Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 21613

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint is about how Belfast Health and Social Care Trust (the Trust) handled a complaint it received in October 2018. The complainant raised concerns with the delays experienced during the complaints process. She raised further concerns about the accuracy of the amended minutes of a meeting held in February 2019. The complainant was also concerned the Trust said in its response that she was not discharged from an independent healthcare provider when she considered she was discharged.

The investigation examined the details of the complaint, the Trust's response, information obtained from the independent healthcare provider, and the Department of Health's complaints guidance. The investigation found maladministration in relation to the Trust's handling of the complaint. In particular, it identified that the complaints process experienced significant delays. It also established that the Trust informed the complainant in its written response that the independent healthcare provider did not discharge her, which was incorrect. Furthermore, it found the Trust failed to outline on what evidence it based this conclusion.

I recommended that the Trust apologise to the complainant for the failures identified. I also recommended that the Trust reminds staff charged with the responsibility of investigating complaints of the need to provide full and accurate responses to all issues of the complaint within a reasonable timeframe.

THE COMPLAINT

1. I received a complaint about how the Belfast Health and Social Care Trust (the Trust) handled a complaint a Member of the Legislative Assembly (MLA) raised on behalf of his constituent (the complainant).

Background

2. The complainant was referred to the Trust's orthopaedic service in August 2012. The Trust referred her to 3FiveTwo Healthcare[1] (3FiveTwo) in December 2012 under a waiting list initiative. The complainant remained under the care of an Orthopaedic Consultant in 3FiveTwo from 2013 to 2016. The Orthopaedic Consultant in 3FiveTwo referred her to the neurology and neurosurgery departments in the Trust in early 2016, and she was discharged from 3FiveTwo. A Neurologist reviewed her in May 2016. The complainant also attended a Neurosurgeon (A) in July 2016. Neurosurgeon A referred the complainant back to 3FiveTwo on 14 July 2016.

3. The complainant said she contacted 3FiveTwo around November 2016, and was informed she was discharged. Her general practitioner (GP) again referred her to Orthopaedics in the Trust on 30 January 2017. The complainant attended a Neurosurgeon in 3FiveTwo (Neurosurgeon B) on 20 February 2017 and underwent further tests and scans. An Orthopaedic Surgeon within the Trust reviewed the complainant on 11 September 2017 and she was added to the waiting list for a total hip replacement. The surgery was undertaken in July 2018.

4. The complainant's MLA initially raised concerns to the Trust's Public Liaison Service[2] in January 2018 about her wait for surgery. These concerns were responded to in June 2018. However, the complainant's MLA initiated the Trust's complaints procedure on 25 October 2018. The complaint related to the care and treatment of the complainant from 2013 until the time of her surgery in July 2018. The complainant and her MLA met with representatives from the

[1] A private medical solutions company in Northern Ireland.
[2] This service manages enquires from complainants' representatives.

Trust to discuss her concerns on 6 February 2019. The Trust issued its first response to the complaint and its minutes of the meeting on 8 May 2019.

5. The complainant's MLA wrote to the Trust in June 2019 regarding its first response to the complaint. He said he and the complainant disagreed with sections of the response and the minutes. He also raised concerns with the length of time the Trust took to respond to the complaint. The Trust provided its second response to the complaint, and the amended minutes of the meeting, on 5 August 2019.

Issues of complaint

6. The issues of complaint accepted for investigation were:

   Issue 1: Whether the Trust handled the complaint 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 how the Trust handled the complaint. The Investigating Officer also interviewed the complainant (accompanied by her MLA) to obtain further information on the issues of complaint.

Relevant Standards

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 make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[3]:

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

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

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 and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards relevant to this complaint are:

   - The Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2009 (the DoH's Complaints Procedure).

10. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the administrative actions of the Trust. It is not my role to question the merits of a discretionary decision taken unless it was attended by maladministration.

11. 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.

12. 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.

INVESTIGATION

Issue 1: Whether the Trust handled the complaint appropriately and in accordance with relevant guidance.

Detail of Complaint

13. The complainant raised concerns with the delays experienced during the complaints process. She raised further concerns about the accuracy of the amended minutes of the meeting held on 6 February 2019. The complainant said the minutes documented that she telephoned an Orthopaedic Surgeon within the Trust herself, which she said she had not. She also said the minutes referred to an appointment she had with a private healthcare specialist, which was not discussed during the meeting. The complainant was also concerned

that the Trust said in its response that she was not discharged. She maintained this was incorrect and said 3FiveTwo informed her it discharged her in February 2016.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies and guidance:

    - The DoH's Complaints Procedure

    Relevant extracts of the guidance referred to are enclosed at Appendix three to this report.

The Trust's response to investigation enquiries

15. In response to enquiries, the Trust explained that the complaint '*was shared with both the senior team in orthopaedic services and contracts for investigation and response, and both teams agreed that it would be more beneficial for Trust staff, [the MLA and the complainant] to meet and discuss the concerns raised'*. It said the meeting occurred on 6 February 2019, and on 8 May 2019 it responded to the complaint and issued a copy of the minutes.

16. The Trust explained that the complainant's MLA '*contacted the Trust on 5 June 2019 as he was unhappy with the delay in being issued with a response and also sought clarification on behalf of [the complainant] in terms of the minutes and also correspondence which had been sent addressed to the wrong consultant'*. It said it issued a further response to the MLA on 5 August 2018. The Trust explained it did not have any further contact from the complainant or her MLA.

17. The Trust apologised for '*the delays they experienced with our complaints handling process'*. It explained that '*there was an initial delay in arranging the meeting with both [the complainant and her MLA] from the time the complaint was received…Unfortunately, due to staff's availability and clinical commitments the first available time that staff could meet was 6 February 2019. I would like to apologise for this initial delay'*.

18. The Trust explained that at the time of the meeting, '*it was determined that there was a delay with 3FiveTwo Healthcare who failed to action an incorrectly addressed letter…which meant that [the complainant] was not referred back to the Trust in a more timely manner. This point therefore required Trust staff to contact 3FiveTwo Healthcare to seek clarification into why this occurred and a response was subsequently received by the complaints department on 19 March 2019'*.

19. The Trust said that '*there was a delay due to the Trust's internal approval process which requires that draft responses are approved by the Co-Director prior to sending it to the Director for final approval and signoff. There was also a delay finalising and approval of the draft minutes'*.

20. The Trust said it received a further letter from the complainant's MLA on 5 June 2019. It explained that staff '*provided a response for approval on 17 June 2019, however our Co-director made a number of comments and sought clarification on some points. These amendments were finally agreed and a response was sent to the Director for signature on 1 July 2019'*. The Trust explained that '*due to a breakdown in the internal administrative process there was a significant delay and for this I sincerely apologise'*. It further explained that '*this process has been reviewed and I can confirm that if a member of staff within Trust Headquarters is off, Complaints staff are notified who the contact person is in their absence'*.

Relevant records

21. A summary of the records considered is enclosed at Appendix four to this report.

Interview

Interview with the complainant and her MLA

22. The complainant said the amended minutes for the meeting held on 6 February 2019 had '*discrepancies*'. She said the minutes documented that during the meeting, the Trust '*brought up an issue of a private appointment I had with the doctor myself at the end of 2015 which they said was mentioned at the meeting but they didn't'*. The complainant also said the Trust '*maintained I rang up and I*

booked that appointment with [the orthopaedic surgeon]. How would I do that…That appointment was arranged through having to be re-referred by 3FiveTwo'. The complainant and her MLA said the process experienced a further delay due to the need for the Trust to correct its errors within the minutes.

23. During her interview, the complainant said the Trust told her she was not discharged. She said she was '*distinctly told by 3FiveTwo I was discharged…without being informed'*.

24. In relation to the delay in the Trust's response to the complaint, the complainant's MLA said they met with the Trust on 6 February 2019. However, it did not provide its response to the complaint until 8 May 2019. The MLA said the Trust informed him that the response was '*on a Director's desk for signoff*'. However, it was not received until months after this. The MLA questioned why this particular part of the process experienced such a delay.

Other information considered

25. In relation to its discharge of the complainant, 3FiveTwo explained that *'the outcome from the complainant's review with [the Orthopaedic Consultant] on the 27.2.16 was a discharge from [his] care and tertiary referral was made to the Belfast Health and Social Care Trust's Neurosurgery Service at the Royal Victoria Hospital'*. It further explained that the Orthopaedic Consultant '*discharged the complainant and referred her onto the neurosurgery department at RVH for further assessment'.*

The complainant's response to a draft copy of this report

26. The complainant questioned why the Trust failed to ask 3FiveTwo whether or not it discharged her.

The Trust's response to a draft copy of this report

27. The Trust acknowledged that the delays in the process were '*unacceptable*'.

Analysis and Findings

28. The complainant raised concerns with delays experienced during the complaints process. I note a complaint was raised with the Trust on 25 October

2018. The DoH Complaints Procedures states that *'a full investigation of a complaint should normally be completed within 20 working days'*. However, I note the Trust did not provide its initial response until 8 May 2019. This is more than 130 working days after the complaint was submitted. I find this delay significant and unacceptable.

29. The complainant's MLA raised concerns with the Trust regarding its initial response to the complaint in his letter dated 5 June 2019. The Trust provided its response to these concerns 40 working days later, in its letter dated 5 August 2019. I note the Trust explained a written response to these concerns was first drafted before 17 June 2019. I also note that although its written response was amended, the final draft was sent for signature on 1 July 2019. This was more than one month before the letter was issued. I also find this delay significant and unacceptable.

30. I accept it may not always be possible for the Trust to fully respond to a complaint within the stated 20 day timeframe. However, I expect bodies to take immediate and appropriate action to investigate and respond to issues raised. Having reviewed the records, I do not consider those involved in the process demonstrated sufficient urgency to respond to the complaint within an acceptable timescale. I acknowledge the Trust arranged to meet with the complainant (and her MLA) to discuss her concerns. However, a meeting was only suggested one month after the complaint was submitted, and did not occur until over three months after the process began. I also acknowledge the Trust made enquiries of 3FiveTwo as part of its investigation process. However, the records document that this process took only six weeks (from 6 February to 19 March 2019) and would not account for the extensive delays experienced. I note the Trust acknowledged that internal processes led to the delays and I welcome its acceptance that the length of time taken to respond to the complaint was unacceptable.

31. The complainant also raised concerns with the accuracy of some of the information contained in the Trust's final response to her complaint, issued on 5 August 2019. The Trust documented in its letter that 3FiveTwo did not discharge the complainant, which she said was incorrect. I note that in

response to my enquiries, 3FiveTwo explained it discharged the complainant from its clinical pathway in February 2016. Therefore, I am satisfied the Trust incorrectly informed the complainant that 3FiveTwo did not discharge her.

32. The complainant questioned why the Trust did not ask 3FiveTwo if it discharged her before responding to her complaint. I note the Trust made enquiries of 3FiveTwo during its investigation. However, its records do not outline what enquiries it made. They also do not document 3FiveTwo's response to the enquiries, or the Trust's consideration of the information obtained. Therefore, I cannot determine whether or not the Trust asked 3FiveTwo if it discharged the complainant. I also cannot determine what led the Trust to find that 3FiveTwo did not discharge the complainant. I am critical of the Trust's failure to retain a copy of its enquiries. While I cannot conclude on this matter, the Trust's failure to provide the complainant with accurate information regarding her discharge leads me to believe that it did not put this question to 3FiveTwo in the course of its investigation. This gives me concern about the quality of the Trust's investigation of this particular issue of complaint.

33. The DoH Complaints Procedure states that information provided in responses to complaints ought to be accurate and '*address the concerns expressed by the complainant and show that each element has been fully and fairly investigated*'. I am satisfied the complainant (and her MLA) raised this specific issue during her meeting with the Trust in February 2019. However, I do not consider the information the Trust provided in its response was accurate. Furthermore, by not outlining on what evidence it based its finding, the Trust failed to fully address this element of the complaint in its response. Therefore, I am not satisfied the Trust demonstrated that it fully and fairly investigated this issue. By failing to do so, I consider the Trust failed to act in accordance with this element of the DoH Complaints Procedure.

34. The complainant also raised concerns with the accuracy of the minutes taken at the meeting on 6 February 2019. I note the Trust amended the majority of the inaccuracies the complainant's MLA highlighted in his letter dated 5 June 2019. However, the complainant and her MLA remained dissatisfied with the accuracy of the final version issued in August 2019.

35. The complainant said the minutes document that she telephoned an Orthopaedic Surgeon in the Trust. However, she said she did not telephone him, and questioned how she would know to do this. I note that in its second letter of response, dated 5 August 2019, the Trust informed the complainant that it amended this error. However, I note the amended minutes still document that the complainant telephoned the surgeon.

36. The complainant also said the minutes document that the attendees of the meeting discussed a private medical appointment she attended, which was unrelated to the Trust's or 3FiveTwo's treatment of her. She said this was not discussed during the meeting and should not be included in the minutes. I note the complainant and her MLA raised this point with the Trust. In response, the Trust maintained that the attendees discussed a letter relating to the appointment, and the point remained in the minutes. Based on the evidence available, I am unable to conclude whether or not the complainant's private appointment was discussed during the meeting, and as such, whether it ought to have been included in the minutes.

37. I acknowledge that disagreement of meeting minutes is commonplace. I note the DoH's Complaints Procedure does not outline a process for this situation. However, when it occurs, I expect bodies to make efforts to seek agreement as much as possible. While I note the Trust considered the points of disagreement raised, it continued to issue the final version without consulting further with the complainant (or her MLA) about the outstanding points of disagreement. I consider that had it done so, the Trust may have been able to clarify any misunderstandings and may have reached agreement on the minutes. I would ask the Trust to consider taking this action in future.

38. I consider the failings identified in paragraphs 30 and 33 of this report amount to maladministration. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with complaints promptly and avoid unnecessary delays. Furthermore, the Third

Principle of Good Complaint Handling requires bodies to provide full, clear and evidence-based explanations for their decisions, and to keep clear and accurate records. I consider the Trust failed to act in accordance with these Principles in its handling of the complaint. I am satisfied that this constitutes maladministration. As a consequence, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration and uncertainty. Furthermore, I am satisfied that it caused the complainant the time and trouble of bringing her complaint to my office.

CONCLUSION

39. I received a complaint about how the Trust handled a complaint it received in October 2018. My investigation found maladministration in relation to the Trust's handling of the complaint. In particular, it identified that the complaints process experienced significant delays. It also established that the Trust failed to provide full and accurate information to the complainant about her discharge from 3FiveTwo in its response to her complaint.

40. I am satisfied that the failures identified caused the complainant to experience the injustice of frustration and uncertainty. I am also satisfied that it caused the complainant the time and trouble of bringing her complaint to my office.

Recommendations

41. I recommend within **one** month of the date of this report:

    i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice experienced caused to her as a result of the maladministration identified; and

    ii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to provide clear, full and accurate responses to all issues of the complaint within a reasonable timeframe. This will enable the Trust to meet the target timeframe set out in relevant guidance.

MARGARET KELLY
Ombudsman **March 2021**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **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.

4. **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 and actions 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

5. **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.

6. **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 learning from complaints.

    - Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.