Northern Ireland
Public Services
Ombudsman

Ombudsman's Report

2016 | 2017

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ANNUAL REPORT

of the

Northern Ireland Public Services Ombudsman

2016-17

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

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Introduction

I am pleased to present my general report on the functions of my Office for the year ended 31 March 2017. I was appointed Northern Ireland Public Services Ombudsman on 1 April 2016, so the report covers all of my first year as Ombudsman.

I independently and impartially investigate complaints from individuals about public services in Northern Ireland. My remit is broad and includes complaints of maladministration about central and local government, education, health and social care, housing and justice bodies. In health and social care I can investigate not only maladministration but also professional judgement.

In my role of Northern Ireland Local Government Commissioner for Standards I am responsible for investigating and adjudicating on complaints about alleged breaches of the Local Government Code of Conduct for Councillors.

From 1 April 2016 the functions of the Northern Ireland Judicial Appointments Ombudsman in relation to complaints about judicial appointments also transferred to my Office.

Public Services Ombudsman Act (NI) 2016

This report is laid before the Northern Ireland Assembly as the formal document of record for the newly created Office of the Northern Ireland Public Services Ombudsman, which was established by the Public Services Ombudsman Act (Northern Ireland) 2016 ('the Act'). The Act repealed legislation which provided for the former Offices of the Assembly Ombudsman for Northern Ireland and Northern Ireland Commissioner for Complaints. Given that a significant number of investigations under the old legislation remained open when I took up office, a key objective of my first year as Ombudsman has been to conclude these cases.

In addition to that challenge, the Act has provided for extensions of jurisdiction (particularly in the education sector) and new powers to consult, co-operate and share information with other ombudsmen and oversight bodies, such as the Regulation and Quality Improvement Authority (RQIA) and the Northern Ireland Audit Office. Work has begun with these bodies to establish protocols to ensure there is no duplication of investigative resource in areas where my jurisdiction overlaps with other regulatory roles.

Foreword
from the Ombudsman

In this year, both myself and my staff have undertaken speaking engagements and outreach work to better inform the public and bodies in jurisdiction about the new Office and its extended powers. The new legislation now makes it easier for individuals to complain and there is no longer a requirement for a complaint to be made to the Office in writing. One of my key aims is to increase awareness of the Office and to ensure it is as accessible to the public as possible.

The vast majority of the complaints about public services come from a person aggrieved or someone acting on their behalf. However, I can now, unlike my predecessors, investigate complaints referred by a body where it has been unable to resolve a complaint.

Further the Act places a statutory duty on all bodies in jurisdiction to refer complainants to the Office at the conclusion of the internal complaints process.

This report describes how complaints received between 1 April 2016 and 31 March 2017 were investigated and complements my Annual Report and Accounts published in June of this year, which provides information on the Office's corporate governance and financial position for the same period. A copy of this Report can be found at www.nipso.org.uk.

Complaints Activity

Overall complaints activity in the past year increased by **12%** with 3,385 complaint contacts in 2016-17, compared to 3,057 in 2015-16.

Forty one percent of complaints related to health and social care matters, with the majority of these relating to Health and Social Care Trusts. Less than 1% of complaints to the Office in 2016-17 related to general health care providers such as GPs, dentists, opticians and pharmacists.

Given the recent reform of local government, it is notable that concerns about the actions of local councils resulted in a total of **62** (11%) complaints, a reduction from 82 complaints received in the previous year. A number of these relate to planning issues as well as public procurement.

Detailed statistics and further information on complaints received during 2016-17 is available in Section Two and Appendix A of this report.

Early Resolution of Complaints

As Ombudsman I am the final arbiter of complaints about public services in Northern Ireland. Most complaints which come to the Office have been through the internal complaints procedure of a public body but have not been resolved to the satisfaction of the complainant.

The Office is structured so as to ensure that when these complaints are received, where possible they are resolved at an early stage. The ASSIST (Advice, Support

Service and Initial Screening Team) team performs an essential 'triaging' role for all complaints to the Office. This has been a success in ensuring that early resolution can be achieved for the benefit of the public and the body concerned. A sample of case work in this team is summarised on pages 15 and 16.

Innovation in Investigations

A number of new investigation initiatives were introduced during the year to speed up the investigation and reporting processes, reflecting streamlined requirements in the new legislation. A new staff manual was developed to take account of the legislative requirements and investigating officers undertook training in evidence and report writing.

I am grateful to my colleague, the Welsh Ombudsman, for his assistance and that of his staff in developing a new report template. Staff have been working hard to produce clear, succinct reports with a view to publishing when it is in the public interest to do so under the new legislation.

Working jointly with the Northern Ireland Human Rights Commission, a manual which demonstrates the Human Rights Based Approach to ombudsmen investigations was launched in May 2016. Supported by the International Ombudsman's Institute (IOI) this new investigative approach has had much international acclaim.

The launch of the Human Rights Manual in May 2016

The purpose of the manual is to ensure that our work is rooted in protecting individuals and in assisting bodies to effectively apply human rights principles.

I was privileged to be invited to speak at the IOI world conference in Bangkok and there was keen interest in the experience of introducing this approach to investigations in cases that raise human rights issues.

In October 2016 I hosted the Public Services Ombudsman Group for a visit to Northern Ireland to discuss good practice in complaints handling and the role of the Ombudsman in remedying injustice.

The group comprises public services ombudsmen from the United Kingdom, Ireland, Malta and Gibraltar and meets twice a year to share learning and good practice.

Principles of Good Administration

When I commenced my tenure as Ombudsman I knew that the fundamental principles of good public administration were acknowledged and embedded across all public services in Northern Ireland. This is due in no small part to the hard work and dedication of my predecessor Dr Tom Frawley CBE.

I continue to use the Principles of Good Administration as a benchmark for assessing the actions and decisions of all public service providers in Northern Ireland. The Principles can be found in Appendix B of this report.

There are a number of issues which I wish to highlight from my in-depth investigations and which bodies in my jurisdiction will need to consider. I continue to receive cases where the complainant is dissatisfied with the way the body in jurisdiction has handled their complaint. Issues raised include the length of time taken to complete the complaints process, questions or concerns raised remaining unanswered and reasons for decisions not being properly explained.

The Principles of Good Complaints handling are now well established and should be embedded into the complaints policy and procedures of bodies in my jurisdiction. The policy and procedures should be underpinned with training for those who will be involved in the management or investigation of complaints.

The quality of records created and maintained by public service providers remains a concern. Too often my investigators find that at key points in the decision making process records to support the decisions have either not been kept or are of poor quality.

Maintaining clear and accurate records is a fundamental facet of good administrative practice. Records must provide evidence of how decisions have been reached and the factors which were taken into account in arriving at the decision. The absence of appropriate records has the potential to undermine the public's trust and confidence in the decision making process and the decision taken.

New Accountability

2016-17 was a year of continuous change and challenge for the new Office, with extended jurisdictions in Further and Higher education, increased powers to access information and new responsibilities for judicial appointments. Revised accountability relationships were also created for NIPSO by the Act.

For the first time I presented the Office resource bids for scrutiny by the Audit Committee of the Northern Ireland Assembly. A Memorandum of Understanding was developed with that Committee to outline the reporting obligations and responsibilities of myself and the Committee.

A NIPSO Audit and Risk Committee with independent Chair and Members was also created to support me in my role as Accounting Officer. Despite the increase in jurisdiction and increasing case numbers, for a time I was unable to progress staff recruitment due to uncertainty over the allocation of increased funds for my new areas of work. I am pleased to record however that these issues were resolved and funding secured for the 2017/18 year.

This has been a year of change and transition to new ways of working and increased responsibilities. A transfer of staff and the move away from secondment to direct employment of all Office staff brought increased responsibilities as an employer. I am grateful to my Deputy Mr Paul McFadden, the Senior Management team and staff for their resilience and hard work in facing the increased pressures and commitments necessary to establish the new Office. In this first year my staff have demonstrated their professionalism and dedication to improving public services by the investigation of complaints from the public.

Marie Anderson

MARIE ANDERSON

Northern Ireland Public Services Ombudsman

Section One
NIPSO Report 2016-17

Increased Remit and Powers

The first year of NIPSO brought significant change with greatly increased remit and enhanced investigation and reporting powers as compared to its predecessor, the Assembly Ombudsman for Northern Ireland and the Northern Ireland Commissioner for Complaints (AOCC). NIPSO now can investigate complaints about:

- professional judgment in social care (April 2016)
- maladministration by the Northern Ireland Audit Office (NIAO), the Northern Ireland Assembly Commission, and the Northern Ireland Judicial Appointments Commission (April 2016)
- maladministration in government commercial and contractual matters (including procurement) (April 2016)
- maladministration by Colleges of Further and Higher Education, the Queen's University of Belfast, the Ulster University and their affiliated colleges (October 2016).

In addition, from April 2017 NIPSO has responsibility for the investigation of complaints about the Board of Governors of publicly funded schools (approximately 1,200 in number). During 2016-17 a considerable amount of work was completed in preparing for the acquisition of this very significant new jurisdiction.

One of the main Northern Ireland Assembly policy objectives in the establishment of NIPSO was the desire to increase accessibility to the Ombudsman and to make it easier for the public to complain. The legislative provisions in the Act implementing this aim include:

- members of the public are no longer required to obtain MLA sponsorship in order to make a complaint about a Government Department; although MLAs can act 'on behalf' of a constituent in bringing a complaint to my Office where appropriate.
- public service providers are required to signpost complainants to NIPSO at the conclusion of their complaints process
- an oral complaint can be accepted by NIPSO where previously only a written complaint was acceptable.

In addition to the NIPSO role in investigating maladministration, the Ombudsman was also appointed as the Northern Ireland Local Government Commissioner for Standards. In that role she investigates and adjudicates on complaints about alleged breaches of the Northern Ireland Local Government Code of Conduct. A report on the operation of this important and high profile function in 2016-17 has separately been prepared and published.

Further, the functions of the Northern Ireland Judicial Appointments Ombudsman were also transferred to NIPSO from 1 April 2016.

New reporting powers

The establishment of NIPSO has brought significant new reporting powers that have the potential to further inform the public on the work of the Office. The Act introduced the power, for the first time, to publish reports on investigations in the public interest.

Greater transparency in reporting will give the work of the Ombudsman a much higher profile, and lead to a heightened awareness of its functions and role as a final arbiter in public services complaints resolution.

The Ombudsman has given careful and detailed consideration over the course of 2016-17 to the practical application of her new reporting powers. There are a number of factors the Ombudsman will consider in deciding whether publication of a report is in the public interest, such as where the investigation reveals serious maladministration. The power to publish in the public interest plays an important role in delivering transparent public services.

The Ombudsman will publish her first public interest reports during the course of 2017-18 and will also develop and publish appropriate case digests and other forms of reports which wil serve to inform the public and stakeholders about the work of the Office. A key aim of these publications is to share the learning from investigating complaints across a wide range of public services.

Another important change has been the ability of the Ombudsman to share her investigation report with any other person that she considers appropriate. This power was not provided for previously and enables the Ombudsman to highlight instances of maladministration with other bodies whose role complements her own. This may include other regulators such as the General Medical Council or the Regulation and Quality Improvement Authority and will greatly enhance the ability to share matters of common interest relating to public service improvement or issues relating to patient safety.

Own Initiative powers

Continuing the increase in remit, 2018/19 will bring a significant new role for the Ombudsman, with the addition of Own Initiative powers. This will allow the Ombudsman to undertake investigations into potential systemic maladministration and injustice, enabling the Ombudsman to look beyond the individuals who bring complaints to issues which potentially affect many people. In 2017/18 preparations will begin for this important new role, including engagement with public bodies, regulators and other key stakeholders.

Complaints Standards Authority

The Act also contains provisions to establish NIPSO as a complaints standards authority (CSA). These provisions, in Part 3 of the Act must be commenced separately by the Northern Ireland Assembly. They have been modelled on the provisions introduced for the Scottish Public Services Ombudsman in 2010.

This role, subject to commencement, will enable NIPSO to lead the development and implementation of new complaints handling procedures across public services in Northern Ireland. Its purpose will be to support continuous improvement in complaints handling by guiding all public service providers under NIPSO's remit towards a simplified, accessible and standardised complaints procedure. These procedures must put the service user at the heart of the process, focus on early resolution, and valuing complaints as tools for feedback, learning and service improvement.

During 2017-18 NIPSO will be progressing work to research complaints handling in Northern Ireland, develop a stakeholder engagement framework and take forward the necessary steps to commence Part 3 of the Act.

Engagement with New Jurisdictions

On 1 October 2016, all further education institutions in Northern Ireland, Queen's University and the Ulster University came within the Ombudsman's jurisdiction for the first time. NIPSO staff held an outreach event in September 2016 and met with staff from further education colleges, Universities and Students Unions to explain the Ombudsman's role.

Complaints of maladministration about the Boards of Governors of grant-aided schools came within the Ombudsman's jurisdiction on 1 April 2017. In preparation for this extension of the Ombudsman's jurisdiction ASSIST staff were involved in engagement with the Education Authority to inform the schools sector about the role of the Ombudsman, including publication of information leaflets on this sector.

Staff have been actively involved in engaging with public bodies and users groups to increase awareness of the Ombudsman's role. As part of this engagement ASSIST staff have provided information sessions on how to complain to the Ombudsman to a number of advocacy groups who provide advice and support to the public.

Section Two
Casework Performance

ASSIST (Advice, Support Service and Initial Screening Team)

The Advice, Support Service and Initial Screening Team (ASSIST) is the public's first point of contact with the Office. The Ombudsman's remit covers complaints of maladministration about the majority of public services in Northern Ireland.

The term maladministration is not defined but is generally taken to mean poor administration or the wrong application of rules. The Ombudsman can also consider complaints about the professional judgment of health and social care professionals.

Some examples that the Ombudsman may regard as maladministration include:

- Unfairness
- Avoidable delay
- Faulty procedures or failing to follow the correct procedures
- Not telling someone about any rights of appeal they have
- Bias or prejudice in decision making
- Giving misleading or inadequate advice
- Discourtesy and failure to apologise properly for errors
- Mistakes in complaint handling

Examples of where the Ombudsman would not generally investigate a complaint are if:

- It is made to the Ombudsman more than 6 months after completing the body's complaints procedure (unless the Ombudsman decides there are special circumstances)
- It is about government policy or legislation
- It is about private health care or private education
- It is the subject of civil or criminal proceedings
- It has been or is the subject of an inquiry

In 2016-17 we received **3,385** complaints contacts. This was a **12%** increase from the 2015/16 period.

ASSIST plays an important role in providing advice and guidance to members of the public who want to pursue a complaint. Making a complaint is free, but importantly the Office does not investigate every complaint it receives.

There are three main stages to NIPSO's case handling process. These are:

ASSIST plays a key role in ensuring that the Office resources are focused effectively and provides a high level of customer service by informing complainants in a timely way about what action we can take regarding their complaint.

ASSIST assess all complaints received to decide if the Ombudsman can investigate under the terms of the Act. Where we decide that we cannot take any further action, complainants receive a clear explanation as to how and why the decision was reached and, where useful, are provided with information about other potential sources of assistance.

It is important that members of the public receive an answer to their complaint as quickly as possible. In 2016-17 ASSIST issued a decision on 96% of initial assessments within 10 working days.

ASSIST regularly obtains more information from the organisation concerned to build our knowledge of the complaint and as foundation for assessing if there was prima facie evidence of maladministration. In our assessment work we use what we call the 3P's policy to decide if:

1. An investigation is appropriate and necessary in the circumstances (**Proportionality**)
2. An investigation by the Ombudsman would directly bring about a solution or adequate remedy (**Practical outcome**)
3. Investigating the issues of complaint could be of potential benefit to the general public (**Public interest**).

Settlements

The Act provides for the Ombudsman to take a decision to resolve a complaint at Assessment without carrying out an investigation. This is described as a settlement and can provide a speedy, effective and practical resolution of the complaint. When considering the possibility of settlement ASSIST staff identify the action needed to resolve or remedy the cause of complaint. This may take the form of timely service provision, an apology for failures in service, reimbursement of expenses incurred or an improvement in service.

In 2016- 17 settlement was achieved in **11** cases. The following case summary shows an example of a settlement where ASSIST helped a complainant recover the child support payments which had been incorrectly withheld from her by the Child Maintenance Service.

Case Summary

Child Support payments recovered following complaint to Ombudsman

A complainant stated that she had not received her three most recent payments of Child Support.

ASSIST's enquiries with the Child Maintenance Service (CMS) helped them to establish that a clerical error and an incorrect application of the legislation meant that the money owed had not been paid. In recognition of the errors the CMS:

- Paid the complainant what she was owed, plus an additional consolatory payment of £300 in acknowledgment of the financial hardship and upset caused by the errors
- Provided the complainant with an apology
- Issued guidance to the CMS complaint handling team to prevent similar errors occurring in the future.

The Ombudsman can also use alternative methods to resolve a complaint. The case summary below illustrates how we were able to obtain bespoke support for a vulnerable complainant.

Case Summary

Support worker appointed to assist vulnerable complainant

A member of the public complained about the Northern Ireland Housing Executive (NIHE) in relation to outstanding repairs to her property, difficulties with her neighbours and that she had been interviewed and warned about her anti-social behaviour.

During the assessment of her complaint it was noted that the complainant had mental health issues but was refusing to accept support or treatment for these at that time.

As part of the Ombudsman's power to resolve complaints using alternative resolution it was suggested that the NIHE explore the possibility of appointing a support worker from the Assisting People and Communities scheme (APAC) to assist the complainant with the difficulties she was clearly experiencing at that time.

The appointment of a support worker required extensive and sensitive discussion with the complainant to ensure that she wanted to accept such help. It was explained that this type of support worker could offer the complainant the type of advocacy and support that this Office could not.

The complainant accepted this assistance and was pleased with the outcome achieved for her.

In other cases complaints are not accepted for investigation because there is no prima facie evidence of maladministration. The following is an example of such a case.

Case Summary

Queen's University provided 'full, accurate and appropriate advice' prior to complainant's exam resits.

The Ombudsman decided at assessment stage that Queen's University Belfast had acted appropriately when asking a Masters student to withdraw from her course after she failed four out of five examination resits.

The student complained to the Office when her appeal against the University's decision was rejected.

Consideration was given as to whether an investigation would be proportionate, practical and in the public interest.

Evidence was received from both parties to help make the decision.

The student alleged that the University did not tell her that she could spread the resits out, meaning that she was forced to take them all within one month at a medically and emotionally difficult time for her. She also stated that she was not made aware of the full implications of failing the exams for a second time.

The University provided the Office with their 'Fit to Sit' examinations policy, 'exceptional circumstances' guidance for students, and documentation from three Student Support Meetings they had with the student.

The Ombudsman concluded that the University had acted appropriately in the matter, providing the student with full and accurate advice and guidance throughout the process.

Alongside the information and policies provided to her as a student of the course the Ombudsman was satisfied that she was also verbally advised of the implications of taking and failing the resits and of the option to request them being spread out.

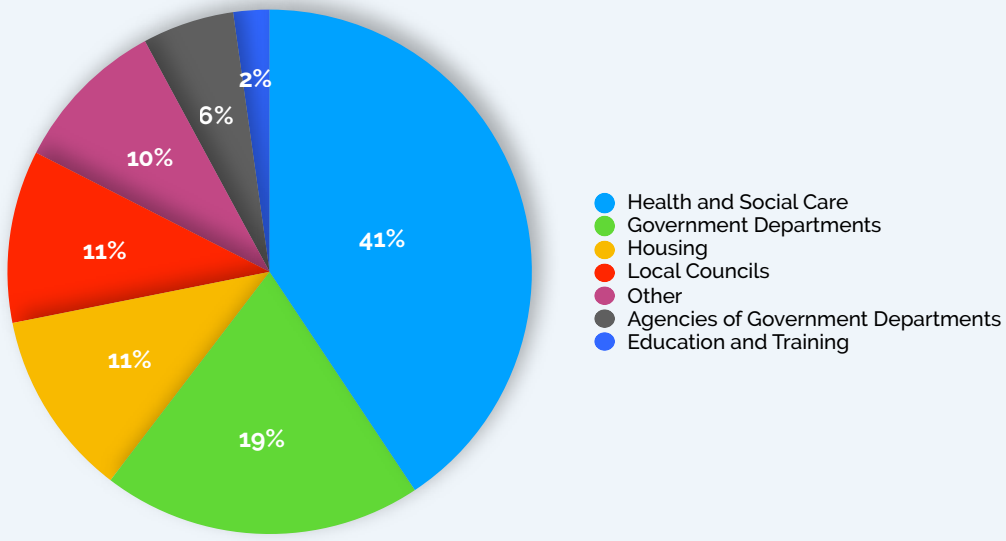
Both parties were informed that the complaint would not be further investigated.

Analysis of Complaints

From the **3,385** complaint contacts received by ASSIST in 2016-17, a total of **575** unique complaints were considered for further investigation. The complaints related to a wide range 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
- Agencies of Government Departments
- Local Councils
- Housing
- Education and Training

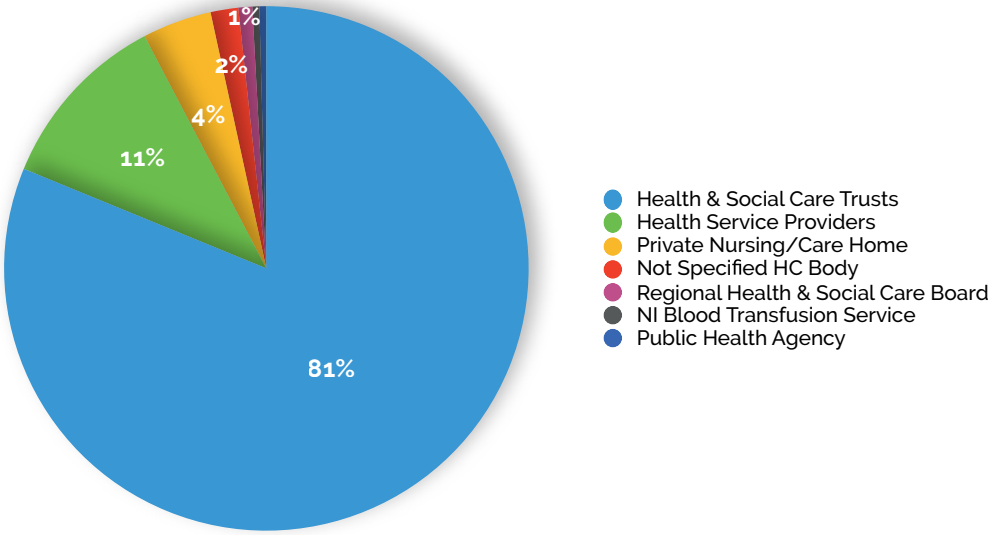
Percentage of Complaints by Sector 2016-17



Sector	Number of Complaints
Health and Social Care	236
Government Departments	107
Housing	67
Local Councils	62
Agencies of Government Departments	33
Education and Training	13
Other	57
Total	**575**

Health and Social Care

41% of complaints related to Health and Social care.



Total Complaints about Health and Social Care.

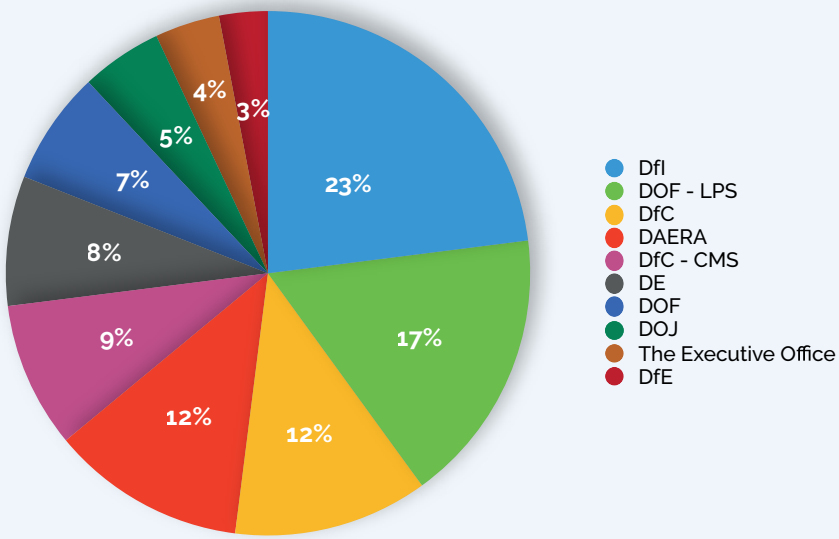
Health and Social Care Sector	Number of complaints
Health & Social Care Trusts	190
General Health Care Providers (GPs, dentists, opticians, pharmacists)	26
Private Nursing/Care Home	10
Not Specified HC Body	2
Independent Health and Social Care Provider	2
Regional Health & Social Care Board	2
Regulation and Quality Improvement Authority	2
NI Blood Transfusion Service	1
Public Health Agency	1
Total	**236**

Total Complaints about Health and Social Care Trusts

Trust	Number of complaints
Belfast Health and Social Care Trust	61
Western Health and Social Care Trust	36
Southern Health and Social Care Trust	33
South Eastern Health and Social Care Trust	31
Northern Health and Social Care Trust	19
South Eastern Health and Social Care Trust (Prison)	8
Northern Ireland Ambulance Service Trust	2
Total	**190**

Government Departments

19% of complaints related to Government Departments.

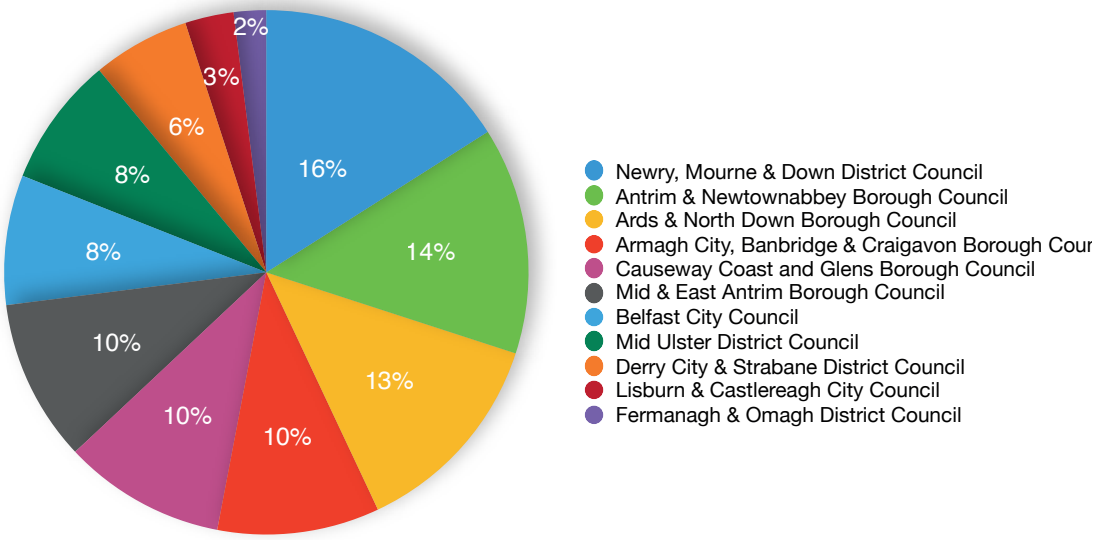


Total Complaints about Government Departments

Government Department	Number of Complaints
Department for Infrastructure	25
Department of Finance - Land and Property Services	18
Department for Communities	13
Department of Agriculture, Environment & Rural Affairs	13
Department for Communities - Child Maintenance Service	10
Department of Education	8
Department of Finance	8
Department of Justice	5
The Executive Office	4
Department for the Economy	3
Total	**107**

Local Councils

11% of complaints related to Local Councils

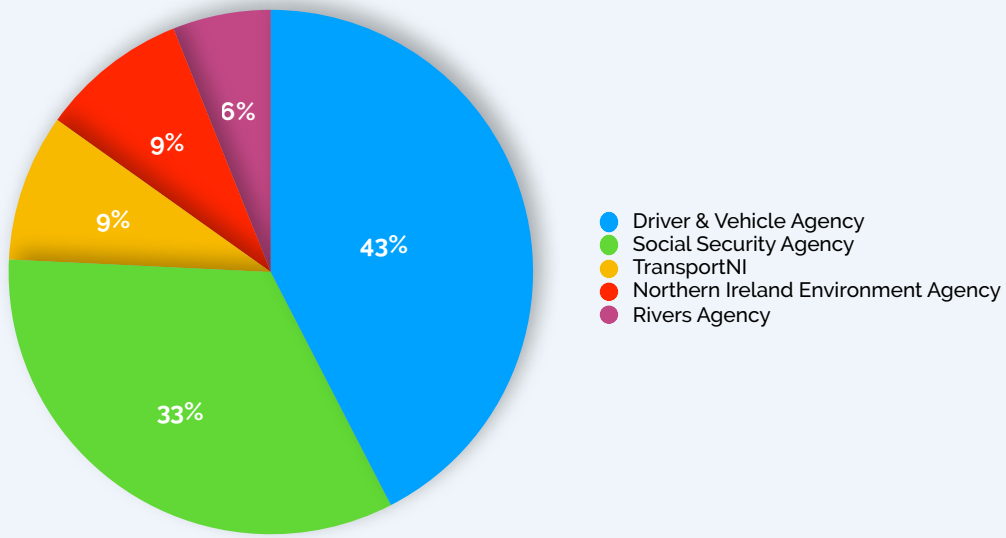


Total Complaints about Local Councils

Council	Number of Complaints
Newry, Mourne & Down District Council	10
Antrim & Newtownabbey Borough Council	9
Ards & North Down Borough Council	8
Mid & East Antrim Borough Council	6
Armagh City, Banbridge & Craigavon Borough Council	6
Causeway Coast & Glens Borough Council	6
Mid Ulster District Council	5
Belfast City Council	5
Derry City & Strabane District Council	4
Lisburn & Castlereagh City Council	2
Fermanagh & Omagh District Council	1
Total	**62**

Government Agencies

6% of complaints related to Agencies of Government Departments

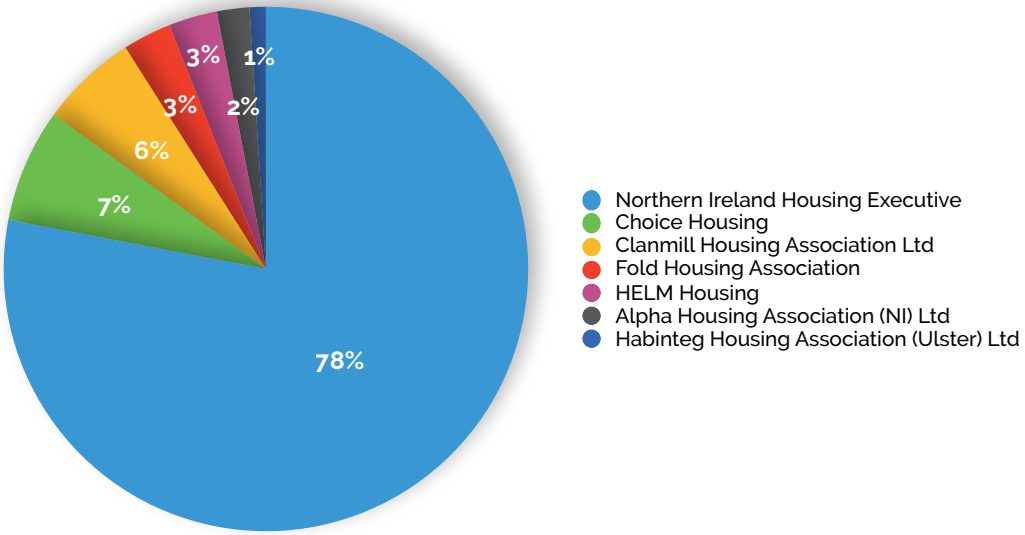


Total Complaints about Agencies of Government Departments

Agency	Number of Complaints
Driver & Vehicle Agency	14
Social Security Agency	11
TransportNI	3
Northern Ireland Environment Agency	3
Rivers Agency	2
Total	**33**

Housing

11% of complaints related to housing.

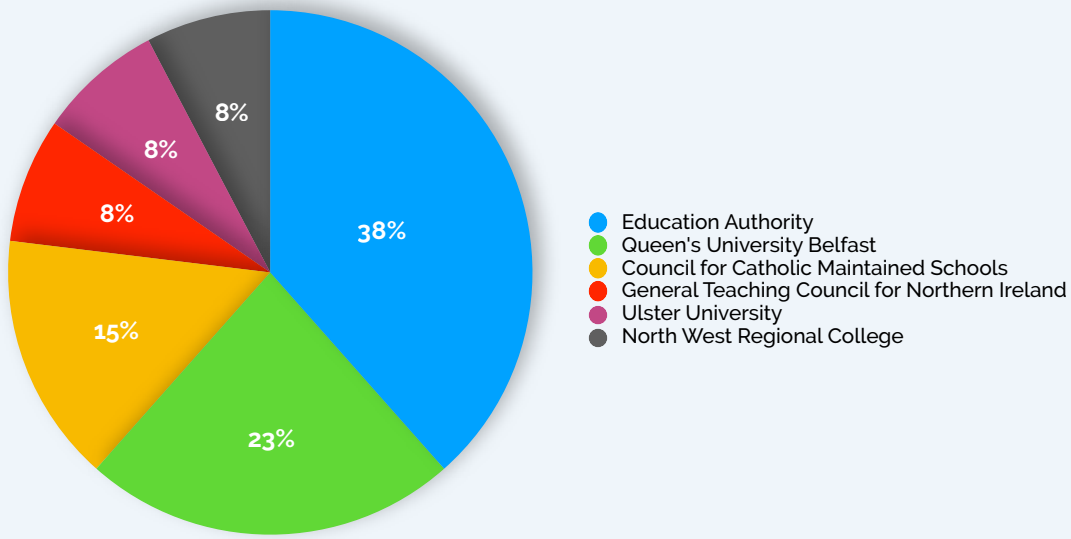


Total Complaints about Housing

Housing Authority	Number of Complaints
Northern Ireland Housing Executive	52
Choice Housing	5
Clanmil Housing Association Ltd	4
HELM Housing	2
Fold Housing Association	2
Habinteg Housing Association (Ulster) Ltd	1
Alpha Housing Association (NI) Ltd	1
Total	**67**

Education and Training

2% of complaints related to Education and Training.



Total Complaints about Education and Training

Establishment	Number of Complaints
Education Authority	5
Queen's University Belfast	3
Council for Catholic Maintained Schools	2
General Teaching Council for Northern Ireland	1
Ulster University	1
North West Regional College	1
Total	**13**

Other

Other	Number of Complaints
Northern Ireland Assembly	1
North-South Body	1
Other	11
Other Assembly Ombudsman	3
Other Commissioner for Complaints	14
Outside Jurisdiction	21
Tribunal	6
Total	**57**

Ombudsman's Investigations Team

Where the ASSIST team decide that they cannot resolve the complaint and there is evidence that the matter requires further detailed investigation, the case is forwarded to the Ombudsman's Investigations Team. A total of **68** cases were referred to the Investigations Team in 2016-17.

This is a dedicated unit of skilled investigators who bring a wide variety of experience to the role. Investigators conduct a detailed independent, impartial investigation of every case by obtaining all relevant evidence, either from the complainant, the public service provider or other party.

The investigation is conducted through correspondence and where appropriate interview with relevant witnesses and staff involved in the complaint. When investigating complaints about health and social care, investigators will also seek advice from a team of qualified Independent Professional Advisors.

An Ombudsman investigation is an inquisitorial rather than an adversarial process. Where maladministration is found the Ombudsman will, if appropriate, make recommendations about how the public service provider should remedy the injustice caused to the individual.

At the end of an investigation a detailed report is sent to both the complainant and the provider complained of. The report will summarize the allegations made by the complainant and then explain what steps were taken by the Office to investigate the complaint. It will assess the response of the provider to the allegations and any findings made during the course of the investigation. The report will conclude by explaining the determination of the Ombudsman and her recommendations to remedy the injustice.

An organisation may be asked to issue an apology to a complainant, or the Ombudsman may recommend changes in practice to bring about service improvements. If the complainant has sustained injustice or distress financial redress may be recommended.

The Investigations Team completed **54** investigations during the course of 2016-17. Within these there were 189 separate issues of complaint, of which **119** (63%) were either upheld or partially upheld. A total of **70** issues (37%) were not upheld.

Summaries of a selection of investigations carried out over the course of the year appear on the following pages.

Case Summary

Health Trust improves support for sign language patients following Ombudsman investigation

A man alleged that the Southern Health and Social Care Trust had failed to provide his deaf mother with a sign language interpreter during her stay in Craigavon Area Hospital.

The man contacted the Office after efforts to resolve the issue within the Trust's own internal complaints mechanism were unsuccessful.

The Ombudsman's investigation revealed that on three separate occasions during her stay in hospital the Trust failed to contact the Royal National Institute for Deaf People, leaving the complainant and his wife struggling to communicate specific medical information themselves.

The Trust's procedure for providing interpreting services for sign language patients was examined and found to be discriminatory and deficient.

The complaint was upheld and the Ombudsman found the Trust's actions to be discriminatory as the failures meant that the complainant's mother was not given the same explanation of her medical care as she would have if she were not deaf. In this regard the Trust did not show sufficient regard to her human rights.

In addition the Ombudsman found that the Trust's internal complaints process failed to properly deal with the man's allegations.

The Ombudsman recommended that the Trust made an apology to the complainant in recognition of the upset, distress and inconvenience caused by its maladministration. A number of other recommendations were made to improve the Trust's procedures for dealing with people with hearing impairments and their specific communication needs.

The Trust accepted these findings and recommendations.

Case Summary

Health Trust's care and treatment of patient was 'appropriate'

A complaint was received from a patient of the Southern Health & Social Care Trust, who stated that he was unhappy about the medical care he had received from the Trust over a number of years.

An investigation was initiated after the Trust's own internal complaints process had been exhausted.

Between 2008 and 2013 the man attended multiple clinicians both privately and under the NHS and had many tests carried out, yet his pain and discomfort remained. He claimed that the root cause of his problems and the source of his pain was mesh which was used to repair a hernia in 2008. He believed that he was too often being referred from one doctor to another, with nobody able to properly help him.

The investigation included an analysis of the patient's medical records and complaints file, as well as other hospital records relating to the case. The Ombudsman also asked an Independent Professional Advisor to comment on various aspects of the Trust's medical care.

The Trust stated that the patient suffered from a complex condition and that the care provided to him by the Consultant Surgeon was exhaustive and appropriate. The Trust added that there were no other treatments which could have been considered to alleviate his pain.

The Ombudsman's medical advisor stated that in complex cases such as this difficulties can arise during treatment, that diagnosis can be elusive and that there was nothing inappropriate in the care given to the complainant.

After reviewing all of the evidence the Ombudsman concluded that the multiple referrals were unfortunately unavoidable, and that the Trust had provided appropriate care and treatment to the man during the period in question.

The Ombudsman did not uphold the complaint.

Types of Investigation

In 2016-17, 41% of the 575 unique complaints received related to the health and social care system. The jurisdiction of the Office in relation to health and social care differs from that of other bodies. The Office may investigate the merits of professional judgements in connection with the provision of health and social care without first having established maladministration. The effect of this is that a higher proportion of health and social care cases are forwarded to the Investigations Team for their consideration.

In 2016-17 therefore, 80% of the cases determined at the investigation stage of our process related to health care.

The majority of these cases related to complaints about secondary care provided by health and social care trusts.

In the 2015/16 reporting year the Office was critical of the considerable delays investigators faced in receiving responses to their enquiries from health and social care bodies. Over the 2016-17 reporting period there has been a marked improvement in this area and health and social care bodies are to be commended for this. Given that unnecessary delay adds to the frustration already experienced by the complainant it is important that this trend continues.

An ongoing issue across all public service providers is the number of cases where the complainant is dissatisfied with the way the body in jurisdiction has handled their complaint. Matters complained of include the length of time taken to complete the complaints process, questions or concerns not being answered by the bodies and reasons for decisions not being given or properly explained.

It is hoped that these issues will begin to be addressed through the Complaints Standards Authority which aims for simplified, standardised complaints handling procedures for all public service providers in Northern Ireland.

Case Summary

Trust apologises for 'significant failures' in care of patient and handling of subsequent complaint

The Ombudsman upheld a complaint about the care and treatment provided to a patient by the Belfast Health and Social Care Trust.

The complainants questioned the standard of nursing care provided to their late daughter during her final hours in hospital. They also stated that they had concerns about the way the Trust had dealt with an investigation into their complaints.

The parents said that their daughter was admitted to hospital one evening with an existing medical condition. During the night she was formally attended to three times by the nursing staff. The parents complained that these observations were incomplete and did not follow the timing intervals appropriate for her condition. The father stated that he was left to carry out basic nursing tasks, including administering fluids, with no assistance.

He also complained that given that their daughter was in the pre-terminal phase of her illness he would have expected some discussion with medical staff about the type of care she required. This lack of consultation and the behaviour of the staff on the ward led them to believe that they were treating their daughter's care as 'end of life'.

The investigation team looked at evidence obtained from the nursing staff on duty at the time as well as other medical staff involved in her care and consulted with an independent medical advisor on aspects of the case.

The Ombudsman found significant service failures in the care provided, most notably in relation to an unreasonable responsibility placed on the father to attend to his daughter during the night. She concluded if the nursing staff had discussed with the parents their expectations of their daughter's care and treatment these failings may not have occurred.

Although the investigation did not determine whether the failings identified contributed to the patient's death, an uncertainty remains whether closer and more regular observation would have identified a deterioration in her condition at an earlier stage. This may have allowed for the girl's mother to be alerted in order for her arrive at the hospital in time to support her daughter in her final moments.

The Trust had carried out its own internal investigation into what happened and subsequently commissioned an 'independent' review panel to examine the complaint. However, the Ombudsman found that the independence of this review was miscommunicated to the complainants, and that the report published by the panel was amended by senior Trust staff prior to its communication to the complainants to omit earlier criticisms.

In light of the significance of the failings identified in the Ombudsman's investigation she recommended that senior representatives from the Trust meet with the complainants to apologise to them in person for the injustices they sustained. She also recommended that the Trust provide the parents with an overview of the number of improvements made as a result of their complaint.

Finally as a recognition of the seriousness of the incident the Ombudsman recommended that a payment of £6000 should be made to the complainants.

These recommendations were accepted and implemented in full by the Belfast Trust.

A significant investigation completed in 2016-17 related to a case involving a bereaved family's search for answers to the cause of post-mortem fractures to their mother's body (see below).

Case Summary

Investigation into post-mortem fractures sustained by a patient of Altnagelvin Hospital

The Ombudsman received a complaint from a family about the actions of the Western Health & Social Care Trust after a post-mortem examination revealed that their mother had sustained multiple fractures shortly after her death.

An investigation was launched into the incident after the family had approached the Ombudsman expressing dissatisfaction with the Trust's own enquiries into the case and its overall handling of the complaint.

The investigating officer took a detailed statement from the complainant, obtained the deceased's medical records and interviewed a number of former and serving hospital staff and other members of the Trust, as well as staff from the Coroner's Service and the pathologist who performed the post-mortem.

In addition the Ombudsman obtained the advice of four Independent Professional Advisors (IPAs) to assist with aspects of the investigation.

Enquiries established that although the Trust had classed the incident as a Serious Adverse Incident (SAI) and had initiated a Critical Incident Review, there were no formal terms of reference drawn up, insufficient interviews conducted with staff who may have been involved in the handling of the deceased's body after her death, and clear evidence of a 'closed mind' attitude adopted throughout.

In addition, and contrary to established investigation protocols, discussions with other Trust staff were conducted by ward staff whose own actions were the subject of its internal investigation.

An examination of the nursing notes also found that staff did not record any details of the after-death care provided to the deceased.

Having considered all of the evidence and the expert clinical opinions, the Ombudsman was satisfied that the fractures were not caused deliberately or as a result of any inappropriate intervention by any person involved in the handling of the deceased's body.

The investigation established that the fractures were most likely to have occurred during the performance of Last Offices, a sensitive procedure involving washing the body and dressing it in a shroud. It also found that one individual was left to undertake this task despite good practice requiring that two people should perform the procedure, one of whom is expected to be a qualified nurse.

The investigation report concluded that the multiple failures by the Trust fundamentally undermined the integrity, effectiveness and independence of the Critical Incident Review. Further, by directing a single person to undertake Last Offices the Ombudsman concluded that relevant staff placed an unreasonable burden and responsibility on one individual.

Included in a number of recommendations made by the Ombudsman were that the Trust should;

- issue a written apology to the family
- review the SAI investigation processes so that the lessons learned from the review be shared with all relevant Trust staff in order to ensure that what happened in this case could not happen again
- establish a protocol for PSNI interviews with Trust staff

The Trust accepted the Ombudsman's recommendations.

Investigations relating to complaints about planning continued to be a significant part of the Investigation Team's caseload during the year. It is important to note that all of the Ombudsman's reports issued in 2016-17 which dealt with planning decisions related to issues prior to the transfer of planning functions to councils in April 2015.

Case Summary

Planning authority failed to inform neighbour of changes in housing development application

A complainant alleged that he was not given the chance to respond to changes to a planning application for a new housing development close to his home. He alleged that the newly built homes were much closer to his house than specified in the previous plans, resulting in less light coming into his house and less power generated by his solar panels.

The Ombudsman's investigation obtained evidence from the Chief Planner in the case as well as a detailed statement from the complainant. The investigation examined a number of planning policy statements and guidance documents issued by the former Department of the Environment.

The investigation found that although the Department notified the complainant of the original planning application and two further notifications of revised plans, there were four further revisions which it failed to notify him about.

The Department informed the Ombudsman that the reason for this was that it did not believe further notification was necessary as the amended developers plans were considered a 'lesser' scheme. However there was no evidence within the planning file that the scheme was considered so by the case officer, nor was a policy on 'lesser' schemes provided in response to investigation enquiries.

Neighbour notification is not required by law, however the Department was publicly committed to carrying it out. The investigation was unable to discover why in this case, when the Department had previously notified the complainant and were fully aware and mindful of his concerns, it failed to notify the complainant of further submissions which directly related to them.

The investigation also identified that when the Department approved the plans it failed to appropriately record its considerations as part of the decision making process.

The Department were also found to have failed to appropriately investigate and respond to the complaint, providing inaccurate and at times misleading information.

The Ombudsman found maladministration and recommended that the Department provide a written apology to the complainant for the failings identified in the investigation. In addition she recommended that it took steps to inform all planning staff at local council level of the failures in this case to share the learning.

The case below highlights a failure to take appropriate and timely enforcement action in relation to a planning case.

Case Summary

Planning authority failed to take enforcement action over unauthorised use of property

An Ombudsman investigation into a planning complaint revealed that the complainant first raised issues in May 2012 about his neighbour's use of his property for car sales. Despite the fact that the property was not authorised for this purpose and that the complainant made repeated requests for the Planning Service to take action, an Enforcement Notice was not issued until 18 months later.

The owner of the car sales business appealed against the Enforcement Notice and put in a request for the business to become lawful. This request was granted within one month, making the Enforcement Notice no longer valid.

The Ombudsman found that a series of unnecessary delays meant that the Planning Service failed to take enforcement action in a timely manner, and that the decision to grant the business a license before the appeal hearing meant the complainants' concerns could not be properly heard.

She concluded that the planning system had failed the complaint, causing him upset, inconvenience and the loss of enjoyment of his home.

A recommendation was made for the Chief Planner to provide a written apology for the maladministration in this case, and for the Planning Service to issue a consolatory payment to him to cover expenses in preparing for the appeal.

Older Cases

During 2016-17 the Office also had a focus on completing older cases which had exceeded their target completion date and had become difficult and time consuming to resolve. On 1 April 2016 there were 29 cases which were considered to be older cases; 23 of these were completed by 31 March 2017 and 6 remained open. However, during the year a further 14 cases exceeded their target with the result that at the year-end 20 cases which had exceeded their target were carried forward into 2017/18.

This reduction in older cases is a welcome sign of progress. This is further supported by a decrease in the average age of cases at investigation from 862 days at the start of the year to 498 by the end of 2016-17.

Recommendations and Impact

NIPSO aims to ensure fairness in any interaction between members of the public and public service providers. While there are clear benefits for individuals in having their complaints investigated by an independent body, the impact of the Ombudsman on public service delivery may not always be immediately apparent.

The NIPSO 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.

One of the ways NIPSO seeks to have a positive impact on public services is by making recommendations where maladministration has caused injustice to the individual.

Of the **54** cases we reported on in 2016-17 a total of **121** recommendations to bodies in jurisdiction. These included recommendations to:

- issue an apology to the complainant
- offer a financial remedy where the complainant suffered monetary loss or significant injustice as a result of maladministration
- review their policies and guidance
- amend their procedures
- disseminate the lessons learned from the complaint

The most common recommendations made in 2016-17 were for service improvement or an apology to a complainant.

Where the Ombudsman finds maladministration and identifies an injustice as a consequence of this maladministration, she may also recommend a payment. Such payments are often nominal and are usually in recognition of loss, frustration, upset, uncertainty and/or for the time and trouble spent pursuing a complaint.

In 2016-17 the Ombudsman recommended a financial remedy on **25** occasions. The majority of these were for sums below £1000. Not all complainants chose to accept the offer of payment from the body.

All of the 121 recommendations made by NIPSO in 2016-17 were accepted, with the exception of one which is still under consideration by the relevant body.

Compliments about NIPSO

The comments below show some of the feedback received by NIPSO staff from members of the public during the year.

"I was very pleased to get such a speedy response"

"We were just glad to feel that someone finally listened to us"

"Your time spent on the case (is) much appreciated. I cannot thank you enough for your impressive and thorough research".

"I would like to say thank you to you, the Ombudsman and your associates for the dedication and hard work you have put in in dealing with this matter".

"I would like to take this opportunity to thank you so much for … all the hard work that went into this investigation".

"I had not used the Ombudsman's Office before and I am very satisfied with the way in which my complaint has been resolved"

"I would like to place on record my sincere thanks for the detailed report, the time, effort and respect shown to myself by you and your colleagues in the Ombudsman's office".

"Thank you for the very extensive investigation into my complaints"

Performance Analysis

How we measure performance

Delivering operational efficiency, efficiency and accountability continues to be a key priority of the Ombudsman, measured through key performance indicators. The performance indicators focus on the time taken to complete casework. Complementary qualitative assessments are completed through established internal procedures. The Office's Key Performance Indicators (KPIs) are described below.

NIPSO COMPLAINTS ASSESSEMENT AND INVESTIGATION

KPI 1 – measures how quickly we establish whether the complaint can be investigated by this Office. We aim to inform the complainant within **2 weeks** or less of their complaint being received. The target is **90%**.

KPI 2 – measures how quickly we complete our assessment of whether a complaint **should** be investigated by this Office or is suitable for settlement. Assessment is a detailed process which involves considering the complaint and the supporting evidence from both the complainant and the body complained of. This represents case-building in the event a case proceeds to investigation. We aim to complete the assessment process and inform the complainant of the decision within **10 weeks** or less of their complaint being received. The target is **70%**.

KPI 3 – measures how quickly we complete the **investigation** of a complaint and issue a draft report to the body involved. We aim to complete this within **50 weeks** or less of the decision being made to investigate. The target is **70%**.

The achievement rates below distinguish between new cases arising under NIPSO's legislation and cases brought forward from the previous Assembly Ombudsman/ Commissioner for Complaints (AOCC) legislation.

KPI	Target	Result for reporting period	Target Met/Partially met/Not met
1	90% (NIPSO)	96%	Met
1	90% (Legacy)	97%	Met
2	70%(NIPSO)	84%	Met
2	70%(Legacy)	65%	Not met
3	70%(NIPSO)	100%	Met
3	70%(Legacy)	46%	Not met

As the table shows, achievement against the KPIs in 2016-17 was broadly positive, particularly regarding the new cases arising under the NIPSO jurisdiction since April 2016.

KPI 1 was met in 96% of NIPSO cases and 97% of former AOCC cases, both well ahead of the 90% target. The average number of days taken to reach the 'can we investigate' decision was 8.

The reported percentage performance for KPI 2 (the 'should we investigate' decision) was 84% for NIPSO cases, again well ahead of the 70% target. The average number of days taken was 62. In relation to legacy cases the Office met KPI 2 in 65% of cases, falling just short of target.

Following on from the 'should we investigate' decision, the KPI 3 performance target was met in 100% of NIPSO cases, albeit this was a relatively small number of cases.

Former AOCC case performance fell significantly short of target. It was met in 46% of cases against a target of 70% and the average number of days taken was 498. This is reflective of the continuing deliberate focus that was placed on resolving a considerable number of older, more complex legacy cases.

The Ombudsman will continue to keep under review the key performance measures as the new NIPSO jurisdictions continue to expand with the extended remit for social care, universities and further education colleges as well as judicial appointments; and with schools coming under jurisdiction from April 2017.

Financial Performance

The reported financial position for 2016-17 was significantly affected by the dissolution of the Northern Ireland Assembly in January 2017. In the absence of a 2016-17 Spring Supplementary Estimate and associated Budget Bill the Office's financial performance was measured against that approved within the 2016-17 Main Estimates.

In addition initial uncertainty surrounding the 2017-18 budget impacted negatively on the Office's longer term (recurring) expenditure commitments such as recruitment which had been planned for 2016-17 onwards. The delay in the recruitment of investigation staff is also a factor which has impacted on the performance of the Office on investigations.

The following summarises of our audited expenditure during 2016-17:

All £k	Maladministration (incl NIJAO)	Local Gov't Ethical Standards (LGES)	Total
Staff Costs	1,107	203	1,310
Other Administration Costs	418	88	506
Total Expenditure	**1,525**	**291**	**1,816**

Staffing

During 2016-17 NIPSO's whole time equivalent (WTE) staff numbers grew from 28.5 to 32.5 – an increase of 14%.

The breakdown of actual staff in post (headcount) at 31 March 2017 was as follows:

	Male	Female	Total
Ombudsman/Deputy Ombudsman	1	1	2
Other Senior Management Team	2	3	5
Other Staff	8	19	28
Total	11	23	34

Sickness absence data for 2016-17 was as follows:

Working Days lost 2016-17	Average days lost per WTE member of staff	Absence Rate 2016-17 %
77	2.7	1.2%

Accountability for NIPSO Performance

The Ombudsman and her Senior Management Team (SMT) monitor performance across all functions at monthly and quarterly SMT meetings. In addition the Audit and Risk Committee review risk as well as financial and casework performance and are provided with assurance in these areas by reports from an Internal Audit Service and the Northern Ireland Audit Office.

Appendix A
Further Casework Statistics

Health and Social Care

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
H&S Care Trusts	65	190	121	26	37	71
General Health Care Providers	4	26	14	6	3	7
Independent HSC Provider	2	2	0	0	2	2
NI Blood Transfusion Service	0	1	1	0	0	0
Not Specified HC Body	0	2	2	0	0	0
Public Health Agency	0	1	1	0	0	0
R H&S Care Board	0	2	2	0	0	0
RQIA	0	2	1	1	0	0
Private Nursing/ Care Home	4	10	5	1	3	5
Total	**75**	**236**	**147**	**34**	**45**	**85**

Appendix A
Further Casework Statistics

Housing

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
Alpha Housing Association (NI) Ltd	0	1	1	0	0	0
Choice Housing	1	5	5	1	0	0
Clanmil Housing Association Ltd	0	4	3	0	0	1
Fold Housing Association	0	2	0	1	0	1
Habinteg Housing Association (Ulster) Ltd	0	1	1	0	0	0
HELM Housing	0	2	2	0	0	0
Northern Ireland Housing Executive	4	52	34	14	0	8
Total	**5**	**67**	**46**	**16**	**0**	**10**

Education and Training

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
Education Authority	0	5	4	0	0	1
Council for Catholic Maintained Schools	0	2	2	0	0	0
General Teaching Council for Northern Ireland	0	1	1	0	0	0
Queen's University Belfast	0	3	1	0	0	2
Ulster University	0	1	1	0	0	0
North West Regional College	0	1	0	0	0	1
Total	**0**	**13**	**9**	**0**	**0**	**4**

Government Departments

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
Department for Communities	0	13	9	3	0	1
Department for Communities – Child Maintenance Service	0	10	6	1	0	3
Department for Infrastructure	11	25	20	6	6	4
Department for the Economy	0	3	2	0	0	1
Department of Agriculture, Environment and Rural Affairs	0	13	6	4	0	3
Department of Education	0	8	6	1	0	1
Department of Finance	0	8	6	1	0	1
Department of Finance – Land and Property Services	2	18	10	8	1	1
Department of Justice	0	5	3	2	0	0
The Executive Office	1	4	2	1	0	2
Total	**14**	**107**	**70**	**27**	**7**	**17**

Appendix A
Further Casework Statistics

Local Councils

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
Antrim & Newtown-abbey Borough Council	0	9	4	3	0	2
Ards & North Down Borough Council	1	8	8	1	0	0
Armagh City, Banbridge & Craigavon Borough Council	0	6	3	3	0	0
Belfast City Council	1	5	4	0	1	1
Causeway Coast & Glens Borough Council	1	6	6	1	0	0
Derry City & Strabane District Council	1	4	2	0	0	3
Fermanagh & Omagh District Council	0	1	1	0	0	0
Lisburn & Castlereagh City Council	1	2	2	0	1	0
Mid & East Antrim Borough Council	0	6	2	2	0	2
Mid Ulster District Council	0	5	2	3	0	0
Newry, Mourne & Down District Council	2	10	3	2	0	7
Total	**7**	**62**	**37**	**15**	**2**	**15**

Agencies of Government Departments

	Brought Forward @ 01/04/16	Complaints Received in 2016-17	Determined at Initial Assessment	Determined at Assessment	Determined at Investigation	Carried Forward @ 31/03/2017
Driver & Vehicle Agency	0	14	9	4	0	1
Northern Ireland Environment Agency	1	3	3	0	0	1
Rivers Agency	0	2	1	0	0	1
Social Security Agency	0	11	8	2	0	1
TransportNI	0	3	3	0	0	0
Total	**1**	**33**	**24**	**6**	**0**	**4**

Appendix B
Principles of Good Administration

Good administration by public bodies means:

1 Getting it right

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

2 Being customer focused

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

3 Being open and accountable

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

4 Acting fairly and proportionately

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

5 Putting things right

- Acknowledging mistakes and apologising where appropriate.

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

6 Seeking continuous improvement

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

These Principles are not a checklist to be applied mechanically. Public bodies should use their judgment in applying the Principles to produce reasonable, fair and proportionate results in the circumstances. The Ombudsman will adopt a similar approach in deciding whether maladministration or service failure has occurred.

Source: Parliamentary and Health Services Ombudsman (2009)

Appendix C
List of Public Authorities

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

Appendix C
List of Public Authorities

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

Notes

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Ombudsman

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