Investigation of a complaint against the Southern Health and Social Care Trust

Report Reference: 202002372

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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 Southern Health and Social Care Trust (the Trust), in its role as Corporate Appointee[1] for the complainant's late sister (the resident). In particular, about the Trust's responsibility to request a determination of the resident's eligibility for continuing healthcare (CHC)[2] during the period 9 January 2019 to 6 July 2020.

The investigation established the role of Corporate Appointee is limited to the application and management of state social security benefits for a person who lacks sufficient mental capacity to manage their own financial affairs. It is separate from the Trust's general duty of care towards the health and social care needs of its patients. It does not include a proactive responsibility to request a determination of CHC eligibility for an individual subject to a corporate appointeeship. The investigation found, therefore, that the Trust, in its role as Corporate Appointee for the resident, did not have a responsibility to request a determination of CHC eligibility for or on behalf of the resident.

I therefore did not uphold this complaint.

As part of its handling of the complainant's original complaint, the Trust undertook to treat the complaint as a request for it to retrospectively consider the resident's eligibility for CHC, once it had received sufficient guidance from the Department of Health to enable it do to so. In light of the High Court's recent Judicial Review decision on CHC, I expect the Trust to honour this undertaking.

[1] Corporate Appointeeship is a statutory administrative appointment provided for in accordance with regulation 33 of the Social Security (Claims and Payments) Regulations (Northern Ireland) 1987. It is a form of trustee relationship which is established to ensure that certain entitlement to benefits can be made along with disbursement of those funds on behalf of a person who may lack capacity.

[2] At the time the complainant submitted his complaint to my Office (March 2022), 'Continuing Healthcare' (CHC) was the term used in Northern Ireland to describe the practice of the health service meeting the cost of any social need which was driven primarily by a health need. Essentially, this meant that if an individual's primary need was for healthcare, rather than for social care (also known as personal social services), they did not have to pay for the care they received, irrespective of where that care was provided. A new policy for determining eligibility to CHC was introduced in Northern Ireland in February 2021. However, that 2021 Policy was quashed by a High Court Judicial Review judgement on 30 June 2023, citation no: [2023] NIKB 72. The High Court reinstated the original approach.

THE COMPLAINT

1. This complaint is about the actions of the Southern Health and Social Care Trust (the Trust). The complainant made the complaint on behalf of her late sister, who is referred to in this report as 'the resident'.

Background

2. The resident had a diagnosis of Schizophrenia[3] for nearly 50 years and lacked the sufficient mental capacity[4] to make decisions about her own financial affairs.

3. Due to the resident's mental incapacity, the Trust became Corporate Appointee[5] for the resident. The Trust was unable to confirm exactly when it commenced acting in this role. However, neither the complainant nor the Trust disputed the Trust acted in this role during the relevant period.

4. In June 2014 the resident left St Luke's Hospital in Armagh following its closure and moved to supported living accommodation, also in Armagh. This facility was not sufficient to meet the resident's complex and evolving needs, and so she started living in a mental health unit in Craigavon Area Hospital on 27 January 2018, which was under the Trust's remit. On 9 January 2019 the Trust transferred the resident from that unit to a nursing home (the nursing home).

5. On 6 July 2020 the resident collapsed in the nursing home and went to Craigavon Area Hospital in an emergency ambulance. She sadly passed away later that day. The Trust recorded her cause of death as '*Acute Peritonitis[6] due to Perforated Duodenal Ulcer*[7]'.

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[3] Schizophrenia is a long-term mental health condition that causes a range of psychological symptoms, including delusions, hallucinations, disorganised thoughts, speech and behaviour.
[4] Mental capacity means the ability of a person to understand information and make decisions about their life. Mental incapacity means a person is unable to make these decisions. A person might have capacity to make more straightforward decisions, such as what to eat. But they may not have capacity for more complicated decisions, such as those with financial implications.
[5] Corporate Appointeeship is a statutory administrative appointment provided for in accordance with regulation 33 of the Social Security (Claims and Payments) Regulations (Northern Ireland) 1987. It is a form of trustee relationship which is established to ensure that certain entitlement to benefits can be made along with disbursement of those funds on behalf of a person who may lack capacity.
[6] Peritonitis is a serious condition that starts in the abdomen, between the chest and the pelvis. Peritonitis happens when the thin layer of tissue inside the abdomen becomes inflamed. The tissue layer is called the peritoneum. Peritonitis usually happens due to an infection from bacteria or fungi.
[7] An ulcer that occurs in the lining in the part of the small intestine just beyond the stomach (the duodenum). Perforation is a rare complication of ulcers where the lining splits open.

6. Following the resident's death, the Trust sought a sum of money from the resident's estate in respect of outstanding nursing home costs. The complainant is one of the administrators of the resident's estate.

7. On 16 December 2020 the complainant wrote to the Trust challenging the resident's estate's liability for the outstanding costs. She subsequently submitted a formal complaint on 7 April 2021. The complaint set out that the Trust was liable for the outstanding sum instead of the resident's estate, because of the '*established principle of continuing healthcare*'.

8. The Trust responded to the complaint on 10 June 2021. The complainant was dissatisfied with this response, and so the Trust re-opened its investigation. The Trust issued its final response on 2 August 2021. The complainant remained dissatisfied, and so submitted her complaint to my Office on 23 March 2022.

Issue of complaint

9. The issue of complaint accepted for investigation was:

Whether the Trust, in its role as Corporate Appointee for the resident, had a responsibility to request that the resident's eligibility for continuing healthcare be determined during the period 9 January 2019 – 6 July 2020?

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 the complainant raised. This documentation included information relating to the Trust's complaints process.

Relevant Standards

11. 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.

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

    (i) The Principles of Good Administration

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.

14. The specific standards relevant to this complaint are:

- Social Security (Claims and Payments) Regulations (Northern Ireland) 1987 (the 1987 Regulations);
- The Health and Personal Social Services (NI) Order 1972 (the 1972 Order)
- Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance; issued by the (then) Department of Health, Social Services and Public Safety on 11 March 2010 (the 2010 Circular);
- Circular ECCU1/2006, HPSS Payments for Nursing Care in Nursing Homes, issued by the issued by the (then) Department of Health, Social Services and Public Safety on 10 March 2006 ('the 2006 Circular');
- Continuing Healthcare in Northern Ireland: Introducing and Transparent and Fair System, Consultation Document, issued by the Department of Health on 19 June 2017 (CHC Consultation Document); and
- Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a Fair and Transparent System, issued by the Department of Health on 12 May 2021 ('the 2021 Circular').

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 Trust for comment on factual accuracy and the reasonableness of the findings and

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

recommendations. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Whether the Trust, in its role as Corporate Appointee for the resident, had a responsibility to request that the resident's eligibility for continuing healthcare be determined during the period 9 January 2019 – 6 July 2020?

Detail of complaint

17. The complainant said the Trust failed to assess the resident's eligibility for CHC during the relevant period. She said the Trust, in its role as Corporate Appointee for the resident, had a '*duty of care*' towards the resident and was '*responsible for acting in her best interests*'. The complainant's position is that this responsibility extended to the Trust making a request of itself to determine the resident's eligibility for CHC during the relevant period.

18. The complainant's position is that if the Trust had considered the resident's eligibility for continuing healthcare, she may not have incurred the nursing home fees the Trust has charged her estate with. She explained she has been unable to finalise the resident's estate because this matter remains unresolved.

Evidence Considered

Legislation, Policies and Guidance

19. I considered the following legislation, policies and guidance:

- The 1987 Regulations;
- The 1972 Order;
- The 2010 Circular;
- The 2006 Circular;
- CHC Consultation Document; and
- The 2021 Circular.

20. I enclose relevant extracts from the above at Appendix two to this report.

The Trust's response to investigation enquiries

21. The Trust stated it '*discharged all roles and responsibilities*' in respect of the resident's Corporate Appointeeship '*in accordance with Social Security Regulations*'.

22. It stated: the '*first request*' the complainant submitted to it about CHC was on 7 April 2021. However, it had received previous correspondence from the complainant on 16 December 2020 about the resident's nursing home fees. It decided it was appropriate to treat the complainant's correspondence of 16 December 2020 as the complainant's first request to retrospectively consider the resident's CHC eligibility.

23. The Trust stated it conducted a person-centred review in respect of the resident on 24 April 2019. It said the resident's family was present at this meeting, including the complainant. It said '*CHC was not referenced by the family during this review*'. Therefore it had no reason to consider the resident's eligibility for CHC at that time.

24. The Trust explained it undertook to consider the complainant's request once the Department of Health has issued sufficient guidance to enable it to do so, and that it informed the complainant about this in writing on 10 June 2021. The Trust said the complainant has the option to pay the outstanding nursing home costs in the meantime in order to finalise the resident's estate. Then if the Trust later determines the resident was eligible for CHC, it will reimburse the resident's estate accordingly.

Documentation and records examined

25. I completed a review of the copy documentation the Trust provided in response to my investigation enquiries, and the documentation I received from the complainant.

Analysis and Findings

Context of CHC in Northern Ireland

26. Before I set out my findings, I should highlight that in February 2021, the Department of Health published the outcome of a public consultation it launched in June 2017 on future arrangements for CHC in Northern Ireland. Later, in May 2021, the Department issued guidance[9] on a new policy for determining eligibility for CHC on the basis of applying a single eligibility criterion. This criterion was whether an individual's care needs can be properly met in any setting other than a hospital. If the answer to this question was 'yes', then the individual was not be eligible for CHC and was subject to the relevant charging policy for the care they received. However, the High Court in Northern Ireland quashed that policy in its Judicial Review decision[10] issued on 30 June 2023. In doing so, the High Court, in practice, reinstated the previous approach, as set out in the 2010 Circular, issued in March 2010.

27. In this instance, the events in question took place prior to February 2021. Therefore it is the policy reflected in the 2010 Circular that is relevant to my consideration of this complaint, that is, that an individual's eligibility for CHC is determined on the nature of their primary need. Furthermore, the Trust has undertaken to consider the complainant's request retrospectively under this system. The complainant confirmed to my Office they had no objection, in principle, to this decision, but still felt the Trust had an obligation to consider the resident's eligibility whilst she was alive. I will therefore refer to the 2010 policy in setting out my findings on the complaint.

28. In considering this complaint, I am mindful that the 1972 Order (the main legislation governing the provision of health and social care services in Northern Ireland) does not provide an explicit statutory framework for the provision of CHC, nor does it expressly require that CHC be provided to people in Northern Ireland. That said, I am aware that the 2010 Circular (which sets out the Department of Health's guidance on charging for social care [also known as

[9] Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system ('the 2021 Circular')
[10] Citation no. [2023] NIKB 72

personal social services] provided in residential care homes and nursing homes) states at paragraph 63, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential or nursing home accommodation arranged by a [Health and Social care] Trust.* ***There is no such requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home'*** (the 2010 Circular's emphasis). There is therefore a clear, and important, difference between healthcare and social care, in terms of a HSC Trust's legal authority to charge for the care it provides to an individual who has moved into a residential care or nursing home.

29. The (then) Minister of Health reinforced this distinction when he responded in September 2013 to an Northern Ireland Assembly Question[11] about CHC. The Minister stated, *'… an individual's primary need can either be for health care – which is provided free – or for social care for which a means tested contribution may be required.'*

30. I note too that the difference between charging for healthcare and social care was highlighted in the Department of Health's June 2017 public consultation document on future arrangements for CHC in Northern Ireland. The consultation document stated that where an assessment of an individual's needs *'indicate[s] a primary need for healthcare, [the relevant HSC Trust] is responsible for funding the complete package of care in whatever setting. This is what is known as continuing healthcare in the local context. Alternatively a primary need for social care may be identified and where such a need is met in a residential care or nursing home setting, legislation requires the HSC Trust to levy a means-tested charge.'*

31. Given the significance of the distinction between healthcare and social care, in relation to a HSC Trust's authority to apply charges for the care an individual receives, I should highlight the difference between the two.

32. Healthcare in the community is delivered through services such as GP surgeries, therapy services and specialist health teams, such as mental health.

[11] Assembly Question AQW 25318/11-15

An individual's identified health needs are normally met either directly by, or under the supervision of, registered nurses, therapists, dieticians etc., depending on the specialism required to meet the identified need.

33. A definition of personal care (or social care) was provided in the 2010 Circular. This states that personal care *'includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on alcohol or drugs; or past or present mental disorder …'.* A further definition of personal care was provided in the Department of Health's 2006 publication, 'Payments for Nursing Care'.[12] This states that personal care is *'care you need to help you in the activities of daily living; for example, help with toileting and other personal needs like bathing, dressing and undressing, getting in and out of bed, moving around and help with feeding. It might also cover advice, encouragement and supervision in these activities. Care assistants rather than registered nurses will usually see to your personal care needs.'*

Findings

34. Regarding a determination of CHC eligibility*, paragraph 17* of the 2010 Circular states '*the distinction between health and social care needs is complex and requires a careful appraisal of each individual's needs. In this context, it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services. In the latter case, the service user may be required to pay a means tested contribution*'.

35. Upon a careful and considered review of all relevant standards and associated documentation, I am satisfied that, on balance, it is more likely than not a HSC Trust must receive a specific application from a party in order to initiate a determination of a specific older person's primary need for the purposes of

[12] https://www.nidirect.gov.uk/sites/default/files/2021-11/hpss-payments-for-nursing-care-information-leaflet.pdf

CHC. I have reached this conclusion, on balance, having considered the following:

- Paragraph 5 of Annex A to the 2021 Circular deals primarily with the eligibility criteria adopted from 11 February 2021 (albeit, now quashed by the High Court, as set out above). However, it also refers to '*any applications for continuing healthcare already in the system prior to this should be assessed in line with previous guidance or policies*'. This demonstrates to me that, under the system in place under the 2010 Circular, the Trust must receive an application from a party before it must make a determination of CHC eligibility. Paragraph 7 of Annex A also refers to '*any applications for continuing healthcare already in the system prior to 11 February 2021*'.

- The CHC Consultation Document discussed the CHC framework in Northern Ireland under the 2010 Circular. Paragraph 17 of this document states '*it would appear that one of the key drivers for HSC Trusts receiving a request for continuing healthcare assessments is once an individual needs to, or has, moved into a nursing home*'. It goes on to state that HSC Trusts responsible for '*making a determination on continuing healthcare applications*' have found it challenging under the system set out in the 2010 Circular. This further demonstrates the Trust must have received a specific request or application for CHC eligibility to be determined before doing so. It demonstrates the Trust does not have specific, proactive obligation to initiate such a determination, as a default position, for all older people in its care, in the absence of a specific request.

- Paragraph 42 of the CHC Consultation Document appears under the heading '*Existing and Pending Continuing Healthcare Applications*'. It makes several references to how HSC Trusts ought to handle existing '*applications*' for CHC. I consider this further demonstrates the need for the Trust to receive a specific request or application before it was obligated to determine primary need for the purposes of CHC eligibility.

- I also refer to Judgment [2023] NIKB 72 of the High Court, discussed above. In this judgment the Judge made frequent references to '*applications*' for a consideration of CHC eligibility under the system in place in the 2010 Circular. Whilst this is not a relevant standard to hold the Trust to, it nonetheless indicates the prevailing understanding in place at the time regarding the need for the Trust to receive a specific request or application before it was obligated to determine primary need for the purposes of CHC eligibility.

36. I am satisfied the resident lacked sufficient mental capacity to apply to the Trust for her primary need to be assessed for the purposes of making a determination on her eligibility for CHC. I am also satisfied the Trust did not receive such an application or request from the resident's family during the relent period. The Trust is treating the complainant's subsequent correspondence of 16 December 2020 as the family's first application for it to retrospectively consider the resident's eligibility for CHC.

37. I am satisfied the Trust would only have been required to make a determination of the resident's primary need for the purposes of considering her eligibility for CHC if it had received a specific application or request to do so.

38. However, I note the complainant's position that because the Trust was also Corporate Appointee for the resident, it had a responsibility to make such a request of itself as part of discharging its responsibilities under that specific role. I therefore examined the role of Corporate Appointee to determine its remit and extent.

39. Corporate Appointeeship is a statutory administrative appointment established under *regulation 33* of the 1987 Regulations. This regulation states that where a person is (or may be) entitled to a social security benefit, but lacks the mental capacity to '*deal*' with it themselves, the Department can appoint a party to '*receive*' and '*deal*' with that benefit on that person's behalf. The relevant Department is currently the Department of Communities (the Department). The 1987 Regulations permit the Corporate Appointee to be either a natural person or an organisation (or a representative of an organisation). On this occasion, it

is an organisation, the Trust, who acted as Corporate Appointee for the resident during the relevant period.

40. I am satisfied Corporate Appointeeship is therefore a form of trustee relationship established to ensure that benefits are obtained, and subsequently disbursed on behalf of a person who lacks the mental capacity to manage the process themselves. I am further satisfied the role is therefore strictly limited to the application, management and processing of state benefits. In particular, to:

    - claim all benefits the person is entitled to;
    - collect all those benefits into a designated account;
    - report any changes in circumstances relating to benefit entitlements;
    - manage and spend benefits in the person's best interests.

41. I am satisfied the role of Corporate Appointee does not confer powers on the Appointee to make legal decisions for a person who lacks mental capacity, or to make any decisions that are non-financial in nature. The role is separate from the Trust's general duty of care towards patients to ensure it meets their health and social care needs. Therefore, the role does not extend to making decisions about a person's healthcare, social care or nursing needs, including assessing where those needs are best met. I am further satisfied the role of Corporate Appointee, as established in the 1987 Regulations, does not extend to applying to the Trust to ask it to consider a person's eligibility for CHC.

42. The issue of CHC in Northern Ireland is complex and vague under the system in place in the 2010 Circular, which impacted greatly on those trying to navigate the system. The position remains uncertain at present, due to the High Court's recent decision to quash the system set in place under the 2021 Circular, and reinstate the previous system. I therefore sympathise with the complainant's position, and the impact this matter has had on her opportunity to settle the resident's estate.

43. However, I am satisfied the Trust did not have responsibility, as Corporate Appointee for the resident, to proactively make a request of itself to determine the resident's eligibility for CHC during the relevant period.

44. I therefore do not uphold this complaint.

45. I note the Trust has accepted the complainant's letter of 16 December 2020 as a request for it to retrospectively consider the resident's eligibility for CHC under the 2010 system. It has undertaken to consider the complainant's request when it is in possession of sufficient guidance to enable it to do so. In light of the High Court's recent Judicial Review decision (discussed above), I expect the Trust to honour this undertaking to the complainant.

CONCLUSION

46. I received a complaint about the Trust, in its role as Corporate Appointee for the resident. In particular, about the Trust's responsibility to request a determination of the resident's eligibility for CHC during the period 9 January 2019 to 6 July 2020.

47. My investigation found the role of Corporate Appointee is limited to the management of social security state benefits. It does not extend to applying for a determination of a person's eligibility for CHC. Therefore, it established the Trust did not have responsibility, as Corporate Appointee for the resident, to proactively make a request of itself to determine the resident's eligibility for CHC during the relevant period.

48. I therefore did not uphold this complaint.

MARGARET KELLY
Ombudsman **2023**

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.