Northern Ireland
Public Services
Ombudsman

Ombudsman's Report

2019~2020

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REPORT
of the
Northern Ireland
Public Services Ombudsman
2019 ~ 2020

Presented to the Assembly pursuant to section 46 (1) of the
Public Services Ombudsman Act (Northern Ireland) 2016.

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Foreword

I am pleased to present this report of the work of the Northern Ireland Public Services Ombudsman for 2019-20.

2019-20 marked the 50th anniversary of the Ombudsman in Northern Ireland – a highly significant milestone for the Office and one which provided us with the opportunity to reflect on the achievements of the last 50 years and on our continuing role in providing redress for Northern Ireland's citizens.

Increase in complaints

Our 50th year coincided with an unprecedented increase in demand for our services. We received 1,043 new complaints, a significant increase of **37%** from the previous year and an increase for the fourth consecutive year. To put this into a longer-term context, in 2015-16 the former offices of the Northern Ireland Assembly Ombudsman and the Commissioner for Complaints jointly received 477 complaints. Since the creation of a single Ombudsman's Office in 2016, complaints about public services have therefore risen by **119%**.

Change in Ombudsman

2019-20 was also a year of change, with the Ombudsman, Marie Anderson, leaving to take up office as the Police Ombudsman for Northern Ireland in July 2019. I would like to place on record my sincere thanks and appreciation – and that of all at NIPSO - to Marie for her enormous contribution to the development of NIPSO, both as Deputy Ombudsman and Ombudsman over a 10 year period.

Earlier this month the Northern Ireland Assembly nominated Margaret Kelly as the new Public Services Ombudsman and Margaret will take up post in the coming weeks. I would like to take this opportunity to congratulate the new Ombudsman on her nomination and to warmly welcome her to the organisation. All of us at NIPSO look forward to working together.

Meeting challenges

The substantial and long term increase in demand brought challenges, particularly with the disruption caused by the change in Ombudsman and in the absence of the Northern Ireland Assembly. As an organisation, however, we have met these challenges with improved performance in a number of key areas.

This report shows that we made more decisions on complaints, increasing the number of complaints concluded at both ASSIST and Investigations. In 2019-20 we closed 96 cases at the Investigation stage, the highest year of investigative output since NIPSO's inception in 2016. This represents a 32% increase on last year,

and equates to an overall 75% increase in the number of investigations reported on per year over the last 4 years.

Some of these investigations are summarised in Section 2 and 4 of this report.

We have also continued to focus on a more proportionate approach to resolving complaints where this is appropriate, significantly increasing the numbers of cases resolved early or settled. While not suitable for all cases, early resolution can be a quick and sensible way of dealing with complaints to the satisfaction of both the complainant and the public body and in the public interest.

Launch of first 'Own Initiative' investigation

In June 2019 we used our Own Initiative Investigation powers for the first time when Marie Anderson formally initiated an investigation into the administration of Personal Independence Payments (PIPs) by the Department of Communities. This was the first use of the Own Initiative powers in a UK context and represents another milestone in the development of NIPSO and the implementation of new powers under the 2016 Act.

Further information about the use of own initiative can be found in Section 3.

COVID-19

In mid-March 2020 we closed our Office to complainants attending in person because of the threat posed by the COVID-19 pandemic. Although we continued to receive complaints via telephone, email and our website, we informed all public services, particularly in the health and social care sectors, that we understood their focus at the time was on minimising the health risks posed by the virus and on providing essential public services. We therefore took a flexible and proportionate approach when making our enquiries.

Although at the height of the pandemic complaints activity reduced considerably, levels are now beginning to return to normal. The lasting impact of COVID-19 remains unclear, but going forward the complaints handling landscape and the public sector in general will continue to face significant challenges. We will work to help ensure that, despite these pressures, the focus of our public services remains on delivering quality services for members of the public.

Summary

This has been a year of change within the Office. I would like to thank all staff for their resilience and hard work in maintaining our service and delivering through this challenging period. Their professionalism and commitment have ensured that this Office continues to provide a valuable contribution to administrative justice and public service improvement in Northern Ireland.

Paul McFadden
Acting Ombudsman

15th July, 2020

50th anniversary

In December 2019 we celebrated the 50th anniversary of the Ombudsman in Northern Ireland. We marked this major milestone in our history by producing a short film and a commemorative publication.

The Office was created as a response to the civil unrest in Northern Ireland in the late 1960s, and has performed an important role in addressing unfairness and injustice ever since. We believed it was important to hear from members of the public about their experience of using our service, and were very grateful to two complainants for their moving explanations of how our investigations helped them following the death of their loved ones.

'When we first went into the office the first thing that struck me was that they were listening. I don't think we could have coped with going down the legal route. What we were looking for was someone who could say 'look this is what happened' and that's what we got with the Ombudsman's office'.

Mrs Vivien Jess

"The report I received back was pretty meticulous … and it took a long time to absorb, but I felt relieved. I felt that I had got part of my life back. It didn't bring my mother back, but it brought me some peace."

Mrs Anne Martin

We were also privileged to attend an event jointly organised by the Northern Ireland Executive and the Irish Embassy in Brussels. The occasion gave us a chance to reflect, in front of an international audience, on the achievements of the last 50 years and on how we can

continue to provide improvements in public services and redress for citizens.

We would like to thank all speakers and attendees, including former Public Services Ombudsman and current Police Ombudsman Marie Anderson, Peter Tyndall (Ombudsman and Information Commissioner for Ireland and President of the International Ombudsman Institute), and Rosita Hickey (senior advisor to the European Ombudsman) for their kind words in support of the work of the Ombudsman in Northern Ireland.

A timeline of former Ombudsmen 1969-2019

Section One

Advice, Support Service and Initial Screening Team (ASSIST)

The ASSIST Team provides the first point of contact with the Office. The team comprises Casework and Investigating Officers who play an important role in providing valuable advice to members of the public or their representatives who want to pursue a complaint.

Complaining to our Office is a free service and the types of complaints we receive are many and varied. In 2019-20 there was a large increase in the number of complaints received by the ASSIST team. The figure of **1,043** was significantly higher than the previous year (762). This is an annual increase of **37%** and is a continuation of the upward trend in complaints received by the Office, which has seen an overall increase of some **119%** since 2015-16.

The increase in complaints occurred across all sectors. As usual the sector with the largest number of complaints was Health and Social Care, with 377 complaints received. This is 36% of the total complaints during the year. A detailed breakdown of the complaints across all sectors can be found in Section Two and Appendix 1.

How we deal with complaints

NIPSO has a 3 stage process for the investigation of maladministration complaints. This process allows us to ensure that our resources are focused on the cases which warrant investigation and where we can most effectively improve public services.

These stages are:

- Initial Assessment
- Assessment
- Investigation

The ASSIST team are responsible for the first 2 stages of our process which involves assessing all of the complaints received and deciding whether a complaint can and should be accepted and, if so, any action that might be taken to resolve the complaint.

Initial Assessment

Initially a complaint is assessed to establish if it can be accepted under our governing legislation, the Public Services Ombudsman Act (Northern Ireland) 2016. In cases where we decide a complaint cannot be accepted at Initial Assessment stage, a complainant is provided with a clear explanation as to how this decision has been reached using reference to the legislation.

Importantly, in cases where we cannot accept a complaint, ASSIST staff will help members of the public by referring them to other organisations who may be able to investigate their concerns. In 2019-20 in 98% of cases we issued a decision to the complainant advising whether we could accept the case within 2 weeks of receiving the complaint. This performance was considerably above our target of 90%. Given that the number of decisions made this

year at the Initial Assessment stage increased by 39%, this performance is particularly noteworthy.

Assessment

Where we decide we have the legal authority to accept a complaint, it is progressed to the second stage of our process, Assessment. During this stage we seek further information and comment from the body to find out whether things may have gone wrong in relation to the service provided. The Investigating Officers from the ASSIST team consider proportionality, practical outcome and public interest when deciding whether a complaint should be progressed to our final stage, Investigation (see Section 3).

We aim to make this decision within 10 weeks from receipt of the complaint. This year we were able to provide the complainant with a response within this timescale in 85% of cases. This was a significant improvement on performance compared with 2018-19, where a decision was issued in 70% cases. It is also notable that over the past 5 years, there has been a 64% increase in the number of cases which have progressed to our Assessment stage.

As can be seen from the tables in Appendix A, the ASSIST team are responsible for making decisions on the vast majority of complaints received by the Office. While some decisions are relatively straightforward (eg. if the complaint is about an organisation the law does not allow us to investigate, such as the police service, or a bank), many others require careful consideration and a close assessment of the facts. This is important to make sure all complaints are dealt with fairly.

Early Resolution of Complaints

Settlements

During 2019-20 the ASSIST team continued to focus on early and alternative resolutions to complaints which we refer to as 'settlements'. Achieving a settlement provides an effective method of resolving a complaint, often obtaining a positive outcome for the complainant at an early stage. This can also be a welcome approach for the public body in preference to a potentially lengthy investigation.

For example, during the year we helped a man who complained that his local council were continually delaying planning approval for his property. We asked the council to consider reimbursing part of the planning fees in recognition of its failures. The council reimbursed the man half of his planning fees (£432) and apologised to him.

Summaries of other cases which were settled at this stage can be found on pages 12 and 13.

The ASSIST team's focus on early and alternative resolution has resulted in a considerable increase in the number of settlements achieved this year (57). The use of settlement during Assessment

stage will remain a key objective for the ASSIST team moving into 2020-21.

Referral for further local resolution

It can often be the case during the assessment process that the ASSIST team identify complaints which may benefit from further local resolution with the organisation complained of. This happens where it becomes apparent during assessment that the complainant's concerns have not been adequately addressed through the complaints process, and where the organisation complained of might have a further opportunity to resolve the complaint satisfactorily.

In 2019-20 the ASSIST team increased the number of cases referred back to the public body for further local resolution by 200% compared to the previous year.

In deciding when to refer a complainant back for further local resolution the ASSIST team must ensure that it would be of real benefit to the complainant. However, allowing the body another opportunity to resolve the matter can be particularly beneficial where the maintenance of a 'relationship' between the complainant and the body is crucial; for example between parents / pupils and teachers in complaints about schools, or between a GP Practice and patient.

This approach also reflects the renewed focus by NIPSO on giving feedback to bodies in jurisdiction to assist them to resolve complaints at source, and to improve their services by learning from complaints. As with settlements, this can be an effective means to achieve an alternative and speedier resolution of complaints, particularly in complaints about poor complaints handling. We continue to receive some very positive feedback from complainants and public bodies about the success of this approach.

Settlement case summaries

Rates bill cancelled after Ombudsman intervention

A man contacted the Ombudsman's ASSIST team to say that he was being unfairly asked to pay an overdue rates bill. He said that the rates demand had left him stressed and worried.

Ombudsman staff looked at the details of the complaint, and contacted the Land and Property Service (LPS) who had sent out the bill, to ask for more information.

The man said he phoned the LPS to make it was aware of an agreement between him and his landlord that the landlord had taken responsibility to pay the rates. This was based on the value of the property. The LPS billed the landlord.

Five years later the man unexpectedly received a backdated bill for over £6,500, telling him that he was now liable. He said that if they had told him earlier he would have known he could not afford to rent the property.

The Ombudsman investigator looked at the information held by the LPS. It showed that the man's wife had telephoned them to discuss the rates issue, but was told she could not do so because of the organisation's data protection procedures.

At this stage the rateable value of the property had changed, making the tenant now liable. However, the LPS incorrectly continued to bill the landlord. When the landlord was declared insolvent a further opportunity to tell the tenant that he was responsible for the rates was missed.

The LPS admitted to the man that there had been mistakes in the way his account had been handled, and that he should have been told he was going to receive a bill backdated three years. It applied a reduction to his account of around £1,300. The man remained upset that he was still being penalised when he believed he had done nothing wrong.

The Ombudsman investigator explained to the LPS that a more detailed investigation may be required but that she was keen to explore whether there could be an early settlement of the complaint. She asked if the LPS were prepared to look again at the case and proposed another reduction beyond the 25% already applied.

In response the LPS replied that it had reconsidered the case, and because of the attempts made by the man to find out if he was liable for the rates it had decided to reduce his liability to zero, thereby cancelling the bill.

The investigator agreed that this Settlement was a satisfactory outcome to the complaint.

School's apology settles complaint

The parents of a primary school child complained about an incident between the school's principal and their daughter. They said that during the incident their daughter, who has autism, was physically forced to make eye contact by the principal and that she had made comments which doubted her condition. They also said that she made a statement which questioned their parenting skills.

They said that the incident had left them stunned and shocked, and had left them uncomfortable about their daughter remaining in the school.

The Board of Governors investigated the complaint and recommended autism refresher training for the principal and other staff. However, the complainants believed that the school should have also admitted that the principal's behaviour had been unacceptable and that she should apologise to them.

When the parents brought their case to the Ombudsman's office an investigator asked the Board of Governors for their response. They agreed that the principal's comments and behaviour were not appropriate.

After the investigator proposed an alternative resolution to the complaint instead of a full investigation, the Governors also agreed to give a full apology and to provide a plan for the pupil to support her future progress through the school.

The parents said they were satisfied with this outcome.

Section Two

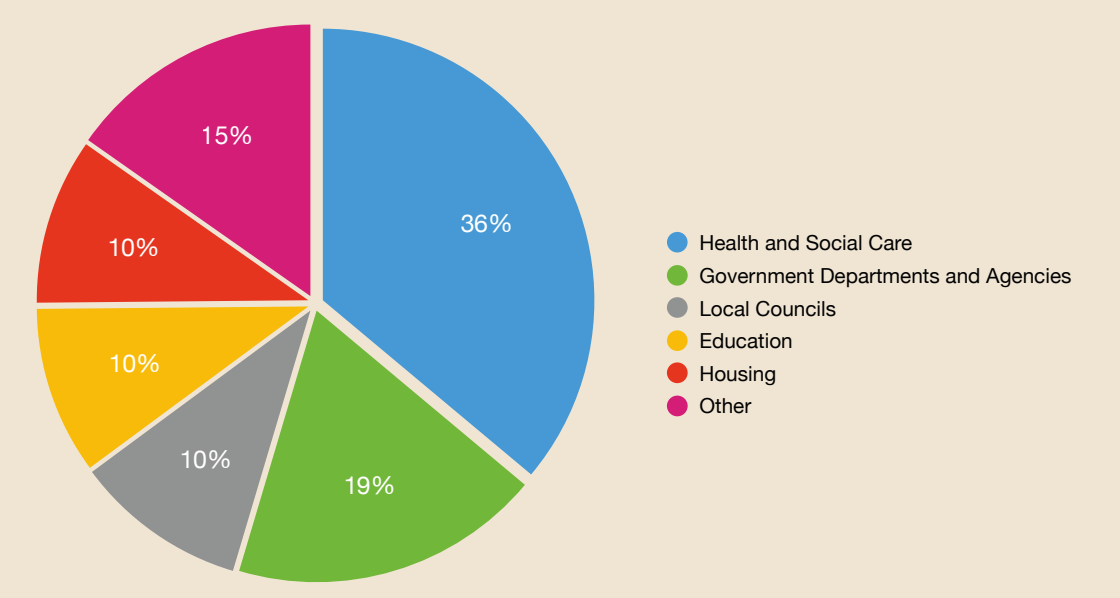
Breakdown of complaints by sector

Analysis of complaints

The **1,043** complaints received during the year related to a wide variety of service providers. For the purposes of statistical analysis they are broken down into the six main areas below:

- Health and Social Care
- Government Departments and Agencies
- Local Councils
- Housing
- Education
- Other

Percentage of complaints by sector 2019-20

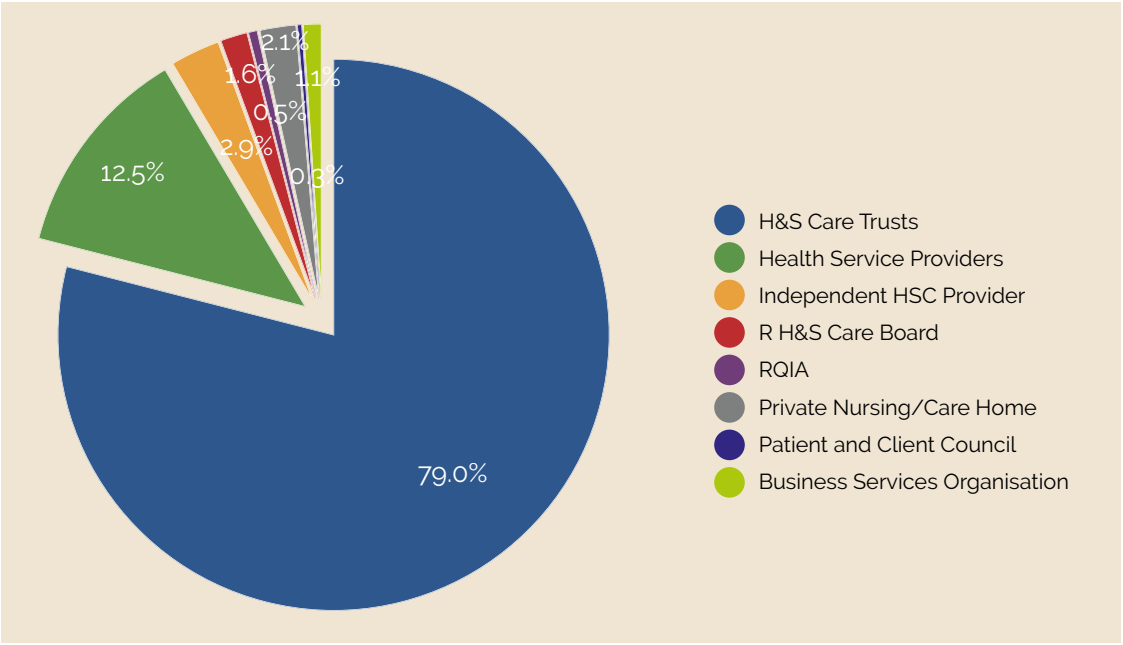


Sector	Number of complaints
Health and Social Care	377
Government Departments and Agencies	193
Local Councils	107
Education	104
Housing	103
Other	159
Total	**1,043**

Health and Social Care

Breakdown of complaints about Health and Social Care

36% of all complaints to the Ombudsman related to Health and Social Care



Sector	Number of complaints
Health & Social Care Trusts	298
Regional Health & Social Care Board	6
Business Services Organisation	4
Health Service Providers - Dentists	12
Health Service Providers - GPs	33
Health Service Providers - Pharmacists	2
Independent HSC Provider	8
Independent HSC Provider - Out of Hours GP Services	3
Independent HSC Provider - Private Nursing Home	8
Patient & Client Council	1
Regulation and Quality Improvement Authority	2
Total	**377**

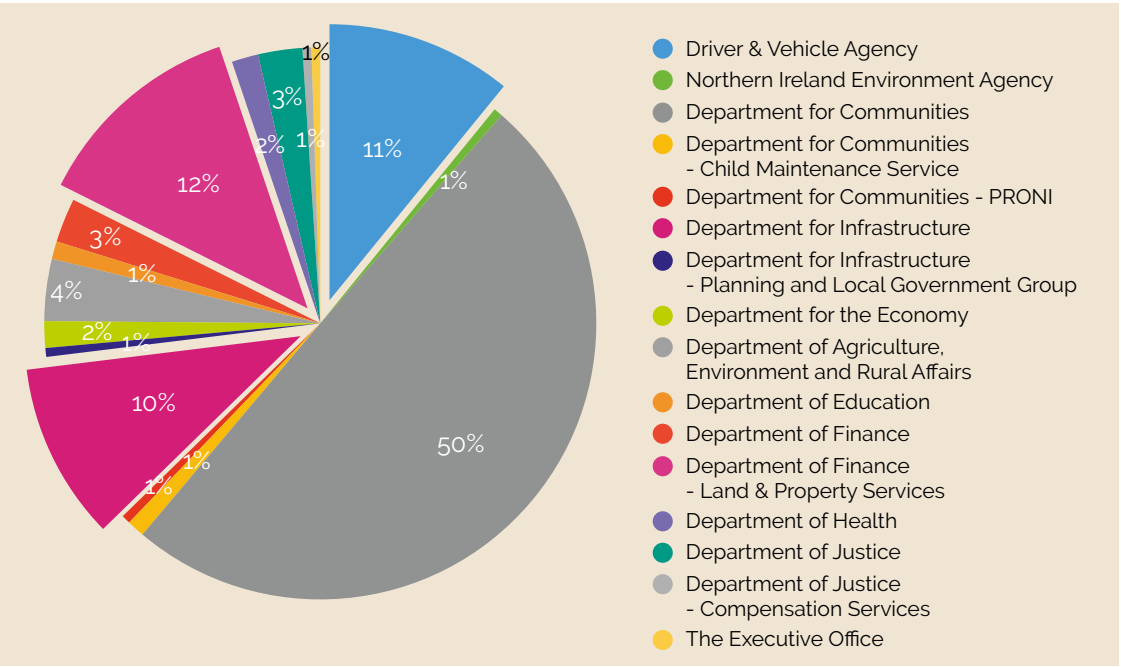
Complaints about Health and Social Care Trusts

Sector	Number of complaints
Belfast Health & Social Care Trust	111
Northern Health & Social Care Trust	46
Northern Ireland Ambulance Service Trust	7
South Eastern Health & Social Care Trust	45
South Eastern Health & Social Care Trust (Prison Healthcare)	8
Southern Health & Social Care Trust	34
Western Health & Social Care Trust	47
Total	**298**

A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1

Government Departments and Agencies

19% of all complaints to the Ombudsman related to Government Departments and Agencies

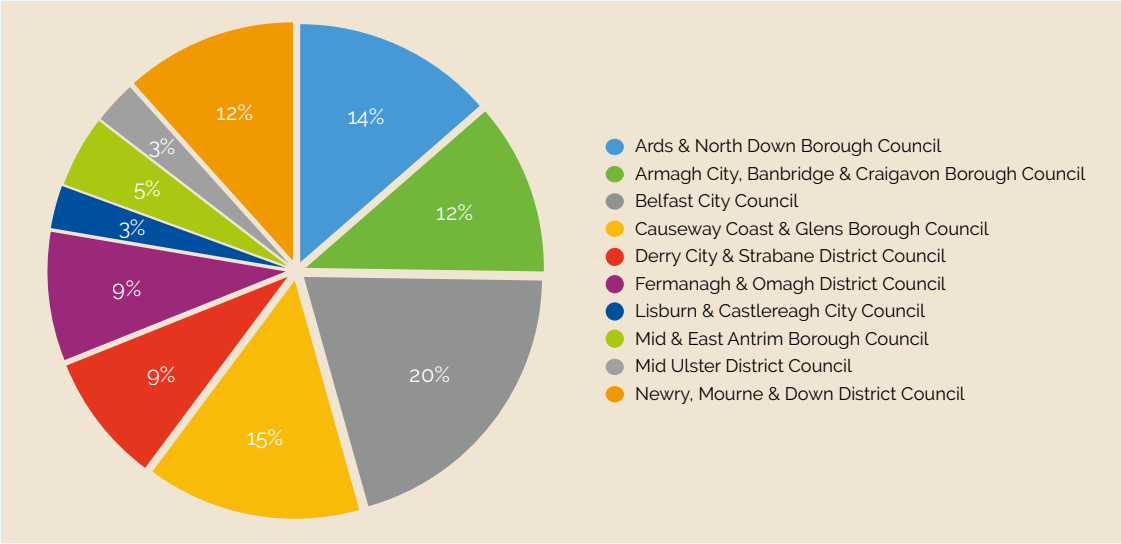


Sector	No. of complaints
Driver & Vehicle Agency	21
Northern Ireland Environment Agency	1
Department for Communities	96
Department for Communities - Child Maintenance Service	2
Department for Communities - PRONI	1
Department for Infrastructure	20
Department for Infrastructure - Planning and Local Government Group	1
Department for the Economy	3
Department of Agriculture, Environment and Rural Affairs	7
Department of Education	2
Department of Finance	5
Department of Finance - Land & Property Services	24
Department of Health	3
Department of Justice	5
Department of Justice - Compensation Services	1
The Executive Office	1
Total	**193**

A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1

Local Councils

10% of all complaints to the Ombudsman related to Local Councils



Local Councils

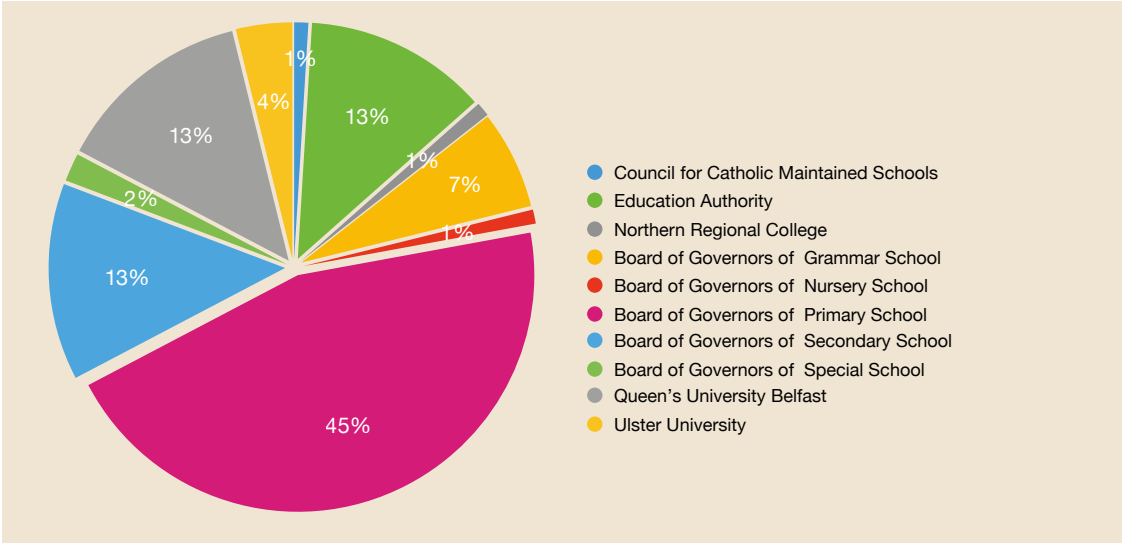
Examples of complaints about local councils include concerns about planning decisions taken by councils, enforcement of planning breaches, and issues relating to tendering for local government projects.

Council	Number of complaints
Antrim & Newtownabbey Borough Council	4
Ards & North Down Borough Council	14
Armagh City, Banbridge & Craigavon Borough Council	12
Belfast City Council	21
Causeway Coast & Glens Borough Council	15
Derry City & Strabane District Council	9
Fermanagh & Omagh District Council	9
Lisburn & Castlereagh City Council	3
Mid & East Antrim Borough Council	5
Mid Ulster District Council	3
Newry, Mourne & Down District Council	12
Total	**107**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Education

10% of all complaints to the Ombudsman related to Education



Education

Complaints in the area of education related to the handling of allegations of bullying, the provision of child protection and support services, and the ways schools dealt with pupils with Special Educational Needs.

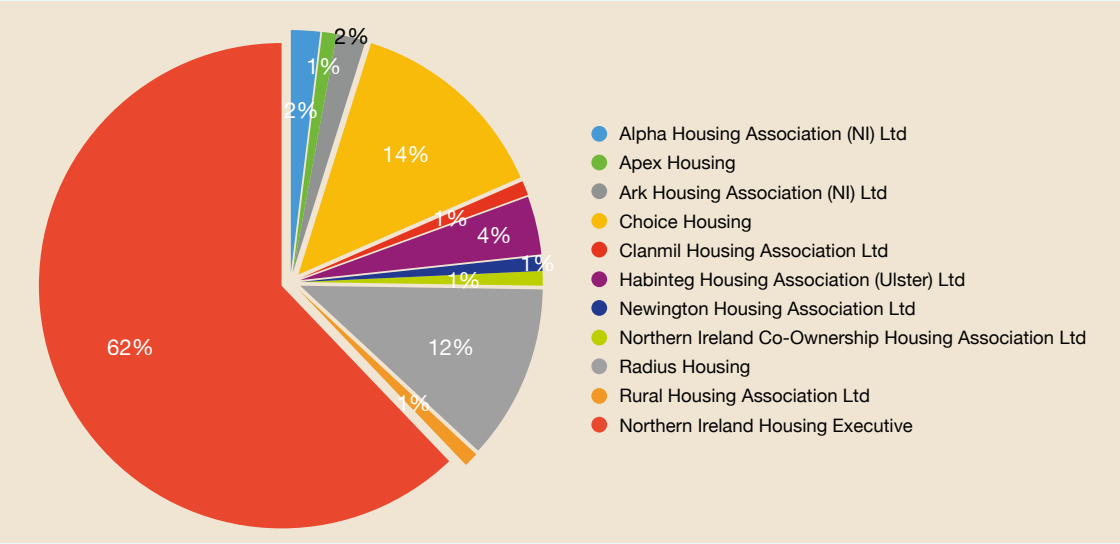
Complaints about education

Education	Number of complaints
Council for Catholic Maintained Schools	1
Education Authority	13
Northern Regional College	1
Board of Governors of Grammar School	7
Board of Governors of Nursery School	1
Board of Governors of Primary School	47
Board of Governors of Secondary School	14
Board of Governors of Special School	2
Queen's University Belfast	14
Ulster University	4
Total	**104**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Housing

10% of all complaints to the Ombudsman related to housing



Housing

Examples of complaints about this sector include how housing associations responded to allegations of anti-social behaviour, issues relating to property repairs and management, as well as about the administration of housing waiting lists and requests for transfers..

Complaints about housing

Housing Authority	Number of complaints
Alpha Housing Association (NI) Ltd	2
Apex Housing	1
Ark Housing Association (NI) Ltd	2
Choice Housing	14
Clanmil Housing Association Ltd	1
Habinteg Housing Association (Ulster) Ltd	4
Newington Housing Association Ltd	1
Northern Ireland Co-Ownership Housing Association Ltd	1
Radius Housing	12
Rural Housing Association Ltd	1
Northern Ireland Housing Executive	64
Total	**103**

*A more detailed breakdown of these complaints, showing the stages at which they were determined by the Office, is available in Appendix 1.

Section 3

Investigation Team

Investigation is the final stage of the NIPSO process. This stage is reached after a detailed consideration of the issues raised in a complaint by the ASSIST Team. In reaching a decision to further investigate a complaint, three factors are taken into account. These are whether an investigation is proportionate, can deliver a practical outcome and is in the public interest.

A total of 96 cases were closed at the investigation stage in 2019-20. The figure for 2019-20 represents a 32% increase on last year, and equates to an overall 75% increase in the number of cases closed at investigation stage over the last 4 years.

The decrease in the number of cases progressed to the Investigation stage this year, 21% on the previous year, is reflective of the ASSIST Team's focus on resolution at Assessment stage. However, over the past 4 years, there remains a steady overall increase of 13% in the numbers of cases accepted for investigation.

During the period 77 cases were passed to the Investigation Team for further investigation, and the number of live cases at investigation stage at the end of the year was 114. Although this is a 14% reduction in the number of live cases at the end of 2018/19, it still represents a 14% increase over the last 4 years.

Like the ASSIST team, the Investigation team will also consider throughout the investigation whether it is possible to resolve a complaint before deciding to produce a report. During this reporting year, in addition to those cases resolved during assessment by the ASSIST team, five cases were also resolved at the investigation stage of the process without the need to prepare a full investigation report.

The increase in output at the Investigations stage was achieved despite the disruption caused by the former Ombudsman taking up a new role in July 2019, and the Investigation Team decanting to a separate building for a 6 month period to allow for office refurbishment work to be completed.

Health and Social Care cases

As in previous years a high percentage of cases at investigation related to health and social care issues. This reflects the Ombudsman's different jurisdiction in the sector, in that the Ombudsman is also able to examine the merits of a decision taken by health and social care professionals as well as investigate allegations of service failure. In addition, all cases where independent professional advice is required will pass to the Investigation Team. This happens more often for complaints in the health and social care sector. The issues raised in health and social care complaints also often have a very significant impact on either those bringing the complaint or their family members, thereby

increasing the likelihood that a detailed investigation is required.

During the year other cases examined by the Investigations Team included concerns relating to local council's management of planning applications, actions by government departments and their agencies, and six investigations in relation to alleged maladministration by schools. In all of the cases our proportionate approach to investigations means that we focus on the key issues of a complaint which remain after it has been considered by the public body.

Summaries of a number of investigations completed by the team throughout 2019-20 can be found in the following Section.

During the year we have continued to consider how the outcomes from our investigation work can be shared more widely to ensure the maximum potential for learning and improvement. We have done this by following up on recommendations to make sure they are implemented, publishing our investigation reports, and publishing Bulletins on our work (see Section Five). We have continued to cooperate with other regulatory and oversight organisations to share intelligence in relation to what our investigations tell us and to ensure the effective use of our resources.

Our completed reports for 2019-20 contained decisions on 127 separate issues of complaint. Of these, 91 were upheld or partially upheld, and 36 were not upheld. The upheld/partially upheld rate of 72% is consistent with previous years.

Also in line with experience in previous years, the most common recommendations following investigations in this period were for an apology where things went wrong, and for service improvements to try and prevent the issue recurring again in the future. When members of the public bring their complaints to us they commonly state that all they are looking for is an apology or for things to change so that others do not have to go through a similar experience. Our recommendations therefore often reflect the desired outcome of the complainant.

The recommendations demonstrate the unique role of the Public Services Ombudsman in the administrative justice system, in providing both remedy for the complaint and working with public bodies to improve their services. The independent and impartial nature of the Ombudsman's role is key to be able to achieve these dual aims.

Our Strategic Plan states that our aim is to improve public services through the investigation of complaints. Other public service ombudsman schemes at regional, national and international levels have a similar goal. Ombudsmen seek to promote good governance and improve accountability in public administration as well as providing remedy in individual cases of injustice.

Reflecting on the investigations completed during the year a number of key service delivery issues were identified. These include the importance

for clear, timely and open communication between public bodies and complainants, an early acceptance when things have gone wrong, and the need for effective proportionate investigations with decisions which are clear and easy to understand.

The acceptance by public bodies of recommendations made in our investigation reports reflects their willingness to improve the services they deliver to citizens.

Launch of first 'own initiative' investigation

From April 2018 NIPSO has had the power, under the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act) to undertake own initiative (OI) investigations where the Ombudsman has a reasonable suspicion of systemic maladministration or systemic injustice. This new power allows the Ombudsman to proceed with an OI investigation where one or more complaints have been made, or even where no complaints have been made. The authority to undertake OI investigations was a key part of the discussions around the development of the 2016 Act with the former Committee for the Office of the First Minister and deputy First Minister.

Commencement of this important new power was a first in UK Ombudsman terms, signalling a move which enabled the Ombudsman to identify and address (significant) systemic failures potentially affecting the wider public and not just individual complainants to ensure significant failings are addressed across sectors as a whole.

Under Section 8 of the 2016 Act the Ombudsman may launch an investigation on their 'own initiative', where:

- The Ombudsman has reasonable suspicion that there is systemic maladministration or that systemic injustice has been sustained (injustice consequent on the exercise of professional judgement in health and social care)
- The Ombudsman has given regard to criteria to determine whether to launch an investigation

Ombudsman's Criteria for OI Investigations

As required by the 2016 Act, NIPSO has published criteria to be used in determining whether to commence an OI investigation. These are:

- The issue of concern has been identified by the Ombudsman to be one of public interest
- The issue of concern affects a number of individuals or a particular group of people
- The investigation has the potential to improve public services

AND

- The Ombudsman considers the investigation of the chosen topic is the best and most proportionate use of investigative resources

Identifying potential OI Investigations

During 2018 preparations began for the new OI power with the development of processes and procedures to capture and assess potential investigations. In developing these the need to effectively manage the limited staff resource was to the fore, particularly managing expectations/requests from members of the public or public bodies to conduct an OI Investigation into a particular subject matter. Furthermore, built into the processes and procedures was the flexibility to enable the scale and scope of investigations to vary according to the subject matter, enabling the power to be used to utmost effect.

Launch of First Own Initiative Investigation

In June 2019 NIPSO launched a systemic investigation into the Department for Communities' (the Department) administration of the Personal Independence Payment (PIP) benefit system.

The purpose of the investigation is to ascertain if there is 'systemic maladministration', or 'systemic injustice' sustained as a result of the exercise of professional judgement. The investigation is examining the actions of the Department and service provider Capita in administrating PIP with a particular focus on the availability and application of further evidence in the PIP benefit decision making and internal complaints processes.

In determining whether maladministration has occurred the Ombudsman is testing the actions of the Department and Capita against the framework of the Principles of Good Administration and can make recommendations should systemic maladministration or systemic injustice be identified through the investigation.

At the conclusion of the investigation the Ombudsman will publish a report with findings and recommendations and will lay a copy of the report before the Northern Ireland Assembly.

Restraint and Seclusion

In May 2019 NIPSO undertook a 'Strategic Inquiry' into the use of restraint and seclusion. This was in response to a number of complaints we received, often involving children who have special educational needs. This work has been carried out alongside the Northern Ireland Children's Commissioner (NICCY).

The response to the Strategic Inquiry suggest that there is little to no regulation of the use of restraint and seclusion in Northern Ireland schools. Specifically, there is no Departmental Policy in contrast to England and Scotland where schools have policies in place and procedures for recording incidents of their use. There is also no legislative obligation to record episodes or incidents involving restraint and seclusion in Northern Ireland's schools.

We will be reporting further on this issue during 2020-21.

Section Four:

Summaries of Investigations Published During the Year

Ombudsman finds that proper care and treatment of patient by Trust 'may have improved her chances of survival'

An Ombudsman investigation found that the Northern Health and Social Care Trust failed to provide adequate care and treatment to a patient who died of multiple organ failure in the Causeway Hospital, Coleraine in September 2015.

The investigation concluded that although the patient was severely ill when she was admitted to the hospital, repeated failures in the care given to her meant she was not given the best possible chance of survival.

Following her death the patient's husband made a complaint to the Ombudsman. He complained that a check to see whether his wife had a bacterial infection was not carried out quickly enough, and that there was a lengthy delay in giving her antibiotics.

He said that when she did receive the antibiotics they were not specifically targeted for her infection. He also claimed that she was weakened by the inadequate nutrition and hydration provided to her while she was in hospital.

The investigator obtained all of the relevant records and information from the Trust. A consultant hepatologist's report commissioned by the Trust into the care of the patient was obtained by the Ombudsman and considered as part of her investigation. An independent consultant hepatologist was also asked for his opinion on the patient's care.

The independent advisor explained that for patients presenting with this type of liver disease it was important for medical staff to obtain a sample of fluid from the abdomen, in a procedure known as paracentesis. This is because bacterial infections are common in such patients and can cause life threatening complications, including sepsis. Therefore careful assessment and prompt treatment with antibiotics is vital.

However, medical records disclosed that despite the patient's ill health upon admittance to hospital on 31 August 2015, paracentesis was not attempted until 12 days later.

Unfortunately this procedure was not successful. Although a clinical note recorded that the Trust considered that another attempt should be made, the procedure was not carried out.

The Ombudsman's investigation also found that the patient was not given an antibiotic until 12 September. This was despite three potential sources of infection having been identified early in the admission and against a background of worsening liver failure.

In relation to the complaint about the patient's nutrition, an examination of

hospital records disclosed that she was not referred for review by a dietitian until 10 days after admission. The Ombudsman found that there was no proactive approach regarding 'aggressive nutritional therapy' as recommended in the guidelines, and that there was no consideration by clinicians of the option of nasal feeding.

Based on the available evidence, the opinion of the independent advisor, the complainant's allegations and responses from the Trust, the Ombudsman concluded that there were multiple and serious failures in the care and treatment of the patient.

The Ombudsman stated, 'This was a sad case in which the patient's limited chances for survival from her illness were dependent on her receiving timely and appropriate care. However, my investigation found a number of significant failures by the Trust and its clinicians.

'Although I cannot conclude that her death was avoidable, I have no doubt that prompt treatment of potential sepsis and the provision of appropriate fluids and nutrition would have improved her chances of survival.'

Given the serious failings, the Ombudsman recommended that the Trust provide a payment of £10,000 to the family in recognition of the upset, frustration, and distress caused.

She also recommended that the complainant and his family receive a personal apology from the Chief Executive of the Trust and from each of the clinicians involved in the patient's care.

The Trust acknowledged the failures identified in the report and accepted the Ombudsman's recommendations.

Belfast Health Trust 'demonstrated a customer focus with a genuine attempt to resolve the issues'

The Ombudsman commended the Belfast Health and Social Care Trust for the thorough way it investigated a complaint about the care and treatment received by a patient at a nursing home.

The complainant's late mother was treated by Domnall Nursing Home. Following her death the complainant wrote to the home to complain about her care. After receiving two detailed responses from the home, the complainant wrote to the Trust. The complainant was still dissatisfied following the Trust's final response, so brought the complaint to the Ombudsman.

The Ombudsman looked at the Trust's correspondence with the complainant and the actions it took, and was satisfied that the complaint was properly addressed.

The Ombudsman found that genuine efforts were made by the Trust to resolve the complainants' concerns as required by the Health and Social Care complaints procedure, which is aimed at providing 'an opportunity for the complainant and the organisation to

attempt a prompt and fair resolution of the complaint'.

It was found that the Trust's response to this complaint demonstrated a customer focus with a genuine attempt to resolve the issues. The nature and detailed responses to the complaint, including a meeting it facilitated with the care home and the complainant, reflected a concerted effort to address the concerns.

The Ombudsman commended the Trust for the comprehensive way it addressed the complaint.

Complaint about patient's hospital care not upheld

A patient who attended Craigavon Area Hospital due to pain in his shoulder and loss of power in his right arm received an appropriate level of care, according to an investigation carried out by the Ombudsman.

The investigation followed a complaint made by the patient's wife, who was unhappy that no blood tests, X-rays or scans were performed on her husband in the Emergency Department. She also alleged that he had suffered unnecessarily due his care and treatment in hospital and that the medication and ongoing paid had caused him depression.

The Investigating Officer obtained the patient's medical notes and records documenting his care and treatment at the hospital. A copy of his GP records were also obtained. These were referred to a Consultant in Emergency Medicine for independent advice.

Having read the advice the Ombudsman accepted that it would not be routine or standard practice to request an MRI scan in the Emergency Department when dealing with musculoskeletal problems. It was also accepted that the assessment carried out, the anti-inflammatory medication provided and the referral for physiotherapy was appropriate and sufficient for the patient's condition.

The Ombudsman therefore found that the care and treatment provided to the patient by the hospital was appropriate and reasonable. The complaint was not upheld.

The care of a patient in the Ulster Hospital, Dundonald

The Ombudsman upheld elements of a complaint made about the care given by the Ulster Hospital, Dundonald, to a patient with type 2 diabetes.

The Ombudsman's investigation involved input from a number of independent medical advisors and a consideration of the relevant medical records.

It was found that there were failures in relation to the patient not receiving her medication at the correct time, not having her blood glucose levels checked after it was administered, and not having her stump wound assessed every day.

A complaint that the patient should have been kept in hospital for further treatment, rather than being returned to her care home, was not upheld. The Ombudsman concluded that this decision by the medical staff was made in good faith and taken in the patient's best interest.

The South Eastern Health and Social Care Trust was asked to make an apology to the complainants for the failures identified.

Doctor's consultation prior to patient's death was 'reasonable and appropriate'

A patient who died three days after visiting his doctor for a routine medical review received treatment that was 'appropriate and in accordance with relevant guidance' according to an investigation by the Ombudsman.

The complainant alleged that her husband's condition was not properly assessed and treated when he went to see his doctor.

The patient complained at the appointment that he had had a sore throat for two or three days, felt warm and had experienced an episode of shaking the previous evening.

The doctor examined his throat and checked his temperature but did not prescribe anything and advised the patient to return if his symptoms did not improve or deteriorated. When the complainant again contacted the GP Practice seeking a home visit for her husband, an emergency appointment was arranged for that afternoon.

The patient attended and was seen by a doctor. He arrived at the hospital and was later transferred to the Regional Intensive Care Unit the same day where despite preparation for further transfer to hospital in London for treatment he sadly died the following day.

The patient's wife complained to the Practice, and then to the Ombudsman about the care and treatment provided by the doctor. She stressed her family's bewilderment at the speed of the deterioration of her husband's condition and the tragic outcome. She emphasised that she was looking for answers to her questions on whether anything should have been done differently at the appointment.

She also stated she wanted the reassurance that an independent body had looked into her complaint.

As the hospital had recorded that the patient had suffered "multiple organ failure, septic shock, and streptococcal pneumonia" the investigation also checked to see if signs of sepsis were overlooked. The investigation looked at the details of the complaint, the Practice's response, and the relevant NICE guidelines. An independent professional advisor was also asked for an opinion on the patient's treatment.

The Practice stated that when the doctor assessed the patient he took his temperature and examined his throat but did not listen to his lungs because of the absence of respiratory symptoms.

He recorded that the throat examination was normal and that the temperature was mildly elevated. The Practice also said that the clinical picture was in keeping with a viral, upper respiratory tract infection and antibiotic treatment was not required.

The independent advisor agreed with this course of action and that there was no requirement to arrange further investigation at the consultation or to seek specialist review. The advisor also stated that there was no indication in the notes that the patient should have been regarded as being at increased risk of developing sepsis.

The doctor's consultation was therefore found to be 'reasonable and in keeping with usual and normal practice.'

The complaint was not upheld.

Ombudsman upholds complaint about Trust's delay in carrying out carer's assessment

The Ombudsman upheld a complaint from a woman who waited 20 months to have a carer's assessment carried out by the Western Health and Social Care Trust.

Carer's assessment are aimed at seeing how a carer's life might be made easier. The woman had been acting as a carer in her family over a period of time before asking the Trust for the assessment. She complained to the Ombudsman about the length of her wait and about the time taken by the Trust to respond to her complaint to them.

The Investigating Officer obtained all relevant documentation from the Trust and discussed the case with the Trust's Clinical Psychologist and an Assistant Director.

The documents showed that in response to the request a Trust Social Worker recorded that an assessment was to be completed. However, despite the carer's ongoing contact with Trust staff over the next number of months, the assessment did not take place.

The Trust stated it had no specific carer's assessment policy during the period being reviewed. It provided copies of "Information and Guidance" for staff on completion of the carer's assessments, and guidance from the Health and Social Care Board (HSCB) setting out the legislative context.

However, there was no record of direct communication with the carer about her assessment until eight months after the initial request. The Trust did not acknowledge her request, explain the delay, nor propose how the assessment would be provided. The assessment was finally completed in August 2014.

The Trust said that the long delay was because the process was relatively new and there was no clinical practitioner to lead on the case. However, the Ombudsman concluded that the Trust was aware at the time of the importance of acknowledging the role of carer and that it had failed in its statutory duty to act on the complainant's request. This

part of the complaint was therefore upheld.

The Ombudsman also criticised the way the Trust handled the carer's complaint. The Trust did not provide a full response until July 2015, a full 21 months after the initial complaint.

Although there were issues relating to consent which the Trust sought to deal with, the Ombudsman's investigation found that limited information about the delay was provided to the carer. The Trust did not attempt to arrange to meet her to discuss the consent matter, or other matters.

The Trust's complaint policy states that there should be a 20 working day response time, with a possible extension not normally exceeding another 20 working days. Although the complaint file contained a large volume of material there was no clearly recorded explanation for almost all of the delays.

The Ombudsman recommend that the Trust's Chief Executive apologise to the carer and that the Trust review its policies and procedures to ensure requests for carer's assessments are properly captured.

Recommendations made to Council after failures found in handling of planning case

The Ombudsman criticised aspects of the way Mid & East Antrim Borough Council handled a planning application for an update of existing sports facilities at St Patrick's College, Ballymena.

A member of the public complained that the Council had ignored a consultation response from its own Environmental Health Department which said that the facility should be closed on Sundays. The complainant said that this condition was removed two hours prior to the Planning Committee meeting, at which the application was approved. This meant that he did not have a chance to raise an objection. He also said that he did not receive an explanation why this happened and at whose request.

The Ombudsman's Investigating Officer obtained all relevant information from the Council, and its comments on the issues raised.

It was established that after visiting the College, the Environmental Health officer provided a draft assessment which recommended that the facility should not be open on Sundays because of the expected increase in noise levels.

However, this assessment was revised a short time after on the basis that Sunday was the centre's busiest day and that it would therefore not be reasonable to suggest closure. The draft response was then changed to remove the reference to Sunday closure, and the revised, final response uploaded to the NI Planning Portal the day before the Planning Committee meeting took place.

The complainant's claim that the condition on Sunday closure was only removed two hours prior to the meeting was therefore not upheld.

However, the Ombudsman was critical of the Council's poor record keeping when dealing with the application. It was found that there was no documented evidence of the visit by Environment Health officials to the facility, and no notes explaining why there was a change of mind about the Sunday opening. There was also a lack of records to show that planning officials considered issues relating to new floodlights.

The Ombudsman found that this amounted to a lack of openness and transparency in the decision making process. This prevented the complainant from understanding why there had been a change of opinion, and denied him the chance to challenge it at the Planning Committee.

It was therefore recommended that the Council issue an apology to the complainant to acknowledge the injustice he experienced.

The Council were also asked to establish new guidance to staff on how to deal with consultation responses, and to include timeframes for how long an amended consultation response ought to be available to the public prior to a Planning Committee Meeting.

Investigation finds planning application was not properly considered

The Ombudsman found that an application to build a residential nursing home in County Down, was, in part, incorrectly assessed by planners.

In 2010 an application was received to extend and change the use of a golf clubhouse to provide a nursing home in Killyleagh. The Department of the Environment (which was responsible for planning matters at the time) granted approval of this application in 2011. In 2013 a further application was received to include ancillary building and associated external works. Departmental approval of this was granted in December 2013, subject to conditions.

After the transfer of planning functions from the Department to the Councils on 1 April 2015, Newry, Mourne and Down District Council then became responsible for all matters relating to the 2010 and 2013 applications.

The Ombudsman received a complaint about the way the applications were processed.

The investigation found that although the 2010 application was for an extension of the original building, it was instead demolished and a new building put up in its place.

Despite this, when the Department received the 2013 application it used the 2010 application as a 'material consideration' during the assessment process. This involved applying '*The conversion and reuse of existing redundant buildings*' section of Planning Policy Statement 21.

The Ombudsman consulted an independent planning advisor, who stated that 'in the circumstances following a demolition, any established use rights are lost and the site has a nil use'.

Once the building had been demolished therefore, this policy should no longer have been used to assess the 2013 application.

The Ombudsman upheld this part of the complaint. In addition, having looked at the complainant's allegations about the Council's complaints handling, it was found that there were failures to follow the Council's policy and a delay in handling the complaint.

In regard to other aspects of the complaint, it was found that the original planning application in 2010 was processed properly, and that the Council took appropriate enforcement action over the developer's breaches of planning control.

Agency's record keeping criticised

An Ombudsman's report criticised the Northern Ireland Environment Agency for not keeping proper records about its decision firstly to commission, and then ultimately not proceed with, a report relating to effluent treatment structures on the River Faughan.

The issue was raised with the Ombudsman by a representative from the River Faughan Anglers, a not for profit organisation with an interest in environmental issues on the river. The complainant had previously been told that an engineer would look at concerns about any risks posed by the effluent treatment structures, and that a report would be issued in due course.

While acknowledging that decision making was a matter for the Northern Ireland Environment Agency, the investigation looked at the way the Agency handled the commissioning of the report.

During the examination of the case, investigators were unable to find contemporaneous records of any analysis, discussions or decisions that took place within the Environment Agency about the issue. There were no records relating to the decision to propose commissioning the engineer's report, the terms of reference for the report, or substantive contact with civil service technical engineering specialists who could provide the report. There were also no records which showed why the decision was taken not to proceed with it.

The Ombudsman referred to the second Principle of Good Administration which requires public bodies to be 'customer focused'. This includes keeping to commitments made. It was clear from the complaint that the River Faughan Anglers were placing significant reliance on the commissioning of the engineer's report, and that the Agency should have considered updating the complainant on the change of position at a much earlier point.

The Ombudsman recommended that the Chief Executive of the Agency apologised to the complainant for the failings identified.

Patient waited five weeks to be seen by hospital psychiatrist

A woman who complained about the time it took for a hospital consultant psychiatrist to treat her mother had her complaint upheld by the Ombudsman.

The woman initially complained during her mother's stay at the Lagan Valley Hospital. She emailed the South Eastern Health and Social Care Trust voicing concerns that the nurses who had seen to her mother were unable to diagnose her underlying condition and provide appropriate treatment.

The Ombudsman's investigation obtained independent professional advice from a consultant psychiatrist and an experienced senior mental health nurse experienced in older people's mental health services.

The investigation found that the patient's medical team asked for assistance from their old age psychiatry colleagues shortly after her initial admission. Three weeks later the patient had still not been seen, prompting the complaint by her daughter to the Trust.

A consultant psychiatrist finally assessed the patient two weeks after this – a total of five weeks after she was admitted.

The Ombudsman found that the delay in assessment by a consultant amounted to a failure in care and treatment by the Trust.

The Trust was asked to apologise to the complainant. In order to improve its service, a recommendation was also made that it should conduct a review of the Psychiatry of Old Age Liaison Service, with a focus on the provision of consultant supervision, timely access to the service, and communication with patients and their families.

Maternity patient not given appropriate advice

A patient complained about the antenatal care and treatment she received while at the maternity unit of the Ulster Hospital.

Her complaint focused on the availability of amniocentesis testing during her pregnancy and the subsequent diagnosis of her baby with a life-limiting genetic disorder after birth. She complained that chromosomal conditions and otherwise isolated cleft issues, and the risks around amniocentesis, were not fully discussed with her. She also said that the abnormalities visible after birth should have been identified during ultrasound scanning.

As there were no stored images for analysis, the Ombudsman was unable to conclude that there were fetal abnormalities capable of being observed on ultrasound. This element of the complaint was not upheld.

In relation to the other part of the complaint, the Ombudsman's investigation found that the medical notes lacked evidence of a clear record of any discussion of the risks associated with amniocentesis. There were also no notes of a discussion of abnormalities associated with cleft lip. The doctor stated that that it is more likely than not

that this took place, but accepted that his note taking was lacking.

The Ombudsman concluded on the balance of probabilities that a request for amniocentesis was made by the complainant, but that appropriate advice and discussion on issues associated with cleft lip was not given and recorded during the consultation. This amounted to a failure in care and treatment.

The Trust apologised for its failures in this case and acknowledged the distress caused to the patient as a result.

Failings found in 'appointee' process

The Ombudsman recommended that the Department for Communities should review its operation of the appointee procedure after investigating a complaint from a woman who said she was concerned about an appointee to act for her aunt, who died in 2016.

An appointee is a person 'appointed' by the Department to deal with social security benefit matters if a benefit customer is incapable of managing their own affairs.

The woman also complained about the choice of the appointee, and that she was unhappy with the way the Department had responded to her concerns.

The Ombudsman's Investigation Officer interviewed the Department's outreach officer who had visited the woman and her prospective appointee.

The Department's own guidance states that because of the possibility of family disputes arising out of the appointee process, a record should be made of the answers given by appointees to questions about the existence of other family members or a next-of-kin.

The complainant's aunt had a number of living family members including a surviving brother as well as several nieces and nephews.

In this case it was found that there was no contemporaneous record of the visit. The Ombudsman was therefore unclear how the Department had been able to satisfy itself of the complainant's aunt's family members, or the existence or otherwise of a next-of-kin.

The Department's guidance also makes it clear that a comprehensive record should be kept of the visit to include information about the reasons for any decision on the mental incapacity of the benefit customer. In this case there was also no record of an assessment of capacity being made.

As a result of the Department's guidance not being followed, the Ombudsman found that the complainant sustained the injustice of distress and frustration. The complaint was upheld, with a recommendation that the Department issue an apology to the complainant.

Care and treatment of a patient by an Independent Healthcare provider

A report by the Ombudsman criticised elements of the care provided to a patient by Spire Independent Healthcare, based in Blackpool (Lancashire). The patient was referred to Spire under a waiting list initiative operated by the Belfast Health and Social Care Trust.

The patient complained that she was unhappy with the outcome of carpal tunnel decompression surgery carried out by Spire, that she should not have been discharged, and that she was discharged without receiving any post-surgery therapies.

Following investigation the Ombudsman concluded that the decision to discharge the patient was appropriate. However, it was found that there was a failure by the healthcare provider to:

- Communicate to the complainant that she was being discharged
- Appropriately inform the complainant of the risks associated with carpal tunnel decompression surgery
- Review the complainant's earlier decision to consent to the surgery, prior to treatment commencing; and
- Record a contemporaneous note of the discharge discussion

As a result of the Ombudsman's findings, Spire agreed to apologise to the patient.

Care and treatment of a patient at Kingsbridge Private Hospital

An investigation found that the overall care and treatment provided by a private hospital to a patient who had a suspected ovarian cyst was appropriate and reasonable. The patient was treated there as a result of a waiting list initiative by the South Eastern Health and Social Care Trust.

The patient attended Kingsbridge Private Hospital Belfast to have the cyst removed. However, the doctor was not able to complete the procedure and she was referred to a different surgeon within the hospital.

After the cyst was removed the patient made a complaint stating that the first procedure had left her in pain and discomfort. She complained that the first doctor was not appropriately qualified to carry out the surgery, and that she was unnecessarily subjected to two procedures.

The Ombudsman's investigating officer obtained a report from the 3fivetwo group who ran the hospital, interviewed the doctor who had been complained about, and received independent advice from a Consultant Obstetrician and Gynaecologist.

After reviewing all of the evidence the independent advisor did not identify any concerns about the doctor's preparation and treatment plan in advance of the surgery, and said that there was no prior indication of a need to make a referral to a specialist surgeon.

The Ombudsman concluded that the doctor's attempt to remove the cyst, but abandon the procedure and refer to another specialist, was appropriate and in line with clinical standards.

However, the Ombudsman identified a failure by the doctor during the assessment process to properly record the patient's severe endometriosis. The report therefore recommended that the Group should apologise to the patient for the uncertainty and confusion this caused her.

Section Five

Supporting learning and improvement, and working with others

Investigation reports and Bulletins

Supporting learning from complaints and improvement in public service delivery is a key strategic aim. We routinely publish investigation reports in the public interest to raise awareness of lessons from our complaints and investigations. This also helps facilitate greater transparency, accountability and learning around complaints. We try to publish as many of our investigation reports as we can because we believe it is in public interest to share the learning identified in them. We also believe that publication helps to improve understanding of our work.

The reports are considered on a case by case basis, mindful of the public interest in highlighting cases of service failure. Investigations into complaints which have found no evidence of service failure are also made public.

All of the reports published during the year can be found on our website at www.nipso.org.uk.

Our work is also shared through the publication of Bulletins and Case Digests. These keep stakeholders informed about new items of interest, including summaries of recently published investigation reports, statistics relating to complaints, and developments in the Office's research into good complaints handling. We send copies to all stakeholders and subscribers to our mailing list, and promote them on social media.

Along with the freedom to publish case digests and other bulletins at the discretion of the Ombudsman, the publication of investigation reports has undoubtedly contributed to the increased public profile of the Office and, in turn, to the steep increases in complaints activity that the Office has encountered.

We continue to use traditional printed leaflets and guides to explain our role. This year we produced a booklet for residents of care homes and their families, which explained what to do if they wanted to make a complaint.

Copies of the booklet were sent to every residential care home and nursing home in Northern Ireland, along with a poster to put on prominent display.

Engagement and outreach

We engage with and provide outreach to a number of key sectors to support good complaints handling and develop awareness and understanding of the Ombudsman's role.

There was very effective engagement on good complaints handling during the year with the schools and housing sectors, both of which received very positive feedback.

In relation to schools, facilitated by the Education Authority we delivered outreach sessions to school principals focusing on best practice in complaint handling and raising awareness of the Ombudsman's role and approach. Complaints from this sector have increased beyond the number anticipated and some particular areas of concern have been raised in particular Restraint and Seclusion, Special Educational Needs. Complaints handling is also an area which has arisen as an issue in our investigations and we will continue to work to support the sector in this area

We also provided outreach sessions to the housing sector, focusing on their approach to complaints handling and work they were undertaking to improve their complaints handling.

We had significant engagement with the Health and Social Care (HSC) sector through the HSC Complaints Policy Forum and had six meetings with HSC Trusts.

We also met with complaints handling teams and senior managers in the Department for Infrastructure, as well as presenting at an all-staff event for the Child Maintenance Service to discuss the role of good complaints handling in customer care.

Outreach session with the Green Party April 2019

Our outreach programme for political parties continued during the year to share the experience and learning from our Investigations and develop an awareness of the developing role of the Ombudsman, including in relation to Own Initiative. We undertook presentations to both the Green Party and Sinn Fein following on from engagement with the Ulster Unionist Party in 2018. Planned engagement with the Democratic Unionist Party was unfortunately postponed in March 2020 as a result of the developing situation with Covid-19.

It is important that we continue this outreach and engagement to help provide insight from our uniquely placed role with oversight of the public sector.

Records Matter

This year we worked closely with the Information Commissioner's Office and the Northern Ireland Audit Office to produce a joint publication for public bodies on the subject of record keeping. 'Records Matter' was based on our collective experience of complaint handling, investigations, audits and inspections carried out over many years.

It includes case summaries of cases that show when something has gone wrong, accurate information is crucial to an understanding of what happened and why.

Our experience shows that failures in record keeping are often at the heart of wider maladministration or failures in service.

In many cases problems can be avoided through the act of making a simple record of how decisions were reached and on what basis. An organisation can then show it has properly thought through the consequences of its actions.

Our joint work with the Information Commissioner and the Audit Office on this project allowed us to make these points more powerfully. It also came at a time when the issue of record keeping and good administration was a particular area of focus in the wider public discourse. We sent a copy of the publication to the Chief Executives of all public bodies in Northern Ireland to increase awareness of this important discipline.

Regulation and Oversight Forum

In 2018 we initiated the re-establishment of the Regulation and Oversight Forum, and welcome the fact that it continues to meet to ensure a collaborative approach to scrutinising our public services. The Forum enables the bodies to consult and share information so as to avoid overlap and duplication of work. This helps us to ensure the efficient and effective use of our investigative resources in the public interest.

This is an increasingly important element of Ombudsman work – working collaboratively across service areas and sharing intelligence to provide a holistic approach to oversight, scrutiny and regulation.

The forum met twice this year, in June and December 2019.

Improving complaints handling

The Northern Ireland Assembly in the 2016 Act provided for the Ombudsman to hold a role as Complaints Standards Authority (CSA), a role held by Ombudsmen in Scotland and Wales. This role, included in the 2016 Act but not as yet commenced by the Assembly, will enable NIPSO to improve complaints handling across Northern Ireland and lead to the development and implementation of a simplified and consistent approach to complaints handling by public bodies.

Complaints improvement focus group – June 2019

It will support improvement by guiding all public service providers towards a simplified, accessible and standardised complaints procedure and clear standards for how complaints should be handled by our public services. These procedures will put the service user at the heart of the process, focus on early resolution, and increase the use of complaints for learning and service improvement.

During the year we carried out a number of activities to prepare for this CSA role in improving and standardising complaints handling. We completed our research into complaints handling procedures across the public sector in Northern Ireland. Our researchers held sectoral focus groups with each sector, interviewed individual complainants, researched complaints information on the websites of public bodies, and reviewed cases handled by the Ombudsman. The research will be

made available later in 2020 and will inform the development of a Statement of Principles and Model Complaints Handling Procedures for eventual adoption by public bodies.

We have also initiated the establishment of sectoral networks to support public bodies in their complaints handing and facilitating the sharing of best practice. The networks will also be used to co-develop the new principles, procedures and standards to be developed by the CSA, and prepared training modules to support staff on good complaints handling techniques.

In addition, we established a network for colleagues in other Ombudsman bodies across the UK and Ireland to share and collaborate on complaints improvement and best practice and related matters. The network will provide opportunities for the members to learn from each other and improve people's experience of complaining about public services.

Complaints about social care

The complaints research we have undertaken, including with complainants and advocacy bodies, shows that the system for complaining about social care is confusing to people.

As part of our work into improving complaints handling we met with the families of residents of Dunmurry Manor care home to understand their difficult experiences in complaining about failings in the social care system. These were issues highlighted prominently in the Commissioner for Older People's Home Truths report in 2018.

It is clear that complaints handling in this sector is failing to provide effective, responsive and empathetic redress where things go wrong, and that complaints about social care issues are not reaching NIPSO in the numbers that we would expect, given the experiences that have been highlighted and in comparison to Ombudsmen in other parts of the UK and Ireland. We will continue to work to help address these issues through further engagement with the sector and through our forthcoming role as a Complaints Standards Authority.

Section Six

Performance Analysis

How we measure performance

NIPSO's operational efficiency and effectiveness is measured through key performance indicators (KPIs). These focus on the time taken to assess complaints and complete investigations. Assessments are completed through well-established internal procedures, which retain a focus on quality as well as timeliness.

Our caseload continues to increase significantly. In 2019-20 we received **37%** more complaints than in 2018-19. This is an overall increase of **119%** from 2015-16.

However, despite this we have managed to improve our year-on-year performance in a number of key areas and made more decisions than at any point since NIPSO's inception in 2016. During the year we handled **64%** more cases at the Assessment stage than in 2015-16. At the Investigation stage we also closed **32%** more cases than in 2018-19, and **75%** more cases than in 2015-16.

The Office's KPIs, together with the recorded performance in 2019-20, are as follows:

Indicator	2019-20 Target	2019-20 Achieved
KPI 1 – measures how quickly we make a decision on whether the Ombudsman can accept a complaint for further assessment. We aim to inform the complainant within 2 weeks or less of their complaint being received in 90% of cases	90%	98%
KPI 2 – measures how quickly we decide on what action we can take on a complaint which has been accepted for assessment. We aim to complete this assessment and inform the complainant of the decision within 10 weeks of their complaint being received.	70%	85%
KPI 3 – measures how quickly we reach a decision on the investigation of a complaint and share the draft report with the body and the complainant. We aim to complete this within 50 weeks of the decision at KPI 2 being made.	70%	60%

Performance Commentary

Despite the considerable increase in complaints and fewer resources available for decision making at the Initial Assessment stage of the process, performance against KPI 1 was 98%. This was considerably above our target of 90% and is particularly noteworthy.

Performance on KPI 2 (the Assessment stage) was also considerably ahead of target in 2019-20, up to 85% against the target of 70%. The increased focus on early resolution and proportionality resulted in a considerable increase in settlements achieved by the ASSIST Team. There was also a 200% increase in the number of cases referred back to public bodies for further local resolution. It has been found that referrals back for further local resolution in appropriate circumstances often result in much better outcomes for complainants.

For Key Performance Indicator 3, our aim was to make a decision and share our report on 70% of our cases within 50 weeks. We achieved this target in 60% of the cases we dealt with. However, this performance has to be seen in the context of a 32% increase in the number of cases closed at this stage compared to last year.

This is a continuation of the significant upward trend in cases closed at Investigation stage (75% increase over 4 years) with this year representing the highest number of closures at Investigations since the inception of NIPSO in 2016.

In addition, due to the Progressive House office refurbishment during the year, the Investigation Team experienced considerable disruption from the decanting of staff and their subsequent return and resettlement in January 2020.

There was also a period of significant disruption due to the departure of the former Ombudsman to take up a new role in July 2019, and the suspension of the Northern Ireland Assembly, meaning succession arrangements could not be confirmed until early 2020.

Governance and accountability

Last year's Ombudsman's Report noted concerns about the absence of the Northern Ireland Assembly and the resulting lack of scrutiny and accountability. The welcome return of a functioning Assembly, including its Standing and Statutory committees, now means that our investigation reports can be sent for consideration and debate. It also means that we can be held to account for our decisions and our use of public money.

In February and March of this year we provided evidence to the Audit Committee on the financial position of the Office, our draft strategic plans for 2020-23, and some further information on the range of our work. We look forward to resuming our engagement with the Committee in the Autumn.

Our Audit and Risk Committee continued to meet, meeting 5 times over the year. I would like to place on record my thanks to the Chair and Committee for their support and constructive challenge which was invaluable through a period of uncertainty and change in governance.

Financial performance

In 2019-20 NIPSO achieved all of the three established financial KPIs.

Of particular note, the overall Net Resource Outturn for the reporting period was 1.5% less than estimated – still within the target of 2% despite the disruptive effects of the Covid-19 pandemic in the latter weeks of the reporting year.

The financial KPIs, together with the recorded performance in 2019-20, are as follows:

Indicator	2019-20 Target	2019-20 Achieved
KPI 6 – we will not exceed the total Net Total Resource expenditure for the year authorised by the Northern Ireland Assembly as detailed in the 2018-19 Spring Supplementary Estimate, limiting any underspend to 2%.	Not > 2%	1.5%
KPI 7 – in supporting the work of the Office the total cash utilised within the year will not exceed the Net Cash Requirement limit authorised by the Northern Ireland Assembly as detailed in the 2018-19 Spring Supplementary Estimate.	n/a	Yes
KPI 8 – we will we will pay 98% of correctly presented supplier invoices within 10 working days of receipt.	98%	99%

The following table summarises NIPSO's audited expenditure during 2019-20:

(All £k)	Maladministration (incl NIJAO)	Local Gov't Ethical Standards (LGES)	Total
Staff Costs	1,685	374	2,059
Other Administration Costs	384	161	545
Total expenditure	**2,069**	**535**	**2,604**

Staff Numbers as at 31 March 2020

	Male	Female	Total
Ombudsman/Deputy Ombudsman	2	1	3
Other Senior Management Team	1	1	2
Other Staff	14	28	42
Total	**17**	**30**	**47**

Appendix One
Further Casework Statistics

Health and Social Care

	Brought Forward @ 31/03/2019	Complaints Received in 2019-20	Determined at Initial Assessment*	Determined at Assessment**	Determined at Investigation***	Carried Forward @ 31/03/2020
H&S Care Trusts	116	298	195	70	55	94
Health Service Providers	16	47	22	14	9	19
Independent HSC Provider	5	11	4	3	5	5
R H&S Care Board	0	6	3	3	0	0
RQIA	2	2	2	1	0	1
Private Nursing/ Care Home	5	8	5	3	3	2
Patient and Client Council	0	1	1	0	0	0
Business Services Organisation	1	4	4	1	0	0
Total	**145**	**377**	**236**	**95**	**72**	**121**

***Initial Assessment**
Complaints determined at this stage include, for example, those made without being first looked at by the relevant public body, made more than 6 months after completing the body's complaints procedure, or where the body complained of is not within our remit.

****Assessment**
If a complaint is referred for further assessment, the ASSIST team will obtain more information from the complainant or the organisation concerned. The information will help them decide whether it can be determined at this stage, either by being closed, referred back to the body for local resolution or settlement, or passed to the Investigation stage.

*****Investigation**
Three factors are taken into account when deciding whether to move a complaint to the Investigation stage. These are whether an investigation is proportionate, can deliver a practical outcome and is in the public interest.

Government Departments and Agencies

	Brought Forward @ 31/03/2019	Complaints Received in 2019-20	Determined at Initial Assessment*	Determined at Assessment**	Determined at Investigation***	Carried Forward @ 31/03/2020
Driver & Vehicle Agency	1	21	21	0	1	0
Northern Ireland Environment Agency	2	1	1	1	1	0
Youth Justice Agency	1	0	0	1	0	0
Department for Communities	9	96	82	16	3	4
Department for Communities - Child Maintenance Service	0	2	1	1	0	0
Department for Communities - PRONI	0	1	1	0	0	0
Department for Infrastructure	2	20	17	3	1	1
Department for Infrastructure - Planning and Local Government Group	1	1	1	0	1	0
Department for the Economy	3	3	3	3	0	0
Department of Agriculture, Environment and Rural Affairs	3	7	6	2	0	2
Department of Education	0	2	2	0	0	0
Department of Finance	1	5	6	0	0	0
Department of Finance - Land & Property Services	1	24	13	9	0	3
Department of Justice	1	5	4	1	0	1
Department of Justice - Compensation Services	**0**	**1**	**1**	**0**	**0**	**0**
Department of Health	**0**	**3**	**2**	**1**	**0**	**0**
The Executive Office	**0**	**1**	**1**	**0**	**0**	**0**
Total	**25**	**193**	**162**	**38**	**7**	**11**

* ** *** See notes opposite.

Housing

	Brought Forward @ 31/03/2019	Complaints Received in 2019-20	Determined at Initial Assessment*	Determined at Assessment**	Determined at Investigation***	Carried Forward @ 31/03/2020
Apex Housing	0	1	1	0	0	0
Alpha Housing Association (NI) Ltd	0	2	1	0	0	1
Ark Housing Association (NI) Ltd	0	2	1	0	0	1
Choice Housing	2	14	14	2	0	0
Clanmil Housing Association Ltd	0	1	1	0	0	0
Habinteg Housing Association (Ulster) Ltd	0	4	4	0	0	0
Newington Housing Association Ltd	0	1	1	0	0	0
Northern Ireland Co-Ownership Housing Association Ltd	0	1	1	0	0	0
Northern Ireland Housing Executive	6	64	51	15	0	4
Radius Housing	0	12	3	7	0	2
Rural Housing Association Ltd	0	1	1	0	0	0
Total	**8**	**103**	**79**	**24**	**0**	**8**

***Initial Assessment**
Complaints determined at this stage include, for example, those made without being first looked at by the relevant public body, made more than 6 months after completing the body's complaints procedure, or where the body complained of is not within our remit.

****Assessment**
If a complaint is referred for further assessment, the ASSIST team will obtain more information from the complainant or the organisation concerned. The information will help them decide whether it can be determined at this stage, either by being closed, referred back to the body for local resolution or settlement, or passed to the Investigation stage.

*****Investigation**
Three factors are taken into account when deciding whether to move a complaint to the Investigation stage. These are whether an investigation is proportionate, can deliver a practical outcome and is in the public interest.

Local Councils

	Brought Forward @ 31/03/2019	Complaints Received in 2019-20	Determined at Initial Assessment*	Determined at Assessment**	Determined at Investigation***	Carried Forward @ 31/03/2020
Antrim & Newtownabbey Borough Council	1	4	3	2	0	0
Ards & North Down Borough Council	1	14	8	4	0	3
Armagh City, Banbridge & Craigavon Borough Council	4	12	9	5	2	0
Belfast City Council	1	21	11	6	1	4
Causeway Coast & Glens Borough Council	1	15	9	3	0	4
Derry City & Strabane District Council	1	9	2	3	0	5
Fermanagh & Omagh District Council	0	9	9	0	0	0
Lisburn & Castlereagh City Council	0	3	2	1	0	0
Mid & East Antrim Borough Council	1	5	3	1	1	1
Mid Ulster District Council	0	3	2	1	0	0
Newry, Mourne & Down District Council	2	12	10	2	2	0
Total	**12**	**107**	**68**	**28**	**6**	**17**

***Initial Assessment**
Complaints determined at this stage include, for example, those made without being first looked at by the relevant public body, made more than 6 months after completing the body's complaints procedure, or where the body complained of is not within our remit.

****Assessment**
If a complaint is referred for further assessment, the ASSIST team will obtain more information from the complainant or the organisation concerned. The information will help them decide whether it can be determined at this stage, either by being closed, referred back to the body for local resolution or settlement, or passed to the Investigation stage.

*****Investigation**
Three factors are taken into account when deciding whether to move a complaint to the Investigation stage. These are whether an investigation is proportionate, can deliver a practical outcome and is in the public interest.

Education

	Brought Forward @ 31/03/2019	Complaints Received in 2019-20	Determined at Initial Assessment*	Determined at Assessment**	Determined at Investigation***	Carried Forward @ 31/03/2020
Queen's University Belfast	2	14	8	7	0	1
Ulster University	0	4	3	1	0	0
Council for Catholic Maintained Schools	0	1	0	0	1	0
Education Authority	0	13	9	1	1	2
Northern Regional College	0	1	1	0	0	0
Board of Governors of Nursery School	0	1	1	0	0	0
Board of Governors of Grammar School	2	7	4	5	0	0
Board of Governors of Primary School	12	47	25	15	4	15
Board of Governors of Secondary School	5	14	8	5	2	4
Board of Governors of Special School	0	2	1	1	0	0
Total	**21**	**104**	**60**	**35**	**8**	**22**

***Initial Assessment**
Complaints determined at this stage include, for example, those made without being first looked at by the relevant public body, made more than 6 months after completing the body's complaints procedure, or where the body complained of is not within our remit.

****Assessment**
If a complaint is referred for further assessment, the ASSIST team will obtain more information from the complainant or the organisation concerned. The information will help them decide whether it can be determined at this stage, either by being closed, referred back to the body for local resolution or settlement, or passed to the Investigation stage.

*****Investigation**
Three factors are taken into account when deciding whether to move a complaint to the Investigation stage. These are whether an investigation is proportionate, can deliver a practical outcome and is in the public interest.

Appendix 2
List of Public Authorities Within Remit of the Northern Ireland Public Services Ombudsman

Northern Ireland Assembly

- Assembly Commission
- The Independent Financial Review Panel

Northern Ireland Departments

- A Northern Ireland department

Local Government

- A district council
- The Local Government Staff Commission for Northern Ireland
- The Northern Ireland Local Government Officers' Superannuation Committee

Education and Training

- The board of governors of a grant-aided school
- An industrial training board
- An institution of further education
- The General Teaching Council for Northern Ireland
- The Northern Ireland Council for Postgraduate Medical and Dental Education
- The Northern Ireland Council for the Curriculum, Examinations and Assessment
- The Education Authority
- University of Ulster
- The Queen's University of Belfast
- The Youth Council for Northern Ireland
- The Council for Catholic Maintained Schools

Policing, Criminal Justice and Law

- A policing and community safety partnership or a district policing and community safety partnership
- The Northern Ireland Policing Board
- The Chief Inspector of Criminal Justice in Northern Ireland
- The Commission for Victims and Survivors for Northern Ireland
- The Northern Ireland Police Fund
- The Probation Board for Northern Ireland
- The Royal Ulster Constabulary George Cross Foundation
- The Northern Ireland Law Commission
- The Police Rehabilitation and Retraining Trust

Arts and Leisure

- The Arts Council of Northern Ireland
- The Board of Trustees of the National Museums and Galleries of Northern Ireland
- The Northern Ireland Library Authority
- The Northern Ireland Museums Council
- The Northern Ireland Tourist Board
- The Sports Council for Northern Ireland

Health and Social Care

- A health and social care trust
- A special health and social care agency
- The Northern Ireland Practice and Education Council for Nursing and Midwifery
- The Health and Social Care Regulation and Quality Improvement Authority
- The Northern Ireland Social Care Council
- The Patient and Client Council
- The Regional Agency for Public Health and Social Well-being
- The Regional Health and Social Care Board
- The Regional Business Services Organisation
- A general health care provider
- An independent provider of health and social care

Investment and Economic Development

- Invest Northern Ireland
- The company for the time being designated under Article 5 of the Strategic Investment and Regeneration of Sites (Northern Ireland) Order 2003
- A development corporation established under Part III of the Strategic Investment and Regeneration of Sites (Northern Ireland) Order 2003

Industrial Relations

- Office of the Certification Officer for Northern Ireland
- The Labour Relations Agency

Harbours

- The Northern Ireland Fishery Harbour Authority
- A harbour authority within the meaning of the Harbours Act (Northern Ireland) 1970

Housing

- A registered housing association within the meaning of Article 3 of the Housing (Northern Ireland) Order 1992
- The Northern Ireland Housing Executive

Children and Young People

- The Safeguarding Board for Northern Ireland
- The Office of the Commissioner for Children and Young People for Northern Ireland

Charity and Voluntary Sector

- Regulator of Community Interest Companies
- Appeal Officer for Community Interest Companies
- The Charity Commission for Northern Ireland
- The Northern Ireland Community Relations Council

Miscellaneous

- The Agri-Food and Biosciences Institute
- Civil Service Commissioners for Northern Ireland
- The Comptroller and Auditor General
- The Equality Commission for Northern Ireland
- The General Consumer Council for Northern Ireland
- The Health and Safety Executive for Northern Ireland
- The Livestock and Meat Commission for Northern Ireland
- The Northern Ireland Audit Office
- The Northern Ireland Authority for Utility Regulation
- The Northern Ireland Fire and Rescue Service Board
- The Office of the Commissioner for Older People for Northern Ireland
- Ulster Sheltered Employment Limited
- A new town commission established under the New Towns Acts (Northern Ireland) 1965 to 1968
- An implementation body to which the North/South Co-operation (Implementation Bodies) (Northern Ireland) Order 1999 applies

Northern Ireland
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Ombudsman

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