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

Report Reference:

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

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.

TABLE OF CONTENTS

Page

Case Reference: 202004159

Listed Authority: Western Health and Social Care Trust

SUMMARY

I received a complaint about how the Western Health and Social Care Trust (the Trust) communicated with the complainant during a Serious Adverse Incident (SAI) investigation.

My investigation found the Trust failed to:

- carry out its SAI investigation within an appropriate timescale;
- update the complainant about the progress of the SAI investigation appropriately;
- provide minutes of the SAI meeting in a timely manner;
- provide the complainant with nursing statements, or if this was not appropriate, failed to tell the complainant it could no longer provide them and the reason for this.
- communicate appropriately with the complainant about next steps in the process once it issued the draft SAI report and failed to establish whether she wished to provide any further comments; and
- respond to the complainant's response to the draft SAI and give her the opportunity to have those comments discussed or considered.

I concluded that these failures constituted maladministration and therefore I upheld the complaint.

I recommended that the Trust provides the complainant and her family with a written apology because of the failings I identified. I also made further recommendations to the Trust for service improvement and to prevent future recurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about how the Western Health and Social Care Trust (the Trust) communicated with the complainant during a Serious Adverse Incident (SAI)[1] investigation. The SAI was about care and treatment the Trust provided to the complainant's late husband (the patient).

Background

2. From 2019, the patient suffered from back pain and falls with decreased mobility. Clinicians also diagnosed the patient with cirrhosis of the liver[2] in 2019. On 22 April 2020, the patient attended the Emergency Department of the South West Acute Hospital (the Hospital) with back pain following a fall. Clinicians admitted the patient for treatment. Both Physiotherapy and Occupational therapy worked with the patient on his mobility. The Substance Misuse Liaison[3] team also saw the patient and commenced him on a sliding scale detoxification regime[4], which he completed on 24 April 2020. Clinicians subsequently considered the patient medically fit for discharge on 28 April 2020. However, to enable discharge, the patient required an enhanced home care package.

3. While the Trust sourced an enhanced home care package, clinicians investigated a possible diagnosis of Korsakoff syndrome[5] with the patient experiencing confusion and agitation. The patient also suffered a further fall on 19 May 2020. Throughout the day on 31 May 2020, the patient deteriorated, experiencing temperature spikes, increased heart rate, decreased oxygen levels and displayed signs of septic shock. The patient continued to deteriorate and sadly passed away on 1 June 2020.

4. On 16 September 2020, following the patient's death, the complainant and her daughters submitted a complaint to the Trust about the care the patient

[1]An incident or event that must be reported to the Department of Health's Strategic Planning and Performance Group. Such incidents and can include a clinical incident resulting in serious harm, and unexpected or unexplained death.
[2]Cirrhosis is the result of long-term, continuous damage to the liver and may be due to many different causes. The damage leads to scarring, known as fibrosis
[3] This team works together to ensure patient centred care with individualised and holistic care plans to support an individual's recovery goals.
[4] Helps to achieve safe discontinuation from a substance of dependence.
[5]A chronic memory disorder caused by severe deficiency of thiamine (vitamin B-1). Korsakoff syndrome is most commonly caused by alcohol misuse, but certain other conditions also can cause the syndrome.

received whilst an inpatient at the Hospital. The complainant and her daughters provided their accounts of events, and each set out questions for the Trust. On 18 May 2021, the Trust responded to the complainant. The complainant provided two further letters in response to the Trust and subsequently met with the Assistant Director of Nursing (ADN) and the Divisional Clinical Director (DCD) (the SAI team) on 15 October 2021. On 18 October 2021, the Trust advised the complainant the complaints process had now concluded, and it would carry out a SAI investigation.

5. I enclose a chronology detailing the complaints and SAI processes at Appendix four to this report.

Issue of complaint

6. I accepted the following issue of complaint for investigation:

Whether the Trust communicated with the complainant regarding its Serious Adverse Incident investigation appropriately and in accordance with relevant guidance.

INVESTIGATION METHODOLOGY

7. 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 and Guidance

8. 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 Principles[6]:

- The Principles of Good Administration

9. 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 of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The Health and Social Care Board's[7] Procedure for the reporting and follow up of serious adverse incidents, November 2016 (HSCB SAI Procedure);
   - The Western Health and Social Care Trust's Adverse Incident Policy, June 2021 (Trust AI Policy); and
   - The Western Health and Social Care Trust's Serious Adverse Incident Information leaflet for patients, clients, families and/or carers[8] (Trust information leaflet).

10. 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.

11. 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 Trust communicated with the complainant regarding its Serious Adverse Incident investigation appropriately and in accordance with relevant guidance.

[6] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[7] The HSCB closed on 31 March 2022 and responsibility for its functions transferred to the Department of Health. All references to HSCB in this report should be read in this context
[8] As provide to the complainant on 18 October 2021

Detail of Complaint

12. The complainant raised the following concerns about the Trust's SAI process:

- She and her family *'…patiently waited for two and a half years[9] for answers…*' about the patient's care.
- The Trust addressed only some questions raised by the family during the SAI process, with other questions being *'…completely dismissed…*'
- The draft SAI report the Trust issued, in parts, was *'…factually incorrect…'* and some of the key issues she and her family raised *'…were not mentioned…'*
- The Trust did not reply to her response to the draft SAI report or to her follow-up letter.

The complainant said she and her family have been unable to grieve properly because of the unanswered questions. The complainant clearly articulated her desire to have those unanswered questions fully addressed by the Trust and to receive crucial information relating to the patient's care and treatment.

Evidence Considered

Policies/Guidance

13. I considered the following policies/guidance:

- The HSCB SAI Procedure;
- The Trust AI Policy; and
- The Trust Information Leaflet.

I enclose relevant sections of the guidance considered at Appendix two to this report.

Trust's response to investigation enquiries

14. I asked the Trust if it considered it had responded fully to the complainant's outstanding points, detailed in her letter of 25 March 2022. It stated that it *'…fully reviewed the care delivered to the late [patient] and provided an SAI*

[9] At time of making complaint to NIPSO

report for the family's consideration…' In relation to the provision of the nursing statements to the complainant, the Trust said the Ward 8 nursing team put together a *'…nursing timeline…which was provided to [the complainant].'*

15. The Trust stated it sent a final draft of the SAI report to the Strategic Planning and Performance Group[10] (SPPG) on 7 July 2022 *'…as there was no response from the family at that time.'* It explained the process of sharing of a SAI report with families included sending a supporting letter that offered *'…the recipient the opportunity to respond'.* It provided this letter to the complainant, given the *'fluid line of communications with [the complainant] throughout the review process'.* The Trust anticipated that the complainant would communicate directly with it if there were any further concerns to raise. It shared the report with SPPG on that basis. Should the Trust consequently receive comments from the family, *'…which on consideration/discussion should be included in the report, then the report will be amended and resubmitted to the SPPG'.*

16. I also asked the Trust if it informed the complainant that it sent a final draft of the SAI report to SPPG or that the SAI process had concluded. It said its information leaflet states it *'…shares report with the SPPG as part of the process to improve quality and to share learning.'*

17. The Trust confirmed it received the complainant's letter dated 24 August 2022 on 8 September 202 as it had mistakenly been redirected to the South West Acute Hospital. Upon receipt of the letter, the Trust started to draft its response. It has a *'partially completed'* draft response on file dated 11 September 2022. It also stated the complainant sent an email, dated 26 September 2022 to the SAI Chair requesting responses to the concerns raised and requesting a further meeting with the family. The Trust wished to '*…apologise for the delay in providing a response…'*

18. The Trust stated that if the information provided to date *'…still leaves elements unanswered for the family, it would request it is afforded a further opportunity to*

[10] The Group is part of the Department of Health and is accountable to the Minister for Health. It is responsible for planning, improving and overseeing the delivery of effective, high quality, safe health and social care services within available resources.

address the concerns (once detailed) in order to help a provide a final comprehensive response.'

Relevant Trust and Complainant records

19. I completed a review of the relevant records. I include relevant extracts from the records at Appendix three to this report.

Complainant's response to draft report

20. The complainant welcomed the recommendations made within the draft report.

Trust's response to draft report

21. The Trust had no comments to provide in relation to the draft report.

Analysis and Findings

SAI process timescales and provision of requested information

i. Timescales

22. The records evidence the Trust notified the complainant, in writing, on 18 May 2021 that the patient's case was *'elevated as a serious adverse incident…'*. This was as part of its response to the complaint originally submitted on 16 September 2020. The Trust hosted a SAI meeting with the complainant on 15 October 2021. It appointed a Liaison Officer to keep the complainant updated and '…*gave a timeframe of 12 weeks as the SAI was already in progress…'*

23. The complainant received the minutes of this SAI meeting on 1 February 2022, just over 15 weeks after it occurred. The complainant received the draft SAI report on 31 May 2022. This was over one year from when the Trust notified the complainant of its decision to commence an SAI investigation and 31 weeks after the SAI meeting. Given the assurance the process would take 12 weeks from the date of the meeting, I consider this delay significant and unacceptable. This is especially as the Trust had already carried out an investigation and provided a response to the complainant's original complaint submitted on 16 September 2020.

24. The Trust's Information Leaflet states SAI investigations *'…will take between 4 to 12 weeks…'* and if the Trust requires more time, it will keep service users *'…informed of the reasons.'* The Trust's *'link person'* will ensure service users *'…are updated and advised if there are any delays…'* Its AI Policy also states *'…Our 'Being Open' policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment…'*

25. I appreciate it may not always be possible for Health Trusts to complete such investigations within the timescale provided. However, as outlined in its leaflet and policy, I would have expected the Trust to notify the complainant of the delay and the reasons for it. I am disappointed to note the Trust did not provide any update to the complainant on the progress of its investigation before the end of the 12 week period. I am further disappointed that it was the complainant who had to instigate communication with the Trust, after the 12 week deadline had passed, to establish how the SAI investigation was progressing.

26. On 17 January 2022 the Trust told the complainant the delay was *'…due to staff shortages & sickness due to covid...'* I also note the Trust's Liaison Officer contacted the complainant on 8 March 2022 and told her the DCD advised the SAI report would be ready on 15 March 2022. She further explained that the additional delays were *'due to the pressures of work…'* and she would ring again on 11 March 2022. I note the complainant, on 25 March 2022, wrote to the Trust's Chief Executive about the delays in the process as she was unable to reach the Liaison Officer after the 11 and 15 March 2022 deadlines had passed.

27. The ADN provided the complainant with an update on 12 April 2022. She stated the Liaison Officer was absent from work, and she would now be the point of contact. I note the ADN said she would update the complainant on 3 May 2022, which she did. She also said the Trust hoped to issue the draft report week commencing 30 May 2022. It met this target and issued the draft report on 31 May 2022.

28. Based on the available evidence, I consider the Trust failed to carry out its SAI investigation within the timescales set out in the Trust's Information Leaflet and of those given to the complainant (12 weeks from 15 October 2021). I acknowledge the Trust's reasons for the delay it provided to the complainant and, appreciate it was under significant pressure at that time. However, I am disappointed it did not take this into consideration when it set the complainant's expectations and agreed timescales passed without action or contact.

29. I note the HSCB SAI Procedure, nor the Trust's AI policy or Information Leaflet, provide guidance on how regularly it should keep service users updated during an SAI investigation or how it should provide minutes after meetings. However, given the Trust provided the complainant with a timeframe of 12 weeks for completion of the SAI process, I find it worrying the complainant had to contact the Trust to seek an update. Clearly the Trust failed to update the complainant about the progress of the SAI investigation appropriately or provide minutes of the SAI meeting in a timely manner. I do not consider this in line with the Trust's 'Being Open' commitment outlined in its AI Policy. However, I wish to note that from the point the ADN offered herself as the point of contact, the Trust provided updates as agreed with the complainant.

30. I will further consider the failures and injustice identified later in this report.

ii. Provision of requested information

31. The records evidence that at the SAI meeting on 15 October 2021, one of the complainant's daughters enquired whether all staff members involved in the patient's care would provide statements. The Trust told her '…*the team reviewing [the patient's] timeline would choose which staff were best placed to provide a statement on the delivery of [the patient's] care...'* However, on 17 January 2022, the DCD verbally told the complainant she had statements from the nurses involved and she would receive copies *'…within a couple of weeks...'*

32. The Trust provided a nursing timeline for the patient's admission on 1 February 2022. The Liaison Officer, during their telephone call on 8 March 2022, told the complainant she would chase up the nurses' statements which the complainant had not received.

33. The Trust said it provided the timeline in response to the complainant's request. I accept it did so. However, it is clear the complainant expected something other than a timeline of the care provided to the patient. That being, a more personal written record stating what the relevant nurses saw and did. I consider this a reasonable expectation given the minutes of the SAI meeting and the complainant's conversations with the DCD and Liaison Officer on 17 January 2022 and 8 March 2022 respectively where she clearly conveyed her request.

34. Given the available evidence, I consider the Trust failed to provide the complainant with nursing statements, or if this was not appropriate, failed to tell the complainant it could no longer provide them and the reason for this.

35. As agreed at the SAI meeting, the complainant and her family submitted, on 26 October 2021, a table of 33 points for the Trust to address under the headings of Sepsis, SAI, Locum Consultant Care, End of Life Care, DNAR and Communication. On 1 February 2022, the Trust provided answers to the 33 points. The complainant responded on 25 March 2022 with 12 points that *'…still need to be addressed…'*

36. I note on 3 May 2022, the ADN verbally told the complainant she had '…*all the information & answers to questions*…' with a hard copy of the SAI report ready to issue in the week beginning 30 May 2022. I also note the Trust's comments that in respect of the complainant's outstanding points in her letter, dated 25 March 2022, it had *'…fully reviewed the care delivered to the late [patient] and provided an SAI report for the family's consideration.*

37. The complainant informed the Trust of her unanswered points as the Trust was drafting the SAI report. Therefore, I accept it would be reasonable for the Trust

address them within the report rather than prolonging the process any further. However, I consider it would have been appropriate for the Trust to clearly inform the complainant of this approach, perhaps in its covering letter with the draft SAI report and explain to her what the next steps of the process would be should she still have any outstanding concerns. I will address the actions of the Trust following the issuing of the draft SAI report in paragraphs 38 to 45 below.

Actions following the issuing of draft SAI report

38. The HSCB SAI Procedure states that for a Level 1 review[11], the reporting organisation, that being the Trust, will submit a SEA Learning Summary report within eight weeks of SAI notification. When the Trust shares the findings of the review and report, the *'…service user/family should be assured that lines of communication will be kept open should further questions arise at a later stage…'* The HSCB SAI procedure also provides strategies the Trust may use when service users remain dissatisfied with the information provided within a SAI report. This includes, *'…Facilitate discussion as soon as possible; Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues…'*

39. The Trust Information Leaflet states once an investigation is complete, the Trust '…*will seek to share the investigation findings with [the service user]. This will be done in a way that meets [the service user's] needs and can include a meeting facilitated by Trust staff…'* The Trust '…*may share the anonymised content of the SAI report with other Health & Social Care organisations.'*

40. The records evidence the Liaison Officer, on 18 January 2022, told the complainant, via telephone, that after the Trust issues the report *'…Then there will be another meeting.'* The Trust's letter to the complainant on 31 May 2022 enclosed the '…*draft report as previously discussed…'* and offered the complainant and her family an opportunity to discuss it further should she wish. I note the complainant responded to the Trust on 24 August 2022, setting out several queries and comments. She also outlined her belief that some parts of

[11] This is level of review (a Significant Event Audit) the Trust completed in relation to the patient's care.

the report were '*factually incorrect',* and stated she still had unanswered questions. The complainant did not receive a reply to this letter. She wrote again, on 1 February 2023, to the Trust's Chief Executive advising she had not received a response.

41. I note the Trust's covering letter with the draft SAI offered the complainant the opportunity to respond to the draft report. It sent the final report to the SPPG on 7 July 2022 only six weeks later *'…as there was no response from the family at that time…'* and it was '…*anticipated that, if there were any further concerns to raise, that [the complainant] would communicate directly with the Trust…'*

42. I note the body of the HSCB SAI Procedure and Trust Information Leaflet do not require the Trust to provide a draft report to service users prior to reporting any final outcomes to SPPG. Rather, it requires the Trust to share the findings of its review/report with the complainant. The records evidence the Liaison Officer, on 18 January 2022, told the complainant, via telephone, that after the Trust issues the report *'…there will be another meeting.'* The Trust's letter to the complainant, on 31 May 2022, enclosed the '…*draft report as previously discussed…'* and offered the complainant and her family an opportunity to discuss it further, should she wish. The Trust did not provide a date for the complainant to submit a response by. Given the Trust's letter of 31 May 2022 references the word *'draft'* and the previous commitment of the Liaison Officer that there would be a meeting after the complainant received the report, I consider it would be reasonable for the complainant to have the expectation she had received a preliminary version of the report which after discussion and consideration the Trust may have amended.

43. In its response to my office, the Trust said its leaflet advises service users it shares the report with public bodies. However, the leaflet does not tell services users when it will share the report. The complainant did not have any deadline for response. I note the reporting timescales in the HSCB SAI Procedure. Notwithstanding these timescales or the time taken by the complainant to respond, I consider, given the complainant's engagement in the SAI process, (and indeed during the previous complaint process), it would not have been

unreasonable for the Trust to anticipate the complainant would wish to make comment on the draft SAI report and to contact her prior to sending the report to the SPPG. Therefore, I consider the Trust failed to communicate appropriately with the complainant about the next steps in the process once it had issued the draft SAI and failed to establish whether she wished to provide any further comments.

44. I note the strategies, at paragraph 38 above, within the HSCB SAI Procedure, that the Trust may use when a service user remains dissatisfied with the content of a report. I consider the complainant did clearly set out her comments about the draft SAI report on 24 August 2022 and the Trust failed to respond to her and give her the opportunity to have those comments discussed or considered. The Trust stated it partially completed a draft response to the complainant's letter of 24 August 2022 and apologised for the delay in providing a response. I consider it is wholly unacceptable the Trust has yet to date provide the complainant with any communication about her letter of 24 August 2022 over two and half years later.

45. I welcome the Trust's comments that if there are still '…*elements unanswered for the family… it would request it is afforded a further opportunity to address the concerns (once detailed) in order to help a provide a final comprehensive response.'* In her complaint to my office and during discussions with my staff, I note the complainant does want the opportunity to meet with the Trust and have her concerns fully addressed. I acknowledge that after such a meeting the complainant may not receive answers to all her outstanding queries but, it is important the Trust identify those issues it cannot provide a fulsome response and explain fully why this is to the complainant and her family. I am also clear that if, after meeting with the Trust the complainant remains dissatisfied with aspects of the care and treatment provided to her late husband, it is open to her to bring those to concerns to my office for investigation.

Summary

46. I refer to my findings at paragraphs 28, 29, 34, 43 and 44. I consider the Trust did not act in accordance with the second, third and fourth Principles of Good

Administration. The Second Principle, '*Being Customer focused*' requires public bodies to keep to its commitments, including any published service standards and to deal with people helpfully, promptly and sensitively, bearing in mind their individual circumstances. It also requires such bodies to inform customers what they can expect and what the public body expects of them. The Third Principle *'Being open and accountable'* requires bodies to be open and clear about policies and procedures and ensure that information, and any advice provided, is clear, accurate and complete. The Fourth Principle '*Acting fairly and proportionately'* requires bodies to treat people are with impartially, respect and courtesy.

47. As a result, I consider the failings identified constitute maladministration and uphold this complaint.

Injustice

48. I considered whether the maladministration caused injustice to the complainant and indeed her family. I consider the complainant, and her family, sustained the injustice of frustration and uncertainty because of delays during the SAI process, the lack of timely updates and, lack of response to requested information and communications from the complainant. I am also satisfied the complainant and her family sustained the injustice of additional time and trouble in bringing their complaint to this office. I further consider they experienced the loss of opportunity to; obtain closure on outstanding issues and to fully grieve the death of the patient as they spent time engaging with the Trust. I fully appreciate how the protracted and incomplete SAI process has undermined the complainant's trust and confidence in Trust going forward.

CONCLUSION

49. I received a complaint about how the Trust communicated with the complainant during a SAI investigation. I upheld the complaint for the reasons outlined in this report. I consider these failures constitute maladministration.

50. I recognise the injustice caused to the complainant and her family, as outlined in paragraph 48, as result of the failures identified.

51. I offer through this report my condolences to the complainant and her family for the loss of her husband and father. I consider it an indication of the love and commitment shown by the family, to him, that the complainant made the decision to continue to pursue this matter and to seek a resolution to her concerns. I would remind the complainant that it is open to her to return to my office, should she have concerns about her late husband's care and treatment at the conclusion of the process.

Recommendations

52. I recommend the Trust 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).

53. I also recommend the Trust:

    i. Organises a meeting with the complainant, with appropriate personnel, to establish and reach an agreement as to what points within the draft SAI report and in relation to the patient's care the complainant wishes the Trust to consider and provide responses on. I propose the complainant's response to the draft SAI report dated 24 August 2022 is used for the basis of these discussions. This meeting should be arranged as a matter of urgency and no later than one month from the date of the final report of this investigation.

    ii. Following its consideration/review of the complainant's concerns about the patient's care and treatment and outstanding issues the Trust, should ensure it has fully and clearly responded to each one, either in the SAI report or in a separate letter. Should the Trust be unable to provide any further information to address any identified concern, it should provide a full explanation as to why.

iii. Informs the complainant of amendments it will make to the draft SAI report, if any, and provides a copy of the updated report to both the complainant and the SPPG if necessary.

iv. Provides the complainant with the nursing statements or provides an explanation as to why it is not able to so.

54. I further recommend for service improvement and to prevent future recurrence the Trust:

i. Undertakes a review and updates as necessary Trust procedures for updating service users during the SAI investigations process to ensure the provision of timely and informative updates. This should also a include mechanisms for updating service users should Liaison officer or other relevant Trust staff go on leave. Provide evidence that this review has been completed and updates made as necessary.

55. I recommend the Trust 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 Trust 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).

56. I was concerned to note that during the investigation process, the Trust took several months to respond to my Office's enquiries. This caused a significant delay to the investigation process. I found its engagement with my Office both concerning and unacceptable. While I appreciate all Health Trusts remain under considerable pressure, I have a responsibility to consider the complainant and progress my investigation in a timely manner. This is to the benefit of all parties involved. I would ask the Trust to consider this in future when responding to enquiries from this Office.

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.