Investigation of a complaint against the South Eastern Health & Social Care Trust

Report Reference: 202003799

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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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SUMMARY

This complaint was about the care and support the South Eastern Health & Social Care Trust (the Trust) provided to the complainant and her son between October 2022 and November 2022.

The complainant's son has complex needs. She was concerned that when she was admitted to hospital for a period of over three weeks and following her discharge in October 2022 the Trust did not provide her with sufficient support to enable her to care for her son. She was also concerned that the Trust put her other son under pressure to care for his brother.

The investigation established a failure in how the Trust assessed the care and support needs of the complainant's sons. This included a failure to accurately consider the child's range of additional needs and how these were to be met while his mother was in hospital as well as a failure to assess if the child's brother could provide care in his mother's absence and what additional support he might need. The absence of any consideration of the child's presenting additional needs was of concern. I upheld this element of the complaint.

Of further concern was the child's need for additional overnight respite which could not be provided because of a lack of available places. The Trust had no plan to help identify what was needed either in the short term for the child while his mother was in hospital , or indeed after the complainant had been discharged from hospital. This resulted in stress and upset to the complainant and her family and was a failure in their care and support. .

The complainant was concerned the Trust did not allocate sufficient Direct Payments and did not backdate the payments when asked it to do so. The investigation did not find any failing in the payment of Direct Payments and I did not uphold that element of the complaint. However, I was concerned that the Trust failed to offer the complainant additional support whilst her Direct Payments application was being processed

I reminded the Trust of the importance of retaining accurate details in relation to the awarding and purpose of Direct Payments. I also recommended to prevent further recurrence and ensure service improvement that the Trust shares the findings of this report with the relevant staff and provides training to relevant staff on the importance of the guidelines and record keeping.

THE COMPLAINT

1. This complaint was about the care and support the South Eastern Health & Social Care Trust (the Trust) provided to the complainant and her son.

Background

2. The complainant's son is 10 years old. He has a learning disability, epilepsy and is non-verbal.

3. In September 2022 the complainant was admitted to the Trust's Mental Health Unit for 3.5 weeks. At the time of her admission the Trust did not have a social worker allocated to her son due to a 'staff vacancy'.

4. Following the complainant's discharge, she believes she did not receive the respite care that she and her son needed. .

5. The complainant is further concerned the Trust did not backpay Direct Payments (DP)[1] it had awarded to her.

Issues of complaint

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

1) Whether the support the Trust provided to the complainant's son was appropriate and in accordance with relevant guidance and standards. In particular:
- **The respite support provided between October and November 2022**
- **Communication with the complainant and her eldest son.**

2) Whether the Trust acted in accordance with relevant guidance and standards in its consideration of the complainant's request to backdate direct payments.

INVESTIGATION METHODOLOGY

7. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

[1] Direct Payments-a personal budget to meet the assessed need of an individual eligible for and entitled to social acre support services. DP is a payment made directly to the individual or their nominated representative.

Independent Professional Advice Sought

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

    - A Children's Social Worker with 20 years' experience. BA Psychology Honours, Class 2; Certificate of Qualification in Social Work; Diploma in Applied Social Studies; and Social Work Practice. Considerable experience in relation to Child Disability Services and Learning Disability Services.

    I enclose the social work advice received at Appendix 2 to this report.

9. 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

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

    The general standards are the Ombudsman's Principles[2]:

    - The Principles of Good Administration

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

    The specific standards and guidance relevant to this complaint are:

    - The Principles of Good Administration

    I enclose relevant sections of the guidance considered at Appendix 1 to this report.

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

Administration

12. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Trust's administrative actions. It is not my role to question the merits of a discretionary decision. That is unless my investigation identifies maladministration in the Trust's process of making that decision.

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

14. 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. Both parties confirmed they had no comments to make.

THE INVESTIGATION

Issue 1: Whether the support the Trust provided to the complainant and her son was appropriate and in accordance with relevant guidance and standards.

- The respite support provided between October 2022 and November 2022
- Communication with the complainant and her eldest son.

Detail of Complaint

15. The complainant is concerned the Trust failed, and continues to fail, to provide her and her son (Son A) with greatly needed support.

16. On7 September 2022 the complainant was admitted to the Trust's Mental Health Unit (MHU) for a period of 3.5 weeks. Following her discharge on 5 October 2022 the complainant asked for additional care and respite for both herself and Son A. She is concerned that she has not received additional help. She said the lack of support has had an adverse impact on her. She is concerned the lack of support could cause a relapse in her addiction recovery and feels the Trust are not listening to her.

17. The complainant said when she was admitted to MHU another son (Son B) used his holiday entitlement from his job to look after Son A. The complainant is concerned the Trust put Son B '*under tremendous pressure'* to provide respite care for Son A.

She considers it was inappropriate that the Trust offered to contact Son B's employer to explain his domestic situation.

18. The complainant said she receives 7 hours of Direct Payments per week. She does not consider this is adequate support.

Evidence Considered

Legislation/Policies/Guidance

19. I considered the following legislation and guidance:
    - The Children (Northern Ireland) Order 1995 (the Order)
    - Understanding the Needs of Children in Northern Ireland 2014 (UNOCINI Assessment Framework)
    - Self Directed Support Practitioner's Guide 2015 (Direct Payments) Extract from The Trust's website 'Children's Disability Services' (the extract)

The Trust's response to investigation enquiries

20. The Trust stated it has provided considerable support to the complainant and her son. This includes:

- October 2022 – December 2022: 4 days Social Work help per week reducing to 2 days per week for after school support.

- 5 hours of Direct Payments (DP) per week to replace Children's' Disability Team (CDT) support which was approved in November 2022.

- Son A is receiving short overnight breaks and is prioritised for any cancellations that may occur in Greenhill . Since October 2022 Son A has had 9 short breaks.

- Referrals completed to Sponsored Childminding and Fostering (THRIVE) for respite, however in June 2023 the complainant stated she no longer wished for the referral to Fostering to remain active.

21. When the complainant was admitted to the MHU, the Trust stated that due to a staff vacancy Son A had *'been an unallocated case within the Child Disability team (CDT).'* When CDT became aware of this Son B was already in a caring role for Son A in the family home. CDT offered additional afterschool support to Son B.

22. The Trust's social worker acknowledges the requirement for Son B to look after his brother whilst maintaining his job may have caused Son B stress. However, the Trust stated with Son B's assistance, Son A was able to remain in a consistent routine in the family home. The Trust explained that CDT offered to contact Son B's employer as a means of support to him as Son B said he was having difficulty with his employment whilst caring for his brother.

Relevant Trust records

- Social Work records

23. I enclose the social work records at Appendix 4 of this report

Analysis and Findings

The care and support provided between October 2022 and November 2022.

24. The complainant is concerned the Trust failed to provide her and Son A with greatly needed support.

25. As a result of my investigation, I consider it necessary to take account of the assessment the Trust's hospital social worker made regarding Son A and Son B when the complainant was admitted to hospital in September 2022.

26. Disabled children, by virtue of their disability, are defined as "children in need" under Article 17 the Order. It is the duty of each Health and Social Care (HSC) Trust to promote the welfare of disabled children by developing a range of personal social services relevant to their needs (under Article 18 of the Order)

27. The extract states that it operates a Children Disability Service (CDS) which divides support into a number of tiers dependent upon the support the child requires. The extract '*Tier 3 category* **:** *'Targets Children with Multiple and Complex Needs. For children with a permanent and substantial learning or physical disability and/or complex health care needs which have a substantial and long-term adverse effect on his/her ability to engage in normal day-to-day activities with a consequent negative effect on family functioning.'*

28. The IPA advised that given '*Son A's complex needs he falls into the Trust's* Tier 3 category for the CDS. I have reviewed the records, and I note that Son A has complex needs. I agree with the IPA that he falls into Tier 3 which the extract says is

a ‘S*ocial Work lead service.* The extract states CDS Tier 3 Service provides amongst other things:-

- ‘*A Social Work service, designed to support families in high level need that can include statutory requirements such as Child Protection and Children in Care.’*
- *A Family Support service to children and their carers who meet the criteria for the service. This includes access to residential short break provision and a Fostering short-break service*

29. Paragraph 1.1 of the UNOCINI guidance states ‘*The purpose of this document is to provide guidance to support staff to better meet the needs of children and their families through a comprehensive process for assessment leading to action.’* Part 1.3 of the UNOCINI Framework Assessment states *UNOCINI has three assessment areas :-*

- *the needs of the child or young person.*
- *the capacity of their parents or carers to meet these needs.*
- *wider family and environmental factors that impact on parental capacity and children’s needs.*

30. The Trust stated that a ‘*UNOCINI will be reviewed when the child’s needs change.’* Paragraph 2.5 of the UNOCINI Guidance says *‘the UNOCINI Preliminary Assessment (Form A1) will be carried out by staff working in universal service, and the community and voluntary sector in situations where there is an early identification about a child’s additional needs. The UNOCINI Referral (Form A1) will be completed whenever a professional or agency wishes to refer a child or young person to children’s social services for support, safeguarding or a fuller assessment of a child’s needs. If Preliminary Assessment Form or Agency Appraisal has already been completed, this will then become the referral to children’s social services’.*

31. The IPA advised *‘ if the A1 indicates that Children’s Social Services (CSS) should become involved then a more detailed and comprehensive UNOCINI Pathway Assessment will be completed. This will be tailored to the type of service most likely to meet the child or young person’s needs.’*

32. The IPA also advised that on 9 September 2022 a hospital social worker completed an A1 Form which:-

- *'Fails to provide the relevant information about the Child's disabilities and complex needs.*
- *Says that the Child lived with the mother and two siblings. As noted, I have not seen any other references to these siblings.*
- *Says that the son 'has carer's responsibility' and goes on to say that there were no immediate actions necessary to safeguard the Child because he was at home with his brother.*
- *Does not indicate that checks needed to be carried out to check on the Child's circumstances and care.'*

33. The IPA advised '*My reading of the forms is that they constituted referrals to CSS'.* Given what the guidance says about the purposes of an A1 Form, I accept this advice.

34. The IPA also advised that '*the absence of any information about the Child's significant disabilities and presenting needs'* in the hospital SW's A1 Form *' is of concern.'* He advised *'There is nothing here about the need to check out how the Child would be cared for in the mother's absence especially since it would / should have been predictable by that time that she would be spending some time in hospital following her [admission].'*

35. I have reviewed the A1 Form, and I concur with the IPA's concerns that there is nothing to indicate what the child's disabilities and presenting needs were. There are no details about Sons B's capacity to provide immediate care for his brother or the need to check how the child would be cared for given the predicted lengthy absence of the child's mother from the home.

36. By not recording the child's needs or checking how the child would be cared for in his mother's absence, the Trust's hospital SW failed to follow the relevant guidance. This resulted in a failure in care and support for Son A.

37. The IPA advised *'In my view, once the referrals had been received by the CDT, an A1 should have been urgently competed to review the Child's needs in order to determine what the Child's circumstances were so that decisions could be taken about what intervention and support needed to be put in place. This was particularly significant given that the Child was being looked after by his brother, who was in employment. This would have helped identify what needed to happen in the short-*

term but should then have led to a more comprehensive Family Support Pathway Assessment when the mother was discharged from hospital because the family's circumstances and needs will most likely have changed at this juncture'.

38. I examined the CDT records, and I see no evidence of an A1 form being completed. I therefore agree with the IPA that because of Son A's needs CDT should have urgently carried out an A1 to determine what his needs were and to allow decisions to be made about the requirement for immediate and longer-term intervention. I also accept the IPA's suggestion that this was particularly important as the child was being looked after by his brother, who I note was a young man in employment. All of this was a failure to act in accordance with the guidelines.

39. The First Principle of Good Administration ' Getting it Right' requires public service providers *to act in accordance with the law and relevant guidance.* By not following the UNOCINI guidance with regard to Son A's assessment of needs, the Trust failed to act in accordance with in the UNOCINI guidance and this therefore constitutes maladministration. maladministration.

40. The failure to act in line with the guidelines resulted in a failure in the care and support the CDS provided to the complainant and her family. The impact of this was that Trust had no plan to help identify what was needed in the short term for Son A, or indeed after the complainant had been discharged from hospital. This resulted in stress and upset to the complainant and her family at a time when she was already experiencing mental health issues. I uphold this element of the complaint.

41. I asked the IPA about the support the Trust provided to the complainant in 2022. He advised ' *The Mother left hospital on 05/10/22. The Child accessed about 7 nights of overnight respite care across September, October, and November 2022. The CDT SW had acknowledged that the family needed more than this; the records show that she made several requests for additional overnights that could not be met. This was down to a lack of resources. Although the Trust made attempts to access alternative sources of overnight respite care these attempts were unsuccessful. This was clearly a service deficiency.* The IPA also advised that between 5 November 2022 and 7 January 2023 there is a gap '*of 2 months between overnight respite care breaks* ***which would have been too long.'***

42. I accept and agree with the IPA's advice that a 2-month gap between respite nights is too long, and I find this unacceptable. I note the complainant repeatedly requested additional respite hours. I welcome that the Trust tried to provide additional respite care for Son A. However, I note those attempts failed due to lack of service provision. This lack of service provision is unacceptable, and I am concerned about the impact this has had on the complainant and her family at a time when she was particularly vulnerable.

43. I observe that Son A had no allocated SW when the complainant was admitted to hospital. Whilst this may have been due to a staff vacancy at that particular time, there is no indication the Trust made any effort to assign a dedicated SW to Son A to carry out the necessary assessments that would provide support to him and his family during and after the sudden change in family circumstances. I am deeply concerned by this. Although I observe that a SW was providing some after school respite, I consider this to be an ad hoc response to the circumstances and not a suitable arrangement with the best interests of the child at its core.

Communication with the complainant's eldest son

44. The IPA stated '*I have not come across a situation like this before'* however, he advised *'I do not believe it was part of the Trust's role to liaise with Son B's employer. He had not asked the SW to do this, and it was not within her remit. This could come across as pressurising Son B to look after Son A overnight when he had already said he was unable to do so.'* The IPA also advised *'The Trust should have considered what Son B needed in terms of specific support from it to enable Son B to continue looking after Son A whilst continuing to work.*'

45. I accept the IPA's analysis of the manner in which the Trust acted towards Son B and the offer to contact his employer. I agree with the IPA that the Trust should have considered what Son B needed in terms of specific support to enable him to look after Son A whilst continuing to work. However, I am satisfied the Trust did not do so, either at the time the Hospital SW completed an A1 Form nor after the case had been referred to CDT. This is a result of the Trust's failure to follow the guidance. I also accept the IPA's advice that the social worker's actions could have made Son B feel pressurised to providing care for Son A. The Trust failed to provide an appropriate level of care and consequently support to Son A and his family. I uphold this element of the complaint.

Issue 2: Whether the Trust acted in accordance with relevant guidance and standards in its consideration of the complainant's request to backdate direct payments.

46. The complainant is concerned the Trust only backdated DPs to February 2023 . She considers DPs should have been backdated to November 2022 when her application was approved.

The Trust's response to investigation enquiries

47. As part of a Family Support Assessment or Short Break LAC Review (which is also an assessment), some direct payment support may be considered in consultation with a parent or carer. . This allows the parent to choose their support network, and they become the employer. If a parent or carer is agreeable the next steps are:

- An application is completed for consideration by the Beds and Family Support panel.
- The panel then discuss the application and determine the need for direct payments and the number of hours.
- This decision is then fed back to the parent.
- There is no appeal process. If a parent is very unhappy or if they have additional information to add, they can discuss this with the Social Worker and Senior Social Worker who will decide upon the merit of re-presenting that specific application.
- If there is a change in circumstances at a future time that the Social Worker feels requires direct payment support, they may submit a new application with additional or new information.

48. The Trust approved 5 hours of Direct Payments (DP) per week in November 2022 to replace the Children's' Disability Team's (CDT) support. Due to outstanding information required from the complainant, payments did not commence until April 2023. The Trust confirmed the Social Worker cannot set up the direct payment until the Access NI safeguarding has been completed. , The Trust emphasised only when this is completed, and all the other requirements are set up can the payments be authorised by the Trust Finance Department. The Trust stated that despite being prompted by Trust staff, the complainant did not complete this aspect of her application until mid April 2023.

49. The Trust confirmed that it stepped outside the remit of the guidance and backdated the complainant's direct payments until the beginning of February 2023. This was a compromise and is not in line with guidance. However, the Trust said it listened to the complainant's views as well as considering the need to have proper governance over public funds before taking that decision.

50. The complainant felt the 5 hours were not sufficient. The Trust explained that the 5 hours had to be set up first and trialled to see how they worked. Then depending on how this worked, they could be reviewed thereafter regarding the possibility of an increase. The service could not agree to increase the hours until it was satisfied with regard to how these 5 hours were being used and that they were working.

51. The Trust stated it does not consider this 'un-reasonable'. ' The service needs to be fair across all service users getting direct payments i.e. test what is awarded first before increasing direct payment hours. The service is accountable for public funds and must evidence they are used effectively before considering an increase.

    The complainant currently has 7 hours direct payments per week. This allows her new direct payment worker to take her son out to give the complainant a break, mostly at the weekends. During the summer months the complainant gets a further 15 hours to allow her son to be looked after so she can attend her support groups and appointments. The complainant was unhappy with the decision of the panel in September 2023. This was reviewed again in October 2023 and February 2024 following further discussions and updates.

Relevant Trust records

- Contact records 29 November 2022 and 2 December 2022

52. I enclose a copy of these records at Appendix 4 of the report.

Analysis and Findings

53. I reviewed the Trust records. I note the complainant made a claim for DP in November 2022. The Trust's letter of offer for DP dated 14 December 2022 states *'in order for you to receive your personal budget you will need to complete Support Plan'* a further undated letter states '*we encourage you to complete the following ….once this has been completed Direct Payments can be commissioned and Payments will*

begin on the first Friday of every month.' I also note the complainant did not complete this paper work until April 2023.

54. I am satisfied the Trust acted in accordance with the guidelines when the arrangement to make the DP was being processed. I do not uphold this element of the complaint.

55. The complainant considers she is entitled to a back payment of DPs from November 2022 as this is the date on which they were approved. I note from the contact record of 2 December 2022 the Trust advised her the purpose of DPs is for immediate use and they cannot be back paid. However, I also note the Trust exercised some discretion and awarded a back payment to February 2023 as Son B was providing some support between February 2023 and April 2023. I accepted the Trust's explanation that this action was not within the guidelines. However, as this departure from the guidelines was to benefit the complainant and the Trust provided documented reasoning , I do not consider it a failure. I am satisfied that the Trust was under no obligation to provide any back payment of DPs to the complainant, and I do not uphold this element of the complaint.

Observations

56. Although this was not specifically complained about, I observe the IPA's advice that '*it is of concern that after the provision of DP was agreed in December 2022, this was not in place until April 2023. Although the records indicate this was down to the mother not providing everything that the Trust needed to enable it to initiate DP, in my view the Trust should have put in alternative support for the child during this period.'*

57. I reviewed the Trust records, and I can see nothing to indicate that alternative Trust support was offered to the complainant and her family during this time. I too am concerned that the Trust did not offer additional support to the family while the DP payments were being progressed.

58. The IPA advised *'I have not seen any information about how the DPs that were allocated were intended to meet the Child and family's needs. Without this , it is not possible to look at how effectively they were being used and, what if anything more, needed to be put in place'.*

59. I have reviewed the records. There is no record of how the allocated DPs were intended to meet the child's needs and how effectively they were being used. I would remind the Trust of the importance of record keeping, especially as any failure to keep accurate records may have a long-term impact on assessing the child's needs now and in the future.

CONCLUSION

60. I received a complaint about the actions of the South Eastern Trust. I upheld elements of the complaint for the reasons outlined in this report. I also made observations about the actions of the Trust in regard to this case.

61. I recommend, for service improvement and to prevent future recurrence the Trust

- Shares the findings of this report with the relevant staff to allow them to reflect on the failings identified
- Provides training to relevant staff on the importance of the UNOCINI guidelines when assessing a child's needs under the Order
- Provides training to staff on the importance of keeping accurate records in relation to Direct Payments and how they are intended to meet the needs of the child

62. I recommend the Trust implements an action plan to incorporate these recommendations and provides me with an update within **three** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY
Ombudsman **January 2025**

Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.