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

Report Reference: 202004130

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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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Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

This complaint was about mental health care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the patient in 2021 and 2022. The patient's GP first referred the patient shortly after the death of his wife in November 2020. The patient was not only grieving the loss of his wife, but also lost the support she provided to enable him to cope with the distress of surviving historical childhood sexual abuse.

The Trust first assessed the patient in January 2021. From then until 22 November 2022, the Trust's Mental Health Assessment Centre (MHAC) conducted four mental health assessments. The patient believed the Trust's assessments were inadequate and failed to provide him with a diagnosis when he expected to receive one of post-traumatic stress disorder (PTSD). Based on the available evidence, the investigation found the Trust conducted its assessments in accordance with guidance. It also found the Trust did not reach a diagnosis following its assessments. Furthermore, the investigation did not find any evidence to suggest the patient should have received a PTSD diagnosis.

The patient raised a further concern that the Trust failed to provide him with an appropriate care plan to meet his needs. He felt '*discarded*' by the Trust's decision to discharge him and refer him to an external body. He said the Trust left him without any treatment for more than 18 months.

The investigation did not identify a failure in the care plans developed for the patient. However, it found the Trust failed to support the patient to achieve the recommendations within the care plan. It also did not communicate its decision to discharge either to the patient himself, or his GP. I was disappointed and concerned that these failures caused the patient to experience an 18-month delay before he received treatment. This is especially given the trauma the patient experienced during his childhood, and also the impact the recent loss of his wife had on his recovery. I offer my sincere condolences to the patient for his loss.

I recommended the Trust apologises to the patient for the injustice caused. I also recommended actions for the Trust to take to prevent these failures from reoccurring. The Trust acknowledged it ought to have followed up on the patient's fulfilment of the care plan during the re-assessments it subsequently carried out with him. However, generally, it denied responsibility for following up on recommendations for self-referrals included in care plans. It also maintained the patient was aware of being discharged.

THE COMPLAINT

1. This complaint was about care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the patient following its receipt of mental health referrals in 2021 and 2022.

Background

2. The patient lives with trauma caused by sexual abuse he experienced during his childhood. He received support from his wife who aided in his recovery. Sadly, the patient's wife died in November 2020.

3. The patient's General Practitioner (GP) sent a routine mental health referral to the Trust on 22 January 2021. The reason for the referral was '*depression / grief*.' The Trust conducted four mental health assessments for the patient during 2021 and 2022.

4. The patient raised a complaint with the Trust on 15 September 2022 regarding these assessments and the subsequent treatment received. The Trust issued a final response to the patient on 26 January 2023.

Issue of complaint

5. I accepted the following issue of complaint for investigation:

   Whether the Trust provided appropriate care and treatment to the patient regarding GP mental health referrals from January 2021.

INVESTIGATION METHODOLOGY

6. 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. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

- A Consultant in Adult Psychiatry with over 30 years' experience.

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

8. 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

9. 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[1]:

- The Principles of Good Administration.

10. 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 National Institute for Health and Care Excellence's Clinical Guidance on Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, Published 14 December 2011, Endorsed in Northern Ireland February 2012 (NICE CG136);
- NHS Mental Health, Your Rights – Mental Health Assessments, Last Reviewed 17 February 2022 (NHS MH Assessments); and
- UK Trauma Council's Definition of PTSD[2] and Complex PTSD (UK

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[2] Post-traumatic stress disorder.

Trauma Council on PTSD).

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

11. 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.

12. A draft copy of this report was shared with the patient and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the comments I received and, where appropriate, incorporated some of these comments into the report.

THE INVESTIGATION

Whether the Trust provided appropriate care and treatment to the patient regarding GP mental health referrals from January 2021.

In particular this will consider:

- The Trust's assessments of the patient; and
- The Trust's treatment and referral for treatment.

Mental Health Assessments

Detail of Complaint

13. The patient said the Trust failed to carry out appropriate mental health assessments following referrals from his General Practitioner (GP).

22 March and 5 December 2021

14. The patient said the Trust's assessments consisted of two 10-minute telephone calls which did not discuss his historical abuse or consider the impact this had on his mental health.

22 November 2022

15. The patient believed the Trust's assessor was not an appropriate person to provide an accurate diagnosis. He explained '*trauma is not a diagnosis*.' He

also said the Trust failed to provide a diagnosis which he requested[3].

Evidence Considered

Legislation/Policies/Guidance

16. I considered the following policies and guidance:
    - NICE CG136;
    - NHS on MH Assessments; and
    - UK Trauma Council's diagnostic criteria.

Trust's response to investigation enquiries

17. The Trust explained its Mental Health Assessment Centre (MHAC)[4] is the first point of access to mental health services within the Trust area. MHAC conducted an initial assessment of the patient's '*presenting needs*.' The aim is to identify what further support a patient may require and develop a plan to best meet their needs. MHAC's primary function is to '*signpost or refer*' the patient to other services, which the Trust or external agencies deliver.

22 March 2021

18. The Trust stated the patient first presented to them for mental health assessment via referral from his GP. A Community Practice Nurse (CPN) initially assessed the patient by telephone. The Trust stated this was a '*detailed and comprehensive assessment*' of the patient's mental health. An initial assessment *'generally'* takes one or two hours.

5 December 2021

19. The Trust stated this was a telephone re-assessment to include a review of '*demographics*' and focus on a '*careful assessment*' of the current presenting symptoms.' The Trust already recorded the patient's social history from the March assessment to which the assessor had access. A re-assessment '*generally*' lasts approximately one hour.

[3] This was stated in the GP urgent referral to the Trust dated 6 September 2022.
[4] Provides a single point of entry to a stepped care model for the delivery of mental health services.

26 September 2022

20. The Trust's Complaints Investigation Overview Report stated it triaged the GP's urgent referral on 7 September 2022. Based on Triage Guidance, the Trust '*downgraded*' the referral to routine.

22 November 2022

21. The Trust stated the assessor was a psychiatrist. It explained the term speciality doctor refers to their grade and not their speciality. The Trust stated it conducted a '*thorough assessment'*. This included a standard history, mental state examination, reading written correspondence provided by the patient's daughter, and taking a collateral history from the patient's friend.

Complainant's Response to Draft Report

22. The complainant said his mental health treatment has been *'non-existent'* and the way the Trust treated him has been '*abhorrent'*. He highlighted a more recent assessment, beyond the scope of the present investigation, also failed to diagnose him with PTSD. He continued to dispute the lack of a PTSD diagnosis.

Relevant Trust Records

23. I enclose relevant extracts of records considered at Appendix five to this report.

Relevant Independent Professional Advice

24. A summary of the independent professional advice is enclosed at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

25. The patient said the Trust did not:
    - Discuss his historical abuse or consider its impact on his mental health during its assessments;
    - Provide an appropriate assessor; and
    - Provide him with a diagnosis.

I will consider each of these in turn below.

The assessments

26. NICE CG136 states an assessment '*will cover all aspects of [the patient's] experiences and life*[5].' The healthcare professional when carrying out an assessment[6] should ensure there is enough time for the patient to describe and discuss their problems.

27. I note the Trust's records of the 2021 assessments state the calls lasted one hour. Neither the Trust nor the patient were able to provide a copy of their telephone records to establish the length of the calls. I have therefore been unable to verify this. However, the IPA considered the notes of the calls and advised they likely took between 40 and 60 minutes. He advised this suggested '*a comprehensive interview'* took place.

28. NICE CG136 also states that clinicians should offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed.

29. The assessment reports did not document the abuse the patient experienced. However, they did record in detail how the abuse impacted the patient's health. The IPA advised that discussing abusive experiences can be traumatic for patients. Therefore, it is '*best left for therapy'*. The IPA advised the Trust's assessments were '*appropriate*' as the clinicians did not ask for details of the abuse.

30. The records also document that the Trust provided the patient with details of several community services. The IPA advised this is evidence of '*support given'*.

31. The IPA advised it is for these reasons that each of the Trust's assessments '*met all the relevant standards*' as set out by the NHS and NICE CG136. I

[5] Section 1.3.2.
[6] Section 1.3.3 relevant to the complaint.

accept this advice. I have not identified any failure in the care and treatment the Trust provided during its assessments of the patient.

The assessor

32. The patient believed the Trust's assessor in November 2022 was not an appropriate person to provide an accurate diagnosis. The Trust stated the assessor was a '*Speciality Doctor in psychiatry…a psychiatrist.*' The IPA advised the assessor was a *'Specialist Psychiatric Registrar.'*

33. The NHS guidance on MH Assessments lists the healthcare professionals a patient may speak with during an assessment. The IPA advised the assessment in November 2022 fulfilled *'all the standards'* of this guidance. I am therefore satisfied the assessor was an appropriate person to conduct the assessment. I have not identified any failure for this element of the complaint.

Diagnosis

34. The patient said the Trust failed to provide him with a diagnosis as he requested.

35. The IPA advised that a clinician may not reach a diagnosis following an assessment. The records evidence that for each assessment, the Trust documented and acknowledged '*the distress suffered'* by the patient and concluded he '*did not suffer from a diagnosable mental disorder*.' The IPA further advised that during the patient's final assessment on 22 November 2022, diagnosis was '*mentioned…only to say'* the patient's symptoms '*did not reach the level of severity required to make a diagnosis of PTSD*.' Therefore, the Trust made '*no psychiatric diagnosis'* following its assessments. The IPA advised this was '*reflective of good practice*.'

36. However, the patient believed he may have PTSD or complex PTSD, which the Trust did not diagnose.

37. I refer to the UK Trauma Council's diagnostic criteria[7] for PTSD. It states that

[7] The IPA advised these criteria use the diagnostic guides DSM-5 and ICD-11.

PTSD is the diagnostic label used to describe a particular profile of symptoms that people sometimes develop after experiencing or witnessing a potentially traumatic event or events. However, the difficulties experienced may not fulfil the criteria for PTSD. I enclose a copy of the criteria in Appendix three of this report.

38. In relation to a PTSD diagnosis, the IPA reviewed the patient's history and mental state examination. He agreed with the Trust's assessment outcome that the patient '*did not reach the level of severity required to make a diagnosis of PTSD*.' Based on his advice, I have no reason to question the Trust's decision not to diagnose the patient with PTSD. I have therefore not identified a failure in care and treatment for this element of the complaint.

39. The NICE CG136 states that if a patient is '*unhappy*' about the assessment and diagnosis, the clinician should offer them the opportunity for a second opinion.[8] The Trust advised it did so and the patient received a second opinion in June 2023. I note the decision regarding the PTSD diagnosis did not change.

The Trust's treatment and referral for treatment

Detail of Complaint

40. The patient said the Trust failed to provide an appropriate care plan to meet his needs. He felt '*discarded*' by the Trust's decision to discharge him and refer him to an external body, Nexus. He said the Trust did not inform him it discharged him, and he does not understand its reasons for doing so. He said, prior to his referral, the Trust did not consider if he met the criteria to receive treatment from Nexus. The Trust left him without any treatment for more than 18 months.

Evidence Considered

Policies/Guidance

41. I considered the following policies and guidance:
    - NICE CG136;
    - Nexus website; and
    - MHACP10 Discharge Procedure.

[8] Section 1.3.4.

Trust's response to investigation enquiries

42. The Trust stated signposting a patient to voluntary services such as Nexus was a common assessment outcome. Nexus offers specialist counselling to patients affected by sexual trauma.

43. The Trust's practitioner on 22 March 2021 felt the patient could benefit from such therapy. The Trust did not identify a clinical need to refer the patient to a secondary care community mental health service.

44. The Trust stated on 5 December 2021 that it determined the patient continuing to await Nexus counselling was '*the most appropriate course of action*.' The Trust's assessor understood the patient would contact Nexus regarding timeframes and that the patient was agreeable to the management plan.

45. Further assessments recommended other patient support, including referral to Action Mental Health and Benefits Advocacy.

46. The Trust stated, following assessment on 22 November 2022, it referred the patient to a Clinical Psychologist. The patient continued with Nexus treatment in the interim.

47. The Trust apologised to the patient for any confusion around responsibility for contacting Nexus.

Trust's Response to the Draft Report

48. The Trust stated the MHAC is an initial point of contact service, generally offering a one-off, initial mental health assessment. This assessment determines if secondary mental health services are needed. If so, it makes the appropriate onward referral. If not, its case with the patient is closed. A common outcome is signposting to the community or voluntary sector.

49. The Trust stated its assessment of the patient, and its outcome, was communicated verbally to the patient, who agreed with the proposed care plan. It also stated it would have made the patient aware verbally there was no

further follow up arranged with the Trust. However, it acknowledged it did not reinforce this with written documentation. The Trust stated it is exploring the possibility of improving its digital records system (Encompass), to ensure its functionalities for recording and communicating the outcome of initial assessments are adequate.

50. The Trust stated it does not accept it was its responsibility to check the patient had self-referred to Nexus and to establish the waiting time for this service, as it was not receiving him into secondary care services after assessment. It may have been good practice to do so, but it is up to the patient to refer themselves if they wish.

51. The Trust stated monitoring self-referrals would be difficult due to staffing levels and referral rates. It is also hesitant to do so because it prefers to promote autonomy for patients. Nevertheless, the Trust stated, at each re-assessment of the patient after the initial one, when the self-referral to Nexus was recommended in the care plan, it ought to have confirmed the patient had carried this out. The Trust stated it will undertake a review of its referral and discharge processes, and this will explore actively encouraging vulnerable patients to pursue self-referrals, and seeking permission to include families or carers in the follow up process.

52. The Trust stated it intends to improve its management of patients' expectations in terms of waiting times by seeking a quarterly update on this from the main community and voluntary agencies, which it will then communicate to patients. It will also develop a leaflet explaining the services provided by the MHAC, to help manage the expectations of patients who attend for an initial assessment.

Complainant's Response to Draft Report

53. The complainant said the Trust discharged him without putting him on a waiting list for treatment. Although the Trust recommended self-referral to Nexus, it is a separate organisation from the Trust and it could not be sure Nexus would ever treat him.

Relevant Records

54. I enclose relevant extracts of records considered at Appendix five to this report.

Relevant Independent Professional Advice

55. A summary of the independent professional advice is enclosed at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

The care plans

56. The patient said the Trust failed to provide an appropriate care plan to meet his needs. Section 1.4 of NICE CG136[9] provides guidance on care plans. It recommends discussing strategies with the patient and incorporating these into their care plan.

57. The Trust's records evidence that it developed care plans with the patient following his assessments. Each of the care plans documented information and advice provided to the patient. The IPA advised the care plans evidence the Trust referred the patient to a wide variety of sources of support and treatment including community resources for survivors of sexual abuse, trauma and bereavement. He further advised that each of the Trust's care plans '*met NHS and NICE recommendations for care plans in adult mental health services'*. I accept this advice.

58. Section 1.4 of NICE CG136 also states that bodies should '*Develop care plans jointly'* with the patient. I considered the Trust's assessment documentation. Each assessment documents that the Trust '*discussed'* and *'agreed'* the plan/recommendations with the patient. The 2021 assessments document the patient's verbal agreement, which he gave either over the telephone or in person in November 2022. The patient also signed the September 2022 assessment[10]. I am therefore satisfied that the patient agreed with the care plans the Trust developed.

[9] Section 1.4 on Community Care.
[10] As enclosed in Appendix 5C.

59. Based on the available evidence, I have not identified a failure in the Trust's development and communication of the patient's care plans.

Referral to Nexus

60. The complainant raised concern with the Trust's decision to refer him to Nexus as part of his care plan. The Trust stated it felt the patient could benefit from therapy from Nexus who provide specialist counselling for sexual trauma.

61. The Trust recommended the patient '*self refer to Nexus for therapy*' following his first assessment on 22 March 2021. The IPA advised this was a '*reasonable piece of advice*.' However, he noted the second and third assessments, on 5 December 2021 and 26 September 2022, documented that Nexus had not yet contacted the patient. In fact, '*Nexus involvement'* was not recorded until the November 2022 assessment.

62. The IPA advised that after making the recommendation in March 2021, it was '*the Trust's responsibility to check that the self-referral had been made*' and to '*establish the approximate waiting time*.' However, in response to investigation enquiries, the Trust said[11] it did not have any '*formal communication'* with Nexus.

63. The IPA also noted there was no evidence prior to the September 2022 assessment to suggest the patient did self-refer. He advised the patient's '*literacy problems may have impacted that*.' The IPA further advised that the Trust '*failed to check'* the patient had self-referred and received treatment '*within a reasonable time*.'

64. I also considered the Trust's assessment forms, which included a section for entering the '*Expected waiting time for service/Estimated waiting time for onward referral.*' I note this section is blank on each of the forms completed[12] for 22 March 2021, 5 December 2021 and 26 September 2022.

[11] By letter dated 27 March 2024.
[12] Enclosed in Appendix five.

65. NICE CG136 requires mental health staff to '*provide support to help [the patient] realise the plan*.' This guidance, and the IPA's advice, indicate it was the Trust's responsibility to follow up on the status of the self-referral, to make sure the patient had self-referred appropriately, and to ascertain the approximate waiting time for treatment.

66. However, I note in its response to the draft report the Trust stated following up on self-referrals is beyond the function of the MHAC. It therefore disputed the relevance of NICE CG136 and disagreed with the IPA's advice. I have taken this viewpoint into consideration, and I accept it may not be usual practice for the MHAC to follow up on the self-referrals it recommends after an initial assessment.

67. Nevertheless, in the same response, the Trust also acknowledged it ought to have followed up on the patient's self-referral to Nexus during subsequent re-assessments on 5 December 2021 and 26 September 2022. Therefore, although the Trust did not accept it had responsibility for following up on the patient's self-referral to Nexus after the initial assessment carried out on 22 March 2021, I am nevertheless satisfied it accepted responsibility for following up on the self-referral as part of its re-assessments of the patient, which it failed to do. This is especially pertinent given the patient's literacy issues.

68. Therefore, due to its failure to follow up on the self-referral to Nexus during later re-assessments, I am satisfied the Trust failed to fulfil its duty to support the patient to realise the care plan it developed with him. I consider this a failure in the patient's care and treatment.

69. I note the Trust apologised to the patient for any '*confusion*' around the responsibility for contacting Nexus. While I appreciate the Trust's decision to apologise to the patient, I do not consider it fully recognised that the failure occurred due to its own inaction. Given the patient's difficult circumstances, which the Trust was fully aware of, it is of deep concern to me that it allowed the situation to continue for so long without checking if the patient completed

the self-referral. This is despite the Trust having clear knowledge at each re-assessment that Nexus had not yet become involved. The IPA advised that the Trust's failings '*left the patient without adequate care for at least 16 months*[13].' Therefore, I am satisfied that the failure identified caused a vulnerable patient to sustain the injustice of a loss of opportunity to receive earlier treatment, frustration, and uncertainty.

Discharge

70. The patient said he felt '*discarded*' by the Trust's decision to discharge him from its mental health services, which left him without treatment for 18 months. He telephoned the Trust on 15 September 2022[14] and reported that he '*wasn't told he was discharged and doesn't understand why*.' He stated he was '*supposed*' to be getting treatment from Nexus.

71. The IPA advised it is common practice for a Trust to discharge a patient from its mental health services following a mental health assessment and the development of a care plan. This is also if the care plan '*does not involve the community mental health team*'. The IPA advised that as this was the case for the patient, the Trust's decision to discharge the patient was '*reasonable and appropriate*.' I accept that advice.

72. The IPA further advised the Trust should inform the patient and GP of its discharge decision. The Trust's Discharge Procedure requires clinicians to complete '*Closure/Transfer Forms'* when processing a discharge. I note the Trust completed these forms following each assessment in compliance with its procedure. I also note the patient's Closure/Transfer Form following his assessment on 5 December 2021 documented; '*no further MHAC role*.'

73. However, there is no evidence in the records that the Trust informed the patient of its decision to discharge him from its service. Furthermore, while the accompanying letter to the GP[15] stated it would follow up the Nexus referral, it did not confirm a cessation of the MHAC role or that the patient was being

[13] Sic 18 months.
[14] Enclosed in Appendix 5C.
[15] Enclosed in Appendix 5B.

discharged. Therefore, there is no evidence the Trust communicated its decision to the patient or to the patient's GP.

74. Section 1.7 of NICE CG136 requires clinicians to plan discharge '*carefully beforehand'* and ensure the process is '*structured and phased'*. I am disappointed that for the reasons outlined, there is no evidence to suggest the Trust involved the patient in its plan to discharge him. Therefore, I do not consider the Trust acted in accordance with this NICE guidance during its discharge process.

75. The guidance also refers to collaboration with other services and requires clinicians to support patients during the referral period. Again, I do not consider the Trust acted in accordance with this guidance, as there is no evidence to suggest it informed the patient's GP of the decision to discharge.

76. In its response to the draft report the Trust stated the patient demonstrated awareness of being discharged during a phone call '*following the assessment in 2022'*, in which he *'spoke badly of being discharged'*. However, this is a misquotation of a phone call record from 14 September 2022, in which the Trust recorded the patient *'complained about being discharged…and spoke badly of [a staff member] doing his last MHAC assessment'*. This phone call took place nine months after the patient's last assessment with the MHAC (on 5 December 2021) and twelve days before his next one (on 26 September 2022). The patient was clearly referencing his discharge nine months prior during this phone call. It is therefore inaccurate to describe the record of this phone call as constituting evidence the patient demonstrated contemporaneous awareness of being discharged.

77. I therefore consider the Trust failed to provide appropriate care and treatment to the patient when it discharged him from his mental health service. In doing so, I am satisfied the patient sustained the injustice of uncertainty and frustration.

78. I note the Trust's Discharge Procedure MHACP10 provides details of services a

patient may be '*discharged t*o' which includes: '*Advised to make a self referral to the Voluntary sector e.g. Relate, Nexus*'. The procedure outlines the process for onward referral for services such as Acute Community Services[16]. However, it does not provide guidance on the process to follow for a self-referral to a voluntary service such as Nexus. This lack of clear procedure, and the lack of clear communication about the scope of the MHAC's role, may have contributed to the failings. I would ask the Trust to consider this when it next reviews its procedure.

CONCLUSION

79. I received a complaint about the care and treatment the Trust provided to the patient following referrals for mental health assessment from his GP.

80. In respect of the mental health assessments, the investigation established these were compliant however, they did not identify or provide opportunity for delays in treatment to be monitored or addressed.

81. In respect of the patient's treatment, the investigation established the Trust appropriately discussed and agreed the care plans with the patient as required. However, the Trust failed to provide the necessary support to ensure the treatment, it recommended, was received by the patient to meet his needs it identified. The Trust also failed to ensure the treatment would be available in reasonable time. These failures resulted in a delay to the patient receiving appropriate care and treatment.

82. I note the Trust received the referral from the patient's GP in January 2021 which was three months after the death of his wife in November 2020. The referral documented that the patient had a history of sexual abuse as a child and by confiding in his wife he had been '*able to manage this over the years*.' Due to the loss of his wife and her support, the patient sought help and communicated to the Trust on 22 March 2021 that the impact of his historical abuse was '*more significant'* as documented in the Trust records above. Despite the patient's disclosures and his needs as identified by the Trust, it left

[16] Etc. as documented in Appendix four.

the patient without appropriate treatment for his '*very distressing symptoms*[17]*'* for an 18-month period. I recognise this caused the patient to feel '*discarded*' by the Trust and the failings caused the patient to sustain the injustice of a loss of opportunity to access healthcare. I further recognise this caused the patient and his family frustration and uncertainty during an already difficult time.

Recommendations

83. In its response to the draft report the Trust outlined several steps it could take to improve its service and prevent the failures identified in this report from happening again. This included improving its digital records system, seeking regular updates from community and voluntary organisations about waiting times, and creating a leaflet to explain the role of the MHAC to patients. I welcome this learning.

84. In addition to the above learning, I recommend that within **one month** of the date of the **final report**, the Trust provides to the patient a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified.

85. I further recommend for service improvement and to prevent future recurrence, that within **three months** of the date of the **final report** the Trust should:
    i) Share the findings of this report with relevant staff to provide them with an opportunity to reflect on the findings identified;
    ii) Conduct a review of its referral/discharge process. The review should consider how staff monitor patients' self-referrals to voluntary services, particularly when it carries out subsequent re-assessments of patients, and the support it provides to service users who transition between services. Following this review, provide training to relevant staff on any changes to the referral/discharge processes;
    iii) Provide training to relevant staff on the requirement to communicate discharge decisions to both patients and their staff; and

[17] As described in the IPA's conclusions.

iv) Implement an action plan to incorporate these recommendations and provide me with an update. 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 **March 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.