Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 202000522

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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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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202000522

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the Trust's decision to appoint an advocate for his son (the resident) who had a number of disabilities and lived in supported housing. He also believed the Trust failed to provide the resident with a suitable bedtime routine.

The investigation established maladministration in relation to the following matters:

- The Trust failed to evidence the reasons for its decision to appoint an advocate for the resident;
- The Trust failed to follow policy in commissioning an advocate;
- The Trust failed to evidence its decision in how it sourced the advocate;
- The Trust failed to seek the views of the next of kin in its decision to appoint an advocate: and
- The Trust failed to monitor if support staff were recording the resident's bedtime routine.

I concluded these failures caused the complainant to sustain the injustice of frustration, upset, uncertainty and the loss of opportunity.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also recommended the Trust holds a best interest meeting to seek the complainant's views on the necessity to appoint an advocate for the resident.

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THE COMPLAINT

1. The complainant raised concerns about the actions of the Belfast Health and Social Care Trust (the Trust). These concerns related to the Trust's appointment of an advocate for his son (the resident) in November 2018. He also believed the Trust failed to provide the resident with an appropriate bedtime routine in the supported accommodation where he lived.

Background

2. The resident has '*severe*' learning difficulties. He is a wheelchair user and unable to bear weight. He is also registered blind with an auditory impairment. At the time of the complaint, the resident lived in supported accommodation managed by the Trust (the Home). Staff employed by a charity (the Charity) sub-contracted by the Trust, provided the patient with care and support within the Home.

3. The complainant said on one occasion he telephoned the Home at 12.00 to enquire about the resident and staff told him he was still in bed. He reported this to the Trust on 5 November 2020.

4. In November 2018 the Trust appointed an independent advocate[1] for the resident.

Issues of complaint

5. I accepted the following issues of complaint for investigation:

   Issue 1: Whether the Trust followed proper procedures and guidelines in October 2018 in relation to the appointment of an advocate.

   In particular:

   - Identifying the need for an advocate;
   - The process of appointing an advocate; and
   - The views of the next of kin.

Issue 2: Whether the Trust appropriately monitored the resident's bedtime routine between November 2020 and 30 April 2021.

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1 An advocate seeks to support individuals to express and have their views heard. Their aim is to redress any imbalance of power between the individual and professional.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[2]:
   - The Principles of Good Administration.

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:
   - Department of Health, Social Services and Public Safety's Care Management, Provision of Services and Charging Guidance, March 2010, (DHSSPS Care Management);
   - Department of Health Social Services and Public Safety's Developing Advocacy Services: a Policy Guide For Commissioners, May 2012, (DHSSPS Developing Advocacy Services);
   - Belfast Health and Social Care Trust's Best Interest Decision Making: A Guide for Social Workers, (The Best Interest Decision Making Guide)[3]; and

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

3 There is no date with this publication but the Trust have confirmed in writing that it was in effect at the time of the complaint.

- The Regulation and Quality Improvement Authority's Review of Advocacy Services for Children and Adults in Northern Ireland, January 2018, (RQAI Review of Advocacy Services).

9. I did not include all information obtained during the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

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 that decision was attended by maladministration.

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant said that he was happy with the report's findings. The Trust stated it did not have any comments to make.

THE INVESTIGATION

Issue 1: Whether the Trust followed proper procedures and guidelines in October 2018 in relation to the appointment of an advocate.
In particular, this will consider:

- Identifying the need for an advocate
- The process of appointing an advocate
- The views of the next of kin.

Detail of Complaint

12. The complainant said the Trust appointed an advocate for the resident without informing him or seeking his views on the matter. The complainant strongly believed that the resident did not need an advocate. The complainant also raised concerns about the fact that the advocate had links to the Charity.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following guidance:
    - DHSSPS Developing Advocacy Services;
    - The Best Interest Decision Making; and
    - RQIA Review of Advocacy Services.

The Trust's response to investigation enquiries

Identifying the need for an advocate

14. The Trust stated '*it was its understanding*' that senior management in its Learning Disability Services and the Charity made the decision to appoint an advocate in the '*best interest[s]*' of the resident during a meeting on 25 October 2018. It stated the Charity '*requested a referral to'* a named advocacy service (the Advocacy Service) following a deterioration in relations between the complainant and Charity staff.

The process of appointing an advocate

15. The Trust stated that following a meeting between Trust staff and the Charity it sourced the resident's advocate from the Advocacy Service in November 2018. It explained this was '*outside*' the normal procedure for sourcing an advocate. It explained its *'contractual arrangements for Advocacy Service is with Bryson Care and the advocate was not sourced from Bryson.* The Trust stated it did not hold a Best Interest Meeting before deciding to appoint an advocate '*because the normal process was not adhered to'*.

The views of the next of kin.

16. The Trust stated its decision to appoint an advocate was '*deemed to be in the best interest* 'of the resident. However, it clarified '*It does not appear that the views of the Next of Kin were sought*'. It apologised for its '*oversight*'.

Analysis and Findings

Identifying the need for an advocate

17. I note the complainant’s view that the resident did not need an advocate as his family already fulfilled that role. The Trust stated it met with management from the Charity on 25 October 2018. The Charity requested the Trust make a referral to the Advocacy Service in view of the deteriorating relationship between the complainant and Charity staff. I note that in its response to this office, the Trust did not provide a record of this meeting and stated that it was its ‘*understanding*’ the meeting occurred. I find this lack of a record of the meeting deeply concerning.

18. I note the Best Interest Decision Making Guide states, ‘*An advocate may be useful in providing support for the person who lacks capacity to make a decision’*. It further states an advocate should be considered when the person ‘*has no family or close friends to take an interest in their welfare*’.

19. I examined the resident’s records, and it is apparent that his father, the complainant was closely involved in decision making around his daily care and general welfare. It is also evident from the records that the relationship between the complainant and staff at the Home was at times adversarial. I note the Best Interest Decision Making Guide states an advocate should also be considered when ‘*family members and professionals disagree about the person’s best interests’*. However, while I acknowledge the Trust’s statement that there were issues between the complainant and support staff, there is no evidence of how the Trust reached its decision that the resident required an advocate.

20. I am satisfied that in making its decision to appoint an advocate for the resident, the Trust failed to evidence how it reached that decision. The first Principle of Good Administration ‘Getting it right’ requires a public body to take reasonable decisions, based on all relevant considerations.

21. The third Principle of Good Administration requires public bodies to be ‘*open and accountable’* in providing honest, evidence-based explanations, giving reasons for its decisions, and keeping full and accurate records. I am satisfied the Trust’s failure to record its decision making in identifying the need for an advocate in this

regard constitutes maladministration. I consider that the complainant sustained the injustice of frustration and upset as a result of the failure identified. Therefore, I uphold this element of the complaint.

The process of appointing an advocate

22. I note the Trust appointed an advocate for the resident following a request from the Charity in October 2018. The Trust stated it sourced the advocate from the Advocacy Service in November 2018. I note its admission that it did not follow '*the normal process*' when it sourced the advocate. It acknowledged its procedure was to source advocates through a company called Bryson Care. I note the Trust did not explain why it sourced the advocate from another advocacy service.

23. I note DHSSPS Developing Advocacy Services sets out a number of principles governing the contractual relationship between commissioners and service providers. Commissioning Principle 2 requires that any advocacy service the Trust commissions is '*structurally independent from all statutory organisations and preferably from service providers'*. I note the complainant's concern that the advocacy service the Trust used was connected to the Charity and the advocate appointed to the resident was therefore not independent.

24. As part of my investigation, I accessed the home page of the Advocacy Service's website. I also carried out a search on Companies House[4] website in relation to the Charity. The employee register documented that a director of Charity at the time of the complaint was also a co-founder of the Advocacy Service. I recognise and share the complainant's concern that there were links between both organisations. This only serves to deepen my misgivings about the lack of clarity in the Trust's decision-making process when it appointed an advocate for the resident. It is of major concern to me and I believe reflects very seriously on the Trust's integrity in relation to this issue.

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[4] An executive agency of the British Government that maintains the register of companies and employs the company registrars

25. The first Principle of Good Administration, '*getting it right*' requires bodies to act in '*accordance with their own policy and guidance'*. I am satisfied that when the Trust sourced an advocate from the Advocacy Service it failed to follow its own policy on the commissioning of an advocate.

26. The third Principle of Good Administration requires public bodies to be '*open and accountable'* in providing honest, evidence-based explanations, giving reasons for its decisions, and keeping full and accurate records. This principle underscores the need for a public body to create and maintain records of decisions. This is a key principle of good administration. To comply with this principle, adequate and contemporaneous records must be retained of matters considered by the public body, decisions made and the reasons for the decisions including the weight given to relevant factors. Without such records being maintained it is impossible for a public body to defend its actions and the decisions it makes when challenged. It can also have the effect of diminishing the public's confidence that decisions made are not arbitrary and outside of due process. I am satisfied the Trust's failure to follow its own policy for commissioning an advocate and the failure to record the decision-making process in how it sourced the advocate constitutes maladministration. I am satisfied the complainant experienced the injustice of uncertainty as a result of the failures identified. Therefore, I uphold this element of the complaint.

The views of the next of kin

27. I note the complainant's concern the Trust did not consult with him or seek his views when it made the decision to appoint an advocate for the resident. I note the Trust's acknowledgement of this. I note further its explanation that it made the decision to appoint an advocate in the '*best interest*' of the resident. The Best Interest Decision Making Guide states that the Trust *'should explore and understand the views of carers and family members, on how they believe the best interests of the service user can be met'*. I note the guidance also states that in reaching a decision the Trust should consider if there was '*evidence that the views of the carer and involved family members been* (sic) *explored'*.

28. I am of the view that the Trust’s failure in this regard fell short of the standards required by the Principles of Good Administration. The first Principle, “getting it right” requires a public body to adhere to its own policy and procedural guidance, and to take account of established good practice and to take reasonable decisions based on all relevant considerations. I consider the Trust’s failure to seek the views of the complainant on the issue of appointing an advocate for the resident constitutes maladministration. I am satisfied that as a result of the failures identified the complainant experienced the injustice of the loss of opportunity to contribute to the decision making process of determining the need for an advocate   Therefore, I uphold this element of the complaint.

Issue 2: Whether the Trust appropriately monitored the resident’s bed time routine between November 2020 and 30 April 2021.

Detail of Complaint

29. The complainant said the resident’s bedtime routine was not appropriate. The complainant believed the Trust was putting the resident to bed early in the evening and allowing him to stay in bed for too long in the morning. He believed the resident was ‘*lacking stimulation*’ as a result.

Evidence Considered

Legislation/Policies/Guidance

30. I considered the following guidance:
    - DHSSPS Care Management.

The Trust’s response to investigation enquiries

Bedtime Routine

31. The Trust stated it held a care management review in November 2020 at which the Charity agreed to trail ‘*an approximate 9pm to 9am bedtime routine*’ for the resident. It stated it the bedtime routine ‘*was reportedly going well*’. However, it stated that it carried out a ‘*Quality Visit*’ to the Home on 14 May 2021 and discovered staff were not recording the times when the resident went to bed or got up. The Trust stated it

carried out another visit on 8 June 2021 and confirmed the times were '*now being recorded*'.

Analysis and Findings

Bedtime Routine

32. I note the complainant's concern that support staff at the Home were putting the resident to bed early and allowing him to stay in bed in the mornings. I examined the Trust's records which document that a Trust Care Manager visited the Home on 10 November 2020 to check the resident's bedtime routine following the complainant's telephone call. The Care Manger noted that support staff informed him the resident's bedtime routine varied '*based upon his mood'*. I note that in response to this the complainant expressed the view that the resident '*deserve[d] a healthy' bedtime routine*'.

33. The records document that the Charity offered to trial a bedtime routine of 9.00 to 21.00 and that staff could '*monitor how [the resident] responds'*. I note the Trust and the Charity agreed to implement the trial in a meeting on 12 November 2020 which the complainant also attended.

34. The records document the Trust carried out a Quality Visit to the Home on 14 May 2020. I note the Care Manager documented that 'staff were '*outlining*' the resident's daily routine, however '*timings were not recorded'.* I note further the Care Manger referred to the proposed trial of a 9am-9pm bedtime routine for the resident and asked for an update on how it had '*been going*'.

35. It is apparent that the Trust failed to check if support staff were recording the patient's bedtime routine as agreed in the care management review on 12 November. I examined the diary that support workers used to record the resident's daily routine and I note that in most of the entries there is no indication of the timings of the resident's bedtime routine.

36. I accept there was no initial requirement for the Trust to record the resident's bedtimes. However, I consider that having agreed to address the complainant's concerns by initiating a trial monitoring period, it ought to have done so.

37. The Trust failed to monitor if support staff at the Home were recording the patient's bedtimes between 12 November 2020 and 14 May 2021. The second Principle requires public bodies to keep their commitments. I consider this failure to meet these standards constitutes maladministration. Therefore, I uphold this element of complaint. As a result of the failings identified I am satisfied the complainant experienced the injustice of uncertainty.

CONCLUSION

38. I received a complaint about the actions of the Trust. The complainant raised concerns about the Trust's decision to appoint an advocate for the resident and its failure to provide the resident with a suitable bedtime routine.

Issue One

39. The investigation established maladministration in relation to the following matters:
    - The Trust's failure to evidence the reasons for its decision to appoint an advocate for the resident;
    - The Trust's failure to follow policy in commissioning an advocate;
    - The Trust's failure to evidence its decision in how it sourced the advocate; and
    - The Trust's failure to seek the views of the next of kin in its decision to appoint an advocate.

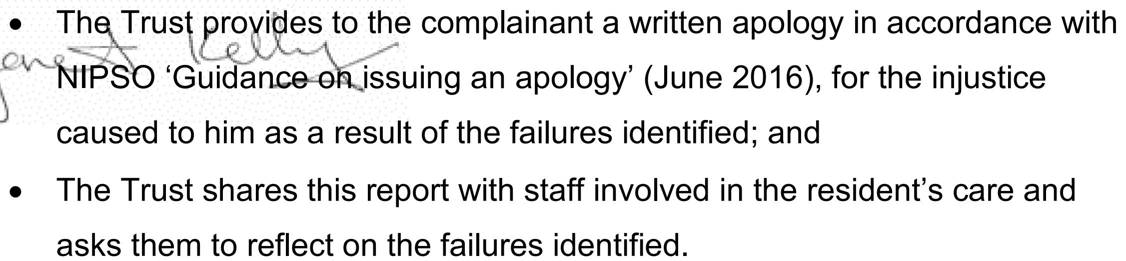
Issue Two

40. The investigation established maladministration in relation to the following matters:
    - The Trust's failure to monitor if support staff were recording the resident's bedtime routine.

41. I am satisfied that the maladministration identified caused the complainant to experience the injustice of uncertainty.

Recommendations

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



- The Trust provides to the complainant a written apology in accordance with NIPSO ‘Guidance on issuing an apology’ (June 2016), for the injustice caused to him as a result of the failures identified; and
- The Trust shares this report with staff involved in the resident’s care and asks them to reflect on the failures identified.

43. I further recommend for service improvement and to prevent future recurrence
    - The Trust holds a best interest meeting to seek the family’s views on the need for an advocate;
    - The Trust undertakes a random sampling audit of patient’s records who were appointed an advocate between November 2018 to present. This is.to assess if commissioning staff followed proper procedures when appointing advocates. The Trust should take action to address any identified trends or shortcomings. The Trust should report its findings to this Office;
    - The Trust ensures that all relevant staff are familiar with the policy on the commissioning of advocate services.

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

Margaret Kelly

Ombudsman **June 2023**

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.

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.