Investigation of a complaint against Belfast Health and Social Care Trust

Report Reference: 201916654

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

SUMMARY ………………………………………………………… 4

THE COMPLAINT ………………………………………………. 5

INVESTIGATION METHODOLOGY …………………………. 7

THE INVESTIGATION ………………………………………….. 9

CONCLUSION …………………………………………………... 23

APPENDICES …………………………………………………… 26

Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201916654

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about how the Belfast Health and Social Care Trust (the Trust) handled requests the complainant made to it for a determination of his late father-in-law's eligibility for continuing healthcare (CHC).[1] The complainant's father-in-law is referred to in this report as 'the Resident'.

The complainant said the Trust informed him initially that CHC was not available in Northern Ireland. Later, despite him highlighting to the Trust that guidance the Department of Health had issued indicated that there was provision for CHC in Northern Ireland, the Trust did not determine whether the Resident was eligible for it.

I obtained all relevant documentation and records from the Trust, together with the Trust's comments on the issues the complainant had raised. I also obtained the Resident's GP records, and records and notes from the nursing home in which he resided during the period my investigation examined. In addition, I sought the advice of an independent professional adviser.

My investigation found that the Trust completed appropriate assessments of the Resident's needs, both before his admission to the nursing home and subsequently. However, it did not determine the nature of his primary need, and consequently his eligibility for CHC, in accordance with the Department of Health's policy direction and guidance that applied at the time. I found too that the Trust failed to provide appropriate responses to the complainant when he asked it to assess the Resident's eligibility for CHC, in that information it provided was inaccurate and misleading.

I upheld the complaint. I recommended that the Trust provide a written apology to the complainant and that it implement a number of service improvements.

The Trust accepted my recommendations.

[1] At the time the complainant submitted his complaint to my Office (July 2020), 'Continuing Healthcare' (CHC) was the term used in Northern Ireland to describe the practice of the health service meeting the cost of any social need which was driven primarily by a health need. Essentially, this meant that if an individual's primary need was for healthcare, rather than for social care (also known as personal social services), they did not have to pay for the care they received, irrespective of where that care was provided. A new policy for determining eligibility to CHC was introduced in Northern Ireland in February 2021. However, that 2021 Policy was quashed by a High Court Judicial Review judgement on 30 June 2023, citation no:]2023] NIKB 72.

THE COMPLAINT

1. This complaint is about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant made the complaint on behalf of his late father-in law, who is referred to in this report as 'the Resident'. It concerns the Trust's handling of requests the complainant made to it for a determination of the Resident's eligibility for continuing healthcare (CHC).

2. The complainant informed me that the Resident was discharged from hospital to a nursing home at the beginning of August 2016. He said he *'requested a "Continuing Healthcare Funding" (CHC) Assessment'* for the Resident because he and other members of the Resident's family considered his needs *'were complex and primarily healthcare rather than social needs'*. The complainant said, *'despite the assessment for the determination of health and social care needs being set out in HSC (ECCU) 1/2010,*[2] *paragraph 17'*, the family '*[was] informed that Northern Ireland did not/does not have CHC funding'*.

3. The complainant also said that despite further requests to the Trust, the Resident's eligibility for CHC was never determined. He informed me that the Resident passed away during the Covid-19 pandemic.

4. The complainant said the Trust's actions meant that '*despite [the Resident's family's] advocacy and tenacity, [the Resident] did not have an assessment of his needs'.* He also said the Trust had *'acted with secrecy and not with a duty of candour'* and he stated that the Trust's verbal responses – *'that there was no such thing as CHC in NI*' – were contradictory to policy and guidance issued by the Department of Health. The complainant said too that the process of requesting the determination of the Resident's eligibility for CHC had *'led to a year long series of frustrating delays, denials and maladministration.'* He expressed the view that if the Trust had determined the Resident's eligibility for CHC when it was requested, his family *'would have been much clearer as to his options in his care setting'*.

[2] Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance; issued by the (then) Department of Health, Social Services and Public Safety on 11 March 2010.

Background

5. The Resident was admitted to hospital on 2 July 2016, having suffered a seizure and respiratory arrest. On 18 July 2016, the Trust completed an assessment of his care needs. It was recommended that the Resident's best interests would be met by a temporary nursing home placement, with a view to this placement becoming permanent. The Resident was discharged from hospital on 1 August 2016 and became a resident of a local nursing home ('the Nursing Home').

6. On 20 June 2019, the complainant telephoned the Resident's key worker ('the Key Worker') to request an assessment of the Resident's eligibility for CHC. The complainant spoke to the Key Worker again on 24 June 2019. The Key Worker advised the complainant that CHC did not exist in Northern Ireland. She also advised he put his request to the Trust in writing.

7. The complainant wrote (by post) to the Trust's Care Review and Support Team (CReST) on 27 June 2019 about the Resident's eligibility for CHC. He contended that the Resident's needs were *'primarily health care needs and [were] far beyond that provided for under "social care".'* He also referred to the Department of Health's guidance on CHC in Northern Ireland,[3] highlighting this stated that the Trust had no authority to charge for healthcare provided in a nursing home.

8. On 27 January 2020,[4] the CReST Assistant Services Manager wrote to the complainant in response to his letter of 27 June 2019 to CReST. In setting out the Trust's *'approach to the issue of Continuing Health Care'*, the CReST Assistant Services Manager advised the Trust *'[does] not place patients with continuing health care needs in nursing homes'.* She also advised the Trust *'does not provide continuing health care assessments for the purposes of abatement of nursing home fees'.*

[3] Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance, March 2010 ('the 2010 Circular')

9. The complainant responded to the CReST Assistant Services Manager's correspondence in a letter the Trust's Complaints Department received by email on 17 February 2020 and by post on 20 February 2020. In his letter, the complainant reiterated the Resident's family's understanding of CHC in Northern Ireland and stated the family was making a formal complaint about the Trust having *'denied [the Resident] his right'* to have his eligibility for CHC assessed. The complainant also indicated the family's aim was to have a *'comprehensive assessment of need'* completed for the Resident, and that they expected this '*to be backdated to when he was first admitted to hospital and when the discharge planning process commenced'.*

10. The Trust's Interim Director of Community Learning Disability and Community Older People wrote to the complainant on 8 July 2020, providing the Trust's response to his complaint. The letter advised that the outcome of the assessments completed at the time of the Resident's admission to the Nursing Home was that *'his primary need was for social care and therefore he had no entitlement to [CHC]'*. In addition, the letter stated that the Trust did not *'routinely place patients with Continuing Healthcare needs in Nursing Homes, as these facilities would not be able to meet their clinical needs.'* It also stated, *'There is currently no policy framework for the abatement of charges for clients when a Care Home placement is considered appropriate to meet a person's needs'.*

11. Being dissatisfied with the Trust's response, the complainant submitted his complaint to my Office.

Issue of complaint

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

    Whether the Trust correctly followed the Department of Health's guidance in relation to the Resident's continuing healthcare assessment.

INVESTIGATION METHODOLOGY

13. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation and records together with its comments on the

issues the complainant had raised. The Investigating Officer also obtained the Resident's records and notes from the Nursing Home, as well as his GP records.

Independent Professional Advice

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

    - a Registered Nurse with 40 years' experience, including 20 years' experience within NHS Continuing Healthcare.

15. The IPA provided me with 'advice'. How I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

17. The general standards are the Ombudsman's Principles:[5]

    (i) The Principles of Good Administration; and
    (ii) The Principles of Good Complaint Handling.

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

19. The specific standards relevant to this complaint are:

    (i) The Health and Personal Social Services (NI) Order 1972 ('the 1972 Order');

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

(ii) Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance; issued by the (then) Department of Health, Social Services and Public Safety on 11 March 2010 ('the 2010 Circular);

(iii) Circular ECCU1/2006, HPSS Payments for Nursing Care in Nursing Homes, issued by the issued by the (then) Department of Health, Social Services and Public Safety on 10 March 2006 ('the 2006 Circular'); and

(iv) Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system, issued by the Department of Health on 12 May 2021 ('the 2021 Circular').

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

21. I shared a draft copy of this report with the complainant and the Trust whose actions are the subject of the complaint, to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Trust submitted comments in response. I gave careful consideration to all the comments I received before finalising this report.

THE INVESTIGATION

Detail of complaint

22. The complainant expressed his dissatisfaction with how the Trust handled requests he made to it for the Resident's eligibility for CHC to be determined. He said the Trust's position that there was no provision for CHC in Northern Ireland was contrary to the Department of Health's policy and guidance. He is aggrieved too that the Trust failed to determine the Resident's eligibility for CHC before he passed away.

Evidence Considered

Legislation, Policies and Guidance

23. I considered the following legislation, policies and guidance:

- The 1972 Order;
- The 2010 Circular;
- The 2006 Circular; and
- The 2021 Circular.

The Trust's response to investigation enquiries

24. I made written enquiries to the Trust about the issues the complainant raised.

Documentation and records examined

25. I completed a review of the copy documentation the Trust provided in response to my investigation enquiries; the records I obtained from the Nursing Home; and the Resident's GP records. The documentation I examined included records relating to the assessment of the Resident's needs prior to his discharge from hospital to the Nursing Home; records relating to reviews of the Resident's needs that were completed while he was resident in the Nursing Home; and the Trust's file relating to its handling of the complainant's correspondence of 27 June 2019 to CReST and the complaint he made on 17 February 2020.

Independent Professional Advice

26. I considered the advice I obtained from the IPA. This advice concerned the assessment of the Resident's care needs, both prior to his discharge from hospital on 1 August 2016 and during the period he was resident in the Nursing Home (1 August 2016 to 9 May 2020).

The complainant's response to the draft report

27. The complainant said in his view, the Resident had a primary health need, particularly during his last weeks of life and that *'the real test would have been to have assessed the [Resident] whilst he was alive. This was denied to us by the maladministration of the Trust'.*

Analysis and Findings

28. Before I set out my investigation findings, I should highlight that in February 2021, the Department of Health published the outcome of a public consultation it launched in June 2017 on future arrangements for CHC in Northern Ireland. Later, in May 2022, the Department issued guidance[6] on a new policy for determining CHC eligibility. The introduction of this new policy means eligibility for CHC is now based on the application of a single eligibility criterion.

29. The new single CHC eligibility criterion is whether an individual's care needs can be properly met in any setting other than a hospital. If the answer to this question is 'yes', then the individual will not be eligible for CHC and will be subject to the relevant charging policy for the care they receive.

30. It is important to highlight that the new single eligibility criterion policy came into effect on 11 February 2021, so it did not apply during the period my investigation examined. Indeed, that policy was quashed by the High Court in Northern Ireland in a Judicial Review decision issued on 30 June 2023 citation no. [2023] NIKB 72. The High Court judgement also made comment on the policy framework in relation to CHC in Northern Ireland and that it was available in settings other than hospitals including nursing homes.[7]

31. The policy that is relevant to my consideration of this complaint is the one set out in the 2010 Circular, which was that an individual's eligibility for CHC is determined on the basis of an assessment of the nature of their primary need. I will therefore refer to this policy in setting out my findings on this complaint.

32. In considering this complaint, I am mindful that the 1972 Order (the main legislation governing the provision of health and social care services in

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[6] Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system ('the 2021 Circular')

[7] The Judicial Review on 30 June 2023 citation no. [2023] NIKB 72 examined the impact and delivery of the 2021 policy. In quashing that policy, the Judge determined the policy was '*in breach of its obligation to have due regard to the need to promote equality between persons of different age under section 75 of the Northern Ireland Act 1998'* and that *'the screening exercise did not begin to properly consider the true impact of the new policy on older people'.* Section 75 of the Northern Ireland Act 1998 is a legal provision that requires public authorities to promote equality of opportunity and good relations.

Northern Ireland) does not provide an explicit statutory framework for the provision of CHC, nor does it expressly require that CHC be provided to people in Northern Ireland.

33. That said, I am aware that the 2010 Circular (which sets out the Department of Health's guidance on charging for social care (also known as 'personal social services') provided in residential care homes and nursing homes) states at paragraph 63, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential or nursing home accommodation arranged by a [Health and Social Care] Trust.* ***There is no such requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home'*** (the 2010 Circular's emphasis). This means there is a clear, and important, difference between healthcare and social care, in terms of an HSC Trust's legal authority to charge for the care provided to an individual who has moved into a residential care or nursing home.

34. The significance of the distinction between healthcare and social care was reinforced by the (then) Minister of Health when he responded in September 2013 to a Northern Ireland Assembly Question[8] about CHC. The Minister stated, *'… an individual's primary need can either be for health care – which is provided free – or for social care for which a means tested contribution may be required.'*

35. I note that the difference between charging for healthcare and for social care was highlighted in the Department of Health's June 2017 public consultation document on future arrangements for CHC in Northern Ireland. The consultation document stated that where an assessment of an individual's needs *'indicate[s] a primary need for healthcare, [the relevant HSC Trust] is responsible for funding the complete package of care in whatever setting. This is what is known as continuing healthcare in the local context. Alternatively a primary need for social care may be identified and where such a need is met in*

[8] Assembly Question AQW 25318/11-15

a residential care or nursing home setting, legislation requires the HSC Trust to levy a means-tested charge.'

36. Given the significance of the distinction between healthcare and social care, in relation to a Trust's authority to apply charges for the care an individual receives, I should highlight the advice I obtained from the IPA on the difference between the two.

37. The IPA advised that healthcare in the community is provided free of charge and is delivered through services such as GP surgeries, therapy services and specialist health teams, such as mental health. The IPA advised too that an individual's identified health needs are normally met either directly by, or under the supervision of, registered nurses, therapists, dieticians, audiologists etc., depending on the specialism required to meet the identified healthcare need.

38. The IPA highlighted that a definition of personal care (or social care) is provided in Annex D to the 2010 Circular. She pointed out this states that personal care *'includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on alcohol or drugs; or past or present mental disorder …'.* The IPA also advised that a further definition of personal care is provided in the Department of Health's 2006 publication, 'Payments for Nursing Care'.[9] She highlighted this states that personal care is *'care you need to help you in the activities of daily living; for example, help with toileting and other personal needs like bathing, dressing and undressing, getting in and out of bed, moving around and help with feeding. It might also cover advice, encouragement and supervision in these activities. Care assistants rather than registered nurses will usually see to your personal care needs.'*

39. For the sake of clarity, I should also highlight the difference between social care and nursing care. This difference is important because the 2006 Circular (paragraph 2) explains that HSC Trusts are responsible *'for paying the cost of nursing care of residents who otherwise pay the full cost of their nursing home*

[9] https://www.nidirect.gov.uk/sites/default/files/2021-11/hpss-payments-for-nursing-care-information-leaflet.pdf

care.' The IPA pointed out that the Department of Health's 'Payments for Nursing Care' publication describes nursing care as *'care by a registered nurse in providing, planning and supervising your care in a care home providing nursing care. It does not include any time spent by any other staff, such as care assistants, who may also be involved in your care. However, it would include the time spent by a nurse in supervising the care you get from others and in monitoring any aspects of your care delegated to other staff'.*

40. I now return to my consideration of the Trust's handling of the complainant's requests for an assessment of the Resident's eligibility for CHC. I examined the Trust's handling of the complainant's verbal request of 20 June 2019 and his written requests of 27 June 2019 and 17 February 2020.

Verbal request of 20 June 2019

41. I note that during a telephone conversation with the Key Worker on 20 June 2019, the complainant made a verbal request for the Resident's eligibility for CHC to be determined. The Trust's record, dated 24 June 2019, of the complainant's telephone conversation with the Key Worker documents that the complainant '*requested a continuing healthcare assessment'.* The same record documents that the Key Worker, having sought the advice of a colleague, informed the complainant that CHC *'does not apply to NI'.*

42. That information was incorrect because the 2010 Circular makes it clear that there is provision for CHC in Northern Ireland. Specifically, the 2010 Circular states, in paragraph 88, *'When contracting with homes, HSC Trusts should contract for the full cost of the placement, and, where there has not been a determination of continuing healthcare need, seek reimbursement …'*

43. The existence of CHC in Northern Ireland was also made clear in the Department of Health's 2017 public consultation on future arrangements for CHC. The Department's consultation document explained the term 'continuing healthcare' describes the practice of the health service meeting the cost of any social need which is driven primarily by a health need. Specifically, it stated, *'… At present, if the outcome of an assessment [of an individual's needs] indicates a* ***primary need for healthcare****, then the HSC is responsible for*

funding the complete package of care in whatever setting. This is what is known as ***continuing healthcare*** *in the local context. Alternatively a primary need for social care may be identified and where such a need is met in a residential or nursing home setting, legislation requires the HSC Trusts to levy a means-tested charge.'* The existence of CHC in Northern Ireland was further reinforced in the High Court Judgement published on 30 June 2023 as referenced above.

Written request of 27 June 2019

44. I note that when the complainant wrote to the Trust on 27 June 2019 to make a formal request for an assessment of the Resident's eligibility for CHC, he made it clear that he and other family members were of the view that the Resident's needs were *'no longer "social care needs" but [were] now increasingly complex and [were] primarily "health care needs".'* The complainant also highlighted specific content of the 2010 Circular, which he considered supported his contention that, despite the information the Trust had provided to him previously, there was indeed provision for CHC in Northern Ireland.

45. My investigation found no evidence that the Trust took action, in response to the complainant's request, to make a formal determination of the Resident's primary need and, consequently, his eligibility for CHC.

46. Rather, when the Trust responded to the complainant on 27 January 2020, it advised, *'… when an individual's needs are increasing or becoming more complex, it is the responsibility of the multi-disciplinary team to provide a comprehensive assessment of both health and social care needs. Where a consultant led multi-disciplinary team determines that an individual's health needs require on-going and specialist clinical supervision, patients will remain in hospital, for extended periods until their condition stabilises, or they can be transferred to community rehabilitation facilities which are not subject to charging. [The Trust does] not place patients with continuing health care needs in nursing homes as these facilities would not be able to meet their clinical needs.'*

47. In my view, this response inferred that because the Trust was satisfied (on the basis of assessments and care reviews already completed) that the Resident's needs could be met in a nursing home, then it followed that his primary need could not be healthcare and, as such, he could not be eligible for CHC.

48. The IPA highlighted this same feature of the Trust's approach to CHC. She advised, *'The Trust, in stating "[it] does not place patients with continuing health care needs in nursing homes as these facilities would not be able to meet their clinical needs" appears to suggest that it is the setting where the patient's needs can be met rather than the patient's needs in themselves that determine their eligibility for [CHC].* The IPA advised she considered the Trust's position was not in keeping with the 2010 Circular, which, she highlighted, *'makes no reference to where a patient with continuing healthcare needs should be cared for, only that they should not be charged for their care.'*

49. I accept the IPA's advice. It is my view that the position the Trust conveyed to the complainant in its letter of 27 January 2020 is at odds with the policy and guidance contained in the 2010 Circular, in particular, paragraph 63, which states, '*There is no … requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home.'* This makes it clear that an individual's placement in a residential care or nursing home does not necessarily preclude their eligibility for CHC; rather, it is the nature of the individual's primary need, and not the setting in which their care is provided, that determines whether he/she is eligible for CHC. I consider, therefore, that was misleading, and contrary to the policy direction set out in the 2010 Circular, for the Trust to imply in its letter to the complainant that because a nursing home placement had been considered suitable for the Resident on his discharge from hospital, he could not be eligible for CHC.

50. The Trust's letter of 27 January 2020 to the complainant also stated, '*The Trust does not provide continuing health care assessments for the purposes of abatement of nursing home fees.'* The IPA advised this statement was another inappropriate response to the complainant's request because the 2010 Circular sets out a clear requirement that in cases where an HSC Trust intends to seek

reimbursement of care home fees, there is an assessment to determine whether an individual's primary need is for healthcare or for social care.

51. Again, I accept the IPA's advice. I am satisfied that the 2010 Circular sets out a clear link between the assessment of needs and determination of primary need, and the authority to apply charges for a nursing home placement. In particular, I note paragraph 17 of the 2010 Circular states that it is only where the individual's primary need is for social care that he/she *'may be required to pay a means tested contribution'*; paragraph 64 states, *'A financial assessment should only commence after an assessment of the service user's health and social care needs has been completed,'*; and paragraph 88 states, *'When contracting with homes, HSC Trusts should contract for the full cost of the placement, and* ***where there has not been a determination of continuing healthcare need*** (my emphasis), *seek reimbursement …'*

52. Consequently, at the time of the events complained of (before the introduction of the new single CHC eligibility criterion in February 2021[10]) there was not only a clear obligation on a Trust to assess an individual's care needs, but also a requirement to determine the nature of that individual's primary need. Such a determination was essential because unless a Trust was certain that the individual's primary need was not healthcare, it did not have the legal authority to seek reimbursement for the cost of the individual's nursing home or residential care home placement. Consequently, it is my view that it was misleading and not in accordance with the 2010 Circular for the Trust to inform the complainant that it did not *'provide continuing health care assessments for the purposes of abatement of nursing home fees*'.

53. In addition, the Trust's letter of 27 January 2020 stated, *'… to provide additional assurance, I had asked [the Key Worker] to make contact with you, to agree a further review of [the Resident's] needs in partnership with Nursing Staff from [the Nursing Home]. This was to ensure that [the Resident's] needs have not significantly changed and that their [sic] needs continue to be adequately met within a care home setting.'*

[10] As stated above, this single eligibility question policy was subsequently quashed by the High Court on 30 June 2023.

54. The IPA advised she considered this was a further inappropriate response to the complainant's request for the Resident's CHC eligibility to be assessed, noting that it did not '*address the points raised in the complainant's correspondence …*' The IPA advised the Trust's reference to the intended purpose of the further review *'appears to suggest that it is the setting where the Resident's needs can be met rather than the Resident's needs in themselves that determine his eligibility for [CHC].'* The IPA advised*, 'This position in not in accordance with [the 2010 Circular] …'*

55. I accept the IPA's advice. As I have recorded already, it is my view that the 2010 Circular (in particular, paragraph 63, which states, '*There is no … requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home'* and paragraph 88, which states, *'When contracting with homes, HSC Trusts should contract for the full cost of the placement, and where there has not been a determination of continuing healthcare need, seek reimbursement …'*) makes it clear that an individual's placement in a residential care or nursing home, in itself, does not mean they cannot be eligible for CHC. Consequently, I consider this was another misleading and inappropriate response to the complainant's request for the Resident's CHC eligibility to be determined.

56. I further note that the Trust's letter of 27 January 2020 to the complainant appears to have been based on a 'template letter', developed for the purpose of replying to enquiries or complaints about an individual's eligibility for CHC. In replying to my investigation enquiries, the Trust provided a copy of what it called its *'Standard Response to Complaints re CHC'*. The content of the Trust's letter of 27 January 2020 to the complainant appears to have been taken from that 'standard response'.

57. The Trust's use of this 'standard response' to representations about CHC eligibility is of concern for two reasons. Firstly, the 'standard response' includes the statements I have highlighted above as misleading and inappropriate, in that, they are contrary to the policy position and guidance the Department of Health set out in the 2010 Circular. Secondly, I consider the existence of the 'standard response' indicates the Trust routinely declined to give proper

consideration to requests for the determination of nursing home residents' CHC eligibility, relying on the position that those individuals' placements in nursing homes inherently meant they could not be eligible for CHC. This means it is very likely that the complainant was not the only person to receive an inappropriate response from the Trust to their enquiry or complaint about CHC eligibility.

Written request of 17 February 2020

58. My investigation found that when, on 17 February 2020, the complainant wrote again to the Trust, he stated he wished to complain that it had *'denied' [the Resident] his right'* to have his eligibility for CHC assessed. The complainant also indicated the family's aim was to have a *'comprehensive assessment of need'* completed for the Resident, and that they expected this '*to be backdated to when he was first admitted to hospital and when the discharge planning process commenced'.*

59. Again, my investigation found no evidence of the Trust having taken any action, in response to the complainant's request, to make a formal determination of the Resident's primary need and, consequently, his eligibility for CHC.

60. Instead, when the Trust replied to the complainant on 8 July 2020, it advised that the outcome of assessments completed in hospital prior to the Resident's admission to the Nursing Home in August 2016 was that *'[the Resident's] primary need was for social care and therefore he had no entitlement to [CHC]'.* The Trust's response indicated that the relevant assessments were those *'completed by Nursing, Physiotherapy and Social Work colleagues'.*

61. I acknowledge that a number of assessments of the Resident's care needs were completed on 18 July 2016, prior to his discharge from hospital to the Nursing Home. These were: a NISAT Initial Assessment by a hospital social worker; a nursing assessment by a registered general nurse; and a physiotherapy assessment. The IPA advised these assessments '*were sufficient and proportionate to identify the range and extent of the Resident's needs at that time. They were also adequate to determine there was no need*

for further multidisciplinary assessments at that time to enable the formal consideration of eligibility for continuing healthcare'.

62. However, despite the Trust having the information it needed to make a formal determination of the Resident's primary care need and, therefore, his eligibility for CHC, at the time of his admission to the Nursing Home, I found no record within the documentation the Trust provided to me of it having done so. Furthermore, I consider that having completed a range of assessments the Trust should have engaged with the Resident's family as part of the process for making a CHC determination.

63. On balance, it is my view, that the Trust did not make a formal determination of the Resident's primary need and, consequently, his eligibility for CHC at the time of his admission to the Nursing Home. I consider, therefore, that the information the Trust provided in its letter of 8 July 2020 – that at the time of the Resident's admission to the Nursing Home, it had determined his *'primary need was social care and therefore he had no entitlement to [CHC]'* – was inaccurate and misleading.

64. The Trust also referred in its response of 8 July 2020 to a further assessment completed in August 2016, which had *'identified that [the Resident's] day to day support needs were being appropriately met within the remit of social care'.* In addition, the Trust referred to subsequent reviews of the Resident's needs that had been undertaken in November 2016, October 2017, November 2018 and December 2019, although I note it provided no comment on the outcome of those reviews.

65. Again, I acknowledge the records the Trust provided to me document that following the Resident's admission to the Nursing Home, reviews of his needs took place on 11 November 2016; 24 October 2017; 1 November 2018; and 30 December 2019. The IPA advised, '*The level of assessment was appropriate and sufficient to establish the Resident's range of health, nursing and social care needs [and] also adequate and proportionate to identify if further in-depth assessments such as NISAT were required to determine if the Resident's needs were primarily health needs.'* The IPA further advised, *'The*

reviews that took place were in accordance with the Trust's processes and were sufficient and appropriate to the Resident's situation. Each review would have been adequate to determine the nature of his needs while he was resident at the nursing home'.

66. I accept the IPA's advice that the Trust completed appropriate assessments and reviews of the Resident's needs. However, as also highlighted by the IPA, there is no evidence of any consideration, following those reviews, of the nature of the Resident's primary need. I conclude, therefore, that throughout the time the Resident was in the Nursing Home, the Trust did not make any formal determination of his primary need.

67. In addition, for the reasons described earlier in this report, I consider the parts of the Trust's letter of 8 July 2020 that appear to have been drawn from its *'Standard Response to Complaints re CHC'*, that is, the statements, *'[The Trust does] not routinely place patient with Continuing Healthcare needs in nursing homes, as these facilities would not be able to meet their clinical needs'* and *'There is currently no policy framework for the abatement of charges for clients when a Care Home placement is considered appropriate to meet a person's needs',* were misleading and contrary to the 2010 Circular.

68. Having examined the circumstances of Trust's handling of the complainant's request for an assessment of the Resident's CHC eligibility, it is my view that despite the complainant having made that request on more than one occasion, the Trust did not, at any time, make a formal determination of the nature of the Resident's primary need, and consequently his eligibility for CHC, in accordance with the policy direction and guidance set out in the 2010 Circular. This meant the complainant could not be assured of the basis on which the Trust continued to apply charges for the Resident's placement in the Nursing Home. In addition, I consider the Trust failed to provide appropriate responses to the complainant's requests because the information it gave him was inaccurate, misleading and contrary to the 2010 Circular.

69. I referred earlier to the Principles of Good Administration being the standards against which the administrative actions of public bodies are to be judged.

These principles require public bodies to get it right; be customer focused; be open and accountable; act fairly and proportionately; put things right; and seek continuous improvement.

70. The First Principle of Good Administration, ‘Getting it right’, requires a public service provider to act in accordance with the law, policy and guidance. The Third Principle, ‘Being open and accountable’ requires a public body to be open and clear about policies and procedures, and to ensure that information it provides is accurate and complete. The failings I highlighted above indicate that in its handling of the complainant’s requests for a determination of the Resident’s eligibility for CHC, the Trust did not meet the standards required by these Principles. I consider this to be maladministration on the part of the Trust.

71. I am satisfied this maladministration caused the complainant to experience the injustice of frustration and uncertainty. In addition, I consider the complainant had a reasonable expectation that the Trust would deal appropriately with his request for the Resident’s eligibility for CHC to be assessed, in accordance with the policy that applied at the time. This would have enabled the complainant to be assured about the appropriateness of the charges the Trust was applying for the Resident’s care. My investigation established that that expectation was not met.

72. I note the complainant’s continuing strongly held view that the Resident’s primary need was for healthcare, particularly in his final few weeks of life and his comment that the ‘*real test would have been to have assessed [the Resident] whilst he was alive*’. I cannot be certain what the outcome would have been had the Trust dealt appropriately, in accordance with the 2010 Circular, with the complainant’s requests that the Resident’s CHC eligibility be determined. I am in no doubt that the Resident’s records document he had a range of social care needs, nursing needs and healthcare needs during the period my investigation examined, that is, from the time of his discharge from hospital to the Nursing Home on 1 August 2016 until his passing on 9 May 2020.

73. I note the IPA provided advice on the nature of the Resident's primary need both at the time of his discharge from hospital to the Nursing Home and during the period he was a resident in the Nursing Home. The IPA's analysis of the Resident's care needs during the period 2016 to 2020 is summarised in her advice report, and extracts of the Resident's records, which the IPA considers illustrate the range of his care needs during that same period, were considered.

74. I am conscious that the IPA, based her advice to me after a detailed examination of the Resident's records, as provided by the Trust, his GP and the Nursing Home. The IPA's view was that the Resident did not have a primary healthcare need during the period my investigation considered. While I note this advice, it is based on a retrospective review of the records and without the appropriate involvement of the Resident and his family in a formal process for determination. I also note the lack of a clear framework such as the national framework for CHC assessment in England, to aid the decision making of the Trust, which is a point made by the High Court in its recent judgement of 30 June 2023. Given this, I do not make any determination on whether the primary need of the resident was healthcare or otherwise.

75. Having found maladministration on the part of the Trust in relation to its handling of the complainant's requests for the Resident's eligibility for CHC to be determined, and being satisfied that this maladministration caused the complainant to sustain injustice, I uphold this complaint.

CONCLUSION

76. I received a complaint about how the Trust handled requests the complainant on behalf of the Resident's family made for his eligibility for CHC to be determined.

77. My investigation found that appropriate assessments of the Resident's needs were completed both before and following his discharge from hospital to the Nursing Home on 1 August 2016. However, the Trust failed to determine the nature the Resident's primary need and therefore his eligibility for CHC, in accordance with the Department of Health's policy direction and guidance.

78. I also found the Trust failed to provide appropriate responses to the complainant's requests for a determination of the Resident's eligibility for CHC. Rather, the Trust relied on its position that because assessments and reviews of the Resident's needs indicated he could receive the care he required in a nursing home setting, it followed he could not be eligible for CHC. While this position is in keeping with the new CHC eligibility policy the Department of Health introduced in February 2021, a policy which has been quashed by the High Court, it does not reflect the policy that applied at the time the complainant requested the Resident's CHC eligibility to be assessed.

79. I consider the Trust's failure to determine the nature of the Resident's primary need, in accordance with the policy that applied at the time, and to respond appropriately to the complainant's representations about his eligibility for CHC, is maladministration. I am satisfied this maladministration caused the complainant to experience the injustice of frustration, uncertainty and the loss of opportunity to have his requests for assessments of the Resident's CHC eligibility dealt with appropriately. I uphold this complaint.

Recommendations

80. I recommend that within one month of the date of this report, the Trust provides the complainant with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[11] for the injustice caused as a result of the failings identified in this report.

81. I also recommend that the Trust implements the following service improvements:

    (i) the learning points highlighted in this report should be communicated to relevant Trust staff;

    (ii) the Trust should take action to ensure that it has in place the necessary framework to enable it to consider all requests for assessment of CHC eligibility in a timely, consistent and transparent manner, and in accordance with the Department of Health's policy direction, as set out in

[11] https://nipso.org.uk/site/wp-content/uploads/2019/07/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-July-2019.pdf

the 2010 Circular and in doing so, the Trust will clearly need to consider the judgement of the High Court [2023] NIKB 72;

(iii) Once such a framework is established the Trust should then make a determination on CHC on this case;

(iv) The Trust should further review other applications for CHC during the last three-year period and decide if a re-consideration of their determination is necessary;

(v) The Trust should provide guidance to relevant Trust staff to assist them in handling requests for assessments of CHC eligibility; and

(vi) the Trust should discontinue the use of the template letter it refers to as its *'Standard Response to Complaints re CHC'*.

86. I recommend that the Trust implement an action plan to incorporate these service improvement recommendations and that it provide me with an update within six months of the date of this report. The update should be supported by evidence to confirm that appropriate action has been taken.

MARGARET KELLY
Ombudsman **14 August 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.