

**Principles of Good
Administration
and Good Records
Management**



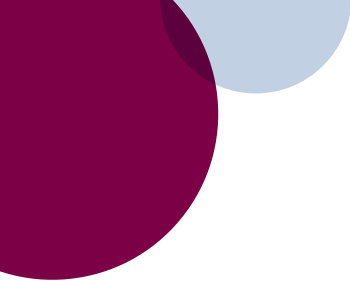
Contents

Joint Introduction – The Principles	02
Principle 1: Getting it right	05
Principle 2: Being customer focused	08
Principle 3: Being open and accountable	11
Principle 4: Acting fairly and proportionately	14
Principle 5: Putting things right	17
Principle 6: Seeking continuous improvement	20
Principle 7: Creating Good Quality Records	22
Principle 8: Managing Records Effectively	24

Joint Introduction – The Principles

As the Public Services Ombudsman for Wales, I provide a service to the public by undertaking independent investigations into complaints about almost all of the wide range of public services for which the National Assembly for Wales has devolved responsibility. I can look into the actions of councils and other local government bodies (including community councils), NHS bodies (including GPs), the Welsh Government and its sponsored bodies, and registered housing associations. The bodies that fall within my jurisdiction under the Public Services Ombudsman (Wales) Act 2005 ('the PSOW Act') are referred to in this document as 'public service providers'. I am responsible for deciding whether the public service provider complained about has acted unfairly or unreasonably, or has provided a poor service. The Ombudsman's view is final, subject only to judicial review by the courts. I apply a test of fairness and reasonableness, taking into account the circumstances of each case; not a test of perfection. I draw attention to any failures and suggest how things may be put right. I also aim to share the lessons learned from complaints to help improve the way public services are provided.

The first six Principles in this document are those which were originally published in the document 'Principles of Good Administration' published by the Public Services Ombudsman for Wales in 2008. A key aim of that document remains, which is to be open and clear with both complainants and the public service providers about the sorts of behaviour expected in their service delivery and the tests I apply in deciding whether maladministration and service failure have occurred. In particular, I want public service providers to understand how I will approach complaints, and complainants to understand how I will consider their case. Central to my assessment of the seriousness of any complaint is the impact of the public service provider's actions on the individuals or organisations concerned. New to this edition of the Principles, is the introduction of examples to illustrate and provide clarification on the behaviours I expect from public service providers. Even though these case studies have been attributed to a particular Principle, many of them have elements that are also applicable to other Principles in this Guidance.




In addition, my investigations have identified time and again occasions of poor records management, which can sometimes have serious consequences. I am extremely pleased therefore to have been able to work with the Information Commissioner during the review of this Guidance document. I am particularly grateful for his contribution in respect of the two new Principles which have been introduced and for the case studies, which all relate to Welsh public bodies, that he has provided.

The Principles are not a checklist, nor the final or only means by which I will assess and decide individual cases. They are broad statements of what I believe the bodies within my jurisdiction should be doing to deliver good administration and customer service. If I conclude that a public service provider has not followed the Principles, I will not automatically find maladministration or service failure. I will apply the Principles fairly and sensitively to individual complaints, which I will, as ever, decide on their merits and the circumstances of the case.

I understand that there is often a balance between being sensitive to the needs of a service user and yet acting proportionately to maximise the effective use of public resources. The actions of public service providers are of course limited by their resources and they have to weigh the highest standards of customer service against what is affordable. All public bodies should spend public money with care. However, finite resources should not be used as an excuse for poor service or administration.

I appreciate that the bodies within my jurisdiction are many and varied, have a wide range of remits and statutory duties, and often have their own demanding standards. Public service providers have to take reasonable decisions bearing in mind all the circumstances; delivering good service often means taking a broad and balanced view of all of the individuals or organisations that may be affected by decisions. Despite their diversity, I believe that the Principles of Good Administration and Good Records Management will provide a framework for all public service providers to follow in fulfilling their duties.

Nick Bennett
Ombudsman



Upholding information rights in the public interest is what the ICO exists to do. But that involves much more than the traditional regulator's enforcement role. An important part of securing compliance with the Data Protection Act 1998 and the Freedom of Information Act 2000 is our work with other regulatory authorities in educating organisations about their responsibilities. We recognise the need for joined up approaches in the joined up world of information handling.

Good administration and information handling are an essential part of delivering high-quality public services. They are also vital to organisations being able to meet their statutory obligations under data protection and freedom of information law. So it is very appropriate that the Public Services Ombudsman for Wales and the Information Commissioner have worked together to produce this publication for public bodies in Wales.

As the Ombudsman points out, poor records management can have serious consequences for service users where a record is incorrect or inaccessible, or where its security is compromised. I have powers to issue substantial fines for such failures, and have done so on a number of occasions both in Wales and across the rest of the UK. Furthermore, for the individuals affected by these errors, timely provision of accurate and relevant information relating to their cases can be crucial to their understanding of what may have gone wrong and why. Consequently it is important that their own legal rights of access to information are properly upheld.

Applying the Principles of Good Administration and Good Records Management will help organisations address the too numerous failures by public bodies which both the Ombudsman and I have identified from complaints made to us by members of the public. These failures are illustrated within the case studies, which all relate to Wales. My office in Wales will now work with the Ombudsman's office to promote the adoption of the Principles by organisations and thus improve practice in record handling across Wales.

Christopher Graham
Information Commissioner

Principle 1: Getting it right

This includes:

- acting in accordance with the law and with due regard for the rights of those concerned;
- acting in accordance with the listed authority'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.

In seeking to achieve the above, public service providers:

- Must comply with the law and have due regard for the rights of those concerned. They should act according to their statutory powers and duties and any other rules governing the service they provide. They should follow their own policy and procedural guidance, whether published or internal.
- Should act in accordance with recognised quality standards, established good practice or both, for example about clinical care.
- Should be alert to possibilities where a novel approach will bring a better result or service. When they decide to depart from their own guidance, recognised quality standards or established good practice, they should record why.
- Should provide effective services with appropriately trained and competent staff. They should plan carefully when introducing new policies and procedures. Where listed authorities are subject to statutory duties, published service standards or both, they should plan and prioritise their resources to meet them.
- In their decision making, should have proper regard to the relevant legislation and guidance. Proper decision making should give due weight to all relevant considerations, ignore irrelevant ones and balance the evidence appropriately.
- Assess risks as part of taking decisions. They should, of course, spend public money with care and propriety. At the same time, when assessing risk, they should ensure that they operate fairly and reasonably.

EXAMPLE

A Care Provider

The Information Commissioner investigated a care provider when a member of the public found ten care plans in the street. The plans related to elderly individuals and included sensitive personal information such as care needs and medication as well as confidential key safe numbers.

The Commissioner's investigation revealed that whilst there was a basic data protection policy in place requiring that care plans were not carried in cars, there was no clear procedure, minimum security requirement or policy on the safe handling and storage of sensitive personal information taken outside the office. The Commissioner also found that the employee in question had been in possession of the files for up to 10 weeks prior to the incident without the apparent knowledge of the organisation as there was no system in place to log sensitive information being taken out of the office. The Director of the organisation entered into a formal Undertaking¹ with the Information Commissioner to ensure proper systems, processes and staff training were put in place to protect the security of personal information both on and off site.

EXAMPLE

A County Council

A profoundly disabled man lived with his parents until he moved to supported accommodation. He had accessed the family home using a lift from street level to the front of the house, which had been installed under a Disabled Facilities Grant. The lift was ageing and after he moved out it broke down beyond repair. His visits since had been very limited and he had to be carried into the home. The Ombudsman's investigation considered complaints that the Council did not properly advise and support the gentleman in maintaining the lift; and that it failed to take proper account of his need to maintain contact with his family in declining to repair/replace the lift.

Having taken account of professional advice, the Ombudsman did not uphold the complaint about support to maintain the lift. However, he upheld the second complaint, concluding that the Council needed to do more to enable the gentleman concerned to be part of his family in the privacy and familiarity of the home environment. The Council agreed to implement a number of recommendations, including:

- provide an apology to the gentleman's parents for the failings identified;
- look for possible solutions to enable the gentleman to visit the family home; and,
- re-consider an application for a replacement lift under the Council's discretionary policy.

The Ombudsman also concluded that Article 8 of the Human Rights Act (the right to respect for private and family life) had been engaged, and that the gentleman's fundamental right to a family life did not appear to have been fully taken account of by the Council.

¹ An Undertaking is a signed agreement that an organisation will take specific actions to improve data protection practice within a set period of time. It is used by the Information Commissioner in cases where he does not feel it is necessary to employ his full powers to bring about the required improvements. At the end of the period the Information Commissioner will investigate whether the required improvements have been made, and if he is not satisfied stronger enforcement action will be considered.



EXAMPLE

A County Council

A woman complained about the actions of the Social Services Department when she asked for her daughter to be accommodated by the department. Although the daughter was initially placed with a foster carer, after a short time the department arranged for her to stay with her mother's sister, despite the relationship between the two women having broken down some time previously. The mother believed that the Social Worker's professional relationship with her sister had caused a conflict of interest leading to a number of failings.

The investigation found that the mother only gave her consent for her daughter to stay with the aunt reluctantly, and that it could not be considered an agreed family placement. It was a placement arranged by the Council, and the aunt should have been assessed in accordance with the Regulations. No assessment of the girl's needs, or the aunt's suitability to care for her, was carried out and no other prospective carers were considered for the girl. In the absence of any assessment of the aunt, the placement was an irregular foster placement. There was minimal contact with her mother after the girl went to stay with her aunt, and the Council failed to provide assistance and services to enable the girl to return home successfully and to help the family to rebuild their relationship. The Ombudsman concluded that the lack of case recordings was reflective of a lack of action on the part of officers rather than just poor record-keeping – the absence of certain documentation meant that the records lacked purpose, and some of the judgements and opinions recorded were not supported by evidence. However, she could not conclude that professionals were influenced by their relationship with the aunt.

Amongst the Ombudsman's recommendations were that the Council should arrange for all social workers in the Child and Family Assessment and Support Team to receive refresher training on the law, regulations and guidance relating to looked after children.

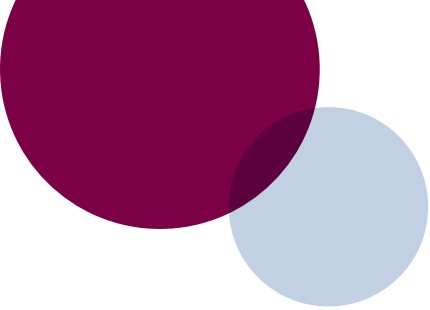
Principle 2: Being customer focused

This includes:

- ensuring people can access services easily;
- informing customers what they can expect and what the listed authority expects of them;
- the public service provider 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.

In seeking to achieve the above, public service providers should:

- Provide services that are easily accessible to their customers. Policies and procedures should be clear and there must be accurate, complete and understandable information about the service.
- Aim to ensure that customers are clear about their entitlements; about what they can and cannot expect from the listed authority; and about their own responsibilities.
- Do what they say they are going to do. If they make a commitment to do something, they should keep to it, or explain why they cannot. They should meet their published service standards, or let customers know if they cannot.
- Behave helpfully, dealing with people promptly, within reasonable timescales and within any published time limits. They should tell people if things take longer than the listed authority has stated, or than people can reasonably expect them to take.

- 
- Communicate effectively, using clear language that people can understand and that is appropriate to them and their circumstances.
 - Treat people with sensitivity, bearing in mind their individual needs, and respond flexibly to the circumstances of the case. Where appropriate, they should deal with customers in a co-ordinated way with other providers to ensure their needs are met; and, if they are unable to help, refer them to any other sources of help.

EXAMPLE

A Housing Association

A couple complained that a housing association had failed to properly administer their application for housing by incorrectly calculating their housing need points. They also complained that one of their applications was suspended, other than in accordance with the housing association's own policy, and that the housing association's own complaints panel had concluded that this resulted in them missing out on a property which they would otherwise have been allocated. They complained that this resulted in a delay of a year in them being allocated a property.

The Ombudsman found that elements of the housing association's policies and information leaflets were confusing and inconsistent. He also found that the housing association had acted other than in accordance with its policies in suspending the couple's application. The Ombudsman concluded that, as a result of these failings, the couple should indeed have been allocated a property a year earlier. Amongst the Ombudsman's recommendations were that the housing association should make various amendments to policies and information leaflets to address the failings identified.

EXAMPLE

A General Practitioner (GP)

A woman complained about a GP, who she said had cancelled an appointment for her son, about whom she was very worried, during a telephone conversation. She added that he was rude. She stated that the GP acted unprofessionally and disrespectfully at a subsequent local resolution meeting after she had complained.

The Ombudsman found that the GP breached two vital aspects of good medical practice. Firstly, he did not properly record the telephone consultation with the complainant about her son. Secondly, he failed to respond appropriately to a complaint by virtue of being rude, dismissive and in error in various aspects. The Ombudsman made a number of recommendations, including that the GP should agree to share his report with his appraiser at the next annual meeting and consider how he can prevent a repeat.

EXAMPLE

A County Council

A gentleman complained about the Council's response to allegations of abuse against him, apparently made to care workers by his autistic daughter, who was removed from his and his wife's care and remained away for six months. During this time, a Protection of Vulnerable Adults investigation and police enquiries took place. Neither investigation substantiated the allegations. The complainant said that the Council should have allowed his daughter to rejoin the family after a few weeks; had failed to communicate properly with him; and did not liaise effectively with the police. He said that his daughter's allegations were made via Facilitated Communication ("FC"). FC was a technique that the family used for day-to-day matters but was not reliable as a method of making allegations. After six months, the Council established that the daughter did not have capacity to decide where she lived. Given that it had been obvious for some months that there was no evidence to support the allegations, the complainant's daughter returned home.

The Ombudsman found that the Council was faced with a very difficult set of circumstances and worked hard in what it believed to be the daughter's best interests. The Council initially determined that the complainant's daughter had capacity to decide where she resided and appeared to consistently state her preference not to return home. However, the Ombudsman agreed with the complainant that FC was not reliable and that the complainant had provided information to that end to the Council in support of his contentions. The Ombudsman concluded that, if the Council had been more flexible in its considerations and more pro-active, the daughter should have returned home about two months earlier than she did. The Ombudsman also criticised aspects of the Council's communications and liaison with the police. Amongst the Ombudsman's recommendations were that relevant staff should reflect on their role.

Principle 3: Being open and accountable

This includes:

- 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;
- taking responsibility for its actions.

In seeking to achieve the above, public service providers should:

- Handle information as transparently and as openly as the law allows. People should be given information and, if appropriate, advice that is clear, accurate, complete, relevant and timely.
- Be open and truthful when accounting for their decisions and actions. They should state their criteria for decision making and give reasons for their decisions.
- Handle and process information properly and appropriately in line with the law. So while policies and procedures should be transparent, public service providers should, as the law requires, also respect the privacy of personal and confidential information.
- Take responsibility for the actions of their staff and those of others who act as their agents.

EXAMPLE

A County Council

A woman's complaint centred on the Council's handling of her housing application.

The Ombudsman's investigation identified shortcomings in the Council's administration of Miss A's housing application which led to periods when it was not dealt with as efficiently or effectively as it should have been. Such administrative inadequacies included documentation being mislaid, the complainant's housing application not being appropriately pointed, as well as instances of poor record keeping.

The Ombudsman's investigation also found evidence that Miss A's housing application had, for a period of time, been erroneously cancelled and this was coupled with other administrative failings. The investigation also found that there was a failure by the Council to recognise when its statutory homelessness duties were engaged.

Finally, given the failings identified, the Ombudsman concluded that the Council's response to the complainant had not been as robust, transparent, or open as it could have been in acknowledging failings in the administration of her housing application.

The Ombudsman made a number of recommendations, including that the Council:

- develop relevant guidance on its housing allocation; and
- provide relevant training.

EXAMPLE

A Health Board

Whilst cycling home from work a medical consultant lost a bag containing sensitive personal information including a patient's mental health tribunal report, a solicitor's letter and CVs for a job vacancy. The documents were in a rucksack that the consultant had believed to be securely fastened to a child seat, and were needed for the consultant to work away from the office.

Investigation by the ICO established that the consultant had not received mandatory data protection induction training at the time of the incident, and that there was no relevant protective marking scheme in place at the time to guide staff on the appropriate handling of documents. The investigation also established that whilst the Board provided suitable alternative means of transporting or accessing the information, such as encrypted portable devices and remote server access, these options were not communicated clearly to staff or supported by clear procedures. The Medical Director entered into a formal Undertaking with the Information Commissioner to ensure appropriate training and policies were put in place to protect information security on and off site.

EXAMPLE

A County Council

Two similar breaches occurred in the Council's Social Services Department within a year. In the first case a mother correctly received a report about her own child that erroneously included a page of highly sensitive information about another child. The mother was able to identify the other child and mother from the information breached. It is not known precisely how the error happened, but it was clear to the Information Commissioner that no checks were made of the report prior to its dispatch. Following this incident the Council advised the Information Commissioner that they would ensure staff had appropriate training, guidance on checking any work before posting, and improved access to secure printing facilities in the department. Within seven months an almost identical breach occurred, with the same mother again being sent details of another child and family that she could identify.

It was clear to the Information Commissioner that insufficient steps had been taken by the Council following the first breach. Taking into account that the Council had failed to take appropriate measures to prevent further breaches, that the contravention was likely to cause significant distress, and that the Council knew – or ought to have known – that there was a risk of further breach, the Information Commissioner served the Council with a monetary penalty of £130,000.

Principle 4: Acting fairly and proportionately

This includes:

- 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.

In seeking to achieve the above, public service providers should:

- Always deal with people fairly and with respect. They should be prepared to listen to their customers and avoid being defensive when things go wrong.
- Treat people equally and impartially. They should understand and respect the diversity of their customers and ensure fair access to services and treatment regardless of background or circumstance.
- Ensure that their actions and decisions are free from any personal bias or interests that could prejudice those actions and decisions, and any conflict of interests should be declared. Public service providers should not act in a way that unlawfully discriminates against or unjustifiably favours particular individuals or interests.
- Ensure that people are treated fairly and consistently, so that those in similar circumstances are dealt with in a similar way. Any difference in treatment should be justified by the objective features or the individual circumstances of the case.
- When taking decisions, and particularly when imposing penalties, behave reasonably and ensure that the measures taken are proportionate to the objectives pursued, appropriate in the circumstances and fair to the individuals concerned.
- Seek to address the unfairness if applying the law, regulations or procedures strictly would lead to an unfair result for an individual. In doing so public service providers must, of course, bear in mind the proper protection of public funds and ensure they do not exceed their legal powers.

EXAMPLE

A County Council

A Council undertook covert surveillance on an employee who was suspected of fraudulently claiming sickness absence. The employee had been off work with a sick note for four weeks at the time the surveillance was authorised. The Council believed she would use the absence to avoid attending compulsory work meetings, but took no action to clarify her ability to attend with her or medical advisors before resorting to the covert surveillance. The employee attended one such meeting before she was aware that the Council had already undertaken covert surveillance. The resulting surveillance report was never used.

After investigating, the Information Commissioner deemed the surveillance to be unfair and unlawful under the Data Protection Act as there were not sufficient grounds at that early stage of the absence to justify covert surveillance. The Chief Executive of the Council signed a formal Undertaking with the Information Commissioner to ensure legal compliance and good practice in any future consideration of covert surveillance.

EXAMPLE

A Health Board

A woman complained about the treatment her late father had received during two admissions at a hospital. Following investigation, the Ombudsman did not uphold the complaint about the first admission. However, he found serious failings with regard to the second admission. He found that there was no systematic approach to diagnosing the patient's condition, no plan about when clinical reviews should take place and no decision made about the frequency that nursing staff should record observations for the patient. In the event, a doctor did not review the patient the day before his death and observations were not sufficient or carried out properly. Had those failings not occurred, the problem with the patient's undiagnosed gastric ulcer might have come to light. The Ombudsman concluded that there was a chance that had that happened, the sad outcome might have been different. The Ombudsman also found that the patient's daughter was right about the poor administration of a drug. Further, he concluded that the Chief Executive should not have signed the complaint response without informing the family of the connection between her and a clinician who had been involved in the patient's care, even though that clinician was not criticised in his report.

The Ombudsman made numerous recommendations to the LHB, which it accepted. These included financial redress to the complainant as an acknowledgement of the uncertainty she had to live with concerning whether her father might have survived the episode with better care; providing evidence that effective systems are in place regarding nursing observations; carrying out an audit to ensure that patients requiring daily clinical reviews are receiving them; and introducing a written conflict of interest policy.

EXAMPLE

A County Council

A gentleman complained about the Council's decisions to grant consent for the extension of a caravan site close to his home. There were a number of aspects to his complaint. One of these was that he said that there was a conflict of interest because of the involvement of a senior planning officer, who was a former consultant to the applicant. Amongst the Ombudsman's findings were that in terms of the alleged conflict of interest of a senior planning officer, exchanges of e-mails on the file were inappropriate and gave a perception of bias which could be damaging in the eyes of the public. Also the appropriate written declarations within the planning department, or to the Monitoring Officer, as required by the Council's code of conduct for officers, had not been made. However, there was no indication that the senior planning officer concerned had directly influenced the outcome of the applications, which had been dealt with by the case officer and managed by another more senior planning officer. On this aspect the Ombudsman recommended that the Council should remind officers in the planning service of the need to make declarations of interest in accordance with the code of conduct for officers, including the more informal business of the Council e.g. when e-mailing, to avoid the perception of undue influence and partiality.

Principle 5: Putting things right

This includes:

- 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.

In seeking to achieve the above, public service providers should:

- When mistakes happen, apologise, explain what went wrong and put things right quickly and effectively.
- Recognise that putting things right may include:
 - reviewing any decisions found to be incorrect;
 - reviewing and amending any policies and procedures found to be ineffective, unworkable or unfair; and
 - giving adequate notice before changing the rules.
- Recognise that their actions can sometimes bear more heavily on an individual because of their particular circumstances, even though statutory duties, service standards or both have been met. They should therefore be alert to this and respond flexibly to avoid or, where appropriate, put right any such undue effect.
- Provide clear and timely information about methods by which people can appeal or complain.
- Provide information about appropriate organisational or independent ways of resolving complaints.

- Operate effective complaints procedures, which are:
 - compliant with statutory requirements (for example, health and social services), if applicable, and consistent with the principles for dealing with complaints, as set out in the Model Concerns and Complaints Policy issued by the Welsh Government in July 2011²; and include:
 - providing information about possible sources of help for the service user, particularly for people who may find the complaints process daunting;
 - investigating complaints thoroughly, quickly and impartially;
 - providing an appropriate range of remedies to the complainant and any others similarly affected when a complaint is upheld. As a minimum, an appropriate range of remedies should include an explanation and apology from the public service provider to the complainant, remedial action, financial redress for the complainant or a combination of these. The remedy offered should seek to put the complainant back in the position they would have been in if nothing had gone wrong. Where this is not possible - as will often be the case - the remedy offered should fairly reflect the harm the complainant has suffered.

EXAMPLE

A Welsh Government body

The complainants expressed, amongst other points, dissatisfaction with the way that a Welsh Government body had dealt with their complaint. The Ombudsman's investigation identified shortcomings, including in the area of complaints handling. He was of the view that it would have been appropriate, given the Investigating Officer's previous dealings in the complainants' case, for the Stage 1 investigation to have been carried out by another officer. The Ombudsman noted that it was unfortunate that the inference of bias had tainted the complaints process.

The Ombudsman made a number of recommendations including that, in terms of complaints handling, the body concerned should take steps to ensure that its complaints procedure was compatible with the aims and objectives of the Welsh Government's Model Concerns and Complaints Policy and Guidance.

² Model Concerns and Complaints Policy:
<http://gov.wales/topics/improving-services/publications/public-service-complaints-policy/?lang=en>

EXAMPLE

A Health Board

A woman complained about the standard of care provided to her. She complained that she had no care and treatment plan and was not made aware who her care co-ordinator was. When she made a complaint, she did not feel that the Health Board responded properly.

Amongst the Ombudsman's findings was that Health Board's response to her complaint was poor and did not comply with the NHS Redress 'Putting Things Right' measures, in that the investigating officer was someone who was named in the complaint. The Ombudsman made a number of recommendations, including that the Health Board should review how it investigates complaints to ensure that its actions are compatible with 'Putting Things Right'.

EXAMPLE

A National Park Authority

A man complained about inaction and delay on the part of the Park Authority in dealing with three breaches of planning control on land near his property. One of the breaches had been resolved before the investigation of these complaints commenced. Formal action was taken by the Park Authority in relation to the two other breaches during the period of the investigation.

The investigation found that there was evidence of maladministrative delay and inaction on the part of the Park Authority in respect of two of the three complaints brought to this office. That maladministration led to the complainant suffering an injustice. Those complaints were therefore upheld. The investigation did not find evidence of maladministrative delay on the part of the Park Authority with respect to the third complaint, which was not upheld.

The Ombudsman made a number of recommendations, including apologising for the delay in dealing with the two issues where there had been maladministration and for the detrimental impact this had on the complainant. The Ombudsman also recommended a redress payment to reflect the injustice suffered by the complainant, and that the body review its case file management procedures with a view to requiring regular reviews of open and /or unresolved cases.

Principle 6: Seeking continuous improvement

This includes:

- 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 service provider learns lessons from complaints and uses these to improve services and performance.

In seeking to achieve this, public service providers should:

- Put in place processes to ensure policies and procedures are regularly reviewed.
- In the process of reviewing their policies and procedures, actively seek and welcome all feedback, both compliments and complaints to improve their public service delivery and performance.
- Capture and review lessons learned from complaints so that they contribute to developing and improving services.

EXAMPLE

A County Council

A gentleman complained that he had a long-standing complaint with the Council over his rubbish collection. He said that he had experienced repeated problems with rubbish and recycling collections. He said that even though he contacted the Council repeatedly the service did not improve.

Following contact from the Ombudsman's office, the Council stated that it was aware of previous issues but understood these had been resolved. The Council advised that the complainant would be placed on the weekly monitoring list and receive a weekly phone call to check that the rubbish and recycling had been collected.

EXAMPLE

A County Council

A gentleman complained (with the help of an advocate) that the Council, under pressure from an Inspectorate, had changed a policy to his and others' detriment. He explained that tenants living in supported accommodation could provide food to Council-funded carers during visits. However, that this policy was changed so that carers were not allowed to accept food. The complainant stated that this restricted the opportunity to share meals and refreshments with carers and enjoy the social pleasures that this allowed. He added that the decision was contrary, and made without due regard to the Mental Capacity Act 2005, the Human Rights Act 1998 and the Equality Act 2010.

The Ombudsman recognised the difficulties authorities face when devising policies that involved concerns about competing principles such as choice, equality and protection. An investigation was commenced to ensure that these matters had been fully considered; however, it became clear that the Council and the Inspectorate were both content that a choice-based policy, with safeguards to protect against possible exploitation of vulnerable adults, was feasible and appropriate. The Ombudsman pointed out that miscommunication between the bodies might have led to the change in policy. He invited the Council to reconsider the change in policy in conjunction with Inspectorate, and suggested that both parties write to the complainant's advocate to explain the situation. The Council and the Inspectorate agreed to do so. The complaints were settled on that basis without the need to prepare findings.

EXAMPLE

Health Board

A woman complained about the care her late husband – who was deaf – had received in hospital during his final illness.

The Ombudsman's investigation resulted in a number of findings, but included that the Health Board had failed to make reasonable adjustments, as required by the Equality Act 2010, to accommodate the gentleman's deafness whilst treating him for his medical condition. Amongst the Ombudsman's recommendations in relation to this case were that his report should be discussed at a meeting of the working group responsible for the Health Board's "Dignified Care?" action plan.

Principle 7: Creating good quality records

This includes:

- keeping records which are accurate and up to date;
- keeping records which are comprehensive, relevant but not excessive;
- keeping records which are reliable.

In seeking to achieve the above, public service providers should:

- Ensure that facts recorded accurately reflect the transactions or activity they document. To be reliable, these facts should be correct. Where necessary, they should also be kept up to date.
- Ensure that records are supported by information about the circumstances in which they were created and used. Records cannot be fully understood without adequate knowledge of the activity that gave rise to them, the wider function of which that activity forms part, and the administrative context, including the identities and roles of the various participants in the activity.
- Ensure that it is possible to prove that records created are what they purport to be. It goes without saying that if a record is worth keeping it is worth keeping well, so that there can be no doubt as to its reliability as evidence of the past and for use in the future. Where information is later added to an existing document within a record, the added information must be signed and dated. With electronic records, changes and additions must be identifiable through audit trails.

The National Archives produce guidance on records management best practice³. The importance of good record keeping in the health sector is also emphasised in the Good Medical Practice guidance issued by the General Medical Council.⁴

³ Available on their website: www.nationalarchives.gov.uk

⁴ Available on their website: www.gmc-uk.org

EXAMPLE

A Health Board

A gentleman complained about a number of matters, including delays by a hospital in arranging a referral and the pain and distress his wife experienced during a procedure. He also complained about later delays by the hospital's radiology department in forwarding copies of his wife's scans to another hospital in England.

Amongst the Ombudsman's findings were that there had been an unreasonable delay on the part of the hospital in arranging the patient's test and a failure by the hospital to retain records documenting the manner in which the request had been managed. Due to conflicting evidence, the Ombudsman was unable to arrive at a finding about the level of distress experienced by the patient during the procedure.

The Ombudsman's recommendations included that the Health Board should:

- remind relevant staff who consider referrals for radiological investigations of the need to appropriately document all clinical decisions relating to a patient's management;
- ensure, if it had not done so already, that any referrals it receives for radiological investigations are documented, preferably electronically, at all stages;
- ensure that it has a robust process for recording and managing all requests for investigation results such as images, and that all relevant staff receive sufficient training in its implementation.

EXAMPLE

General Practitioners (GPs)

A woman complained about the diagnosis arrived at by two GPs, and their response to her complaint, which contained inaccurate information, belittled her concerns and did not acknowledge that both GPs had failed to diagnose her bowel cancer. The complainant sadly passed away during the course of the investigation.

The Ombudsman found that the treatment the complainant received did not fall within the bounds of acceptable clinical practice. He also found that the records did not meet the standards expected by the GMC Guidance. Whilst the complaint response from the Practice did not contain inaccurate information (although there were concerns about the standard of record keeping, casting doubt on the sufficiency of what was recorded), the lack of recognition that the complainant should have been clinically examined, may have given the impression that her concerns were belittled.

The Ombudsman made a number of recommendations, which the GPs agreed to implement, including: reviewing the standard of record keeping to ensure compliance with the GMC Guidance.

Principle 8: Managing records effectively

This includes:

- public service providers ensuring they have effective records management systems in their organisations that enable them to manage records according to statutory duty⁵ and recognised standards;
- ensuring that all staff are aware of what is expected of them in regards to records;
- having an Information Asset Register for the organisation, and appropriate “Information Asset Owners” for its records;
- maintaining records in such a way that they are both retrievable and usable.

In seeking to achieve the above, public service providers should:

- Ensure that staff at all levels are aware of:
 - what records to keep
 - where to keep them
 - who should keep them
 - when to keep them
 - how long to keep them
 - how to securely dispose of them when no longer required
 - how to look after and ensure traceability of records if they are taken off site, for example when visiting service users at home.
- Identify what should be kept, according to statutory duty or business need. Decisions as to what records are to be kept should be documented in a way that can be used by staff in their daily work and can serve as evidence of the organisation’s intentions.
- Never destroy a record without having the authority to do so. Good records management aims to ensure that retention decisions are made rationally, and shows why any particular records were destroyed. The existence of a structured retention system allows the organisation to prove that any destruction took place as part of normal business practice.

⁵ For example, the Public Records Act 1958

- Adhere to the Code of Practice on the management of records issued under section 46 of the Freedom of Information Act 2000
- Ensure that records are stored and managed in such a way that they can be discovered when there is a need to consult them. There should be measures in place to ensure that retrieval is efficient and that the records have been appropriately and securely stored.

EXAMPLE

A Health Board

The Health Board arranged therapy sessions for the complainant in Bristol, and agreed to fund them. However, they refused her requests to pay her travel expenses to attend them. She attended the sessions, mostly weekly, during a period of five years.

The Ombudsman noted that non-emergency specialist transport may be provided by a Health Board in case of clinical need, but that there had been no suggestion that the complainant had needed or qualified for transport. A patient is entitled to be reimbursed travel expenses if they are in receipt of one of a number of benefits, or may qualify for help if he is otherwise on a low income. An independent investigator who had considered the woman's complaint at stage 2 of the Health Board's complaints procedure had recommended that the Health Board should reconsider its decision not to pay her travel expenses.

The Ombudsman found that the Health Board's panel, convened to consider this recommendation, focussed on whether the woman qualified for specialist transport, and thus had misinterpreted the panel's recommendations.

The Ombudsman made a number of recommendations, which included an apology and payment of redress in recognition of the time and trouble to which she had been put in pursuing her complaint and that it should:

- convene a panel to reconsider the recommendation, and the complainant's application for payment of her travel expenses. The panel should consist of members who were not involved in the original consideration of the matter and should consider all relevant information. A record should be kept of the matters the panel considered, their deliberations and the outcome; and,
- remind members of staff making administrative decisions of this nature of the importance of keeping records of the decision-making process.

EXAMPLE

A County Council

The Information Commissioner was asked to assess a Council's handling of an individual's subject access request. (A subject access request is a request by an individual under the Data Protection Act to an organisation to be informed of and receive a copy of all information that organisation holds about them.)

As a result of investigation the Commissioner found that the Council had failed to respond to the request within the statutory 40 days, due primarily to systemic failures in the Council's storage of paper records and their approach to handling requests. The Chief Executive signed a formal Undertaking with the Information Commissioner to ensure implementation of proper policies, procedures and staff training to handle requests. In addition, it specified improvements to records management systems and regular performance reporting on request handling to senior management to ensure that requests are responded to in an appropriate and timely manner in future.

EXAMPLE

General Practitioners (GPs)

A woman complained about the standard of care provided to her late daughter. She stated that, despite numerous attendances at the GP practice, her daughter's diagnosis of cancer was missed. It was only when the family had subsequently taken their daughter to A&E, as she appeared so ill, that her cancer was diagnosed. The complainant said that a referral to hospital should have been made by the GPs involved in her daughter's care. She also raised a concern about the quality of the computerised GP records.

Having investigated, the Ombudsman concluded that the daughter had not presented with the typical symptoms of the disease and therefore the Ombudsman did not criticise the fact that a hospital referral was not made. However, he was critical of the poor quality of the record keeping, which lacked clarity and appropriate detail of clinical assessment, physical signs and examination and made the following recommendations:

- the practice should review its standard of record keeping to ensure record keeping by GPs comply with GMC guidelines;
- that the GPs should specifically reflect on the adviser's comments and the findings of this report in relation to record keeping;
- the practice should provide a full written apology to the complainant and her family for the shortcomings in record keeping identified in this report and make a financial redress payment in acknowledgement of the uncertainty and distress that the poor recording had caused.



**Published by the Public Services Ombudsman for Wales
February 2016**

1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ
Tel: 01656 641150
Fax: 01656 641199

E-mail: ask@ombudsman-wales.org.uk
Web: www.ombudsman-wales.org.uk
Twitter: [@OmbudsmanWales](https://twitter.com/OmbudsmanWales)