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

Report Reference: 2020001539

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: Northern Health and Social Care Trust

SUMMARY

I received a complaint about community care which the Northern Health and Social Care Trust (the Trust) provided to the complainant's brother (service user) living with Korsakoff's Syndrome[1]. The Trust provided support to the service user over several years, via Self Directed Support[2]. In March 2020, the Trust assessed the service user's mobility and increased his support from one to two carers, to manage the risks to his safety and those caring for him. During the following 18 months, staff made other face-to-face visits to the service user, which the complainant said included further *'walking assessments'*. The complainant said the Occupational Therapy and District Nurse health professional disciplines made face-to-face visits which were unnecessary and caused her brother increased stress and anxiety. The service user felt the Trust was planning to place him in a care home, which he feared having been '*abused'* by staff in a care home previously. The complainant believed the Trust made these further visits to reduce the level of care to that which was previously in place, the assistance-of-one.

In keeping with the service user's wishes, his family had cared for him at home over the long term. This involved significant commitment on the part of family members, including the complainant.

My investigation found that Trust staff made several face-to-face visits with the service user in the 18 months that followed the March 2020 assessment. At the end of that period, a Trust social worker raised concern about the number of visits which she believed were having a detrimental effect on the service user.

Taking account of independent professional advice and available documentary evidence, the investigation found that each visit was conducted for a valid reason and carried out in accordance with the relevant guidance and procedures then in

[1] A memory disorder that causes memory loss and problems managing day-to-day tasks.
[2] A way of providing social care support that empowers individuals to have informed choice about how support is provided to them with a focus on working together to achieve individual outcomes.

place. The investigator found evidence which suggested staff carried out several visits with the service user's consent or in response to a request from the family.

I accepted the service user's previous poor experience in a care home provided a rationale for his expressed anxiety. However, whilst it was unfortunate the service user found the identified face-to-face visits to be stressful, I considered they were necessary to ensure both his own safety and that of his carers.

I did not uphold the complaint.

THE COMPLAINT

1. This complaint was about the community care the Northern Health and Social Care Trust (the Trust) provided to the complainant's brother (service user) between March 2020 and September 2021.

Background

2. The service user was diagnosed with Korsakoff's Syndrome in 2005. From 2007, his mother cared for him at home, following a brief and unsuccessful spell in a care home. The Trust provided a long-term care package via Self Directed Support[3].

3. The service user's mother died in 2013 after which his sister (the complainant) became his main carer. She cared for him in his own home. However, for part of the period of complaint, he moved in with her family while the NIHE carried out renovation works to his own home after it was flooded.

4. On 5 March 2020, the Trust carried out a face-to-face manual handling risk assessment on the service user. The Risk Assessor found the service user was *'unsafe with assistance of one carer'* and *'at risk of falls working with one worker'.* The Risk Assessor recommended **'assistance of 2 for all transfers and personal care tasks.'**

5. On 11 March 2020, two District Nurses carried out a further face-to-face assessment of the service user, including an assessment of his walking. Their report included that, when the service user was walking, he required *'2 carers to assist either side at all times.'* An '*uplift'* to the service user's care package was subsequently arranged which adjusted the financial support from one to two carers.

6. During the following 18 months, Trust staff carried out more face-to-face visits with the service user. The complainant felt the further visits were unnecessary and they caused her brother much stress and anxiety.

[3] A way of providing social care support that empowers individuals to have informed choice about how support is provided to them with a focus on working together to achieve individual outcomes.

Issue of complaint

7. I accepted the following issue of complaint for investigation:
Whether the number of assessments of the service user, between March 2020 and September 2021 were in accordance with relevant guidance and procedures.

8. During phone conversations with the Investigating Officer on 29 August and 5 September 2023, the complainant clarified her concern in relation to this issue. She said that after the two assessments carried out in March 2020 (which she was satisfied were reasonable) the Trust conducted what she considered to be excessive *'walking assessments'*.

9. On 6 September 2023, the complainant provided email confirmation of the assessment dates which she considered excessive:
22 January 2021 – Occupational Therapist (OT)
15 June 2021 – District Nurse
30 June 2021 – District Nurse
7 July 2021 – District Nurse
The investigation therefore focussed on these dates.

INVESTIGATION METHODOLOGY

10. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

11. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):
    - An Occupational Therapist with 7 years' experience of practice, including the psychiatric occupational therapy setting (OT IPA); and
    - A Senior Nurse with 22 years' experience across primary and secondary care (Nurse IPA).

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

12. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs 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

13. 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 Principles of Good Administration, (Appendix one). These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

14. 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 COT's[4] Code of Ethics and Professional Conduct, 2015 (The COT standards);
    - The RCOT's[5] Professional Standards for Occupational Therapy Practice, Conduct and Ethics, 2017 (The RCOT standards);
    - The NMC's[6] Future nurse: Standards of proficiency for registered nurses, May 2018 (The NMC standards);
    - The RCN's[7] Moving and Handling Advice Guide (The RCN guidance); and
    - The HCPC's[8] Standards of Conduct, Performance and Ethics, January 2016 (The HCPC guidance).

    Reference to the standards and guidance is made within the IPA advice

[4] College of Occupational Therapists
[5] Royal College of Occupational Therapists
[6] Nursing and Midwifery Council
[7] Royal College of Nursing
[8] Health and Care Professions Council

enclosed at Appendix two and in the body of this report.

15. I did not include all information obtained during 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 recommendations.

THE INVESTIGATION

Whether the number of assessments of the service user, between March 2020 and September 2021 were in accordance with relevant guidance and procedures.

Detail of Complaint

17. The complainant said in the months after the Trust assessed the service user as needing two carers to walk safely (March 2020) the Trust carried out further face-to-face *'walking assessments'* on him. She became concerned that staff were visiting the service user too often. The complainant considered the number of face-to-face visits made the service user anxious and made him fear that the Trust wished to place him in a care home. The service user had a previous traumatic experience in a care home; the complainant said a member of staff had abused him.

18. The complainant believed that once an assessment had been made (March 2020) a further assessment should not have been necessary unless there was a change in the service user's condition or circumstances. The complainant also believed the Trust carried out further assessments in an attempt to return the service user to the former level of care which the Trust had financed – the assistance-of-one.

19. The complainant provided specific dates where Trust staff had conducted face-to-face *'walking assessments'* on the service user, which she said were excessive (see paragraph 9).

20. The complainant said the service user's human rights had been breached. She referred to an assessment the service user's social worker carried out to support this allegation. That assessment, dated 15 September 2021, included that the assessor felt *'there has been an infringement of his Article 8 Rights*[9]*.'* See Appendix three for the full reference to the alleged infringement.

Evidence Considered

Legislation/Policies/Guidance

21. I considered the following standards and guidance:
    - The COT standards;
    - The RCOT standards;
    - The NMC standards;
    - The RCN guidance; and
    - The HCPC guidance.

Trust's response to investigation enquiries

22. The Trust explained *'ongoing assessment and review are a fundamental element of ensuring service users' needs are appropriately met*.'

23. The Trust said it conducted a review which included the number of face-to-face visits its staff had made to the service user since December 2019. The Trust stated it was satisfied that the number of assessments were *'proportionate and necessary to ensure [the service user's] care needs continue to be appropriately met.'*

24. The Trust denied there had been an infringement of the service user's Article 8 human rights.

Relevant Trust records

25. The investigation considered a table of meetings, assessments and reviews relating to the service user which the Trust compiled. The table covered the

[9] Right to rrespect for private and family life. See Schedule 1 of the Human Rights Act 1998.

period December 2019 to December 2021.

26. The investigation considered OT and District Nurse records relating to face-to-face visits, referred to in the table. These included visits which the complainant said were unnecessary and excessive:
    - 22 January 2021 (OT)
    - 15 June 2021 (District Nurse)
    - 30 June 2021 (District Nurse)

27. The investigation also noted a *'Specialist Assessment Summary'* dated 7 July 2021 which a District Nurse completed.

Relevant Independent Professional Advice

OT IPA

28. Referring to the HCPC guidance, the OT IPA advised there are *'no defined procedures that would place a limit on the number of contacts there should be with a service user.'* However, he also advised that where a service user does not consent to OT input, the OT should *'respect their decision'* and *'withdraw from treatment'.*

29. The OT IPA advised it is not unusual for an OT to *'reassess [a service user's] functional performance'*, particularly a service user *'living with a condition like Korsakoff's Syndrome.'* The OT IPA advised that, where *'expensive home adaptations'* are involved, it is *'not uncommon'* for further OT assessments *'over a period of time to get a true picture of occupational performance.'*

30. The OT IPA advised *'the case notes make no mention that the client was distressed during [the OT] interventions, nor were there concerns raised about other professionals involved in the case.'*

31. The OT IPA found evidence of consent being sought before the OT visited the service user, for example, the visit that occurred on 22 January 2021. The OT IPA advised this was consistent with the COTS standards that address the

issue of consent.

32. The OT IPA advised that the evidence of OT involvement for the period under review, does not appear to justify the subsequent comments relating to an Article 8 human rights infringement which was recorded in the Trust's assessment dated 15 September 2021.

Nurse IPA

33. The Nurse IPA advised the patient was *'unable to use walking aids'* due to a '*loss of sensation in both feet (neuropathy) and damage to his right shoulder which increased the risk of dislocation'.*

34. The Nurse IPA advised that two face-to-face clinical interventions with the service user (10 and 19 August 2020) regarding his blood pressure were *'appropriate and in line with national standards and guidance'.* The first visit related to support for diabetes control. The second visit was a response to a GP request *'due to low blood pressure'.*

35. The Nurse IPA advised the District Nurse visit that took place on 15 June 2021 was a *'routine annual moving and handling assessment'*. The Nurse IPA advised these are necessary *'to ensure that the patient's carers continue to receive the training and support needed for safe manual handling.'*

36. Referring to the Trust's written records, the Nurse IPA advised that the district nurse visit that took place on 30 June 2021 was arranged because there were *'concerns that the patient may need three carers at times, which was not recommended within the annual assessment conducted on 15 June 2021.'*

37. The Nurse IPA did not agree with the 15 September 2021 recorded comments concerning the alleged infringement of the service user's Article 8 human rights.

Other information considered

38. The Trust offered no comments on the draft investigation report.

39. The complainant said a visiting senior Trust official caused the service user stress resulting in the service user needing to attend hospital. The records indicate the visit occurred on 21 November 2021, which falls outside the period under investigation.

40. The complainant disagreed with the OT IPA advice that OT visits were reasonable and conducted in accordance with the guidance and standards that govern OT therapists. Referring to a visit not listed in paragraph 9, and therefore one which fell outside the scope of the investigation, the complainant said an OT verbally attacked her in front of the service user and third-party witnesses.[10]

41. The complainant noted that the OT IPA and the Nurse IPA advised they found no evidence to substantiate the alleged human rights infringement. The complaint considered NIPSO did not receive all records from the Trust. Referring to paragraph 37 of the draft report, the complainant claimed the Nurse IPA did not agree with the social worker's analysis because *'notes were withheld from the file'.*

42. Referring to paragraph 35 of the draft report, and therefore to the District Nurse visit that took place on 15 June 2021, the complainant said *'no nurse'* had shown the family how to '*walk'* the service user.

43. The complainant reiterated her view that the home visit which Trust staff made on 30 June 2021 was unnecessary; staff should have relied on information gleaned from the home visit that occurred two weeks previously.

44. In relation to the OT visit on the 22 January 2021, the complainant said that, contrary to Trust policy, only one OT visited the service user to carry out a walking assessment.

Analysis and Findings

45. The service user's family had cared for him at home over the long term. This

[10] Although my investigation did not include this issue, the Investigating Officer subsequently raised it with the Trust. I was pleased to note the Trust offered to provide a written apology to the complainant. I consider this was a reasonable outcome.

involved significant commitment on the part of family members, including the complainant. The service user's complex health care needs meant he needed considerable support with the various activities of daily living. I note and accept the Nurse IPA advice that the nature of his condition meant he was unable to safely use walking aids and instead relied on the assistance of carers when mobilising.

46. The complainant agreed that assessment was a necessary part of the care process for her brother. However she believed that, once assessed as requiring the assistance of two people in March 2020, her brother should not have been subject to further face-to-face walking assessments from Trust staff, unless he experienced a change in his circumstances or condition. The complainant said assessments prior to March 2020 had been uncommon and she expressed concern that '*excessive'* face-to-face visits caused her brother to feel anxious and unsettled him for days afterwards.

47. Against this, both the OT IPA and the Nurse IPA have given categorical advice, independent of the parties and independent of each other. Their advice raised no issue with the various contacts that were made with the service user during the period in question. Both advised that, with Korsakoff's Syndrome, assessment is a necessary part of the care regime to monitor the service user's needs and those of his carers. Each adviser examined the Trust's documentary record of face-to-face visits to the service user during the period of complaint and found the visits to be reasonable, including the specific visits highlighted by the complainant.

OT visits

48. As indicated, the OT IPA advice did not raise an issue with any OT visit that was made with the service user between March 2020 and September 2021. The OT IPA advised the visits were reasonable and in accordance with the guidance and standards that govern OT therapists. The report is attached in full at Appendix two.

22 January 2021 visit

49. The complainant said the OT's face-to-face visit included a walking assessment which was not necessary. The visit related to a proposed housing extension; a representative from the NIHE was in attendance. The complainant said it was unnecessary for the OT to do a walking assessment because the one carried out in March 2020, 10 months earlier, was still valid. The complainant said nothing had changed since then and therefore a new assessment was not needed. The complainant said that Trust staff confirmed this general point in a more recent care management review conducted in June 2023.

50. The OT IPA advised that, on 22 January 2021, the service user was living with his sister (the complainant) because his *'bungalow is flooded'*. A functional assessment was carried out to *'ascertain occupational performance in this environment'.* The OT IPA advised the visit was also linked to proposed *'large scale adaptations'* to the service user's own property, in terms of enabling safe access. The OT IPA advised that consent was obtained for the visit and its purpose was discussed. The case notes state the OT phoned the service user's sister (the complainant) to *'inform'* her of the visit. The notes also state *'consent gained for input'*. The OT IPA advised this was consistent with the COTs Standards; paragraph 3.3.2 states that '*Service users with capacity should be given sufficient information, in an appropriate manner, to enable them to give consent to any proposed intervention/s concerning them.'*

51. I note from the Trust's records that two OTs attended on that occasion. In the absence of relevant independent evidence, I am unable to consider the complainant's assertion that there was only one OT in attendance.

52. I consider the service user's temporary change of dwelling and the proposed adaptations to his usual dwelling appear to explain the reason for the OT visit. There is no indication that the visit was a cause of distress to the service user on that occasion. In light of the OT IPA advice, I consider that on balance the OT visit on 22 January 2021 was reasonable.

District nurse visits

53. The Nurse IPA examined records relating to face-to-face visits with the service user, including visits at the GP's request to check blood pressure and blood sugar. The IPA advised *'all visits by district nurses were appropriate to support routine monitoring of chronic conditions (diabetes, low blood pressure) and to ensure the safety of the patient and his carers during the provision of care.'*

54. I acknowledge the complainant was satisfied that some District Nurse (and OT) face-to-face visits were appropriate. Those District Nurse visits that the complainant disagreed with are considered below.

15 June 2021 visit

55. The Nurse IPA advised the district nurses visited the service user on 15 June 2021 *'to conduct their annual moving and handling assessment.'* Since the previous District Nurse assessment had taken place in March 2020, 15 months earlier, I accept this visit was an annual review. The Nurse IPA advised that, given his condition and his associated needs, it is likely the service user would need *'at least annual moving and handling risk assessments.'* I acknowledge that this would have included a mobility or '*walking'* assessment'.

56. The advisor referred to the RCN guidance which states that '*risk assessments must be reviewed periodically or when circumstances change to ensure they remain current.'* I consider this guidance corroborates the complainant's assertion that assessment is necessary when there has been a change in circumstances. However, it also clarifies that periodical assessment is a reasonable aspect of good practice. Taking account of the Nurse IPA advice, which I accept, I consider the annual review conducted fits comfortably with what might be expected to ensure the needs of the service user and those caring for him were adequately reviewed. I have found no independent information which would either confirm or refute the complainant's remarks that *'no nurse'* had shown the family how to '*walk'* the service user (see paragraph 42).

57. Referring to the NMC code, the Nurse IPA advised that practitioners must work

in partnership with service users and *'recognise when people are anxious or in distress'*. I accept this advice. I consider this is relevant to the complainant's claim that this visit, and the others highlighted, were a source of distress for the service user. I do not doubt the complainant's claim that the service user experienced stress because of this visit. However, the Trust's record does not indicate the service user exhibited distress during this visit.

30 June 2021 visit

58. The Nurse IPA advised, according to the Trust's records, the District Nurse visit that occurred on 30 June 2021 was arranged to address a query the service user's family (the complainant) raised in relation to a third carer being required on occasion. The records are clear that staff arranged the visit specifically to address this query.

59. During the investigation, the complainant clarified that, at a meeting with the Trust dated 21 June 2021, she sought advice on whether she should inform the insurance company[11] that the service user had two or three carers. The complainant said the March 2020 assessment had acknowledged the service user needed three carers on occasion, for example when he was particularly tired.

60. The Trust record indicates the Trust responded to this enquiry by arranging the 30 June visit. The record includes that staff arranged with the complainant, by telephone, that a visit at 15:00 on 30 June would facilitate an attempt by staff to discern whether there may be a need for a third carer at times.

61. Whilst this appears to be a straightforward response to a query that had been raised, I note the complainant was clear she *'did not request any walking assessments'*. I appreciate the visit occurred several days after an annual review had taken place. However, the Trust's record indicates the reason for the visit and the arrangements made by all parties, including the complainant, to enable staff to address the query she had raised.

[11] Insurance rrequired as part of the SDS process.

62. The Nurse IPA advised that this visit was in line with patient safety and in line with national guidance. I accept this advice. I also note the record of the decision in March 2020, that the service user needed the assistance of two to mobilise, did not refer to the possibility of a third carer on occasion if the service user was tired. That being so and taking account of the Nurse IPA's advice regarding safety, I am satisfied an attempt to determine the service user's needs at a time of day when he was more likely to be tired, was a reasonable and safer approach to take. According to the Trust's records, the best time to visit was agreed with the complainant to be 15:00 on 30 June 2021.

63. As with my findings in relation to the visit conducted on 15 June 2021, the Trust's record does not indicate the service user experienced distress during the 30 June visit attributed to the actions or behaviour of the staff in attendance.

7 July 2021 Specialist Assessment Summary

64. The Nurse IPA advised the record dated 7 July 2021 did not relate to a face-to-face visit with the service user. This corresponds with the complainant's subsequent confirmation that no face-to-face walking assessment was conducted on that occasion. I have therefore not included this date in my analysis.

65. Taking account of the independent professional advice I received, and the related guidance, I am satisfied the visits which the complainant highlighted were reasonable and carried out in accordance with the relevant guidance. I therefore do not uphold the issue of complaint.

66. The complainant said Trust staff requested '*more walking assessments'.* There is evidence that further *'Specialist Dementia OT and physio assessment'* were recommended. However, according to the record, these did not take place. Since there is no evidence that further face-to-face assessment occurred during this period, I do not consider it necessary to address this matter.

Human rights

67. The complainant referenced the alleged infringement of the service user's human rights which the social worker's documented record supported, dated 15 September 2021. That documentary record forms a part of the service user's care history and has significance as an official Trust record. However, it is not my role to adjudicate on whether there has been a breach of human rights. That is a matter for the courts.

68. Nevertheless, I would expect a listed authority to have regard to a service user's human rights. In acknowledging that *'some people need help to enjoy their right to a private life'* the Nurse IPA advised *'risk assessments ensure that care is proportionate and meets the [service user's] needs in the least restrictive way.'* With that in mind, I consider a balance must be struck between the management of risks to a service user (and their carers) in the community and interference with their privacy. On the basis of the records made available to me, and the professional independent advice I obtained, I am satisfied the balance was appropriate in this case. In the absence of independent evidence which supports the complainant's assertion that the Trust did not provide all relevant records to NIPSO, I am unable to consider this matter further.

69. I acknowledge public bodies should be vigilant to ensure they meet the needs of vulnerable people, especially when their vulnerability may make it more difficult for them to articulate and express concerns. I have indicated in this report that I am satisfied the identified Trust visits were appropriate and were undertaken in accordance with the relevant guidance and procedures.

CONCLUSION

70. I received a complaint about the number of assessments carried out on a service user between March 2020 and September 2021. From my investigation, I was satisfied the Trust's visits where necessary to assess the service user's needs and to maintain the safety of both the service user and those caring for him.

71. I acknowledge the commitment made by the complainant and the wider family to ensure the service user was appropriately supported to enable him to live in the community, which was his preference.

MARGARET KELLY
Ombudsman

April 2024

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.