# Investigation of a complaint against the South Eastern Health and Social Care Trust

**Report Reference: 202000683**

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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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**Case Reference: 202000683**

**Listed Authority: South Eastern Health & Social Care Trust**

## SUMMARY

I received a complaint about the actions of the South Eastern Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her in respect of a cyst in her jaw, which was identified in 2010 and operated on in 2010 and 2011. Scans taken in 2016 and 2017 showed the presence of a radiolucent area which the Trust said was consistent with the appearance of a treated and healed cyst. The Trust did not review the patient in 2018 and a CT scan taken in 2019 found the presence of a large cyst in the complainant's jaw. The complainant believed that the Trust failed to properly monitor her condition and could have identified the recurrence an earlier stage. She believed that if the Trust had identified the recurrence of the cyst in a timely manner she would not have had to undergo a painful and uncomfortable procedure to drain it.

The investigation examined the details of the complaint, the Trust's response and relevant guidance. I also obtained independent professional advice from a Consultant Oral & Maxillofacial Surgeon.

The investigation established that the Trust's decision to adopt a 'watch and wait' approach to monitoring the cyst in 2016 and 2017 was reasonable. However, it found that the Trust failed to inform the complainant of the exact nature of the cyst in March 2016. I concluded that this failure did not lead to an injustice for the complainant as the Trust subsequently informed her in December 2016 of the possible recurrence of the cyst. The investigation was unable to conclude that the missed review of 2018 affected the complainant's eventual outcome, however it found that the Trust's failure to carry out the review caused the complainant to experience the injustice of a loss of opportunity to have her cyst reviewed and the uncertainty of not knowing if a painful procedure could have been avoided.

The investigation also established failings in the Trust's handling of the complaint.

I am satisfied that the maladministration I identified caused the complainant to experience frustration and uncertainty and the time and trouble of bringing a complaint to this office

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the maladministration I identified. I also recommended service improvements in relation to appointment booking and complaint handling.

## THE COMPLAINT

1. The complainant raised concerns about the actions of the South Eastern Health and Social Care Trust (the Trust). The complainant believed that the Trust failed to monitor a cyst in her jaw, which resulted in her having to undergo an unnecessary and painful procedure to drain the cyst.

### Background

2. An x-ray of the patient's jaw taken in July 2010 showed the presence of a large odontogenic keratocyst[1]. Surgeons drained the cyst in August 2010 and excised it in May 2011. The Trust reviewed the patient annually between 2011 and 2016 as keratocysts have a high risk of recurrence.

3. In February 2016, the patient had a CT[2] scan as part of her annual review. The scan results showed '*a well-defined cyst identified within the left side of the ramus[3] of the mandible[4]*' the appearance of which was '*consistent with a treated and healed keratocyst*.' The complainant said that a member of staff contacted her following the CT scan and told her that her jaw was healing well and that no further action would be required beyond standard monitoring.

4. The complainant said that she attended an annual review in March 2017 following a CT scan in January 2017. She said that the reviewing clinician did not inform her of any concerns. The Trust was due review the complainant again in March 2018. The Trust cancelled the review due to pressures on the service and eventually reviewed the complainant again in June 2019.

5. A CT scan from 2019 showed that the site previously identified as a treated and healed keratocyst had grown in size and would require drainage and excision. Surgeons inserted a drainage tube in the complainant's jaw for 8 months to drain

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[1] a rare and benign but locally aggressive developmental cyst. It most often affects the posterior mandible. Odontogenic keratocysts make up around 19% of jaw cysts.

[2] A computerised tomography **(CT) scan** uses X-rays and a computer to create detailed images of the inside of the body.

[3] an arm or branch of a bone

[4] the largest bone in the human skull and supports the lower teeth.

the cyst. The complainant said that she suffered pain and discomfort throughout the period and also suffered temporary loss of feeling in her mouth.

**Issues of complaint**

6. The issues of complaint accepted for investigation were:

**Issue 1: Whether the care and treatment provided to the complainant by the Trust between February 2016 and June 2019 was reasonable and in accordance with relevant standards?**

In particular, this will include consideration of

- Interpretation of CT scan of February 2016 and subsequent review;
- Interpretation of CT scan of January 2017 and subsequent review;
- Missed review 2018.

**Issue 2: Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?**

## 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 handling of the complaint.

**Independent Professional Advice Sought**

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

- Consultant Oral & Maxillofacial Surgeon BDS FDSRCS MBBCh FRCS since 1996. Employed in current role since 1999.

9. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how this

advice was weighed, within the context of this particular complaint, is a matter for my discretion.

**Relevant Standards and Guidance**

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

    The general standards are the Ombudsman's Principles[5]:

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

11. 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 Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2019 (the DoH's Complaints Procedure);
    - South Eastern Health and Social Care Trust (SEHSCT) Policy and Procedures for Management of Complaints and Compliments/Service User Feedback June 2018 (Trust Complaints Policy)
    - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
    - https://www.sciencedirect.com : Management and recurrence of keratocystic odontogenic tumor: a systematic review Nigel R.JohnsonBDSc (Hons), MBBSaMartin D.BatstoneMBBS, BDSc (Hons), MPhil (Surg), FRACDS (OMS), FRCS (OMFS)bNeil W.SavageMDSc,

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

PhD, FFOP (RCPA), FICD (2013);

- https://pubmed.ncbi.nlm.nih.gov: A systematic review of the recurrence rate for keratocystic odontogenic tumour in relation to treatment modalities T Kaczmarzyk , I Mojsa, J Stypulkowska (2012)
- https://pubmed.ncbi.nlm.nih.gov: Systematic review of the treatment and prognosis of the odontogenic keratocyst N Blanas , B Freund, M Schwartz, I M Furst

12. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

13. 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 complainant said she disagreed with the IPA's advice that the missed review of 2018 did not affect her overall care and outcome. She said that the whole point of regular reviews was to ensure that if her keratocyst recurred, it would be identified an earlier stage, thus avoiding the need for a lengthy and painful drainage procedure before removal. She said that because the Trust did not review her in 2018 and she had to undergo an unnecessary procedure, her outcome was '*decidedly poor*'. She believed it was '*highly likely*' her cyst had recurred by March 2018 given its size in 2019. I considered the complainant's response and obtained additional independent professional advice.

14. The Trust stated it was not possible to inform the complainant of the exact nature of the cyst in March 2016. It stated the medical notes indicated the complainant's doctor gave her the option of surgery and she rejected it. It also stated it had carried out a thorough investigation of the complaint and provided an honest response to the complainant based on the information. I have considered the Trust's comments and while I acknowledge its view, I am satisfied that my findings were correct.

# THE INVESTIGATION

**Issue 1: Whether the care and treatment provided to the complainant by the Trust between February 2016 and June 2019 was reasonable and in accordance with relevant standards?**

*CT scan 2016 and follow up*

**Detail of complaint**

15. The complainant said that following her CT scan in February 2016, the Trust contacted her in March 2016 and told her that her jaw was healing well and that no further action was required beyond the usual monitoring. The complainant said that the results of the scan were '*not definitive'*. She said that the scan revealed an area in her jaw that was '*felt to represent either a residual cystic area, or possibly an area of healing*'. She said the Trust did not inform her of this, or raise the matter as an area of concern. She said the Trust's claim that her consultant discussed the possibility of surgery with her and that she was not keen to proceed was incorrect. She pointed out that the Trust had previously told her that her jaw was healing well and questioned why it would have offered her surgery if this was the case.

**Evidence Considered**

**Legislation/Policies/Guidance**

16. I considered the following guidance:
    - GMC guidance;

**The Trust's response**

17. The Trust stated that the CT scan of February 2016 showed '*the cyst within the jaw was in keeping with a treated and healed keratocyst*'. It stated it had informed the complainant of the result by telephone in March 2016. It stated the complainant's consultant discussed the matter with her again in December 2016 when he advised her of the character of the cyst. It added that the consultant advised the complainant '*that it was difficult to say if the situation was continuing to improve or not*' and suggested a repeat CT scan to monitor it.

18. In its original response to the complainant the Trust stated that the stable

appearance of the cyst over a ten month period '*was why [your consultant] opted to observe you, rather than intervene with surgery. I am aware that surgical exploration was discussed…and you declined this.*' The Trust acknowledged that it did not document any such conversation.

**Relevant Independent Professional Advice**

19. The IPA advised that following the CT scan of 2016 the patient was symptom free and that the radiolucency[6] '*may have been residual scar tissue and not a true cyst recurrence, it was not possible to confirm that a cyst had recurred*'. The IPA clarified that the Trust ought to have made the complainant aware in March 2016 of a possible recurrence of the keraotcyst; however, he reiterated that it was also possible that the area showed '*residual scarring from the previous surgery mimicking a new cyst*'

20. The IPA advised that the complainant's consultant informed her of the existence of the cyst during a consultation in December 2016, which he characterised as a resolving picture. The IPA said for this reason the consultant suggested a repeat CT scan. The IPA advised that this course of action was reasonable and appropriate. He clarified that the consultant could have undertaken a biopsy to determine the nature of the cyst, however this would have led to '*destruction of further bony tissue and resulted in significant further pain*' for the complainant. The IPA advised that as keratocysts are slow growing it was reasonable to wait for a year before reviewing again to determine the character of the cystic area. He advised further that '*most consultant oral and maxillofacial surgeons would have adopted a watch and wait treatment plan, as demonstrated in this case*'.

**Clinical records**

21. The records document that on 26 February 2016, the CT scan found '*a cyst identified within the left side of the mandible at the junction of the angle and ramus which has a well defined sclerotic*[7] *wall and is filled with some soft tissue*'. The

[6] a material or tissue that allows the facile passage of X-rays
[7] Relating to sclerosis i.e. pathological hardening of tissue especially from overgrowth of fibrous tissue or

report concluded that the '*appearances are consistent with a treated and healed keratocyst'.*

22. The records document that on 22 March 2016 a staff member phoned the complainant and '*explained that CT result showed consistent with treated & healed keratocyst*'

23. The records document that on 7 December 2016, the complainant met with her consultant who noted '*CT scan Feb 2016. Improvement in appearance but residual cyst. Patient unaware of cyst following phone call. Discussion involving character of cyst cavity and advised this may be resolving picture. Suggest repeat CT scan. See my clinic 3/12* (March 2017)'.

**Analysis and Findings**

24. The complainant was concerned that the CT scan of February 2016 was not definitive and said the Trust did not advise her of any concerns. She said the Trust only advised her that the scan showed her cyst was healing. I note the IPA agreed with the complainant that the scan was not definitive and that it was impossible to tell if the cyst had recurred. However, the IPA advised that due to the slow growing nature of keratocysts, it was reasonable for the Trust to wait for a year before reviewing the cystic area. I accept the IPA's advice.

25. I carefully examined the complainant's clinical records, which document that a member from the surgical team told her in March 2016 that the CT scan indicated the radiolucent area in her jaw was consistent with a treated and healed keratocyst. The staff member did not give the complainant any additional information. I note the IPA's advice that the Trust ought to have made the complainant aware in March 2016 of a possible recurrence of the keraotcyst. I refer to the GMC Guidance which requires doctors to share with patients' *the information they will need to make decisions about their care, including:*
*a their condition, its likely progression and the options for treatment, including associated risks and uncertainties*'. I consider that the Trust's failure to inform the complainant about the uncertain character of her cyst in March 2016 constitutes a

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increase in interstitial tissue

failure in her care and treatment. I therefore partially uphold this element of complaint.

26. However, I do not consider that the complainant experienced an injustice as a result of this failure. This is because the complainant's clinical records document that in December 2016 her consultant told her of the existence of the cystic area and characterised it as a '*resolving picture'*. In addition, I note the IPA's advice that the Trust suggested a repeat CT scan in 2017 to monitor the progression of the cystic area. I am therefore satisfied that the Trust eventually advised the complainant of the possibility of a recurring cyst in December 2016. In addition, I am satisfied the Trust's '*watch and wait*' approach to treating the cyst was appropriate, given the alternative of a painful and potentially damaging biopsy.

27. In relation to the Trust's claim that it '*would have*' discussed surgical options with the complainant, I addressed this under the issue of complaint handling.

*CT scan 2017 and follow up*

**Detail of Complaint**

28. The complainant said that the Trust did not raise any concerns following her CT scan and annual review in 2017.

**Evidence Considered**

**Legislation/Policies/Guidance**

29. I considered the following guidance:
    - GMC Guidance.

**The Trust's response**

30. The Trust stated that following a CT scan in January 2017, the complainant attended a review in March 2017. It stated that the results of the CT scan showed '*there was no evidence of recurrence and the plan was to continue with annual review*'.

**Relevant Independent Professional Advice**

31. The IPA advised he had examined the CT scan and agreed with the Trust that it showed no change to the cystic region when compared to the previous scan of 2016. He advised that the report specifically stated that '*no new lesion was identified*.'

32. The IPA advised that the Trust's decision to continue to monitor the cystic area by yearly review was appropriate. He advised '*[n]o surgeon would operate on a benign lesion without radiographic evidence of change*.'

**Clinical records**

33. The records document that on 31 January 2017 the results of the CT scan indicated that '*there is no change compared to the previous scan performed in February 2016*'

34. The records document that on 22 March 2017, the patient attended a review of the results of the CT scan. The notes show '*Pt* (patient) *advised re CT findings. Does not seem that intervention is req'd…. Pt happy to continue to monitor on annual basis…Not keen on open biopsy/enucleation*.'

**Analysis and Findings**

35. The complainant was concerned that the Trust did not inform her of any concerns during the review of her CT scan in 2017. I note the IPA's advice that his examination of the CT scans led him to agree with the Trust that there had been no change in the radiolucent area. I consider that as there was no change in the cystic area the Trust would have had no cause to raise additional concerns. The IPA advised '*[n]o surgeon would operate on a benign lesion without radiographic evidence of change*'. I accept the IPA's advice. In light of this, I am satisfied that it was appropriate for the Trust to continue with the '*watch and wait*' treatment plan it employed in 2016. Therefore, I do not uphold this element of the complaint.

*Missed review 2018*

**Detail of Complaint**

36. The complainant questioned the Trust's decision not to review her in 2018, given that the CT scans of 2016 and 2017 were not definitive about the nature of her cyst.

The complainant said that because the Trust failed to monitor her appropriately, it missed the opportunity to deal with her keratocyst at an earlier stage. She said that as a result she had to undergo an unnecessary and painful procedure to drain the cyst before it could be surgically removed. The complainant said that the drainage tube remained in place for approximately eight months and that during this time she suffered discomfort and temporary nerve damage. The complainant said that her file '*should have been marked to say that regular monitoring was an absolute requirement*'.

**The Trust's response to the complainant.**

37. The Trust acknowledged that keratocysts can recur and that ideally patients with a history of the condition ought to have regular reviews. It stated however, that due to pressures on the NHS it was not always able to meet its targets.

38. The Trust stated the location of the complainant's cyst within her jaw was '*an area harder to get at with surgery*'. It also stated that when a cyst recurs '*a single procedure would carry a higher risk of not fully removing all the cyst contents… leaving the patient at risk of a recurrence'*, as well as increasing the possibility of permanent nerve damage. It reiterated that the consultant would have advised the complainant of these risks. It stated that on this basis it recommended draining the complainant's cyst before removal.

**Relevant Independent Professional Advice**

39. The IPA advised that the complainant could have avoided undergoing marsupialisation had the Trust identified the recurrence of the cyst at an earlier stage. The IPA said that it was possible that the Trust would have detected the complainant's cyst had it reviewed her in March 2018, but he could not say it was '*highly likely*'. He clarified that he did not know if it had recurred and advised he '*did not think that anyone would know'.*

40. The IPA advised that while it was not ideal that the Trust did not review the complainant in 2018 he believed that it would not have affected her eventual outcome. He advised that he believed that the delay in reviewing the patient did not

cause her '*any significant harm*'. He clarified that the best outcome for the complainant was '*successful surgery and removal of the pathology*'.

41. The IPA concluded that overall the Trust's management and care of the complainant was '*excellent*' and that the missed review caused by service issues '*will not have affected her overall care and outcome significantly'*.

**Clinical records**

42. The records document that that on 19 June 2019 the Trust's radiology department took an x-ray of the patient's jaw which showed '*the previously noted site in the left ramus of the mandible has increased in size when compared to examination of 3 February 2016'*.

**Analysis and Findings**

43. The complainant believed the Trust's decision not to review her in 2018 contributed to the late discovery of a cyst in her jaw which resulted in her having to undergo an otherwise avoidable procedure. I sympathise with the complainant; it is evident that the procedure she underwent was uncomfortable and painful and she was forced to live with a drainage tube in her jaw for eight months.

44. The Trust stated that it did not carry out a review of the complainant's cyst in 2018, due to the pressures on the service. I acknowledge the difficulties the Trust faces and the demands placed on departments across the NHS. I also accept the IPA's advice that the delay in reviewing the complainant, '*did not cause her any significant harm*' as a keratocyst is a benign condition. However, I do not consider it acceptable that the Trust cancelled the complainant's review without prior notification and that she had to wait over 15 months for another appointment. The CT scan of 2016 established that the cyst in the complainant's jaw might have been a recurrence of an earlier cyst and that it was a '*resolving situation*'. The Trust agreed that because of this, the complainant should have a yearly review to monitor the progress of the cyst. I consider that the Trust's failure to review the complainant in 2018 is a failure in care and treatment.

45. There is no indication in the clinical records of when the cyst recurred. The IPA advised that he did not know if it had recurred. However, the complainant noted that a keratocyst was slow growing. She said it had grown to such an extent in June 2019 that it was necessary to drain it before removing it. It was therefore '*highly likely*' that a review in March 2018 would have detected it. I acknowledge the IPA's advice and as such I cannot definitively conclude that had the Trust reviewed the patient in 2018 it would have changed her outcome. However, I consider it may have changed her clinical pathway and therefore prevented the requirement to drain the cyst before excising it. I am satisfied that as a result of this failure the complainant experienced the injustice of uncertainty and the loss of opportunity to have a yearly review which may have prevented unnecessary surgery. I therefore partially uphold this element of the complaint.

**Issue 2**: **Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?**

**Detail of complaint**

46. In its response to the complainant as part of the complaint handling, the Trust stated that during a consultation in 2016, it had spoken to her about the option of a surgical procedure to remove the cyst and that she *'was not keen*.' The complainant said that this was incorrect. She said that the Trust told her in 2016 that her jaw was healing well and there was no suggestion of a problem. She said '*no-one suggested surgery and I did not refuse it*'.

**Evidence Considered**

**Legislation/Policies/Guidance**

47. I considered the following guidance:
    - Trust Complaints Policy; and
    - The DoH's Complaints Procedure

**The Trust's response**

48. The Trust stated that the complainant's consultant discussed the results of the CT scan and the plans for repeat imaging during a consultation with her in December 2016. It stated '*if at that time [the complainant] had questions about why further*

*imaging was being requested, then the likely surgical options for her would have been talked about in order to help her understand why the new scan was being requested.*'

49. The Trust stated that during her annual review in March 2017, a doctor discussed the findings of the CT scan from January 2017 with the complainant. It stated that the complainant's notes showed that '*she was happy to be monitored on an annual basis*' and '*she was not keen on open biopsy and enucleation*[8]'

**Analysis and Findings**

50. I carefully examined the complainant's clinical records, which document that she met with her consultant on 7 December 2016. The consultant recorded that the complainant was '*unaware of cyst following phone call…*' He noted that he discussed the nature of the cyst with her and suggested a repeat CT scan. There is no indication in the notes that the consultant and complainant discussed the option of a surgical procedure to remove the cyst.

51. The clinical records also document that the complainant attended a review on 22 March 2017 to discuss the results of the CT scan of January 2017. The notes document that the doctor advised the complainant of the findings. The doctor noted that it did '*not seem intervention [was] required*' and that the complainant was '*happy to continue to monitor on annual basis*'. The consultation notes also record '*not keen on open biopsy/enucleation'.* However, it is unclear if this is the view of the complainant, the doctor, or her consultant who was not present at the consultation. There are no other references to any discussions relating to possible surgical options to remove the cyst.

52. The Third Principle of Good Complaint Handling 'Being open and accountable' requires public bodies to provide '*honest evidence-based explanations and giving reasons for decisions'.* In addition the Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' requires public bodies to ensure '*that complaints are investigated thoroughly and fairly to establish the facts of the case*'. In its response to the complainant in which it stated that she and her consultant had

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[8] shelling out the entire cystic lesion without rupture

discussed the option of surgery to remove her cyst, I do not consider that the Trust meets these standards for the reasons outlined above. I consider that this failure to conduct a thorough and accurate investigation constitutes maladministration.

53. Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this element of the complaint

## CONCLUSION

54. I received a complaint about the actions of the Trust. The complainant believed that the Trust failed to monitor a cyst in her jaw, which resulted in her having to undergo an unnecessary and painful procedure to drain the cyst. The complaint also concerned the Trust's handling of the complaint.

*Issue One*

55. The investigation established failures in the care and treatment in relation to the following matters:
    - The failure to provide the complainant with an accurate assessment of the character of her cyst in March 2016; and
    - The failure to carry out an annual review in 2018

56. I am satisfied that the failures in care and treatment identified caused the complainant to suffer the injustice of uncertainty and a loss of opportunity to have a yearly review of her cyst review which may have prevented unnecessary surgery.

57. The investigation established maladministration in relation to the following matters:
    - The failure to provide the complainant with an honest evidence based explanation; and
    - The failure to conduct a thorough and accurate investigation

58. I am satisfied that the maladministration identified caused the complainant and the patient the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office.

**Recommendations**

59. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO ‘Guidance on issuing an apology’ (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report

60. I further recommend for service improvement and to prevent future recurrence:

    - The Trust carry out a random sampling audit of patients’ records within the Oral Surgery department between 1 April 2022 to the date of issue of the final report. This is to ensure that patients due for annual review are being given appointments

    - The Trust provides evidence that it has reviewed why its own investigation did not identify or acknowledge all the failings highlighted here

61. I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

**MARGARET KELLY**

**Ombudsman** **July 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.

# 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.