera and light) into the stomach and duodenum to search for abnormalities.

³ Metastatic oesophageal cancer starts in the oesophagus and then travels through the blood or lymphatic system to other organs or lymph nodes. Cancer cells then form tumours in other areas of the body.

⁴ Dexamethasone is a type of medicine called a steroid (or corticosteroid). Steroids cause weight gain by altering the body's electrolyte and water balances, as well as its metabolism.

Independent Professional Advice Sought

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

- A senior General Practitioner, MBBS BSc FRCGP ILM5 MSc (med ed) (the IPA).

I enclose the clinical advice received at Appendix 3 to this report.

11. 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

12. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles⁵:

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

13. 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:

- The General Medical Council's, Good medical practice, March 2013 (the GMC Guidance);
- The National Institute for Health and Care Excellence's, Gastrointestinal tract (upper) cancers - recognition and referral, February 2021, Clinical Knowledge Summary (CKS) (the NICE CKS);

⁵ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

- The National Institute for Health and Care Excellence's Gastrointestinal tract (upper) cancers – recognition and referral, NG12, February 2021 (the NICE guidance); and
- The Surgery's Complaint Procedure, October 2023 (the Practice's Complaint Procedure).

14. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Practice's administrative actions. It is not my role to question the merits of a discretionary decision. That is unless my investigation identifies maladministration in the Practice's process of making that decision.
15. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.
16. A draft copy of this report was shared with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations. All responses were carefully considered before finalising the report.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Practice provided the patient was appropriate, reasonable and in accordance with relevant policies and standards.

Detail of Complaint

17. The complainant said during the period 2019 – 2022, the patient "*continued to lose weight*" and had several appointments with GP 2 within the Practice. This was a period of "*extreme frustration*" for them. Every time the patient raised the issue of his weight loss, GP 2 responded with "*dismissive comments*" and did not take the patients "*concern seriously*".

18. The complainant said they did not have any confidence in GP 2 and the patient's Cardiologist within the Belfast Trust "*reaffirmed this*". The complainant said GP2 failed to provide the patient with proper care and treatment.
19. The complainant said there is a possibility had the patient's concerns regarding weight loss been investigated at the time, the patient's "*cancer may have been detected at a much earlier stage*" and he "*may have been fit enough to undergo chemotherapy*". Instead, the patient "*endured months of delay*", initially caused by GP 2.
20. The patient received his cancer diagnosis in early April 2023 and within eight weeks he had passed away, leaving the complainant and her family in "*total shock and devastation*".

Evidence Considered

21. I considered the following guidance:

- The GMC guidance;
- The NICE CKS; and
- The NICE guidance.

The Practice's response to investigation enquiries

22. GP 2 responded on behalf of the Practice on 29 November 2023. GP2 has since retired from the Practice.
23. GP 2 stated GP 1 did not retire before the Covid Pandemic and was a "*senior partner working 2 days a week up to and including the 31 March 2021*". As such, GP 1 "*would have been available to see the patient*" up until this date.
24. GP 2 stated he was "*not made aware of any weight loss*", nor could he see any reference to weight loss on his "*outpatient or hospital contacts*". The patient did not "*mention any symptoms of oesophageal cancer*" such as problems "*swallowing or food sticking*". The Practice completed the patient's bloods in March 2022 which were "*within satisfactory range*" and would not "*cause concern*".
25. GP 2 stated he reviewed the letter from the cardiologist who saw the patient on 15 April 2022 and "*cannot see any reference to weight loss*".

Information from the cardiologist

26. The patient's cardiologist responded to investigation enquiries.
27. The consultant stated they had no recollection of "*specific issues regarding weight loss*" and was unable to "*add additional comments regarding this*".

Relevant Trust records

28. I completed a review of the documentation the Practice provided in response to my investigation enquiries, and the documentation I received from the complainant. I refer to the relevant records in the Analysis and Findings section of this report.

Relevant Independent Professional Advice

29. The IPA advised the symptoms typically associated with Oesophageal Cancer include "*loss of appetite and weight loss*". The patient was "*presenting with symptoms of appetite loss and weight loss that was unexplained*".
30. The IPA referred to the NICE guidance which recommends that GPs should consider "*non-urgent direct access upper gastrointestinal endoscopy*" to assess for oesophageal cancer in people aged 55 years or over who present with symptoms of "*Nausea or vomiting with any of the following: Weight loss, Reflux, Dyspepsia and Upper abdominal pain*".
31. The IPA advised the exact cause of oesophageal cancer is unknown, but certain things can "*increase the risk of it developing*". The patient was a pipe smoker and suffered with GORD⁶, both are "*risk factors*" for this condition. It is unclear from the medical records that the Practice took "*appropriate steps*" to monitor the patient's risk of oesophageal or other cancers.
32. The IPA advised clinical records demonstrate the patient did present on "*multiple occasions with weight loss, reduced appetite and concerns about his weight*". From clinical records the patient weighed "*82.55kg*" on 7 May 2008 with the final weight recorded by the Practice as "*64.2kg*" on 24 August 2019.
33. The IPA advised whilst a referral was referenced by different clinicians during consultations, it is unclear if the Practice made a referral or if the patient attended an appointment.

⁶ GORD is a common condition where stomach acid leaks up into the oesophagus, causing heartburn and other problems.

34. The IPA advised the patient's symptoms and concerns regarding "*weight loss, poor appetite and difficulty putting on weight*", along with his history of being a pipe smoker and suffering from GORD, should have prompted the Practice to follow the NICE guidance and refer the patient for "*further investigations*". The NICE guidance advises for patients who present with unexplained appetite loss, clinicians should carry out an assessment for "*additional symptoms, signs, or findings that may help to clarify which type of cancer is most likely*".
35. The IPA advised given the patient's symptoms the Practice should have referred the patient for "*urgent investigation or a suspected cancer pathway referral*".
36. The IPA recommended the Practice reviews its processes for managing patients with unexplained weight loss/loss of appetite and highlights the NICE guidance at its next educational event for clinicians in the Practice.

Further response from the Practice

37. The Practice was asked to confirm if a referral was made for the patient. The Practice stated it cannot make a direct referral to endoscopy and instead has to make a gastroenterology surgical referral. Having reviewed the patient's records, the Practice confirmed the only referral it made to secondary care for abdominal pain and weight loss was on 22 July 2016.

GP2's response to the draft report

38. GP2 provided the following comments in response to the draft report:
- The patient was seen by other clinicians at the Practice including GP1. The patient was also referred to / seen by a number of hospital specialists with results coming back as normal. Every concern presented by the patient was treated appropriately at the time.
 - He cannot see any reference to weight loss in correspondence from secondary care. None of the clinicians who had consultations with the patient felt it was necessary to investigate the patient for oesophageal cancer.
 - The patient attended the Practice from 2016 onwards regarding a number of symptoms including weight loss. In November 2017, the Southern Trust informed the Practice it had thoroughly investigated the patient's weight loss and felt it had nothing further to add.

- The patient attended the practice on 14 March 2019 raising concern about his kidney function. The patient's weight was recorded as 65.2kg which was an increase from 21 September 2018 when the patient's weight was recorded as 64kg.
- He did see the patient on several occasions and completed telephone consultations with the patient during the period 2019 to 2022. He cannot see from the patient's records, nor does he recall, that the patient raised concerns about weight loss. Had the patient done so, it would have been his normal practice to weigh the patient. All blood results for the patient were within the normal range.
- The patient attended A&E on 10 September 2021. The Hospital admission form records the patient complained of "*weight loss and night sweats*". Despite being admitted to hospital, it did not investigate the patient's concerns, nor did it advise the Practice.
- The patient attended A&E on 17 January 2022. Any weight loss and symptoms seem to be put down to a recent Covid infection and the patient's significant heart condition.

The Practice's response to the draft report

39. The Practice stated the report will be shared to allow Practice clinicians to reflect on the findings. The Practice will also remind staff of the requirements outlined in the NICE CKS at its next educational event.

The complainant's response to the draft report

40. The complainant wished to express their disappointment in the response received from the cardiologist. The patient's wife recalls the appointment as it was very '*alarming and traumatic*' for her. She remembered the cardiologist spoke to her privately, stating he was alarmed at the patient's weight loss, and that he was '*borderline emaciation*'.

Analysis and Findings

41. I considered the NICE CKS which advises clinicians to refer the patient for "*urgent direct access upper gastrointestinal endoscopy*" to assess for oesophageal cancer in people "*aged 55 years and over with weight loss and reflux*" (GORD).

42. In its response to enquiries, the Practice stated the patient did not report any symptoms of oesophageal cancer. However, the clinical records clearly demonstrate the patient attended the Practice and reported concerns of weight loss / being unable to gain weight on six occasions. The IPA advised the patient's symptoms and concerns regarding "*weight loss, poor appetite and difficulty putting on weight*", along with his history of being a pipe smoker and suffering from GORD, should have prompted the Practice to follow the NICE guidance and refer the patient for "*urgent investigation or a suspected cancer pathway referral*".
43. I considered the GMC Guidance which requires clinicians to "*adequately assess the patient's conditions*" and "*promptly provide or arrange suitable advice, investigations or treatment where necessary*". Having considered the evidence available, I find it concerning the Practice did not meet this standard. I consider the Practice's failure to refer the patient for further diagnostic treatment, despite numerous presentations from the patient with similar ongoing symptoms constitutes a significant failure in care and treatment. I therefore uphold this element of the complaint.
44. I cannot determine if earlier referral of the patient would have changed his ultimate prognosis. However, it is clear the failure identified caused the patient to sustain the injustice of a loss of opportunity for earlier treatment which may indeed have prolonged his life. Further, his family sustained the injustice of uncertainty as they will always question whether the patient's outcome would have been different if the Practice had appropriately referred him in a timely manner.

Issue 2: Whether the Practice handled the complaint in accordance with relevant guidance.

In particular the following issues were considered under this heading:

- *The decision for GP 2 to investigate the complaint; and*
- *The written response to the complainant.*

Detail of Complaint

45. The complainant said he did not feel GP 2 responding directly to a complaint made against him is the "*best professional approach*". This is why she addressed the complaint to the "*Practice Manager*".

46. The complainant said the written response was presented as a *“list of doctor’s notes of appointments”*.

Evidence Considered

Legislation/Policies/Guidance

47. I considered the following policies/guidance:

- The Practice’s Complaint Procedure; and
- The Principles of Good Complaints Handling

I enclose relevant sections of the Practice’s Complaints Procedure at Appendix 4 to this report.

The Practice’s response to investigation enquiries

48. GP 2 stated the reason he answered the complaint was due to him being the only contractor at the Practice since March 2021. GP2 stated he tried to answer the questions *“as best”* he could.
49. The Practice stated it *“does not have any record of the investigation”*. Therefore, it is unable to demonstrate how the Practice *“fully and fairly investigated the complaint in accordance with the Practice’s Complaint Procedure”*.
50. The Practice updated its Complaint Procedure and from 1 January 2024 and complaints will be *“investigated in line”* with the updated procedure. The Practice stated under the new procedure, *“records of the investigation will be saved appropriately”*.
51. The Practice stated it is *“unable to provide rationale”* for it not advising the complainant of the right to *“avail of the services provided by the SPPG Complaints Department”⁷*. The updated complaints procedure *“includes a patients’ right to avail of the services provided by the SPPG Complaints Department”*.
52. The Practice stated the updated complaints procedure includes the requirement to signpost a complainant to NIPSO. The updated procedure *“fulfils its statutory obligations under Section 25 of the Public Services Ombudsman Act 2016”*.

⁷ The role of the SPPG is to act as “honest broker” between complainant and practitioner – ‘honest broker’ is where the complaints manager at the Strategic Planning and Performance Group (SPPG) acts as an intermediary in an attempt to resolve the complaint locally.

The Practice's response to the draft report

53. The Practice stated it has provided training on its complaints policy, which will be reviewed on a yearly basis.

GP2's response to the draft report

54. GP2 stated he responded to the complaint as he was the only GP principle remaining within the Practice as of the end March 2021. He responded with a list of appointments to demonstrate the Practice, and secondary care had no recent record of weight loss.
55. GP2 stated with hindsight, it may have been better to request a neighbouring Practice to investigate the complaint as an independent intermediary, but this would have delayed the response. He recognised he could also have highlighted further steps available to the family if they felt the complaint had not been satisfactorily resolved, including SPPG and onward referral to NIPSO.

Analysis and Findings

56. I have identified a number of areas in which the Practice's investigation fell short of standards set out in the Practice's Complaints Procedure and the Principles of Good Complaint Handling.
57. The Practice's response to this office's enquiries confirmed it, *"does not have any record of the investigation"*. This is of concern to me. In the absence of these records, I cannot be satisfied the Practice fully and fairly investigated the complaint. I also do not consider its written response fully addressed the issues the complainant raised. While the letter outlined some consideration of the patient's records, its decision on the complaint and rationale for that decision are not clear. This was not in line with the Practice's Complaint Procedure, which requires the response to, *"address the concerns expressed by the complainant and show that each element has been fully and fairly investigated"*.
58. The third principle of Good Complaints Handling requires a public body to keep *"full and accurate records"*. The fourth principle requires a public body to *"ensure that*

complaints are investigated thoroughly and fairly to establish the facts of the case". I do not consider the Practice met these standards when it considered the complaint.

59. I am satisfied GP 2 should not have responded to the complaint, given he was central to the issues raised in the complaint. This is poor practice. The fourth principle of Good Complaint Handling requires a public body to ensure that *"complaints are reviewed by someone not involved in the events leading to the complaint"*.
60. The Practice's Complaints Procedure states staff should be able to distinguish those issues which *"would be better referred to the Practice Manager or GP partner on duty for more detailed investigation"*.
61. Therefore, the Practice should have referred the complaint to someone not subject to the complaint. I appreciate this is more difficult for smaller Practices. However, in this case, the Practice should have considered the use of the Strategic Planning and Performance Group (SPPG) to act as an intermediary to try and resolve the complaint. There is no evidence to suggest it took any of these steps to ensure the investigation process was fair and independent.
62. My review of the Practice's response to the complaint also identified a failure to signpost the complainant to NIPSO. Section 25 of the Public Services Ombudsman Act 2016 requires a listed authority to advise the complainant the *"complaints handling procedure is exhausted"* and *"the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman"*.
63. I consider the Practice's failure to:
- fully investigate and address each of the issues of complaint;
 - have the complainant reviewed by someone not involved in the events leading to the complaint;
 - consider the use of SPPG;
 - failure to keep full and accurate records of the investigation; and
 - signpost the complainant to this office.

constitutes maladministration. I am satisfied the maladministration identified in the Practice's handling of the complaint caused the complainant to experience the

injustice of frustration and the time and trouble of bringing a complaint to this office. Therefore, I uphold this issue of complaint.

64. I note the Practice updated its Complaints Procedure in January 2024 which will ensure, *“records of the investigation will be saved appropriately”*. I welcome this learning already identified and the service improvements the new Complaints Procedure should bring to anyone wishing to make a complaint.

CONCLUSION

65. The complaint concerned care and treatment the Practice provided to the patient and its handling of the complaint. I upheld elements of the complaint for the reasons outlined in this report.
66. I consider that by not making a non-urgent direct access upper gastrointestinal endoscopy referral the Practice failed in its care and treatment of the patient. I also consider that the Practice’s failure to properly deal with the subsequent complaint constitutes maladministration.
67. I am satisfied the failures identified caused the patient to sustain the injustice of a loss of opportunity for earlier treatment and caused the patient and his family to experience uncertainty about whether his outcome could have been improved. I am also satisfied it caused the complainant to sustain the injustice of frustration and the time and trouble of bringing a complaint to this office.
68. I offer through this report my condolences to the complainant and their family for the loss of their stepfather and husband.

Recommendations

69. I recommend the Practice provides to the complainant a written apology in accordance with NIPSO’s ‘Guidance on issuing an apology’ (July 2019), for the injustice caused as a result of the maladministration identified (within one month of the date of this report).
70. I recommend that within one month of the date of this report, the Practice:

- reminds relevant staff of the requirements outlined in the NICE CKS at its next educational event for clinicians in the Practice.
- shares this report with relevant staff to allow them to reflect on the failures identified.
- reminds staff charged with the responsibility of investigating complaints of:
 - i. the requirement to conduct a robust investigation and provide a full and accurate response to each issue of complaint; and
 - ii. to ensure complaints are reviewed by someone not involved in the events leading to the complaint.

71. I recommend the Practice implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. The Practice should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY
Ombudsman

March 2025

Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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 relevant guidance, 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.

