Northern Ireland
Public Services
Ombudsman

OMBUDSMAN'S REPORT

2020-2021

CONTENTS

EXECUTIVE SUMMARY

2020-2021 IN FIGURES

Despite an unsettling year in the face of the pandemic, we have adapted to enable our Office to continue its function of investigating complaints about public services.

1600+ People

We helped over 1,600 people, either through independently assessing their complaint or by directing them to the appropriate public body or advice service.

927 Complaints

This was 11% lower than the previous year. Complaint numbers dropped significantly at the start of the pandemic, but by the year-end returned to pre-Covid levels.

87 Investigation Reports

We investigated these cases based on our '3Ps' – proportionality, public interest, and practical outcome. We published 56 of these investigations on our website.

88 Covid-related complaints

Many of these came to us before the complaint was made to the public body. We are likely to see the outworkings of these complaints in the coming year.

SECTION ONE

FOREWORD FROM THE OMBUDSMAN

"Like every other organisation our service was affected by the COVID-19 Pandemic."

OMBUDSMAN - MARGARET KELLY

FOREWORD

For me, being the Public Services Ombudsman is about making a difference for people and public services in Northern Ireland.

Making a difference to the many people who come to my Office seeking an independent and impartial investigation, an answer to what has occurred in their own personal circumstance, and for there to be learning so that 'it doesn't happen to someone else or their family.'

It is also about making a difference to public services, providing opportunities to learn from mistakes and to recognise that complaints can be both an early warning system and an opportunity to identify trends and the need for change.

This is the first Ombudsman's Report of my seven year term, and while I have been in post for just half of the year covered in this report I am pleased to share the wide range of work undertaken by my Office and to demonstrate the difference we have made through our casework.

To illustrate this work, the report is split into three sections:

- Helping people
- Oversight and accountability of public bodies
- Improving public services

As I continue as Ombudsman, over the course of my term I want 'making a difference', and demonstrating that difference, to be a core theme and

one that grows in importance and impact. I believe that in order to make that difference my Office needs to be connected and accessible and in this, my first year as Ombudsman, I have sought to connect to a wide number of groups, individuals and public services to more fully understand the issues and challenges we face.

I believe that it is important that the wider public is aware of the Ombudsman's Office, and of when and how we can help. Equally I believe that it is important that we have a positive working relationship with public services, where learning from and valuing complaints is part of the norm. I plan to ensure we connect more and are more accessible, as well as more clearly demonstrate the outcomes and impact from our work.

This was of course no ordinary year, and every one of us was impacted by Covid-19, with too many losing loved ones. Health and social care services were at the frontline and were hugely impacted, but all public services, including my Office, felt the effects of Covid-19. Complaint numbers dropped significantly when the pandemic hit and only began to return to expected levels towards the end of the year. This trend was in line with other Ombudsman services. We have provided information on our Covid-19 complaints on page 15, and these demonstrate the issues of concern among the public. We will continue to see the out-working of these complaints in the months ahead.

Despite the challenge presented by the pandemic I am pleased to say we continued our work without any notable disruption to our service, and I would like to thank the NIPSO staff for their enormous efforts in making sure we carried on receiving and investigating complaints despite the sudden move to home working.

I would also like to acknowledge and thank those public bodies who continued to co-operate and respond to our requests for information despite the difficult circumstances. I would also like to thank the public for their patience throughout this time.

There has been an Ombudsman's Office in Northern Ireland for over 50 years and I am honoured to hold this role. Over the next six years I aim to use the significant powers of my Office to continue its long tradition of providing independent investigation and remedy for individuals, and to ensure learning and improvement to make a difference for all.

Margaret Kelly
Ombudsman

SECTION TWO

WHAT WE DO

WHAT WE DO

The main purpose of the Northern Ireland Public Services Ombudsman is to investigate unresolved complaints about public bodies in Northern Ireland. These include:

Central Government

Departments of the Northern Ireland Assembly and other government agencies.

Local Government

The 11 local councils in Northern Ireland.

Housing

All social housing associations.

Education

All schools, colleges of Further Education, and universities.

Health and Social Care

Hospitals, nursing homes, and family practitioner services such as GPs, dentists, opticians, etc.

Our service is free, impartial and independent.

- **Initial Assessment**

  We look at all cases to see if we can investigate. Generally speaking we are only able to accept a complaint if it has already been examined by the public body. We can also only look at complaints if a person thinks they have sustained an injustice because of an unfair or unreasonable decision made by the public body.

- **Assessment/First stage investigation**

  During this stage we ask the public body for information about the complaint before making a decision about whether we should investigate further. If we believe that a complaint can still be resolved without us becoming fully involved we will try to arrange a settlement between the complainant and the public body. We may also return a case to the body if we think someone's concerns have not been properly addressed in the complaints process.

- **Investigation**

  If we cannot help resolve a case at the Assessment stage, and think that we need to take a more detailed look, the complaint will be sent to the Investigations team.

SECTION THREE

CASELOAD OVERVIEW 2020-21

Caseload overview – 2020-21

We received a total of 927 complaints last year. This is a reduction of 11% on 2019-20. Although we have not carried out detailed research into why complaint numbers dropped so significantly, it is reasonable to assume they fell as a result of Covid-19.

To illustrate this, in February and March 2020 we received 97 and 82 complaints respectively. However, in April 2020 we received only 30 complaints, a drop of 55% from the total in April 2019. Complaint numbers continued to be lower than usual throughout the year, until they climbed to 136 in March 2021.

These figures mirror the situation in other Ombudsman offices in the UK, Ireland and internationally.

The things people complained about were broadly in line with previous years. They are reflected in our analysis of Investigation Reports (see pages 15-20). However, throughout the year we also recorded complaints which referenced Covid-19 to help us monitor any notable trends.

See the Appendix for further details on these findings.

- 33% Health and Social Care
- 19% Govt Departments & Agencies
- 14% Other
- 12% Education
- 11% Housing
- 11% Local Councils

We received a total of 88 Covid-related complaints, with the largest group (20) concerning the allocation of Small Business Grants. There were 14 complaints in the health sector, relating to a number of issues including denied access to loved ones, death certificates, and clinical care. Ten of the complaints were about the education sector, primarily the awarding of grades, and eight were about the availability or cancellation of driving tests.

We were unable to progress many of these complaints because they came to us before they were dealt with by the relevant public bodies, but Covid-related complaints are likely to feature throughout the coming year and beyond.

A common theme, consistent with previous years and featuring across all sectors, was the number of investigations into **poor complaints handling** and **poor record keeping** by public bodies. This demonstrates the importance of our ongoing work to simplify and standardise complaints handling procedures throughout public services in Northern Ireland.

Further details on the type of complaints we investigated during the year can be found throughout this report.

Health and Social Care

Examples of cases we investigated include complaints about poor communication with patients and their families, concerns about patient medication, delays in treatment, misdiagnosis, and discharge from care.

See page 42 of the Appendix for further details on these findings.

33%

of all complaints related to Health and Social Care

	Complaints Received in 2020-21
Health & Social Care Trusts	234
Health Service Providers	51
Independent HSC Provider - Private Nursing Home	11
Independent HSC Provider	7
Regional Health & Social Care Board	4
Patient & Client Council	1
Public Health Agency	1
Business Services Organisation	1
Guardian Ad Litem Agency	1
Regulation and Quality Improvement Authority	1
Total	**312**

Government Departments and Agencies

Examples of cases include complaints about the refusal of small business grants and welfare benefits, concerns about business and domestic rates, the availability of driving tests, and Departmental responses to planning applications.

See page 45 of the Appendix for further details on these findings.

	Complaints Received in 2020-21
Department for Communities	74
Department for Infrastructure	21
Driver & Vehicle Agency	19
Department of Finance - Land & Property Services	19
Department for the Economy	17
Department of Finance	11
Department of Agriculture, Environment and Rural Affairs	6
The Executive Office	4
Assembly Commission	2
Department of Education	2
Northern Ireland Environment Agency	2
Department of Justice	1
Department of Health	1
Total	**179**

19%

of complaints related to Government Depts and their agencies

Education

Examples of cases include how schools dealt with concerns about bullying, complaints about grades following Covid-19, and school responses to issues around Special Educational Needs.

See page 46 of the Appendix for further details on these findings.

	Complaints Received in 2020-21
Board of Governors of Primary School	42
Board of Governors of Secondary School	15
Education Authority	11
Queen's University Belfast	10
Ulster University	9
Board of Governors of Grammar School	6
Board of Governors of Nursery School	4
Board of Governors of Special School	3
North West Regional College	3
General Teaching Council for Northern Ireland	2
College of Agriculture, Food & Rural Enterprise	1
Northern Regional College	1
South Eastern Regional College	1
Total	**108**

12%

of complaints related to education

Local councils

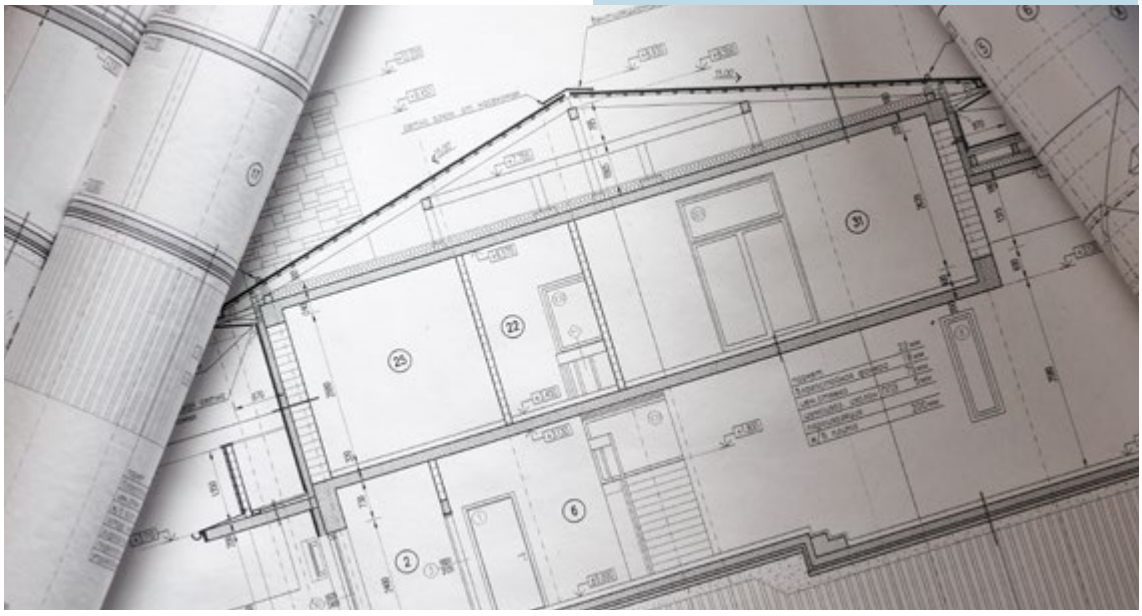
Examples of cases include complaints about the handling of planning applications, (including council responses to breaches of planning permission), as well as concerns about record keeping and poor complaint handling.

See page 43 of the Appendix for further details on these findings.

11%

of complaints related to local councils

	Complaints Received in 2020-21
Belfast City Council	18
Newry, Mourne & Down District Council	14
Antrim & Newtownabbey Borough Council	11
Lisburn & Castlereagh City Council	10
Causeway Coast & Glens Borough Council	9
Derry City & Strabane District Council	7
Mid & East Antrim Borough Council	7
Mid Ulster District Council	7
Ards & North Down Borough Council	6
Armagh City, Banbridge & Craigavon Borough Council	6
Fermanagh & Omagh District Council	3
Total	**98**



Housing

Examples of cases included complaints about repairs, waiting lists, eviction, nuisance neighbours, and housing benefit.

See page 44 of the Appendix for further details on these findings.

11%

of complaints related to housing

	Complaints Received in 2020-21
Northern Ireland Housing Executive	65
Radius Housing	12
Choice Housing	11
Habinteg Housing Association (Ulster) Ltd	5
Clanmil Housing Association Ltd	3
Apex Housing	1
Ark Housing Association (NI) Ltd	1
Total	**98**

SECTION FOUR

HELPING PEOPLE

Helping people

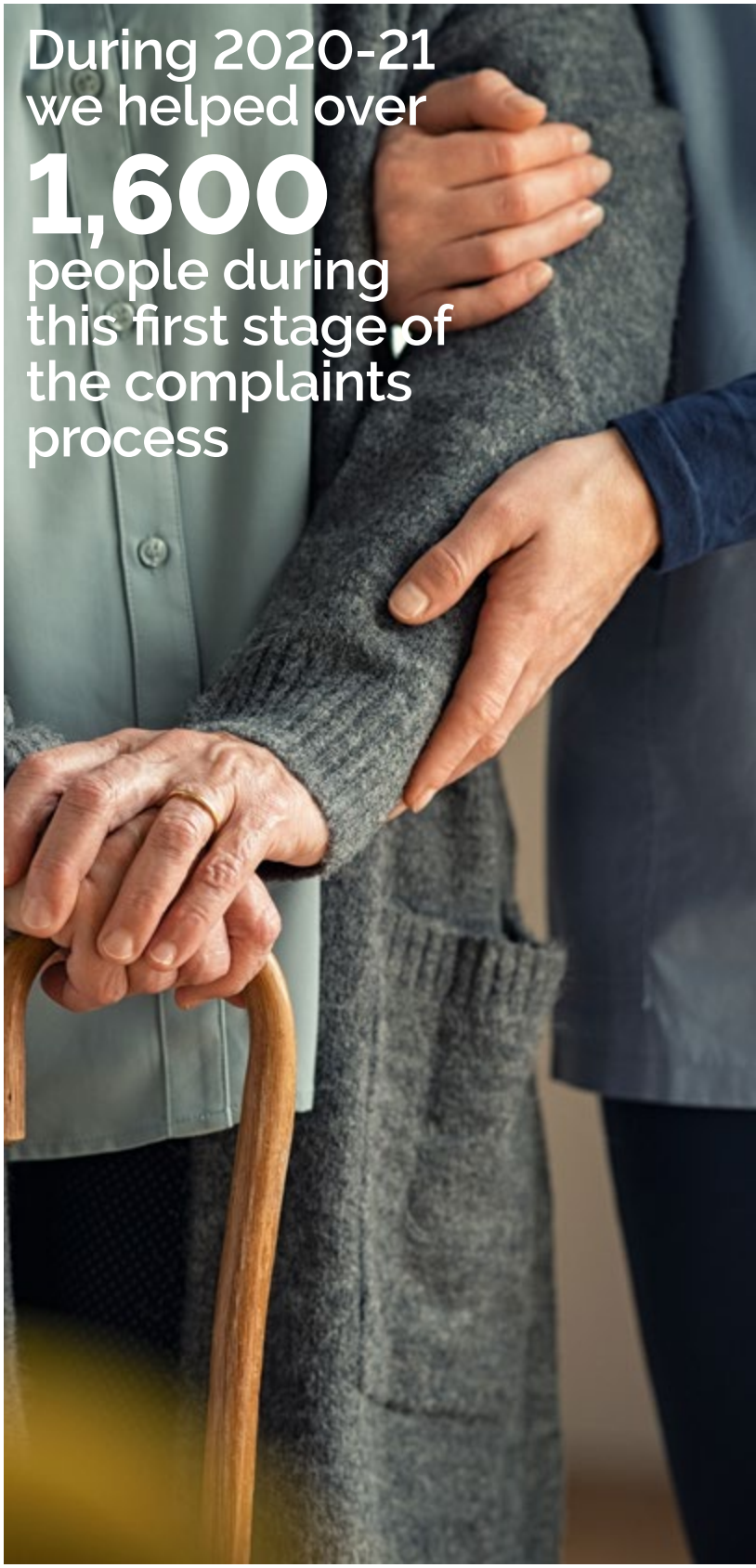
We help people by investigating their complaints or by referring them to others.

Our frontline staff listen carefully to people when they first contact us, and provide advice on whether we are the most appropriate organisation to look into their complaint. Sometimes, if we are unable to accept a complaint, for example if the person has not already complained to the public body, or if their complaint is about an organisation we cannot by law investigate, such as the police, a bank, or other private sector body, we advise who they should contact instead.

We also let people know that they can get support in making their complaint, either from an advice service, advocacy body, or local representative.

When we accept a complaint for further assessment we look to see what practical, flexible and innovative steps we can take to get the issues resolved quickly. We ask the public body what it has done to investigate the complaint, and if we feel more could have been done for the complainant we ask the body to take another look at it.

In our experience many people with a grievance just want their concerns to be acknowledged. We therefore encourage public bodies to resolve complaints themselves. Where this is possible it avoids complainants having to repeat their allegations to us and helps them find the outcome they want much quicker.



During the year we resolved 62 cases via settlements and local resolution.

In cases which do go for further investigation, our aim is to find out whether the allegations made in a complaint are true. Through our independent assessment of cases we can help resolve grievances which may have existed for some time. In health complaints, for example, often people tell us they just need to know what happened during their care and treatment so they can get peace of mind and reassurance things were done properly. They also want to make sure that if anything went wrong, a hospital or care home can rectify any mistakes to prevent others from going through the same experience.

We completed 87 investigation reports during 2020-21.

If our investigations find that the actions of a public body have unfairly caused a complainant distress, we will ask it to try and redress the injustice. We aim to put the complainant back in to the position they would have been if there had been no failure in service. Sometimes, if the complainant has suffered a financial loss, we recommend that the public body provide a payment. In other cases we recommend that it acknowledges the fault and apologises to the complainant.

"I just wanted to say thank you so much to your office for taking the time to consider my concerns during this process."

Case Summary 1

We helped a man whose business was turned down for the Covid-19 Small Business Support Scheme because the business he shared the premises with had already applied and received the £10,000 grant. The Scheme states that only 1 grant can be paid to each rateable property.

We discussed the case with the Department for the Economy who created the scheme. We highlighted a failure to identify that such a scenario might occur, and that it could have addressed the issue when the complainant appealed the decision.

The Department acknowledged that the complainant should have been given a part of the grant, and confirmed he would be paid an appropriate amount.

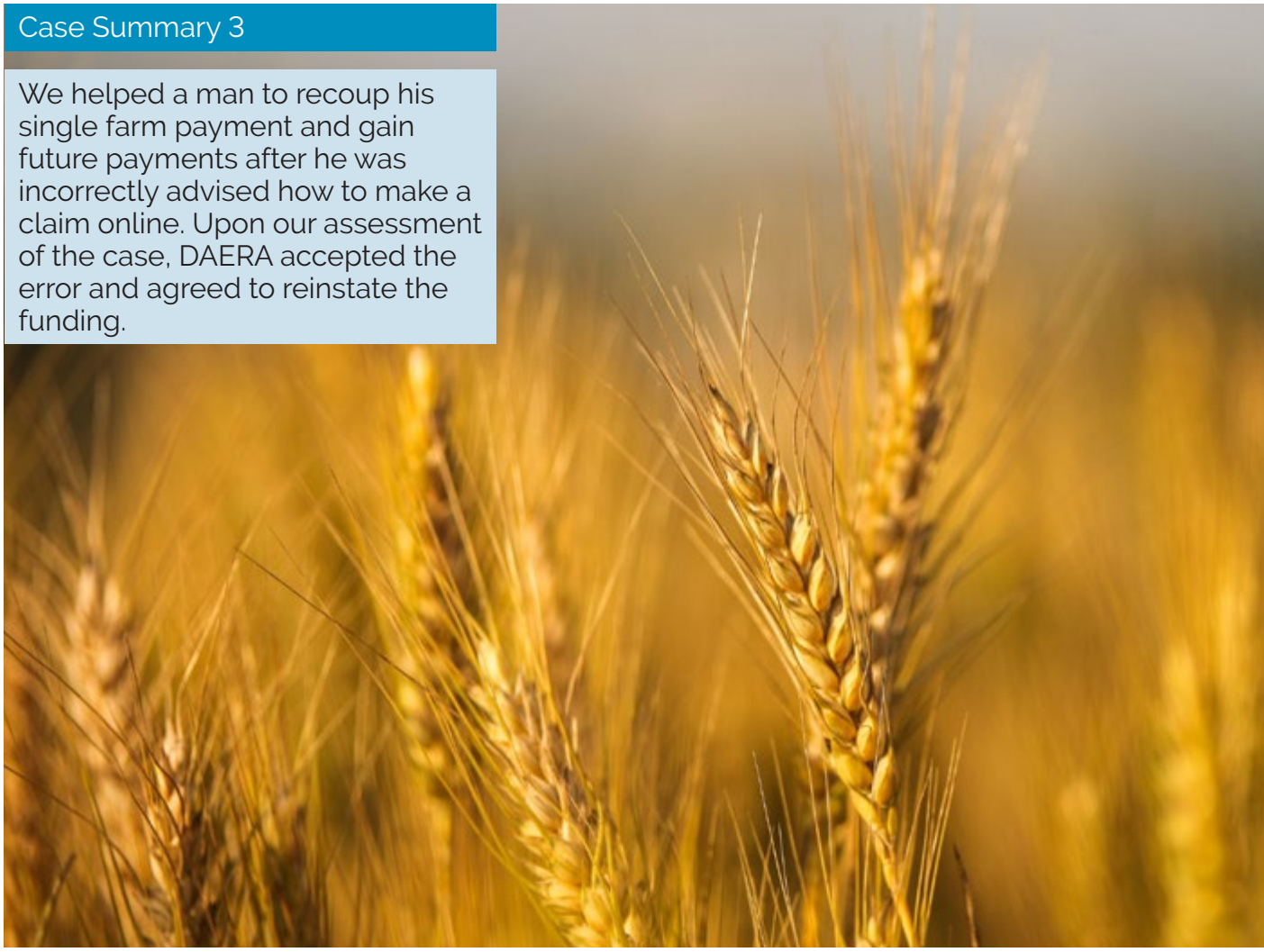
Case Summary 2

We helped a man whose personal items had gone missing in hospital whilst in an induced coma with COVID-19. Some of the items were of sentimental value. Following our enquiries the Belfast Health and Social Care Trust reimbursed him fully for the items to the cost of over £2,000.

"Thank you for the time and effort that went into this and for keeping me updated throughout."

Case Summary 3

We helped a man to recoup his single farm payment and gain future payments after he was incorrectly advised how to make a claim online. Upon our assessment of the case, DAERA accepted the error and agreed to reinstate the funding.



Case Summary 4

We helped a mother who wanted to complain about the way a school dealt with her daughter's Special Educational Needs (SEN). The school had refused to provide her with a response to her complaint, saying that it was a matter for a Tribunal.

After we explained to the Board of Governors that the matters fell within its complaints policy, the school agreed to look at the mother's concerns.

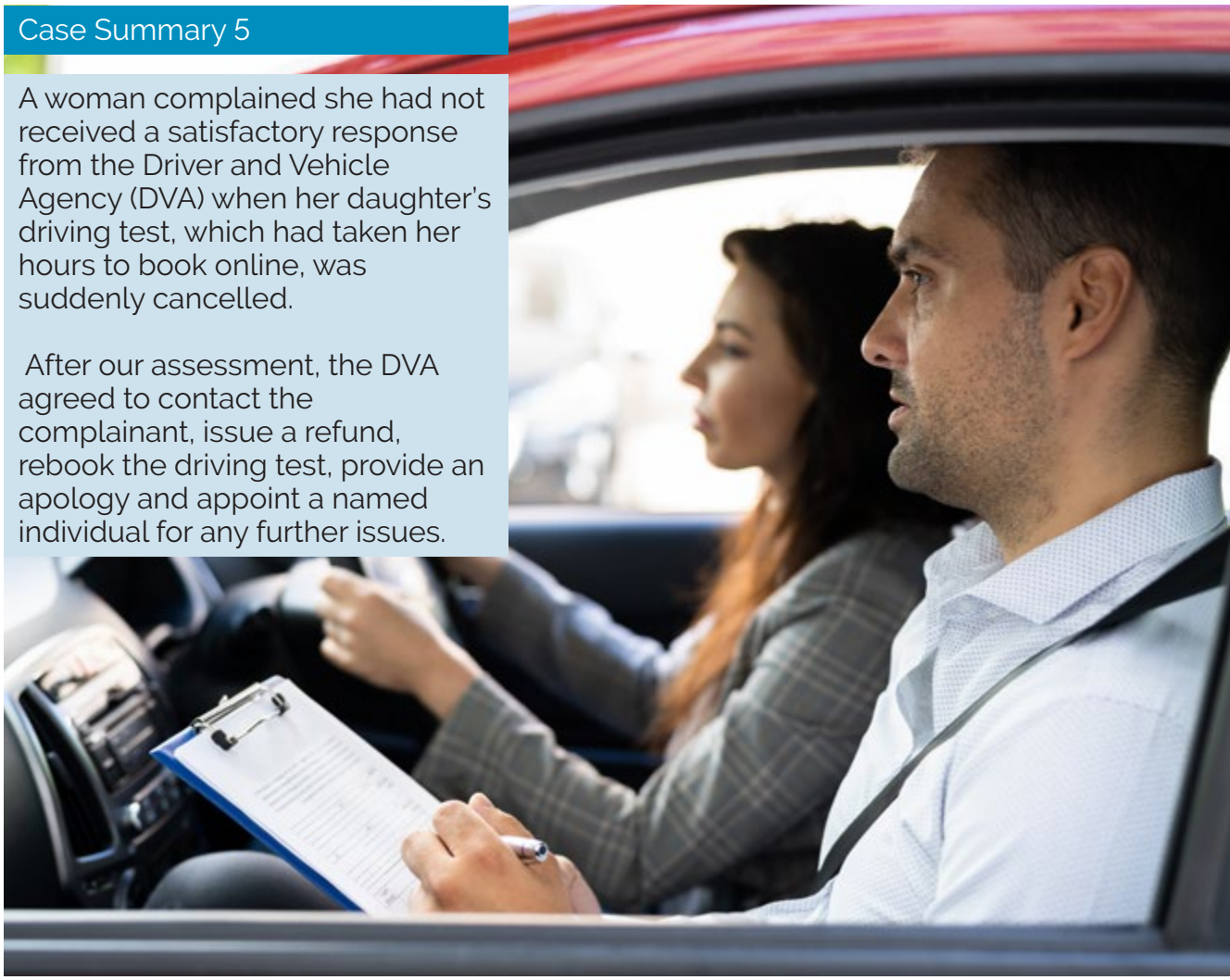
"I want to thank you in particular for the caring and professional manner in which you dealt with me, and kept me updated on the progress … in the case."

"I want to thank you for the dignity and respect you have shown me and your professionalism during this process."

Case Summary 5

A woman complained she had not received a satisfactory response from the Driver and Vehicle Agency (DVA) when her daughter's driving test, which had taken her hours to book online, was suddenly cancelled.

After our assessment, the DVA agreed to contact the complainant, issue a refund, rebook the driving test, provide an apology and appoint a named individual for any further issues.



"We are very pleased with the report and the focus on specific system change. We hope that this will improve care long term."

"You have been very thorough and balanced in your approach and have dealt with us with great sensitivity."

SECTION FIVE

OVERSIGHT & ACCOUNTABILITY

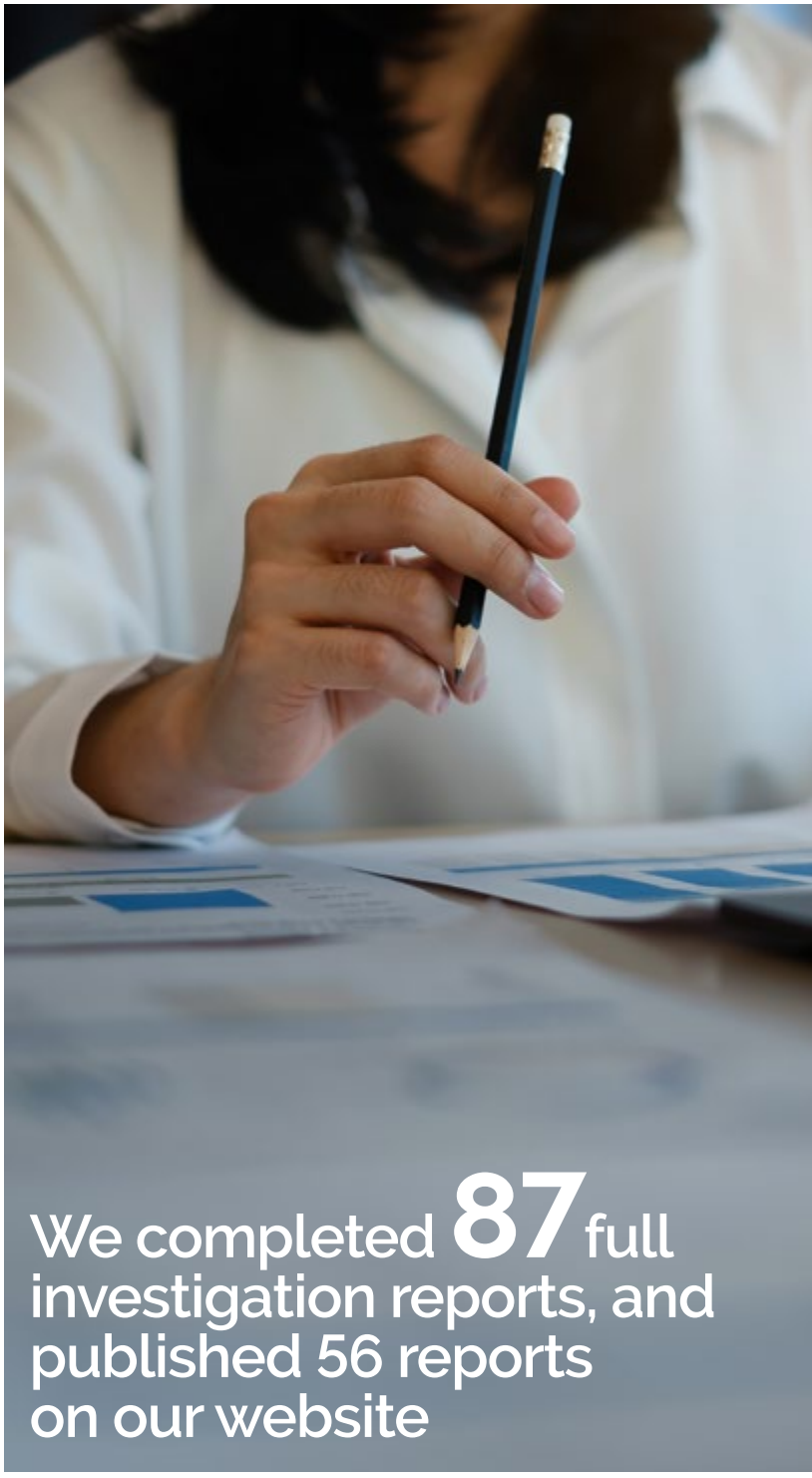
Oversight and accountability of public bodies

We hold bodies to account for their actions. This helps to increase people's trust in public services.

As an independent and impartial organisation we look at complaints without bias. We do not take sides in any investigation. During an investigation we look at the allegations made by the complainant and ask the public body for its response. If we do not see any evidence of fault by the public body we will say so.

However, our investigators are rigorous in asking questions to help them understand how and why things happened. If they request information from a hospital, care home, school, government department or any other organisation within our remit, then by law that organisation should provide it. This is the basis on which all Ombudsmen work, and is seen as crucial to making sure that public services are accountable for their actions and decisions.

We also hold public bodies to account by publishing our investigation reports. Although we do not publish all of our reports out of respect for the privacy of complainants or members of staff, we believe it is often in the public interest to release our findings. The reports show not only how comprehensive our investigations can be, but also provide an interesting insight into the workings of public bodies. They are also important in showing how we, as an open and accountable organisation, carry out our role.



One of our main functions during an investigation is to find out whether public bodies have acted properly in their dealings with the public, and specifically whether they have delivered 'good administration'. The sorts of things expected under good administration include a focus on getting decisions right, being customer focused, acting proportionately and fairly, and putting things right when they go wrong.

Maladministration is the opposite of good administration, and includes actions which were careless, taken by mistake, or were otherwise unjust, unfair, or unreasonable.

Our focus on good administration means we adopt a consistent approach to our investigations, providing public bodies with a framework by which their actions can be held to account.

During the year we continued work on our first Own Initiative investigation into the handling of Personal Independence Payment assessments.

Case Summary 6

We found multiple failings in the way the Belfast Trust handled a couple's adoption application.

We found that it failed to state clearly its concerns with the couple's suitability to adopt, and did not retain appropriate assessment records. Our report also concluded that the Trust failed to follow sections of the Adoption Regulations, as well as its own guidance. We said that the Trust did not provide the couple with clear reasons why it stopped their assessment, and that it failed to provide them with the opportunity to have an Adoption Panel consider their application.

Acknowledging the injustice of distress, uncertainty, and the loss of opportunity to have their adoption application properly considered, we put forward a number of recommendations to the Trust. These included a written apology to the complainants, the opportunity for them make a new application, and for the Trust to carry out an audit of previous adoption applications. We also asked the Trust to reflect on our report findings and engage staff in further training on this issue.

"Thank you so much for your intervention. My Dad … is so grateful for what you have done have done for him. Once again a big thank you. Keep up the amazing work."

Case Summary 7

We criticised Derry City and Strabane District Council for not making contemporaneous records over whether to carry out a Habitat Regulation Assessment during a planning case.

Case Summary 8

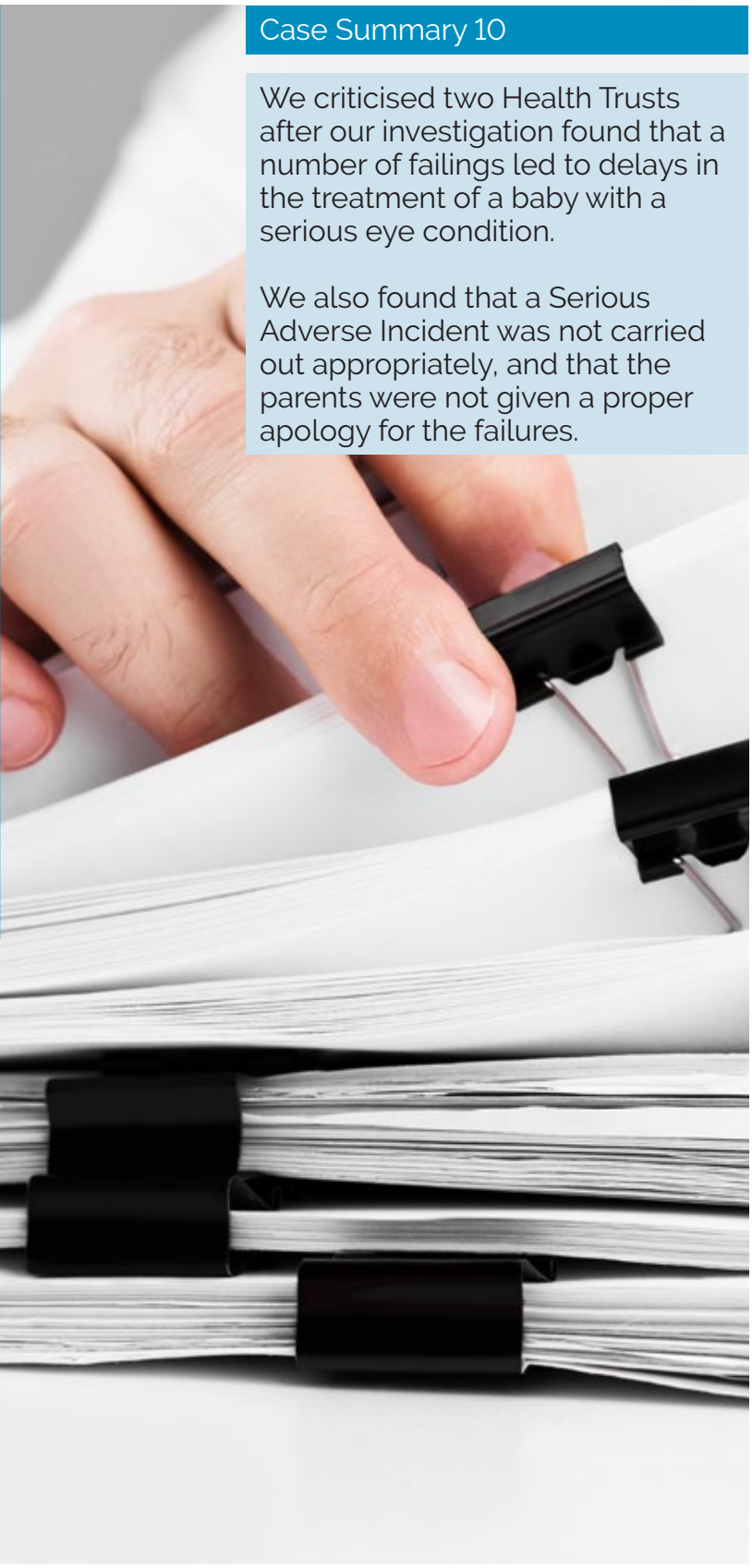
We asked the Chief Executives of three Health Trusts to apologise after an error in recording a man's date of birth led to him being confused with another patient.

"I am so thankful for all your help with this matter and [that] it has now been resolved."

Case Summary 9

We found that delays by the Driver and Vehicle Agency (DVA) in managing a complainant's renewal form, caused his taxi driver's licence to expire, leaving him temporarily unable to earn a living.

As a result we asked the DVA to review the way it carries out medical assessment applications, conduct an audit into licence renewals where medical assessments are undertaken, and review its service level agreement with the Occupational Health Service.



Case Summary 10

We criticised two Health Trusts after our investigation found that a number of failings led to delays in the treatment of a baby with a serious eye condition.

We also found that a Serious Adverse Incident was not carried out appropriately, and that the parents were not given a proper apology for the failures.

Case Summary 11

Our investigation into a complaint about the Southern Health and Social Care Trust found that it did not consider all of the available information when making a child's autism diagnosis. We asked it to apologise to the child and her mother after appropriate intervention and support only became available following a correct diagnosis over two years later.

Case Summary 12

Our investigation found that the South Eastern Trust failed to properly assess the risks faced by a patient who took his own life, and could have done more to help him before his death.

SECTION SIX

IMPROVING PUBLIC SERVICES

Improving public services

We help public bodies learn from mistakes to improve services for all.

Our investigations allow us to remedy individual cases of injustice. However, just as importantly, by making recommendations for service improvement we are able to help public bodies minimize the risk of similar errors occurring in the future. By doing this we can also help make things better for people who haven't directly complained to us.

Improving Complaints Handling

Throughout 2020-21 we continued work on a set of complaints handling standards for public bodies. Our 50 years' experience of looking at how public bodies deal with complaints has given us an excellent understanding of how they should be dealt with. Our proposals, which will simplify and standardise complaints handling procedures across the public sector, are aimed at helping public bodies provide the best complaints service to the public. They are also intended to encourage them to learn from the experiences of those who use their service..

During the year we had a total of 8 meetings with the complaints handling teams in government departments, local councils and health trusts. We established these Complaint Network meetings to support good practice in complaints handling. The Networks gave us, as well as each of the bodies, valuable insights into the main issues across each sector, particularly when they were being faced with the challenges of providing frontline services at the height of the pandemic.

We also carried out other engagement activities across the public sector. We met with 3 political parties (DUP, SDLP, TUV) to explain our work in detail and our plans for the period ahead. Meetings with the other political parties will take place during 2021-22. We also gave presentations to a number of advocacy bodies, including AdviceNI and NICVA, to explain to their members how we help the people they represent.

Continuing Healthcare in Northern Ireland

In February this year we called for an end to the confusion over who is responsible for paying the fees of those in care homes in Northern Ireland.

We released three investigation reports into complaints that health trusts had not properly assessed claims for Continuing Healthcare. Continuing Healthcare (CHC) relates to the practice of assessing whether a person's needs are primarily health care related or primarily social care related. This assessment can have an impact on whether a person is required to make a contribution to the cost of their care.

Our investigations found that Trusts were unsure of their responsibilities around CHC, even to the point of stating that it was not available in Northern Ireland. We upheld the complaints, finding not only that Trusts failed to carry out the assessments but also that they did not have the proper tools in place to carry them out.

Speaking at the time, Ombudsman Margaret Kelly said, "The concerns over the improper application of Continuing Healthcare have been around since they were highlighted in a report by AgeNI in 2014.

Failures to carry out assessments for CHC caused the families who complained to us real distress and frustration. It's vital that other families who may be facing a decision over whether to use life savings or sell the family home to fund the care of a loved one are given clarity over whether they are entitled to CHC."

The Ombudsman called on the Trusts, together with the Department of Health and others to agree a uniform approach for assessing all future applications for Continuing Healthcare in Northern Ireland, and to make this information available to those in care and their families.

Since the publication of the reports the Department of Health has published a paper entitled *'Continuing Healthcare in Northern Ireland: Introducing a Transparent and Fair System'*, and has committed to introduce a clear and easily understood test to ensure a standardised approach in continuing healthcare outcomes across Northern Ireland.

To reduce the potential for any ongoing confusion on this issue, we will continue to liaise with the Department over the coming year.

Case Summary 13

Following our investigation into a complaint from a woman with endometriosis who waited 4 years for an operation, we asked the South Eastern Trust to monitor the care of others with the same condition by reviewing a random sample of patients.

Case Summary 14

After we found that a procedure to insert a patient's catheter should have been abandoned, we recommended that the South Eastern Health Trust carry out staff training to help improve communication with patients who become distressed during post-birth procedures.

Case Summary 15

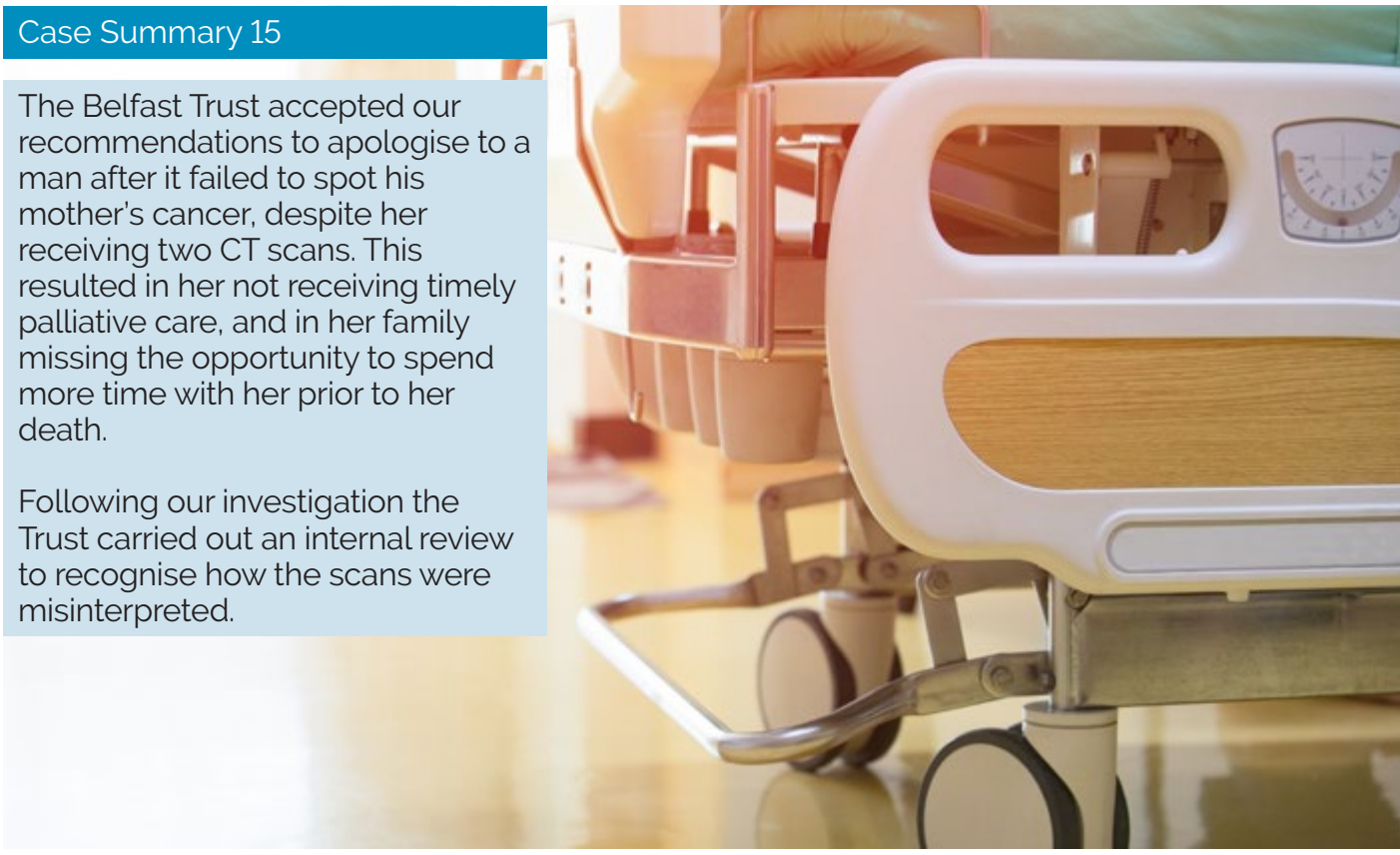
The Belfast Trust accepted our recommendations to apologise to a man after it failed to spot his mother's cancer, despite her receiving two CT scans. This resulted in her not receiving timely palliative care, and in her family missing the opportunity to spend more time with her prior to her death.

Following our investigation the Trust carried out an internal review to recognise how the scans were misinterpreted.

Case Summary 16

A General Practice acknowledged and addressed failures with its appointment booking system after our assessment highlighted the complainant's difficulties and frustrations in booking an appointment online.

Following our assessment, the Practice confirmed that it would discontinue the online booking system, make more phone lines available for appointment bookings, provide staff training and, update their complaints procedure.



The use of restrictive practices in Northern Ireland schools

During the year we expressed concern with the use of restraint and seclusion in some Northern Ireland schools.

In three investigation reports we found a number of recurring themes, including;

- A lack of up-to-date policies and procedures for dealing with the issue of seclusion and/or restraint
- Failure to consult with parents on this issue and failure to fulfil the requirement to inform parents of each incident of restraint or seclusion
- Poor recording of times when the practice had been used
- Failures to properly deal with complaints from parents

We asked the Department of Education and others in the education sector if the practice of withdrawal, or use of a room for isolation was widespread. The responses identified that little to no regulation is undertaken in regard to the use of seclusion and/or restraint.

Our recommendations to the schools we investigated included;

- Reviews and implementation of appropriate policies and practices, with a focus on record keeping and engagement with parents;
- Enhanced training to staff
- A requirement for improved recording of decision making around the use and monitoring of restrictive practices.

These findings and recommendations highlight the need for the Department to introduce standardised policies for the restraint and seclusion of children.

They further support the continued drive, from Parent, Carer and Advocacy bodies, for improvement in parental involvement and communication, not only in the drafting of the new policies but also, on an individual level when Restrictive Practices are used. Several of the complaints we received may have been avoided if the parents of the child had been informed and/or provided with an opportunity to engage with the schools from the outset.

Case Summary 17

Our investigation into a complaint about the care and treatment of a cancer patient led to a review of the issue of pain management on two wards in the Mater and Royal Victoria hospitals.

Case Summary 18

We reminded Mid and East Antrim Borough Council of its record keeping responsibilities following our investigation of a complaint brought by an MLA. We also asked it to consider developing a formal policy around the role of public representatives in the planning process.

"Thank you for...
all your hard work in investigating this complaint.

Case Summary 19

We investigated a woman's complaint that her new-born baby had contracted an infection after being held by a paramedic on the way to hospital. We asked the Northern Ireland Ambulance Service Trust to look at providing suitable equipment for ambulances to help them safely transport babies and infants.

SECTION SEVEN

REPORT OF NIJAO

Northern Ireland
Judicial Appointments
Ombudsman

Introduction

The role of Judicial Appointments Ombudsman was created by the statutory framework set out in the Justice (Northern Ireland) Act 2002 and provides an independent and external element for those persons who wish to complain about any administrative aspect of their own experience as applicants during an appointment process for judicial office.

Background

A wide ranging review of the criminal justice system in Northern Ireland concluded in March 2000. One of its recommendations included the appointment of a person to oversee, monitor and audit the existing appointment procedures for judicial roles. This in turn led to the creation of the role of Commissioner for Judicial Appointments who carried out a review of the existing processes for appointing judges. Following the passage of legislation, this resulted in the establishment in Northern Ireland of Northern Ireland Judicial Appointments Commissioner (NIJAC) in 2005 and the Northern Ireland Judicial Appointments Ombudsman (NIJAO) in 2006.

Legislation and Status

The 2002 Act provided the statutory framework for the establishment of the Northern Ireland Judicial Appointments Ombudsman. Sections 9A to 9H of the 2002 Act defined the arrangements for investigating complaints which were made to both NIJAC and to the Judicial Appointments Ombudsman respectively and how they were to be reported.

The 2002 Act provides for the Judicial Appointments Ombudsman to submit a report at the conclusion of each financial year. Following the devolution of policing and justice matters to the Northern Ireland Assembly in April 2010, such reports were laid by the Minister of Justice before the Assembly. However, the legislation governing the procedures for laying a report were amended by the Public Services Ombudsman Act (Northern Ireland) Act 2016 (the 2016 Act) to provide for the report to be laid before the Assembly by the Ombudsman. Copies of previous Annual Reports can be obtained from the website www.nipso.org.uk

The statutory role of the Judicial Appointments Ombudsman is defined as a corporation sole and is independent of the Assembly, Government, the judiciary, NIJAC, the Northern Ireland Courts and Tribunals Service or the Department of Justice (Northern Ireland).

Complaint Activity 2020-21

During 2020-21 no complaints about NIJAC were received by the Judicial Appointments Ombudsman.

SECTION EIGHT

APPENDICES

Appendix 1

Breakdown of statistics

Health & Social Care

	Brought Forward @ 01/04/20	Complaints Received in 2020-21	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2021
Health & Social Care Trusts	94	234	133	39	51	105
Business Services Organisation	0	1	1	0	0	0
Guardian Ad Litem Agency	0	1	0	1	0	0
Health Service Providers	19	51	26	14	12	18
Independent HSC Provider	5	7	4	4	2	2
Independent HSC Provider - Private Nursing Home	2	11	7	1	1	4
Patient & Client Council	0	1	0	1	0	0
Public Health Agency	0	1	0	0	0	1
Regional Health & Social Care Board	0	4	0	3	0	1
Regulation and Quality Improvement Authority	1	1	0	0	2	0
Total	**121**	**312**	**171**	**63**	**68**	**131**

Complaints Received in relation to Health Care Trusts 2020-21

Trust	**Number of complaints**
Belfast Health & Social Care Trust	78
Northern Health & Social Care Trust	42
Northern Ireland Ambulance Service Trust	9
South Eastern Health & Social Care Trust	29
South Eastern Health & Social Care Trust (Prison Healthcare)	10
Southern Health & Social Care Trust	24
Western Health & Social Care Trust	42
Total	**234**

Complaints Received in relation to local Councils 2020-21

	Brought Forward @ 01/04/20	Complaints Received in 2020-21	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2021
Antrim & Newtownabbey Borough Council	0	11	2	8	0	1
Ards & North Down Borough Council	3	6	1	5	2	1
Armagh City, Banbridge & Craigavon Borough Council	0	6	3	3	0	0
Belfast City Council	4	18	13	3	1	5
Causeway Coast & Glens Borough Council	4	9	8	2	0	3
Derry City & Strabane District Council	5	7	4	4	0	4
Fermanagh & Omagh District Council	0	3	1	1	0	1
Lisburn & Castlereagh City Council	0	10	4	6	0	0
Mid & East Antrim Borough Council	1	7	6	1	0	1
Mid Ulster District Council	0	7	0	5	0	2
Newry, Mourne & Down District Council	0	14	10	1	0	3
Total	**17**	**98**	**52**	**39**	**3**	**21**

Complaints Received in relation to Housing 2020-21

	Brought Forward @ 01/04/20	Complaints Received in 2020-21	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2021
Apex Housing	0	1	1	0	0	0
Alpha Housing Association (NI) Ltd	1	0	1	0	0	0
Ark Housing Association (NI) Ltd	1	1	0	2	0	0
Choice Housing	0	11	5	0	5	1
Clanmil Housing Association Ltd	0	3	2	1	0	0
Habinteg Housing Association (Ulster) Ltd	0	5	4	1	0	0
Northern Ireland Housing Executive	4	65	51	16	1	5
Radius Housing	2	12	8	2	0	0
Total	**8**	**98**	**72**	**22**	**6**	**6**

Complaints Received in relation to Government Departments & Agencies 2020-21

	Brought Forward @ 01/04/20	Complaints Received in 2020-21	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2021
Assembly Commission	0	2	2	0	0	0
Driver & Vehicle Agency	0	19	7	11	0	1
Northern Ireland Environment Agency	0	2	2	0	0	0
Department for Communities	4	74	61	13	1	3
Department for Infrastructure	1	21	17	4	0	1
Department for Infrastructure - Planning and Local Government Group	0	0	0	0	0	0
Department for the Economy	0	17	5	5	0	7
Department of Agriculture, Environment and Rural Affairs	2	6	4	4	0	0
Department of Education	0	2	2	0	0	0
Department of Finance	0	11	9	2	0	0
Department of Finance - Land & Property Services	3	19	5	10	0	7
Department of Justice	1	1	1	1	0	0
Department of Justice - Compensation Services	0	0	0	0	0	0
Department of Health	0	1	1	0	0	0
The Executive Office	0	4	2	1	0	1
Total	**11**	**179**	**118**	**51**	**1**	**20**

Complaints Received in relation to Education 2020-21

	Brought Forward @ 01/04/20	Complaints Received in 2020-21	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2021
Board of Governors of Grammar School	0	6	3	2	0	1
Board of Governors of Nursery School	0	4	3	1	0	0
Board of Governors of Primary School	15	42	18	18	5	16
Board of Governors of Secondary School	4	15	10	4	1	4
Board of Governors of Special School	0	3	1	0	0	2
College of Agriculture, Food & Rural Enterprise	0	1	1	0	0	0
Education Authority	2	11	6	4	2	1
General Teaching Council for Northern Ireland	0	2	1	1	0	0
North West Regional College	0	3	2	1	0	0
Northern Regional College	0	1	1	0	0	0
Queen's University Belfast	1	10	2	5	0	4
South Eastern Regional College	0	1	0	1	0	0
Ulster University	0	9	4	3	0	2
Total	**22**	**108**	**52**	**40**	**8**	**30**

Appendix 2

Summary Financial and Staffing Information

The Following summarises NIPSO's audited expenditure during 2020-21

(All £k)	Maladministration (incl NIJAO)	Local Gov't Ethical Standards (LGES)	**Total**
Staff Costs (net of secondment income)	1,885	374	**2.259**
Other Administration Costs	707	57	**764**
Total expenditure	**2,592**	**431**	**3,023**

In overall terms this represents a growth in expenditure of some 21% from the £2,494k incurred in 2019-20. Over both years the level of expenditure was more than 98% of the final agreed budget (i.e. a minimal level of underspend against budget),

Further details of NIPSO's expenditure against budget are available in the Annual Report and Accounts for 2020-21.

Staffing

The breakdown of actual staff in post (headcount) at 31 March 2021 was as follows:

	Male	Female	Total
Ombudsman	-	1	1
Acting Deputy Ombudsman/ Commissioner	1	1	2
Other Senior Management Team	1	2	3
Other Staff	16	29	45
Total	**18**	**33**	**51**

Further details of NIPSO's staffing are also available in the Annual Report and Accounts for 2020-21.

Northern Ireland
Public Services
Ombudsman

The Northern Ireland Public Services
Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Telephone: 028 9023 3821 or
Freephone: 0800 34 34 24
Text Phone: 028 9089 7789
Email: nipso@nipso.org.uk

www.nipso.org.uk