Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 202000635

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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 Reference: 202000635

Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

I received a complaint from a mother acting on behalf of her daughter, N, who at the time of the complaint was 16 years old, in relation to the care and support received from the South Eastern Health and Social Care Trust (the Trust). N has autism, significant communication difficulty (non-verbal), sensory issues and a severe learning difficulty meaning that she requires constant care and attention.

The complainant moved back to Northern Ireland from England with her two daughters, N and an older sibling in 2017. N was referred to the Children's Disability Service in January 2018 and while the complainant was allocated a named social worker, she complained of gaps in the service provided and a lack of continuity leading to deficiencies of support. She also complained regarding the shortage of provision of Trust respite care, the scarcity of emergency provision and a lack of carer support leaving both N and the complainant feeling let down, left alone, and isolated by the Trust.

Following my investigation, which involved the receipt of independent social work advice, I found maladministration by the Trust in a failure to allocate a designated social worker for an extended period of time, possibly for as much as two years, As a consequence, I consider the complainant sustained the injustice of frustration, uncertainty and upset together with a loss of opportunity to receive a level of emotional support for both she and her daughter. I did not uphold a complaint in respect of the level of respite received and domiciliary care.

My investigation of this complaint has revealed the difficult position the Trust has had to work through over a prolonged period and the problems caused through scarcity of staff, lack of suitable facilities within which to provide respite care to those with assessed and recognised needs and the devastating effects of the recent covid pandemic. Unfortunately, the experience of the complainant is not unique. Without a

sustained period of significant political input and commitment regarding resources I fear that this will remain the case, at least for the immediate future.

THE COMPLAINT

1. The complainant is acting on behalf of her daughter N who at the time of the complaint was 16 years old (N turned 18 in August 2022 and is now under the care of Adult Services). The complaint is in relation to the care and support received from the South Eastern Health and Social Care Trust (the Trust). N has autism, significant communication difficulty (non-verbal), sensory issues and a severe learning difficulty meaning that she requires constant care and attention.

Background

2. The complainant moved back to Northern Ireland from England with her two daughters, N and an older sibling in October 2017. Initially the complainant had difficulty in securing a school place for N and this was not achieved until September 2018. She was referred to the Children's Disability Service in January 2018 and while the complainant was allocated a named social worker, she complained of gaps in the service provided and a lack of continuity leading to deficiencies of support. She also complained regarding the provision of respite care by the Trust, the scarcity of emergency provision and a lack of carer support. As a consequence, the complainant felt that both her daughter and she have been let down, left alone, and isolated by the Trust.

Issue(s) of complaint

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

Issue 1: The adequacy of the provision of Social Work support and communication

Issue 2: Provision of respite care

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This included the social work records relevant to this complaint.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from a professionally qualified independent Social Work advisor (ISWA):

   I enclose the clinical advice received at Appendix two to this report.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The ISWA 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. 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[1]:

   - The Principles of Good Administration

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

   - UNOCINI (Understanding the needs of Children in Northern Ireland)
   - Childrens Disability Care programme (April 2018)
   - Caring behind Closed Doors (2020)

9. 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.

10. 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

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

recommendations.

THE INVESTIGATION

Issue 1: Provision of Social Work support and communication

Detail of Complaint

11. The complainant said that in early 2018 she accessed a disability social worker and that N was put on a waiting list for respite. She complained that subsequently N did not have a designated disability social worker for over a year and a half and that any contact she had with the service was hampered by lack of continuity in the personnel she was dealing with.

Evidence Considered

The Trust's response to investigation enquiries

12. In response to investigation enquiries, the Trust stated that '*N was referred to the Children's Disability Service in January 2018 and was allocated to a named social worker in March 2018. This social worker had continued involvement with N until she went on sick leave in September 2019 and this became a long term absence. Nonetheless, the Trust stated that N received a significant and thorough service at that time. The initial assessment was completed and a Family Support Plan was being progressed to include an application for domiciliary support and respite provision. N was then allocated ten hours domiciliary support in June 2018 and her name was added to the waiting list for Short Break Provision. N was also referred to the Children's Disability Team Intensive Support Behaviour Service and charity applications were made on the family's behalf by the Social Worker*'.

13. '*Due to capacity issues within the Down Children's Disability Team relating to staff being unavailable (due to sickness and maternity leave), in addition to the pressures resulting from the Covid-19 pandemic, unfortunately the case was not re-allocated until November 2020. There was limited availability from other sources such as the bank staff and agencies. This was a disruptive and unsettling time for all the staff who found themselves firefighting and dealing primarily with emergencies and the more complex cases'.*

14. The Trust stated that during this time, there were '*a number of contacts with the complainant by the Duty Social Worker, Allied Health Professionals and the Community Learning Disability Nursing Team. During this period, the complainant reported that N was well although it was acknowledged that respite would be very beneficial to the family. A senior social worker also spoke directly with the complainant during this period and acknowledged the need for respite once the service was available, although transport remained an issue which required clarification. The case was transferred to an agency social worker, in November 2020'.*

15. When the complainant formally raised her concern about needing more support in January 2021, the case was under the management of an agency social worker '*who was new to the service and trying to get to know her families, the area of work and deal with priority cases'.* The Trust also stated *'At the time of the complainant's initial complaint, the agency social worker had not had the opportunity to introduce herself. In response to the initial complaint, the Children's Disability Service apologise for any delay or distress experienced by the complainant and N. At the time, N had been on the waiting list for Lindsay House Short Breaks for two years and 3 months, and her frustration and upset was both understandable and recognised'*.

16. The Trust further stated that '*The agency social worker was a temporary member of staff who left at short notice in the middle of June 2021. The case was then managed by a senior social work practitioner before being handed over to a senior social worker in August 2021. The Trust acknowledged that when a family is in need and particularly in the midst of Covid-19, parents can feel isolated and alone. It is recognised that the complainant did not receive a consistent social work service between September 2019 and January 2021'*. However the Trust stated that although not having had an allocated social worker, '*there were a number of 'checking in' contacts with the family. It is also recognised that delays and lack of timely follow up were a feature of these interim months with the Down Children's Disability Team'*. The Trust also stated that certain features of its contact demonstrated that a '*range of social work staff across the service have kept in contact with the complainant, completed*

assessments, presented to panel, identified and sourced appropriate resources and been in regular contact via telephone, face to face and zoom, updating on developments and providing good support. This was very evident with the first allocated social worker and post January 2021'.

17. The Trust informed me that part of the learning from issues which have arisen from unallocated cases has resulted in the appointment of a senior social work practitioner, and two support workers in March and April 2021 respectively. This new service has been working on a future process map for the management of unallocated cases when the immediate backlog has been adequately processed.

18. In addition, the Trust confirmed the Children's Disability Service has been restructured. As part of its development, work and consultation has been undertaken to begin to develop the Trust Children's Disability Strategy. As part of the consultation process, it has become evident that there is a need to review staffing across the Children's Disability Service.

Relevant Independent Professional Advice

19. The ISWA advised that the family '*did not have a dedicated social worker for a period before the covid epidemic. This was due to staff shortages largely due to ill health and maternity leave absence. The Trusts encountered difficulty in backfilling these posts. This complaint refers to a period when the community, in general, was under exceptional pressure to respond to and address the circumstances of the Covid outbreak. This included restrictions on general services, self-isolation of individuals and families, recommended and imposed restrictions on travel, and considering other measures to combat the spread of this virus in the community. It should be noted that demands created by Covid were in the context of pre-existing demands on health and social care services and the limited resources to provide these'.*

20. '*These have been well documented in public over recent years. It is clear that regardless of specific social work input that there were already limited services*

for both children's and adults' disability services. Recent research from Carers UK (incorporating Carers NI) "Caring Behind Closed Doors" (2020) details that:

"Throughout the COVID-19 pandemic, the majority of carers have had to provide more care. It has left many exhausted and close to burning out. They urgently need more support to help them through winter.
The COVID-19 pandemic has had a devastating effect on the lives of carers and those they are caring for. A majority have had to provide extraordinary hours of care for loved ones with increasing needs during the crisis, often without the usual help from family and friends, and with limited or no support from local services.

As a result, many people providing care have been left exhausted, socially isolated, and close to burnout. Adding to these considerable pressures, carers have also taken a financial hit, and seen their health and wellbeing decline."

It concludes that:

- *4 in 5 unpaid carers (81%) are currently providing more care than before lockdown.*
- *More than three-quarters (78%) of carers reported that the needs of the person they care for have increased recently.*
- *Most carers (64%) have not been able to take any breaks at all in the last six months.*
- *More than half (58%) of carers have seen their physical health impacted by caring through the pandemic, while 64% said their mental health has worsened.*

While this is a national UK publication there is no reason to suggest that the picture in Northern Ireland is much different. It is also reasonable that the picture is similar across the five Health and Social Care Trusts in Northern Ireland.

21. Regarding the question as to whether the absence of a designated social worker contributed to the limited services the family received, the ISWA advised that '*There is no indication that the lack of a designated social worker has contributed to the limits of direct support services that the family could*

have received through the Trust given the issues and demands which were being confronted by Covid. The Trust has listed the services which the family did receive'.

22. When asked if the actions the Trust took appear to be reasonable or are there other actions or referrals which should have been taken but which were not, the ISWA advised that *'Referrals are noted to a number of statutory and voluntary care providers as are initial contact inquiries. These include education and day-care, respite care and residential care. There is evidence in the files of limited success in identifying and implementing services for the Complainant and her daughter.*

23. The Trust arranged a meeting with the complainant regarding the concerns that she had raised. '*This took place on 14 September 2021 and was chaired by the Head of Children's Disability Services. This meeting was also attended by a Senior Social Worker and a Senior Practitioner from the Trust. This allowed the Complainant to express her concerns and to seek clarity on current and future service provisions. Trust personnel gave clarity on the range of services that were currently, possibly available. They further explained that these limited support services needed to be prioritised. This reflected the pressures that were apparent in providing limited support for arranging of services*'.

24. In addition, the ISWA advised that the '*meeting reflected that while the Complainant and her daughter had not received all of the services and support initially outlined in her daughter's support and in the carer support documents, some support had been provided and then had to be withdrawn. Reasons for this included:*
    - *Lack of transport to access outreach services;*
    - *Concerns presented by her daughters behavioural problems;*
    - *Staffing shortages in overall provision provided by the Trust or their care Partners'.*

25. In summing up on this aspect of the advice the ISWA advised that '*It is possible to suggest that the lack of a designated social worker will have left*

the Complainant and her daughter feeling isolated and ill-informed. A key role of social work is to provide emotional support and advice on well-being and self-care. In the absence of practical services, this is an increasingly important role. However, it should be noted that social work intervention was limited largely to increased demands and the limited number of staff to carry out these roles. It should also be noted that this has been addressed and the family now has a dedicated social worker. Additionally, a range of services was provided, and contact was maintained with the family as indicated below:

- *The initial assessment was completed and a Family Support Plan was being progressed to include an application for domiciliary support and respite provision (2018).*
- *The Complainant's daughter was allocated ten hours of domiciliary support in June 2018 and her name was added to the waiting list for Lindsay House Short Break Provision.*
- *She was referred to the Children's Disability Team Intensive Support Behaviour Service and charity applications were made on the family's behalf by the initial social worker.*
- *There were a number of contacts with the Complainant by the Duty Social Worker, Allied Health Professionals and the Community Learning Disability Nursing Team.*
- *The Trust states that the senior social worker spoke directly with the Complainant during this period and acknowledged the need for respite once the service was available, although transport remained an issue that required clarification.*
- *The case was transferred to an agency social worker, in November 2020'.*

Analysis and Findings

26. A central element of this complaint is the fact that the complainant did not have a designated social worker for an extended period of time, the consequence of which was that she was left for over 18 months without professional help and assistance. The complainant said that there was a general lack of contact with

social services over this period of time, no continuity in dealing with personnel which left her with a general feeling of being left alone to cope with her situation on her own.

27. I note the Trust's response which outlined the difficulties faced within the Down Children's Disability team, relating to staff being unavailable, due to sickness and maternity leave, in addition to the pressures resulting from the Covid-19 pandemic, the case was not reallocated until November 2020. It also stated that there was limited availability from other sources such as bank staff and agencies. It stated that this was a disruptive and unsettling time for all staff who found themselves 'firefighting' and dealing primarily with emergencies and the more complex cases. The Trust did acknowledge that when a family is in need and particularly in the midst of Covid-19, parents can feel isolated and alone. It recognised that the complainant did not receive a consistent social work service between September 2019 and January 2021 and said that it acknowledged this delay and the distress caused.

28. In considering this complaint I am conscious of the timespan over which it occurred, which included, from March 2020, the consequences of the worldwide Covid-19 pandemic which had devastating effects on societies and public services everywhere. Within the context of Northern Ireland, it is also the case that the National Health Service, and the social care sector in particular, has faced multiple significant challenges over many years, before Covid-19 struck, from resource issues, staff shortages and a lack of suitable facilities and investment.

29. I also note the research, quoted by the ISWA, from Carers UK (incorporating Carers NI) stating '*The COVID-19 pandemic has had a devastating effect on the lives of carers and those they are caring for. A majority have had to provide extraordinary hours of care for loved ones with increasing needs during the crisis, often without the usual help from family and friends, and with limited or no support from local services. As a result, many people providing care have been left exhausted, socially isolated, and close to burnout. Adding to these*

considerable pressures, carers have also taken a financial hit, and seen their health and wellbeing decline."

30. This quote and the accompanying statistics are particularly stark in showing the devastating effects the global pandemic has had on individuals trying to access public services, coming on top as it did, of an already severely stretched service for both children's and adults' disability services.

31. Having said that, I note the Trust acceptance and acknowledgement that the complainant did not receive a consistent social work service between '*September 2019 and January 2021',* a period of 17 months. Having examined the timeline regarding the allocation of social workers, I would suggest that this period of inconsistent social work service may have been longer than this. The initial social worker allocated was no longer available from September 2019. An agency social worker was sourced and allocated in November 2020. However, the Trust acknowledged that at the time of a complaint from the complainant, relating to lack of support, in January 2021, the agency social worker was still in the process of familiarising herself with her allocated cases and had not yet contacted the complainant. There was then limited contact before the agency social worker left at short notice in June 2021 and the case was handed to a senior social work practitioner in August 2021. From this timeline, therefore, there would have been very little direct social work contact with the complainant between, not September 2019 and January 2021, but rather between September 2019 and August 2021, a period of 24 months.

32. I accept the advice of the ISWA that irrespective of the above, a range of services were nevertheless provided from first contact in March 2018 and there was some contact with the family, although I note that most of this interaction occurred prior to September 2019. The ISWA advised that the initial assessment and family support plan was completed to include an application for domiciliary support and respite, a referral was made to the Children's Disability Team Intensive Support Behaviour Service and charity applications. There were also a number of contacts by the complainant with the duty social

worker, other health professionals and the Community Learning Disability Nursing Team.

33. I accept the ISWA's advice that two of the key roles of social work are to provide both practical and emotional support for service users, in particular at a time of reduced public services. I note that the positive interactions and referrals referenced in the preceding paragraph in the main occurred prior to September 2019. After that time, up to November 2020, the complainant was allocated an agency social worker who had very limited contact prior to her departure in June 2021. As the ISWA advised this lack of allocation would have decreased the emotional support available to both the complainant and her daughter. I am also conscious that lack of continuity in personnel responding to the complainant's enquiries would have increased her sense of frustration. This, the ISWA states would '*possibly be detrimental on the complainant's wellbeing'*. Given the complainant's circumstances I can understand how this limited interaction with social services would have felt for the complainant from September 2019 onwards.

34. When I then take into consideration the situation from March/April 2020 when the full consequences of the Covid-19 pandemic took hold with the associated lockdowns, social distancing, self-isolation and other restrictions being implemented, I can further understand the complainant's feelings of isolation and of being left alone to cope with caring for her daughter. I agree with the statement of the ISWA that during this time '*it is apparent that a designated social worker would have presented opportunities for the family to articulate needs and anxieties'.* I consider that while a temporary gap in care provisions can sometimes be unavoidable and acceptable because of staff or resourcing issues, a period of two years is too long. The Trust accepts the complainant should have had consistency and continuity in the allocation of a social worker and that her situation warranted this.

35. I refer to the first and second Principles of Good Administration, which requires public bodies to 'get it right' in taking proper account of established good practice, and to 'be customer focused' in ensuring that people can access

services easily. Having considered the circumstances of this complaint, I am satisfied that the complainant did not have access to a designated social worker for an extended period of time, possibly for as much as two years. I consider this to represent maladministration and I uphold this issue of complaint. As a consequence, I consider the complainant sustained the injustice of frustration, uncertainty and upset. This is because there was a decrease in the level of emotional support available to both her and her daughter, as well as the time and trouble in pursuing his complaint to this office. I deal with the appropriate remedy in the conclusion of this report.

36. While making a finding of maladministration, I acknowledge the difficult position the Trust has had to work through over a prolonged period of time and acknowledge that it still continues to struggle to cope. I welcome the fact that staffing levels have improved somewhat. Nonetheless, it is no doubt the case that the National Health Service, and the social care sector in particular, have faced multiple significant challenges over many years from under resourcing and staff shortages. The effects of the recent Covid-19 pandemic and the challenges to public finances have exacerbated the challenges it continues to face. Unfortunately, the experience of the complainant is not an isolated one as evidenced by the research carried out by Carers UK and referenced by the ISWA. Without a sustained period of investment in the social care sector I fear that the complainant's experience will not be unique. It remains the case that without significant political input and commitment about resources this will continue to be the situation, at least for the immediate future.

Issue 2: Provision of respite care

Detail of Complaint

37. The complainant said that in January 2018, she was provided with a disability social worker for N who was put on a waiting list for respite at a facility, Lindsay House. The complainant said she was subsequently informed that N was at the top of a waiting list but was then told that N could not access the placement due to transport difficulties.

38. In April 2021, N was allocated outreach, which was supplied by staff from Lindsay House. She had one session which she loved. N has also had one weekend of respite at another facility, Greenhill which she also enjoyed. The complainant realises that Greenhill is a new provision/setting and going forward she is aware that it cannot be classed as permanent. There are only two beds in the setting, so the complainant accepts that realistically respite is going to be sparse, irregular and not fully permanent. Nonetheless due to a recent health scare the complainant states that she needs to find a setting where, if anything were to happen to her, she can be assured that N can secure an emergency bed and be catered for and looked after.

39. The complainant said that she finds herself in a situation where she has no support at home. Previously she had assistance from a carers agency who looked after N for 10 hours a week, but this has ceased. In addition to losing this support, N's older sister who provided help in the caring role has commenced university and is no longer available to assist. The complainant said that she feels like she is constantly firefighting day to day, that she has been let down by the people who are supposed to help. In her complaint she said '*N will be an adult soon and has much right to a life and choices as a neuro-typical person. I want her to explore things and find out who she is an what she wants to do. I don't feel like she has these options right now. Also, I am unable to work at the minute due to looking after N…*'

Evidence Considered

The Trust's response to investigation enquiries

40. The Trust stated it is its responsibility to provide short breaks in its area when this is the assessed need and to agree with parents how best to facilitate transport to the short break when they are one of its families. It stated that '*N went onto the Lindsay House waiting list on 26 August 2018…. she was never formally offered a place in Lindsay House as one did not open up…. If and when that space did become available N would have been considered, although there was no guarantee that a bed would have been allocated as it*

would have depended on the current circumstance for a range of children on the waiting list.'

41. The Trust stated that *'N was referred to the Children's Disability Service in January 2018 and an initial assessment was completed and a Family Support Plan progressed to include an application for domiciliary support and respite provision. N was then allocated ten hours domiciliary support in June 2018 and her name was added to the waiting list for Lindsay House Short Break Provision. N was also referred to the Children's Disability Team Intensive Support Behaviour Service and charity applications were made on the family's behalf.'*

42. During this period it was acknowledged that respite would be very beneficial to the family, however, **'***Lindsay House was stood down in March 2020 due to the pandemic and remained closed from June 2020. When other Short Break Units across the region were able to open up and provided limited places, Lindsay House needed to provide short term care for four children who experienced placement breakdown in the initial lockdown. In March 2020, Lindsay House operated eight beds per night, four for the South Eastern Trust and four for the Belfast Trust. Since reopening, each Trust has one bed per night, 25% of the original provision'.*

43. '*Due to the length of time parents across the Trust area were without short breaks, the Children's Disability Service developed two new services, Weekend Short Break Service in Greenhill, and Lyne Outreach Service. Both were aimed at helping support families in whatever way possible, in the face of the pandemic and ongoing restrictions.*

44. *'The Trust stated that the lack of provision for this group across education, child care, the independent sector and Trust Short Break provision had put huge pressure on families with many on the cusp of breakdown. It stated that in view of this, the Trust were very sympathetic to all its families including the complainant and N and wanted to do all it could to support them..…The complainant and N's needs were reassessed on 10 February 2021'.*

45. *‘parents are currently being offered a two day break on an eight weekly cycle and this is made clear to parents when it is offered to them. There are no plans to remove N from this eight weekly cycle. Any change to this will be determined by the ongoing assessment of need by the social worker, which is carried out in discussion with the young person where feasible, and their parent/carer. N’s Family Support assessment was updated again in November 2021 in line with the UNOCINI Family Support process’.*

46. *‘In the interests of fairness and equity of allocation, families are offered one service or the other, not both, i.e. overnight short breaks or Lyne Outreach, with the most suitable service provision being determined on assessment.*

47. *The Trust stated that the Children's Disability Service, does its utmost to support families facing emergencies, although assurances cannot be given that overnight short breaks will be available as required in the event of an unexpected emergency arising in the family. If this is the assessed need by the social worker at the time, the Trust will do all it can to provide appropriate support within the services. It is important to note N is accessing overnight short breaks in Greenhill, this is not, nor will it ever be, a provision that is in a position to provide short term care*.’

48. *In the event of short-term care being required, the Trust would look to the extended family in the first instance, and in view of the complainant’s anxieties about the future, consideration should be given to an in-depth discussion on this matter with family, friends and the social worker in terms of contingency planning for N if a worst case scenario were to arise.’*

49. Regarding domiciliary care, the Trust stated that ‘*JARK Domiciliary Care was to provide support for ten hours per week within the home. The carer left the post and a replacement was due to start at the end of May 2021, which left the family without support for a short time. A further application was made to the Beds and Family Support Panel on 13 May 2021 for additional outreach support until the JARK carer started. There was no availability for Lyne Outreach at that time and the request was added to the waiting list. The complainant did source a new direct payments care worker providing the*

support hours for a period of time but currently she receives no domiciliary care'.

Relevant Independent Professional Advice

50. The ISWA advised that '*The restrictions in services and support relating to residential care were fully detailed by the Director of the Trust in a letter to Colin McGrath, MLA, dated 12 October 2021, entitled 'Short break care for Children with Special Needs. The detail in this letter included that:*
    - *Between March 2020 and June 2020, all short break provision was closed;*
    - *When short breaks were allowed to resume again in June 2020, it was only possible to make two beds available in each unit due to the need to socially distance and maintain high levels of hygiene*.'

    The ISWA advised that these restrictions continue to be in place.

51. The ISWA also advised that prior to the pandemic, the Trust '*had four short break beds in Lindsay House. This was in addition to a further four short break beds belonging to the Belfast Trust as Lindsay House is a facility that is shared across both Trust areas. These beds were available seven nights per week for the most complex children with severe learning disabilities. The Trust stated that the short breaks provided had reduced from 58 to 21 beds per week. This in turn has resulted in less availability for families and longer periods between overnight short breaks.'*

52. *'In response to this, the Children's Disability Service secured funding to develop Outreach provision. There are currently 16 whole-time equivalent social work and social care staff going into families' homes, meeting up with both children and parents face to face to provide vital support to them at times of significant stress. Both of these developments are temporary services developed as a direct result of Covid 19 and it is anticipated these will continue whilst the short break restrictions remain in place. There are no indications at this juncture from the Public Health Agency or the Department of Health about timescales for starting to expand the number of short break beds. This has and will likely continue to be strongly influenced by the current trends in the Covid*

19 pandemic and indicates the restrictions on services and the competing demands for those services. It is not possible to comment on the demands or priorities when allocating these limited respite services in normal (non-Covid) times let alone in the particular circumstances surrounding the pandemic.'

53. In a letter to NIPSO from the Trust's Chief Executive and quoted by the ISWA, the Trust assessed and highlighted the need for respite for both the complainant and her daughter, N. However, it further details the issues in providing such services, especially with the shortage of respite care beds. '*This. in effect, meant that there was a waiting list for beds, and this was further exacerbated by the reduction in the number of beds available because of health issues related to Covid-19. Had there been further availability in residential respite this would not necessarily mean that N would have automatically received a place. The Trust has an assessment process that prioritises the needs of all clients and allocates resources accordingly.'*

54. In response to the question of whether the Trust had undertaken the required assessments, panel meetings, UNOCINI, etc to assist the complainant and the times carried out, the ISWA advised that *'there is evidence that N's needs were assessed on an ongoing basis by the Trust's Beds Panel Meeting chaired by the Head of Children's Disability Services. For example, on 13 May 2021 the Panel assessed N's needs and detailed gaps in provision. The Panel set out a plan to explore possible access to respite bed provision. The Panel report agreed that her needs should be maintained on the list and assessed on an ongoing basis. Additionally, the Panel noted information provided by the family's social worker in reaching decisions and providing a plan for the way forward. There is also evidence of the Family Social Worker advocating on their behalf.'*

55. Concerning the provision of direct payments, the ISWA advised that the initial assessment indicates that Direct Payments was discussed, and that the complainant refused this on the grounds that she did not wish to become an employer, (24 July 2018). The Carers Support Needs Review (Feb 2021) also indicates that Direct Payments was discussed with the complainant.

56. In conclusion the ISWA advised that '*While the particular circumstances surrounding this complaint is key to this report, they also need to be seen within the wider context of Trust resources and demands for those resources. This reflects the Trust's need to allocate resources across all disciplines including health, social care, hospitals, special services, and community care. Within Social Care, there is a further need to allocate resources across specific disciplines such as Children and Young People's services, Adult services, Older Peoples services, and specific services such as discharge from the hospital. As a multi-service provider, the Trust faces competing demands for resources in residential, community, and hospital care. Inevitably this has had an impact on families and individuals in need of services and support which reflect their individual circumstances. It should further be noted that circumstances continue to change and fluctuate often over short periods of time. In this environment, it is important that levels of continuity of care are maintained as far as possible. It is important that levels of social work contact are maintained. This reflects two key roles within social work which provide both practical and emotional support to service users'.*

57. *'Unfortunately, the lack of allocation on different occasions will have decreased the emotional support of both family members. It should be noted that this would possibly have been detrimental health on the complainant's well-being. This consequence for the complainant, of possible withdrawal/lack of provisions for N has been recognized by the Trust. For example, the temporary gap in care which was unavoidably caused by staff shortages was noted in SOS care needs as "mum will feel the pressure without this service for five weeks". It should be noted that the Social Worker made efforts to address this but again, due to a lack of resources, this was unsuccessful*.'

58. '*There is evidence of Trust engagement even when there was no designated social worker. Nonetheless, it is apparent that a designated social worker would have presented opportunities for the family to articulate needs and anxieties. In these instances, both the family and the Trust faced considerable challenges especially as the pandemic developed. It is fair to conclude that the Trust had*

provided an acceptable range of services and supports to the family given the challenging environment in which these were being provided.'

Analysis and Findings

59. This issue of the complaint is about the complaint's concerns over the paucity of the level of respite she received from the stage that she was first allocated a social worker and put on a waiting list in 2018. Within this area of complaint, she has expressed her concerns over potential emergency needs and the level of domiciliary care received.

60. Throughout my consideration of this complaint, I note that the Trust is fully in acceptance of the fact that N, at the time of this complaint was a child, and is now a young adult, with many needs who requires constant care both day and night. The ISWA had confirmed that N's needs have been assessed on an ongoing basis and that there is evidence of the family social worker advocating on the complainant's behalf. In response to enquiries the Trust confirmed that respite would be very beneficial to this family. It is also recognised and accepted that the care provided to N is supplied by the complainant on her own. For this reason, I note the Trust fully recognises that short breaks from this demanding role are required to support the complainant. I note that, overall, the purpose of providing short breaks to carers, in addition to the obvious benefit of enabling them to receive a break from their challenging caring role, but it also helps to avoid a crisis scenario whereby a breakdown in care would potentially arise leading to an increased demand for emergency interventions.

61. I am satisfied that respite provision is assessed as being required for the family and acknowledge that the Trust fully accepts this as being the case. I note that the complaint is regarding the amount of respite provision which has been received. In her letter of complaint to this office, the complainant said that at that stage N had only received one session of outreach support at Lindsay House and that she had received one weekend of respite at Greenhill.

62. In response the Trust explained that N was put on the Lindsay House waiting list for respite in August 2018. It accepted that when the complaint was raised with the Trust N had been on the waiting list for Lindsay House Short Breaks for a period of over two years and it acknowledged that her frustration and upset to this was both understandable and recognised. In response to the complainant's suggestion that she had been told at an earlier date, that N was at the top of a waiting list, the Trust stated that N was never formally offered a place in Lindsay House as unfortunately one did not open up. The Trust explained that staff at Lindsay House would not have access to the waiting list and would not have been in a position of giving a starting date. It stated that if and when a space had become available N would have been considered, although there was no guarantee that a bed would have been allocated as it would have depended on the current circumstance for a range of children on the waiting list at that time

63. Regarding respite after the arrival of Covid-19 in March/ April 2020, the Trust explained the devastating consequences this had on its ability to provide respite services to its clients. The ISWA confirmed between March 2020 and June 2020 all short break provision was closed. When it was reopened in June 2020 the availability of beds to the Trust was in effect more than halved, down from 58 to 21 beds per week, due to the need to socially distance and for hygiene reasons. These restrictions continue to be in place which has had the effect of, as well as reducing availability for families, resulted in families having to await longer periods between any short breaks offered.

64. I note the efforts the Trust and the Children's Disability Service have made in attempting to improve this situation and to limit the consequences of reduced respite provisions to clients. I note that outreach provisions have been developed, whereby social work and social care staff visit families in their own homes. A weekend short break service had also been developed at Greenhill. The Trust recognised, that while the development of these facilities are beneficial, they cannot bridge the gap between what is available and what is needed, particularly in the work needed with the children with disabilities who had the most complex needs and highly challenging behaviours'. The Trust

accepts that the lack of provision for this group across education, child care, the independent sector and Trust Short Break provision had put huge pressure on families with many on the cusp of breakdown. It stated that in view of this, the Trust were very sympathetic to all its families including the complainant and N.

65. I understand that more recently parents are now being offered a two-day respite break on an eight weekly cycle and that currently this is being availed of by the complainant and N. The Trust stated that there are no plans to remove N from this eight-weekly cycle. In the interests of fairness and equity of allocation, families are offered one service or the other, not both, i.e., overnight short breaks or Outreach, with the most suitable service provision being determined on assessment. I accept in such circumstances that the Trust must allocate scarce resources based on assessed need and I do not criticise its decision to offer one service or the other but not both.

66. As with the allocation of a social worker, it is evident that the provision of respite offered by the Trust has suffered from a shortage of facilities offering short break beds for persons with complex needs/challenging behavior, not only within the Trusts geographical area but throughout Northern Ireland. The Trust explained the steps it has taken to try and respond to this challenging environment to increase the number of short break beds within its locality. However, I note that in addition to the lack of public facilities available to provide respite there is reluctance on the part of the independent sector to provide this service within their facilities. This situation has existed for a number of years with the number of available beds declining in the period leading up to the covid epidemic. Covid-19, simply put, made a bad situation immeasurably worse with many facilities closing for several months. When they opened up subsequently, the number of beds available was much reduced and this remains the case today. Thankfully the complainant currently receives respite on a eight weekly cycle and the Trust has stated that there are no plans to change this.

67. The question then remains as to what fault should be attached to the Trust for the levels of respite provided to the complainant and her daughter from she first went on to the Lindsay House waiting list in August 2018. Having given this matter careful consideration and taking into account the Trust's need to allocate finite and reducing resources across all the various disciplines which it has responsibility for, I find that I do not consider the amount of respite received by the complainant and N to constitute maladministration. I consider that this particular complaint has to be seen within the wider context of the overall availability of Trust resources and the increasing demands on those services. Given the limited amount of resources allocated and available, it is inevitable that individuals whom even though they have a recognised need, will fail to be accommodated. Covid-19 has undoubtedly exacerbated and immeasurably heightened the pressures being experienced with resources having to be prioritised and allocated to those most in need and towards crisis cases. I am satisfied that, had the spaces and facilities been available that the complainant and N would have received a more acceptable level of respite care. The simple but unavoidable fact is that the spaces and facilities, in the necessary numbers, do not exist, and given the current state of public services and finances will not exist for the foreseeable future. It is the case that I cannot attribute a term such as maladministration to a situation whereby a Trust assesses and acknowledges that a level of respite would be beneficial to a family but it has not been allocated the resources to provide for this assessed need. This again is a situation which without significant political input and commitment regarding resources will continue to exist for the immediate future.

68. It is for this reason, together with a recent health scare, that the complainant has sought assurances that her daughter can be catered for in a potential emergency situation. In response to this question the Trust stated that '*In the event of short term care being required,(*which I take to refer to potential emergency care*) the Trust would look to the extended family in the first instance, and in view of the complainant's anxieties about the future, consideration should be given to an in-depth discussion on this matter with family, friends and the social worker in terms of contingency planning for N if a worst case scenario were to arise.'* Given the current difficulties being

experienced regarding the provision of respite services generally and the lack of suitable facilities, I consider that this statement from the Trust unfortunately represents the reality of an imperfect system. However, I would encourage the Trust to arrange a meeting as suggested with the complainant where '*an in-depth discussion on this matter with family, friends and the social worker in terms of contingency planning for N if a worst case scenario were to arise.'* in order that the assurances the complainant seeks can be explored. I refer to this point in the conclusions and recommendations section of this report.

69. The complainant also expressed concern over the level of domiciliary care which she has received. The complainant said that she has no support at home. Previously she had assistance from a carers agency who looked after N for 10 hours a week, but this has ceased and currently she receives no domiciliary care.

70. It is the case that N has been allocated ten hours domiciliary support from June 2018 but that this has been only intermittently received. It was initially provided by a company engaged by the Trust but staffing problems led to that ceasing. The complainant did source a direct payment care worker to provide the support hours within her own home for a period of time but again that ceased.

71. The ISWA has advised that the initial assessment indicates that Direct Payments were discussed with the complainant. This was not proceeded with, as despite the complainant's efforts, assistance could not be sourced. The ISWA also advised that the Carers Support Needs Review of February 2021 also indicates that Direct Payments were discussed with the complainant. I am aware that the direct payment system currently in place has been developed because of the shortage of facilities and staff to provide assistance to those assessed as requiring it. It is also more reflective of the desire and thrust for Trusts to be more flexible to its clients' needs and to allow families the ability to decide for themselves how care can be provided in the absence of more direct provision.

72. Whilst I can fully appreciate the difficulties and frustrations experienced by the complainant in her day-to-day life in the face of not receiving the 10 hours of domiciliary care to which she has been assessed as requiring, I am satisfied that finance from the Trust in the form of direct payments to support domiciliary care has been discussed with the Trust and would be available should it be sourced. However, a shortage of staff or personnel available to provide this service is once again the problem. The complainant said that she does not know of anyone who is available to provide the domiciliary care required and has referenced the difficulty in finding suitable people in areas outside large population centres. The Trust has indicated its willingness to pay for such a service but has pointed to the fact that agencies such as it previously engaged are increasingly no longer in this business.

73. As I am satisfied that direct payments would be available to the complainant to provide the domiciliary 10 hours care required to assist in the care of N, should a suitable person be found, I find that I am unable to make a finding of maladministration against the Trust and do not uphold this element of the complaint. Nonetheless, I am aware that increasingly a lack of people to provide assistance in the care of the most vulnerable in our society, the elderly, the sick and disabled, is placing an intolerable burden on those individuals who are providing care for loved ones, particularly those who are doing so without the support of family and friends. The ISWA advised that many in this situation have been left exhausted, socially isolated, and close to burnout, often with consequences to their own health. Whilst I cannot uphold this element of the complaint, I do have the deepest sympathy for the complainant's plight in what I consider overall to amount to systemic societal failures.

CONCLUSION

74. I received a complaint concerning the level of support received from the Trust regarding the provision of a designated social worker, the level of respite received and the provision of domiciliary care to the complainant's daughter. Following my investigation, I am satisfied that the complainant did not have access to a designated social worker for an extended period of time, possibly

for as much as two years, which I consider to represent maladministration. Consequently, I consider the complainant sustained the injustice of frustration, uncertainty and upset and a loss of opportunity through a decrease in the level of emotional support available to both she and her daughter, as well as the time and trouble in pursuing her complaint to this office. I did not uphold the complaint in respect of respite received and domiciliary care.

Recommendations

75. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified, that is the lack of a designated social worker for an extended period of time, (within one month of the date of this report). (Paragraph 34)

76. In light of the content of this report I would ask the Trust to provide me with an update (within three months of the date of this report), on the progress of its mapping for the management of unallocated cases, the restructuring of the Children's Disability Service, consultation undertaken to develop the Trust Children's Disability Strategy and its review of staffing across the Children's Disability Service as referenced in paragraphs 17 and 18.

77. In light of the complainant's concerns over the potential for the need of emergency care, I would encourage the Trust to arrange a meeting as suggested with the complainant where '*an in-depth discussion on this matter with family, friends and the social worker in terms of contingency planning for N if a worst case scenario were to arise.'* in order that the assurances the complainant seeks can be explored.(paragraph 68). Should such a meeting be arranged I would ask that the Trust provide me with a summary of the discussions held.

Margaret Kelly
Ombudsman **March 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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