Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Southern Health and Social Care Trust

NIPSO Reference: 201912205

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case References: 18265 and 18696
Listed Authority: Southern Health and Social Care Trust

SUMMARY

I received a complaint about the Southern Health and Social Care Trust (Trust) in relation to arrangements for meeting the care needs of the complainant's mother and sister (Patient A and Patient B) who lived together as a family unit. The complainant said that their care needs assessments were inadequate and accurate information was not obtained. She also raised a specific issue regarding the provision of a stair rail adaptation in Patient A's home. The complainant also expressed dissatisfaction with the time taken to deal with the complaint.

The complaint concerned the care provided to and decisions made regarding Patient A and Patient B. The Trust dealt with the complaint in a consolidated manner for both patients. I decided that it was appropriate to investigate and report in a similar way. This composite reports deals with the outcome of my investigation regarding Patient A and Patient B. I obtained all relevant information, including Trust care records for Patient A and Patient B, complaint records and applicable Trust policies and guidance. Detailed enquiries were also made to the Trust regarding the issues raised by the complainant.

I also obtained independent advice from an experienced social worker to assist with my consideration of the issues raised by the complainant.

My investigation found failures in the assessment of Patient A's and Patient B's care needs as no regard was taken of their interdependency. Patient A and Patient B lived together at home for more than 40 years with Patient A being Patients B's main carer. Patient A was 93 at the time of Patient B's assessment and discharge from hospital and no account was taken of her continued ability to provide the care necessary despite the fact that she had been assessed as needing assistance. There was a need for better communication between the different teams responsible for the assessments to ensure that there was a person

and family centred approach to assessment which provided the best outcome available. There was also a need to ensure the better provision of information so that decisions could be taken by the family.

I also found failures in how the Trust handled the complaint.

I recommended that the Chief Executive apologised to the complainant.

I made recommendations for reviews of care needs assessments and the Trust complaint handling function.

THE COMPLAINT

1. I received a complaint about the actions of the Southern Health and Social Care Trust (SHSCT/Trust). The complainant said she had concerns around the provision of a stair rail for her elderly mother (Patient A) and meeting the care needs of Patient A and her sister (Patient B) who lived together. While the complaint involved the provision of care to two individuals responsibility for which fell to two different teams within the Trust I have produced one report as the family circumstances were such that the care needs for both Patient A and Patient B needed to be considered together. I considered that a composite report provided the best opportunity for learning from these complaints.

Background

2. Patient A was aged 93 years at the relevant time and had cared for her daughter, Patient B, aged 66 years in the family home for more than 40 years. Patient A had dementia, glaucoma, osteoarthritis and was diagnosed as blind. Patient B had severe mental health issues that required regular medication. Following family concerns the complainant engaged with the Trust regarding care needs for Patient A and B including the provision of a stair rail extension from April 2016.

Issue(s) of complaint

3. The issues of complaint accepted for investigation were:

   Issue 1: Whether the care needs of Patient A and Patient B were properly assessed in line with relevant policies.

   Issue 2: Whether the complaint regarding the care needs of Patient A and Patient B was handled reasonably and in line with relevant policies.

INVESTIGATION METHODOLOGY

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

the Trust's handling of the complaint. The Investigating Officer also conducted interviews with relevant Trust staff. The Senior Investigating Officer and Investigating Officer met with relevant Trust staff to discuss the detail of the complaint and potential for employing alternative methods to resolve the complaint given the ongoing care arrangements. .

Independent Professional Advice Sought [delete if not relevant]

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - An experienced Registered social worker with experience in elderly care and support for carers – ("Social Work IPA")

    The clinical advice received is enclosed at Appendix four to this report.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[1]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling
    - The Public Services Ombudsmen Principles for Remedy

8. The specific standards and guidance referred to are those which applied at the

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

time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- "People First: Community Care in Northern Ireland in the 1990s", 1993 DHSS;
- Care Management, Provision of Services and Charging Guidance, ECCU 1/2010, March 2010 DHSS;
- Southern Health and Social Care Trust Assessment and Care Planning on Service Users…Staff Operational Procedures and Guidance, 2015 (Care Planning SOP Guidance);
- Southern Health and Social Care Trust Case management leaflet;
- Department of Health Social Services and Public Safety, Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services, May 2010 (Promoting Quality Care Guidance);
- Southern Health and Social Care Trust Mental Health Inpatient Services Admission & Discharge Protocol and Procedures, 2015 (Inpatient Discharge Protocol);
- Southern Health and Social Care Trust Complaints Policy "Working Draft" 2015
- Regional Health and Social Care Complaints Procedure Guidance and Directions (2009)
- Health and Social Care Board (HSCB) - SAI Procedure, 2013

Relevant sections of the guidance considered are enclosed at Appendix three to this report.

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

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything I consider to be relevant and important in reaching my findings.

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care needs of Patient A and Patient B were properly assessed in line with relevant policies.

Detail of Complaint

12. The complainant raised a number of issues with my office regarding the care of her two family members. She was dissatisfied with the response to her complaint from the Trust. The main issues raised were: Trust failure to install a stair rail adaptation/handle that led to Patient A failing at home in September 2016; and inadequate Trust provision of care arrangements for Patient A and Patient B when both were discharged from Hospital including arrangements for care payments up to December 2017.

13. The complainant understood that the Trust contractor had attended in August 2016 with the wrong part for the stair rail adaptation/handle and had not returned. The Trust responded to the complainant that Patient A had refused to allow the contractor to fit the adaptation/handle. The complainant said that the contractor failed to attend with the appropriate adaptation/handle. Following the contractor attendance the complainant emailed the Trust staff member to indicate what occurred. The complainant said the Trust did not follow up on the matter. The complainant linked the lack of rail adaptation/handle with Patient A's fall and injury requiring hospital admission in September 2016. Patient B

who travelled to hospital with Patient A was admitted to a hospital Mental Health Unit in a distressed state.

14. The complainant raised with the Trust what she viewed as the inadequacy of the assessment of the care needs of Patient A and Patient B when they were respectively discharged from hospital. Patient A was provided with a limited package of care by the Trust on discharge from hospital. The complainant on her behalf engaged additional care on a daily basis on a privately funded arrangement. She felt that limited consideration was given to the fact that Patient A and B had lived together as a family unit for more than 40 years. Patient A was the carer for Patient B taking care of her daily care needs. Patient B was not initially provided with a package of care because the privately funded package was in place. The privately funded package costing in excess of £1400 per week was paid for by Patient A from her own funds/savings. A letter from the Trust to the complainant dated 6 July 2017 stated:

"…the Trust will continue to work with [Patient B] and your family to meet her assessed care needs which remain as requiring 24hrs care…Based on [Patient B's] assessed needs the Domiciliary Care panel have agreed to provide Direct payments up to the value of what it would cost the Trust to support [Patient B] in a residential placement. This would approximate to the equivalence of 30 hrs Self-Directed Supports. I must inform you however that back payment for any previous privately funded care arrangements will not be reimbursed."

In the event Patient A and Patient B were assessed at increasing levels of support in their individual packages of care. Each package ultimately over time exceeded any notional '30 hr cap'. The complainant also sought and understood in meetings with Trust staff she had secured a commitment to backdating of some direct care payments. The Trust written response to the complainant declined to reimburse back payment for any prior privately funded care arrangements. The complainant also raised a lack of timely, accurate information around the care assessment process, criteria, payment processes and reviews.

15. The following summary chronology sets out relevant dates:

Date	Comment
April 2016	Initial complainant contact for support for Patient A
June 2016	Occupational Therapy assessment including stair assessment
18 August 2016	Trust internal request for rail extension/handle to be fitted
24 August 2016	Contractor arranged visit to Patient A's home
30 September 2016	Patient A falls at home and is admitted to hospital
	Patient B admitted to Mental Health unit at hospital
20 October 2016	Patient A discharged home and assessed for 13 hour "care package"[2]
24 October 2016	Patient B in hospital assessed as requiring 24 hour supervision
2 November 2016	Patient B discharge home from mental health unit
27 January 2017	Complaint letter to Trust via MP about care payments
3 April 2017	Trust letter response to MP
24 April 2017	Complainant letter response to Trust
6 June 2017	Meeting between complainant and (4) Trust staff
6 July 2017	Trust response to complainant
21 July 2017	Meeting between complainant and (4) Trust staff
3 August 2017	Trust email requesting complainant accept assessments

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following policies and guidance:

- "People First: Community Care in Northern Ireland in the 1990s", 1993 DHSS;
- Care Management, Provision of Services and Charging Guidance, ECCU 1/2010, March 2010 DHSS;
- SHSCT Assessment and Care Planning on Service Users…Staff Operational Procedures and Guidance, 2015 (Care Planning SOP Guidance);
- SHSCT Case management leaflet; and
- Promoting Quality Care, Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services, May 2010 (Promoting Quality Care Guidance);

[2] "Care Package" is the provision of services after assessment of need taking account of support needed with personal care tasks, toileting, transfers, meals and medication.

In view of the extensive length of the guidance considered, I included relevant extracts and hyperlinks at appendix three to the report.

Trust response to investigation enquiries

Installation of stair rail adaptation

17. The Trust response to my office dated 19 December 2017 provided detailed information regarding the investigation of the complaint. In relation to the stair rail adaptation the Trust stated:

"The Trust apologises for the delay in placing the request with the contractor…it was unfortunate that the staff member went off sick. On her return, she actioned an urgent request with the contractor which was responded to by them the next day. [Patient A] however declined the extension to the stair rail when the contractor attended to fit it"

[Emphasis Added]

In a further letter of response dated 17 April 2019 the Trust stated:

"There is no requirement under the SAI process to conduct an SAI review because the service user and or their family members have complex needs. The SAI process is not for the investigation of the ability or lack of ability of a carer to provide care to a dependent. Similarly, [Patient A] fell in her own home when there was no Trust involved in delivering care at that time and at a time when [Patient A] had refused to move to a downstairs sleeping arrangement and had refused the fitting of the handrail extension…The Trust refutes that it is a failure on their behalf that this was not fitted and therefore, it is not appropriate to offer an apology that this work was not completed. There is no documented evidence to advise if [Patient A] fell in the area where the internal rail extension would have been applied. The Trust can only confirm [Patient A] had an unwitnessed fall at home…Directorates were aware that no SAI was warranted and that the complaint issues were being investigated solely under the HSC Complaint Procedure."

[Emphasis Added]

Care needs assessment for Patient A and Patient B

18. The Trust response letter of 19 December 2017 stated:

"…there is no specific guidance advising that Domiciliary Care is 'capped at 30 hours'. Each client is dealt with as an individual and subject to a person

centred individualised assessment, to allow eligible needs to be identified…eligibility criteria are used to identify those most at risk and give those individuals priority...Trusts have a statutory duty to consider using a self-directed support approach in relation to Domiciliary Care. This approach is a flexible way of providing social care support, which offers more choice over the way care and support needs are met…These include:

- *Direct Payments*
- *Managed Budget*
- *Trust arranged support or*
- *A combination of these options"*

19. In a further letter of response dated 17 April 2019 the Trust stated:

"With regard to clearer guidelines on the extent of payments, each case is considered in relation to an individual's need and the availability of family members/carers to support care in the home. Every case is different and cases can change at any time so there is a need to continually review the care package in place and make amendments as necessary based on assessment at that time. The Trust accepts that clear information on preparing patients and their carers for discharge from hospital is required and Mental Health Services have recently completed a protocol for "Patient Choice" which outlines the options which can be considered to support someone at home and the processes involved. Clear information leaflets and staff/advocacy support are also available which we hope will provide improved communication and guidance to service users and their carers."

The Trust provided a copy of the A4 folded "Case management" Leaflet.

Interviews

20. The Investigating Officer conducted a series of interviews with Trust staff to facilitate a better understanding of the sequence of events and decisions made by the Trust. The Trust staff interviewed included:

- Support and Recovery Service Co-ordinator Mental Health Services
- Acting Head of Service for Support and Recovery Mental Health Services

- Team Leader Integrated Care Team
- Consultant Mental Health Inpatient Unit
- Clinical Social Care Governance Co-ordinator for Mental Health Disability Services
- Assistant Director Mental Health and Disability
- Head of Integrated Care Team (covering 7 localities)
- Social Worker Community Mental Health Team

21. I am grateful for the time and assistance provided by Trust staff. I take several points from the information supplied during the interviews:
    - Patient A and Patient B had limited previous engagement with Trust social services before April 2016;
    - Trust Staff were committed to providing care and support to Patient A and Patient B within existing policy and guidance;
    - Where Patient A made decisions on declining offers of support those decisions were respected;
    - The Integrated Care Teams in the Trust were undergoing geographical reorganisation during this period;
    - The assessment of Patient B requiring 24hr care led to a presumption of the need for her placement in a residential care setting as the most appropriate setting;
    - The post of Social Worker on the Mental Health Inpatient Unit was vacant at the time in October/November 2016;
    - The Multi-Disciplinary Team in the Mental Health Inpatient Unit agreed to Patient B returning home only when the complainant outlined a substantial 24hr package of private care was in place;
    - Patient B was discharged without a Trust provided package of care or Trust funded package;
    - Front line staff had working assumptions of a 30 hr weekly cap of a package of care equivalent to the cost of residential care;
    - There are limited records of the reasoning behind decisions taken eg decision of backdating of care package or adjustment of care package hours allowance;

- Less than 2% of Trust packages involve live-in, sit-in or 24hr care; and
- The complexity of addressing the complaint was exacerbated by the evolution of Patient A and Patient B's care needs and ongoing care decisions;

Relevant Independent Professional Advice

22. The Social Work IPA advised, in relation to care assessments for Patient A and Patient B:

"There is evidence that, in general, the process of assessing Patient A needs was thorough and that an appropriate range of professionals were involved in the process. However what is less clear is where the assessment process took into consideration the needs placed on Patient A in her role of supporting her daughter Patient B who had ongoing serious mental health problems…

There should have been a more considered assessment of Patient A needs being carried out in conjunction with the assessment of Patient B needs. This would have given a more thorough assessment of all of the needs of both individuals and reflected their interdependence and wishes. The fact that some services were subsequently identified as duplication of resources within the household and withdrawn indicates the limit/gaps that occurred in the process.
[Patient B]… the assessment was carried out by appropriate staff using the SHSCT forms and criteria. At different stages her needs was subject to both formal and informal review.
While the processes of assessment are similar to those which addressed Patient A needs the same concern presents in Patient B assessment as in that of her mother. Notably this assessment appears to be largely focused on her needs and not carried out in conjunction with the needs assessment of the two people who present as interdependent for their social and practical needs. In effect, the deterioration in Patient A health does not appear to have been a key consideration in assessing Patient B health and safety when leaving hospital. Ongoing assessment appears to be largely focused on Patient Bs medical needs whilst not addressing her changing care needs which are increasing as Patient As health deteriorates.

[Emphasis Added]

23. The Social Work IPA further advised:

"There are no clear guidelines on the cost or provision of care within Trust regarding what people should or could be entitled to for their care needs. Cases are reflected on and decisions made in light of any number of complex considerations.

These include physical, emotional and mental wellbeing, practical health and safety, professional conclusions and recommendations, personal circumstances and family/community support. These in turn are underpinned by finite resources and wide demand for services and support.

A balance between needs and strengths. 'It is recognised that there may be a point where the intensity of needs, the safety of the care worker, pressure on family and cost effectiveness of the care package will mean that residential or nursing home care becomes the most appropriate care option….' Section 72 Care Management Provision of Services And charging Guidance HSC (ECCU) 1/2010."

24. The Social Work IPA concluded:

"This case is very complex and reflects a number of different teams and professions within the SHSCT contributing to different assessments, development, delivery and monitoring of care packages. Staff are to be commended on the high level of support given on a practical basis to both Patient A and Patient B. However there is a need for the structure to be reviewed to ensure better communication and clearer lines of responsibility."

25. I considered the Trust response to the IPA advice set out in the letter of 17 April 2019 from the Trust Chief Executive. The Chief Executive welcomed the IPAs comments that "in general. The process of assessing…needs was thorough…" The Chief Executive confirmed that the directorate dealing with Patient A had not introduced Standard Operating Procedures for care assessments and the directorate dealing with Patient B used its own assessment tool. The Trust did dispute the IPAs characterisation of failure to fit the handrail and failure to investigate the resulting fall as a Serious Adverse Incident (SAI). The Trust also indicated that they were aware of Patient A's deterioration in eyesight from

October 2016 and her registration as blind from July 2017. The Chief Executive reiterated that an SAI investigation was not warranted in respect of Patient A's "fall" and after receipt of the complaint. The Chief Executive also outlined the Trust timeline in addressing the complaint.

Analysis and Findings

Installation of stair rail adaptation

26. I note the Trust acknowledged and apologised for a relatively short delay in actioning the stair rail adaptation in July and August of 2016 and provided an explanation as to why this happened, though I do not consider that such situations should impact on the service available to vulnerable individuals. The complainant has provided further detail which she considers indicates the Trust contractor attended with the wrong part on 24 August 2016. It would appear that this was not subject to an investigation, in the context of the complaint to the Trust beyond the written assertion that the contractor records show that Patient A declined to have the rail fitted, although it is unclear if this was by telephone or in-person. The complainant provided my office with evidence of a contemporaneous email contact with the Trust indicating that the contractor attended with the wrong part and left to return at a later date. This email was available to the Trust. I also considered the issue of whether the Trust should have contemplated an SAI investigation of this matter and I further address this under issue two.

27. I am unable to conclude on the factual situation due to the lack of a timely contemporaneous investigation of the issue around the installation/non-installation of the stair adaptation. Any consequences from the hand rail adaption not being fitted and the effect of this on where and how Patient A fell were also not investigated. Due to the lack of investigation I cannot reach a concluded view on why the contractor did not return and whether this lack of adaption played any part in Patient A's fall. An investigation of this aspect of the complaint would have afforded the complainant with a response and allowed me to consider the full facts and reach a view.

28. The First Principle of Good Administration ‘Getting it right’ includes 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; and taking reasonable decisions, based on all relevant considerations. I considered that the contemporaneous information made available by the complainant that the handrail was not fitted because a contractor turned up with the wrong part conflicted with the Trust account that the contractor did not attend because Patient A declined the visit. In those circumstances and with that background I considered that an SAI investigation of that information in the context of her subsequent fall was merited. It is not a suggestion as the Trust commented of considering “all falls” as an SAI, but the failure to consider the account given by the complainant that the (non) attendance by the contractor which was raised contemporaneously by email. In conclusion I considered that the Trust failure to fully investigate this aspect, surrounding the (non) attendance by contractor as maladministration. As a consequence of the maladministration. I uphold this element of complaint. I identified I consider that the complainant suffered the injustice of uncertainty, upset and frustration in the handling of her complaint. Patient A suffered the injustice of uncertainty, upset and frustration in not having an aspect of the complaint fully investigated.

Care needs assessment for Patient A and Patient B

29. I considered the IPA advice and the Trust response. I also noted the Trust comments on a draft of this report. I accept the IPA advice. While there is an accepted acknowledgement that the health professionals carried out a thorough and appropriate assessment of needs, there were gaps in identifying and assessing the interdependence of Patient A and Patient B who had lived together at home for more than four decades. In a case such as this involving two individuals across two different programmes of care who clearly had an interdependency, their individual wishes should have figured high in the Trusts considerations. I consider this was a prominent responsibility for the Trust. I considered the Trust failed to deal with the interdependency and individual wishes of Patient A and Patient B in their care assessments.

30. I noted that the Trust staff confirmed there was no liaison social worker in post in the Mental Health Unit when arrangements were being made to discharge Patient B. This post would have been central to liaising with Patient B and her family regarding her wishes and availability of care packages at home. I considered the Trust "Case Management" leaflet provided to the complainant. It provides very limited information on the assessment of care needs and any options or thresholds. I also noted that the Trust introduced a new protocol for "Patient Choice" which outlines options which can be considered to support someone following discharge from inpatient mental health services. Clear information leaflets and staff/advocacy support are also now available. I consider this is a recognition of the lack of clarity and information for service users and carers up to this point, including in this case which I welcome. However I think the absence of this information in this case is a failing. I consider the lack of recognition of the interdependency when Patient B was discharged from hospital as a failure by the Trust. The consequences for the complainant, Patient A and Patient B would have been access to full and accurate information on what Trust care packages may have been available and a saving on private spending that was being funded from savings and state benefits payments.

31. Where the complainant had raised the specific question of the availability of backdated payments or reimbursement for incurred private care costs, I was disappointed to note a divergence of account between what the complainant was told in October 2016, what was agreed at the July 2017 meeting and the written record and response from the Trust. The Trust were unable to provide a contemporaneous record of a decision on the question of backdating other than to state the decision was taken in a 'supervision meeting', there is no recorded rationale for the decision. The Third Principle of Good Administration being open and accountable requires a public body to keep appropriate records of decisions and decision making. They are absent in this matter.

32. The First Principle of Good Administration: 'Getting it right' includes 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; and taking

reasonable decisions, based on all relevant considerations. I also considered the human rights of Patient A and Patient B. I consider that an individual's human rights can be infringed as a result of failings inhibiting access to a care package. The Trust SOP Care Planning Guidance reflects human rights principles of fairness, respect, equality, dignity and autonomy (FREDA Principles) Central to applying human rights in practical terms is the recognition of a patient as an individual and the delivery of care appropriate to their needs. I consider these human rights values when applying the Ombudsman's Principles of Good Administration.

33. The First Principle: "Getting it right" – acting in accordance with the law and with regard for the rights of those concerned – explicitly creates an expectation that public authorities will have regard to published standards such as the Trust SOP Care Planning Guidance and failure to do so will attract criticism. It is my view that the Trust did not show regard for the both patient's human rights in terms of dignity, equality and respect by failing to meet care needs with information about assessment for Trust funded packages at appropriate times. For Patient B this would have been at discharge from hospital. I therefore conclude that not providing such information and access to Trust funded care packages for Patient B is a failure. I consider this failing to constitute maladministration.

34. I consider that the Trust should also have had regard to the Article 8 Right to respect for family life (European Convention on Human Rights) in relation to the wishes of Patient A and Patient B to live together in a family setting at home. This would have required the Trust to have provided accurate information to them and their family around accessing the provision of care services, clear and fair processes for establishing provision or funding arrangements; and accountability mechanisms when complaints or concerns were raised. In conclusion I considered that the Trust failed to provide clear and accurate information to the complainant and by extension Patient A and Patient B, coupled with the failings identified in assessment outlined in paragraphs 28-32 amounts to maladministration. I uphold this element of complaint

35. As a consequence of the maladministration I identified I consider that the complainant suffered the injustice of uncertainty, upset and frustration in the communication of care package information and decisions taking account of all relevant factors. Patient A and Patient B also suffered the injustice of uncertainty, upset and frustration in not having accurate communication of care package information and taking account of all relevant factors, particularly their family situation, lengthy period together at home, interdependency for care and support and future care needs.

Issue 2: Whether the complaint regarding the care needs of Patient A and Patient B was handled reasonably and in line with relevant policies.

Detail of Complaint

36. The complainant initially sought assistance from a local MP to complain to the Trust regarding the financial burden of arranging a private package of care and the lack of Trust provision in January 2017 on behalf of Patient A and Patient B. In a further letter to the Trust the complainant outlined specific areas of complaint including the lack of provision of a stair rail adaptation and inadequate assessment of the care needs of Patient A and Patient B. After arranged meetings the Trust did accept some delay in responding fully to the complainant.

Evidence Considered

Legislation/Policies/Guidance

37. I considered the following policies and guidance:
    - SHSCT Complaints Policy "Working Draft" 2015;
    - Regional Health and Social Care Complaints Procedure Guidance and Directions (2009); and
    - Health and Social Care Board (HSCB) - SAI Procedure, 2013

I included relevant extracts to the above at Appendix three to the report.

Trust response to investigation enquiries

38. I refer to the detail of the Trust response set out at paragraph 17 of the report and which continued:

"The Trust acknowledges that, following the initial complaint and response, the complaint was reopened and there were responses which were delayed. The Trust would also highlight however that meetings took place with [the complainant] during this time (6 June 2017 and 21 July 2017) as part of the complaints process in order to resolve concerns."

Interviews

39. I refer to the detail of the interviews carried out at paragraph 20. In relation to the issue of complaint the main issues arising from these interviews were;
    (i) The Trust considered the evolving detail in the complaint and attempted to answer as much of the detail in the complaint;
    (ii) Dealing with this complaint involved a very considerable time commitment of staff over an ongoing period of time;
    (iii) The Trust did not consider alternative methodologies to employ in addressing the complaint such as conciliation or mediation particularly in the context of an ongoing care arrangement;
    (iv) The Trust did not accept the need to consider a Serious Adverse Incident regarding the failure to achieve a stair rail adaptation as the Trust record was that Patient A declined to allow the contractor to fit the adaptation; and
    (v) The Trust accepted the complaints policy required minor amendment to address the absence of SAI considerations as in the updated Regional Complaint Guidance.

Analysis and Findings

40. All Trusts were required to adopt a complaint policy and procedure in line with the Regional Health and Social Care Complaints Procedure (2009) under the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009. The Trust policy applicable at the time was the 2015 'working draft' version of the Trust's Policy for the Management of Complaints. I would expect the Trust to have adopted a final version formal policy with appropriate review mechanisms as an ongoing governance requirement.

41. The Trust complaints policy states in the section titled 'Policy statement':

"The Southern Health and Social Care Trust …believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving."

42. I examined the information and records the Trust provided about its complaint handling. In considering the records provided by the Trust and the relevant policies at contained in Appendix three to this report, I found the following:

(i) The Trust provided no record to evidence a contemporaneous, appropriate identification of the issues to be investigated rather than a focus on providing a factual narrative response;

(ii) There is no record or contemporaneous evidence of any discussion of the complaint between the Governance Team and relevant Directorate Teams as to the issues to be investigated;

(iii) There is no evidence of consideration of whether the issues raised regarding the provision of stair rail adaptation should be dealt with as a "serious adverse incident" in line with regional policy guidance;

(iv) There is no evidence or record of a contemporaneous discussion of the appropriate level of investigation to be carried out in line with policy and regional guidance;

(v) There is no clear evidence or contemporaneous record of the appointment of any investigators to undertake and complete an investigation into the various aspects of the complaint;

(vi) The Trust did not provide details of actions taken during the investigation or records of an investigation with the exception of meetings and emails outlining the drafting of actual accounts or factual justifications of decisions around the provision of care;

(vii) There are no records or contemporaneous evidence of an appropriate level of investigation which meets Trust policy, regional procedures and HSC Complaint Practice Directions. This is of concern given my findings relating to circumstances surrounding the provision of a stair

rail adaptation and Patient A's fall. The Trust view that falls are now dealt with by a revised regional SAI process fails to consider that the SAI issue is the suggestion from the complainant that the Trust contractor failed to attend and fit the required stair hand rail adaptation due to attending with the wrong part and the complainant raised the issue by email with Trust staff contemporaneously. No remedial action was taken.

In the context of the failings identified I conclude that the complaint investigation and response undertaken by the Trust was inadequate.

43. The failures I outlined by the Trust to properly apply its own policy and procedure for complaints; the regional procedures for complaints and "serious adverse incident" investigations fail to meet the Principles of Good Complaints Handling, individually and collectively, as set out in Appendix two. I conclude that this amounts to maladministration by the Trust in the operation of its complaints procedure.

44. In summary, I find the complaint handling by the Trust attended by acknowledged delay, failure to follow policy/guidance and failure to conduct a thorough investigation specifically addressing the issues raised by the complainant. I uphold this issue of complaint. As a consequence of the maladministration I identified I consider that the complainant suffered the injustice of uncertainty, upset and frustration in the handling of her complaint. Patient A and Patient B suffered the injustice of uncertainty, upset and frustration in not having adequate complaint responses to assist their understanding of the Trust's approach to their care needs

CONCLUSION

45. I received a complaint about the Trust with regard to the handling of the care needs of Patient A and Patient B. The complainant said that the care

needs assessments were inadequate and accurate information was not obtained. She also raised a specific issue regarding the provision of a stair rail adaptation in Patient A's home.

46. I found failures in the assessment of Patient A and Patient B care needs as the evidence suggests limited regard was taken of their interdependency living together at home for more than 40 years. There was a need for better communication with them and their carer. In particular clear information should have been provided about what services or funding may have been available to assist with meeting both Patient A's and Patient B's needs. I acknowledge that the Trust has moved to provide fuller information to patients, their families and staff training since these events.

47. I am satisfied that the maladministration identified caused the complainant to suffer the injustice of uncertainty, upset and frustration in the handling of her complaint. Patient A and Patient B also suffered the injustice of uncertainty, upset and frustration in not having their care needs properly assessed and complaint responses to assist their understanding of the Trusts approach to their care needs.

Recommendations

48. I recommend that the Trust provides the complainant, Patient A and Patient B with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration identified (within **one month** of the date of this report).

49. I recommend that the Trust reconsider the request for backdating of care packages for Patient B from her discharge from hospital in November 2016 made by the complainant and issue her with a written decision based on the applicable legislation/policy/guidance and clearly outlining the reasoning for arriving at the decision given the factual background.

50. In order to improve the service delivery in domiciliary care assessment and the complaint handling function in the Trust:

I recommend:

(i) The Trust should review of the operation of its domiciliary care assessment process in light of the findings in my report including: assessments reflecting interdependency of co-habiting patients; communication with patients and carers and the provision of clear written information on entitlements, process and decisions/outcomes.

(ii) The Trust should report to the Trust Board on the outcome of the domiciliary care assessment review. The report and an action plan incorporating any recommendations should be provided to me within **three** months from the date of my final report.

(iii) The Trust should review the operation of its complaint process in light of the findings in my report including: delays in responding; compliance with complaints policy; adequacy of investigation; and screening for SAI issues.

(iv) The Trust should report on the outcome of the complaint review to the Trust Board. The report and an action plan incorporating any recommendations should be provided to me within **three** months from the date of my final report.

(v) The Trust should update me within **six** months, of the date of my final report, on progress on implementing any recommendations from the reviews. The update should include evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any related policies or procedures).

MARGARET KELLY
Ombudsman **June 2021**