Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Belfast Health and Social Care Trust

NIPSO Reference: 201916522

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Case Reference: 201916522

Listed Authority: Belfast Health & Social Care Trust

SUMMARY

I received a complaint about how the Belfast Health and Social Care Trust (the Trust) applied charges for the care the complainant's brother ('Mr A') received in nursing homes following his discharge from hospital. The complainant said he believed that the Trust ought to have continued to pay for Mr A's care following his discharge from hospital because his care needs were such that he was entitled to continuing healthcare (CHC).[1]

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 Mr A's GP records, and records and notes from the nursing homes in which he was resident during the period examined by my investigation, and I sought the advice of an independent professional adviser.

My investigation found that the Trust undertook appropriate assessments of Mr A's needs but it failed to determine the nature of Mr A's primary need, and 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 accurate and complete responses to the complainant when he asked it about Mr A's eligibility for CHC.

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 (August 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.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant made the complaint on behalf of his brother, who is referred to in this report as 'Mr A'.

2. The complainant said he was dissatisfied with how the Trust applied charges for the care Mr A received in nursing homes, following his discharge from the Trust's Royal Victoria Hospital (RVH) in November 2017. The complainant said he considers that Mr A's care needs are related to his medical condition. He believes that if Mr A had remained in a hospital setting, rather than transfer to a nursing home, he would not be charged for the care he requires.

3. The complainant highlighted in his complaint that the NI Direct[2] website advised that if a person's primary need is for healthcare, their respective health and social care (HSC) trust would pay for all their care, and that this was known as 'continuing healthcare'. He said that he had asked the Trust to explain this but that it had not done so; and he still did not have a clear understanding of why continuing healthcare (CHC) was not applicable to Mr A's position.

Background

4. On 18 July 2017, Mr A was admitted to RVH on 18 July 2017 having suffered a severe stroke at home some days previously. Mr A had surgery on 27 July 2017 to alleviate pressure from bleeding on his brain that had resulted from the stroke. Mr A sustained a number of physical and mental disabilities as a result of his stroke and the subsequent bleeding on his brain.

5. A discharge-planning meeting for Mr A took place in RVH on 20 September 2017. Mr A's consultant geriatrician and stroke physician, allied health professionals, nursing staff and a social worker attended the meeting, as did members of Mr A's family, including the complainant. The Trust considered that Mr A was fit for discharge from hospital and that his needs would be best met in a nursing home.

[2] The official government website for Northern Ireland citizens

6. Mr A was discharged from RVH on 13 November 2017 to a local nursing home ('Nursing Home 1'). Mr A's needs were reviewed on 18 January 2018, by his Care Manager in the Trust ('the Trust Care Manager') and by staff at Nursing Home 1.

7. At the review, the Manager of Nursing Home 1 advised the Trust Care Manager and Mr A's family members that although Nursing Home 1 was able to meet Mr A's physical needs, it was unable to meet his mental health needs. It was suggested that a placement in a nursing home that specialised in brain injuries may be more appropriate for Mr A.

8. On 1 June 2018, a 'Best Interest' meeting, convened by the Trust Care Manager, took place to discuss Mr A's longer term care plan. It was agreed that Mr A should transfer to a nursing home that specialised in needs associated with cognitive impairment ('Nursing Home 2'). Mr A transferred to Nursing Home 2 on 30 July 2018

9. On 2 August 2018, the Trust Care Manager informed the Trust's Finance Department that with effect from 30 July 2018, Mr A's nursing home placement had changed from temporary to permanent. This meant that Mr A was charged for the full cost of his nursing home placement and, from 22 October 2018 (12 weeks after the date his placement became permanent), the value of his home was taken into account when the Trust assessed his finances. The Trust informed Mr A's family of the change in the assessed charges for Mr A's placement at a meeting with its Finance Department on 31 May 2019.

10. On 10 June 2019, the complainant wrote to the Trust to complain about its charging for Mr A's *'residence and nursing care at [Nursing Home 2]'*. The complainant pointed out to the Trust that he was aware that if an assessment of an individual's needs indicated they had a primary healthcare need, their HSC Trust would pay the full cost of their care. The complainant told the Trust he believed Mr A met the eligibility criteria for CHC, and he asked that the Trust complete *'a full medical and health assessment'* in respect of him.

11. On 27 September 2019, the Trust advised the complainant that it did not place patients with continuing health care needs in nursing homes because such care facilities would not be able to meet their clinical needs. The Trust also told the complainant that it *'does not provide continuing healthcare assessments for the purpose of abatement of nursing home fees.'*

12. The complainant wrote to the Trust for a second time on 19 December 2019. He again referred to the explanation of CHC provided on the NI Direct website and indicated his view that Mr A was eligible for CHC.

13. The Trust responded to the complainant on 5 June 2020. The Trust referred to a contribution of £100 per week that it was required to make to the cost of nursing care Mr A received in his nursing home and informed the complainant that this was not a form of CHC. The Trust provided no further information regarding Mr A's eligibility for CHC.

14. Mr A was admitted to the Trust's Holywell Hospital ('Holywell') on 22 April 2020. Mr A was still a patient at Holywell at the time the complainant complained to my Office but I am aware that following his discharge from Holywell, he became a resident of another nursing home ('Nursing Home 3') .

15. Sadly, Mr A passed away in Nursing Home 3 before the conclusion of my investigation.

Issue(s) of complaint

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

> **Whether the Trust correctly followed the Department of Health's guidance in relation to Mr A's continuing healthcare assessment**.

INVESTIGATION METHODOLOGY

17. In order to investigate this complaint, I obtained from the Trust all relevant documentation and records together with its comments on the issues the complainant had raised. The documentation I obtained included information relating to the Trust's handling of the complaints the complainant made to it on

10 June 2019 and 19 December 2019. I also obtained Mr A's records and notes from the nursing homes (Nursing Home 1 and Nursing Home 2) in which he was resident during the period examined by my investigation.

Independent Professional Advice

18. I obtained independent professional advice from a Registered Nurse with 39 years' experience, including 18 years' experience in NHS continuing healthcare.

19. I should point out that the independent professional adviser (the IPA) provided 'advice'; how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

20. 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.

21. The general standards are the Ombudsman's Principles:[3]

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

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

23. The specific standards relevant to this complaint are:

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

[3] 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').

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

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

THE INVESTIGATION

Detail of complaint

26. The complainant considers that Mr A's care needs are related to his medical condition. He said he is aware that if a person's primary need is for healthcare, their respective HSC trust pays for all their care, and that this is known as CHC. The complainant believes Mr A is entitled to CHC and that the Trust should therefore meet the cost of the care he receives in his nursing home.

Evidence Considered

Legislation, Policies and Guidance

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

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

- The 2021 Circular.

28. Relevant extracts of the legislation, policies and guidance I considered are at Appendix Two to this report.

The Trust's response to investigation enquiries

29. I made written enquiries to the Trust about the issues the complainant had raised. Relevant extracts of the Trust's response to my enquiries are at Appendix Three to this report.

Documentation and records examined

30. I completed a review of the copy documentation the Trust provided in response to my investigation enquiries, and the records I obtained from Nursing Home 1 and Nursing Home 2. This documentation included Mr A's RVH records; records relating to the Trust's assessment of Mr A's needs prior to his discharge from RVH; records of relevant meetings with Mr A's family; records relating to reviews of Mr A's needs that were completed while he was resident in Nursing Home 1 and Nursing Home 2; and the Trust's file relating to the complaints the complainant made to it in June and December 2019. Relevant extracts of the documentation I examined are at Appendix Four to this report.

Independent Professional Advice

31. I considered the advice I obtained from the IPA. This advice concerned the assessment of Mr A's care needs, both prior to his discharge from RVH on 13 November 2017, and during the periods he was resident in Nursing Home 1 and Nursing Home 2, before his admission to Holywell on 22 April 2020. The IPA also provided advice on the nature of Mr A's primary need and the Trust's handling of the complainant's representations about Mr A's eligibility for CHC.

32. The IPA's full advice report is at Appendix Five to this report.

Analysis and Findings

33. My investigation established that the complainant's brother, Mr A, was discharged from RVH to Nursing Home 1 on 13 November 2017, following treatment and a period of inpatient rehabilitation for the severe stroke he

suffered in July 2017. Subsequently, in February 2018, Nursing Home 1 informed the Trust that it was unable to meet Mr A's mental health needs, and arrangements were made for Mr A to transfer to Nursing Home 2, a nursing home that specialised in needs associated with cognitive impairment.

34. Mr A transferred to Nursing Home 2 on 30 July 2018. The Trust determined that Mr A's nursing home placement became permanent at that point, rather than temporary. This meant that Mr A was assessed as self-funding and charged for the full cost of his nursing home placement and, with effect from 22 October 2018,[4] the value of his home was taken into account when the Trust was assessing his finances.

35. The complainant informed me of his understanding that if a person's primary need is for healthcare, their respective HSC trust pays for all their care, and that this is known as CHC. The complainant believes that Mr A's care needs are related to his medical condition, so he (Mr A) should be entitled to CHC. The complainant is of the view, therefore, that the Trust should meet the cost of Mr A's nursing home placement.

36. Before I set out my findings on this complaint, 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 2021, the Department issued guidance[5] on a new policy for determining eligibility for CHC on the basis of applying a single eligibility criterion. This new 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. It is important to note that the new single eligibility criterion policy came into effect on 11 February 2021, so did not apply during the period my investigation examined. The policy that is relevant to my consideration of this complaint is the one set out in the 2010 Circular, as issued in March 2010, that is, that an

[4] 12 weeks after Mr A's nursing home placement became permanent
[5] Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system ('the 2021 Circular')

individual's eligibility for CHC is determined on the nature of their primary need. I will therefore refer to this policy in setting out my findings on the complaint.

37. In considering this complaint, I am mindful that the 1972 Order (the main legislation governing the provision of health and social care services in 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. 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). There is therefore a clear, and important, difference between healthcare and social care, in terms of a HSC Trust's legal authority to charge for the care it provides to an individual who has moved into a residential care or nursing home.

38. I note this distinction was reinforced by the (then) Minister of Health when he responded in September 2013 to an Northern Ireland Assembly Question[6] 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.'*

39. I note too that the difference between charging for healthcare and 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*

[6] Assembly Question AQW 25318/11-15

primary need for social care may be identified and where such a need is met in a residential care or nursing home setting, legislation requires the HSC Trust to levy a means-tested charge.'

40. Given the significance of the distinction between healthcare and social care, in relation to a HSC 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.

41. The IPA advised that healthcare in the community 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 etc., depending on the specialism required to meet the identified need.

42. The IPA highlighted that a definition of personal care (or social care) was provided in the 2010 Circular. 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 pointed out that a further definition of personal care was provided in the Department of Health's 2006 publication, 'Payments for Nursing Care'.[7] 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.'*

43. My investigation found that the complainant made specific representations to the Trust on 10 June and 19 December 2019 about Mr A's eligibility for CHC.

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

44. I note that when he wrote to the Trust on 10 June 2019 – to complain about the Trust charging for the full cost of Mr A's care at Nursing Home 2 - the complainant referred to information he had obtained from the NI Direct website. This information was that if the assessment of an individual's needs indicated their primary need was for healthcare, their respective HSC trust would pay the full cost of their care. I note the complainant contended that Mr A met this criterion, and that he (the complainant) specifically requested *'a full medical and health assessment from [the Trust] of [Mr A's] illness/conditions'.*

45. I note the IPA advised that by that stage, the Trust had completed sufficient assessments of Mr A's needs to be able determine the nature of his primary need, that is, whether it was healthcare or social care.

46. Specifically, the IPA pointed out that prior to Mr A's admission to RVH in July 2017, the Trust had carried out a NISAT[8] core assessment in June 2017; it had completed a NISAT initial assessment/short-term assessment on 25 July 2017, and it had undertaken a number of specialist assessments (nursing, physiotherapy and occupational therapy) while Mr A was still in RVH. The IPA highlighted too that after Mr A's discharge from RVH to Nursing Home 1 on 13 November 2017, a Care Home Service User's Review was completed on 18 January 2018; a NISAT Specialist Assessment Summary was commenced on 1 April 2018; and a Care Home Resident Review and a further Care Home Service User's Review were completed on 12 and 15 May 2018 respectively. Subsequently, following Mr A's transfer to Nursing Home 2 on 30 July 2018, a Care Home Service User's Review and a Care Home Resident Review were completed on 22 October 2018 and 25 October 2018 respectively. My own examination of Mr A's records confirmed that these assessments of Mr A's needs had been completed.

47. I note, however, that despite having the information it required to determine the nature of Mr A's primary need, in response to the complainant's enquiry, the Trust did not make such a determination. Rather, when it replied to the complainant on 27 September 2019, the Trust advised him, *'… when an*

[8] Northern Ireland Single Assessment Tool

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 … 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.'

48. In my view, this response inferred that if Mr A's needs were such that they could be met in a nursing home, then it followed that his primary need could not be healthcare and, consequently, he could not be eligible for CHC.

49. A similar focus on the setting in which an individual's care needs could be met, and the view that a resident of a nursing home or residential care home could not be eligible for CHC, was also evident in the Trust's response to my investigation enquiries. I note the Trust stated, *'Should a person require day to day care in a setting which primarily falls within the remit of social care then the Trust must follow their legislative duty and financially assess for that placement. At present, most nursing homes fall within the category of social care.'* The Trust stated too, in response to my specific request for it to explain the basis for its view that Mr A was not eligible for CHC, that the multi-disciplinary assessments of Mr A's needs that were completed before his discharge from RVH had '*determined that his needs could be met in a nursing home'*, and that there was no indication in these assessments *'that the level of care that [Mr A] required could not be met by social care staff in a nursing home.'*

50. I note the IPA highlighted this same issue with the Trust's approach. She advised that that the Trust appeared *'to suggest that it is the setting where Mr A's needs can be met rather than Mr A's needs in themselves that determine his eligibility for [CHC]'.* The IPA advised too that she considered the Trust's position was not in keeping with the 2010 Circular, which *'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.'* .

51. I accept the IPA's advice. It is my view that the position the Trust conveyed to the complainant in its letter of 27 September 2019 is at odds with the 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; it is the nature of the individual's primary need, and not the setting in which their care is provided, that determines their eligibility.

52. In addition, I note that the Trust's letter of 27 September 2019 to the complainant stated, '*The Trust does not provide continuing health care assessments for the purpose of abatement of nursing home fees.'* The IPA advised that this statement by the Trust was another inappropriate response to the complainant's request that Mr A's CHC eligibility be assessed. This is because the 2010 Circular sets out a clear requirement for a Trust to assess an individual's needs when it intends to seek reimbursement of the cost of their care home placement.

53. Again, I accept the IPA's advice. The 2010 Circular sets out a clear link between the assessment of need and determination of primary need, and the authority to levy charges for a nursing home placement. In particular, I note that paragraph 64 of the 2010 Circular states, *'A financial assessment should only commence after an assessment of the service user's health and social care needs has been completed*,*'* while 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 …'*

54. Consequently, at the time of the events complained of (before the introduction of the new single CHC eligibility criterion in February 2021) there was not only a clear obligation on a Trust to assess an individual's care needs, but also to determine the nature of that individual's primary need. Such a determination of primary need was essential because unless a Trust was certain that an 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, I consider it was misleading, and contrary to the policy direction set out in the 2010 Circular, for the Trust to inform the complainant that it did not assess needs for *'the purpose of the abatement of nursing home fees."*

55. I note that when the complainant wrote to the Trust for a second time, on 19 December 2019, he again referred to the NI Direct website providing information about the nature of an individual's primary need being the determining factor in their eligibility for CHC. In addition, I note the complainant again contended that Mr A's needs were such that he '*should not be subject to means testing'*, in my view, clearly inferring that he believed Mr A was eligible for CHC.

56. Again, as the IPA advised, the Trust had sufficient information at that time (from assessments of Mr A's needs already completed, including further reviews carried out in Nursing Home 2, on 30 August and 3 September 2019) to determine of Mr A's primary need. However, once again I found no evidence of the Trust having made that determination in response to the complainant's representations.

57. Instead, when the Trust replied to the complainant on 5 June 2020, it referred to its obligation '*under the Health and Personal Social Services (Assessment of Resources) Regulations (NI) 1993 to carry out a financial assessment of all persons coming into residential and nursing care and seeking funding from the Trust',* and to the £100 contribution it was required to make '*towards the nursing care element of [Mr A's] placement as per legislation'.* I note that the Trust also stated that it hoped its response '*clarifies that [the Trust's contribution] is not a form of Continuing Health Care'*, and it advised that its position on CHC '*remains unchanged and has been outlined in the previous response.'*

58. In my view, the Trust's response of 5 June 2020 did not appropriately address the complainant's enquiry about Mr A's eligibility for CHC because it provided no explanation of why it considered Mr A did not meet the eligibility requirement

(a primary healthcare need) that the complainant had read about on the NI Direct website. In fact, the Trust made no reference at all in its response to the nature of Mr A's primary need. In this regard, I note that when it replied to my investigation enquiries, the Trust acknowledged that its responses to the complainant '*did not clearly explain that [Mr A's] assessments indicated that his needs were … social care … as the majority of his care needs could be met by social care staff employed in a nursing home.'*

59. I accept that, as highlighted by the IPA, the Trust did complete assessments of Mr A's needs. In particular, I note the IPA referred in her advice to the various assessments that were undertaken during Mr A's stay in RVH, and that she advised these assessments were appropriate and adequate to inform the decision about the setting in which Mr A's needs would be best met following his discharge. In this respect, I note the IPA advised that her review of Mr A's hospital records found no information to suggest that his needs could not be met within a nursing home setting at that time. In addition, I note the IPA highlighted in her advice the reviews of Mr A's needs that were undertaken, with the Trust's input, during Mr A's placements in Nursing Home 1 and Nursing Home 2.

60. It remains the case, however, that despite the complainant asking it to do so, the Trust failed to make a determination of the nature of Mr A's primary need, and 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 applied charges for Mr A's nursing home placement. In addition, for the reasons set out above, I consider the Trust failed to provide appropriate responses to the complainant's specific enquiries of 10 June and 19 December 2019 about Mr A's eligibility for CHC. It is not surprising then that, at the time of submitting his complaint to my Office, the complainant remained unclear as to why Mr A was not eligible for CHC.

61. I referred earlier in this report to the Principles of Good Administration being the standards against which the administrative actions of public bodies are to be judged. These principles (which are reproduced at Appendix One to this report) 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.

62. 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 enquiries about Mr A'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.

63. 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 Mr A's eligibility for CHC to be assessed, in order that he could be assured that the charges the Trust was applying for his care were justified. It is clear that that expectation was not met.

64. 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 Mr A's eligibility for CHC be determined. I am in no doubt that Mr A's records demonstrate that, as a result of his stroke in July 2017 and due to pre-existing health conditions, 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 RVH to the time of his admission to Holywell. However, that comprehensive range of care needs does not in itself mean that Mr A's primary need during that time was healthcare.

65. In this context, I am mindful that the IPA's considered view, based on her detailed examination of Mr A's records, as provided by the Trust, Mr A's GP, Nursing Home 1 and Nursing Home 2 , was that Mr A did not have a primary healthcare need during the period my investigation considered.

66. Specifically, the IPA advised that Mr A's records showed that at the time of his discharge from RVH, he had a combination of health, nursing and social care

needs, with the main focus being on supporting him with his activities of daily living. The IPA advised too that *'taking into account the type and quantity of care Mr A required and the knowledge and skills needed to meet his needs both individually and collectively, there is no evidence of a primary need for healthcare on his discharge from hospital on 13 November 2017.'*

67. In relation to the nature of Mr A's primary need following his discharge from RVH and prior to his admission to Holywell, I note the IPA advised that Mr A still had a range of health, nursing and social care needs during this time but that *'in the main, [Mr A's] care needs could be met by care workers under the supervision of a registered nurse …'*; in other words, Mr A did not have a primary need for healthcare.

68. I accept the IPA's advice. On this basis, I am unable to conclude that even if the Trust had made a determination of Mr A's primary need, in response to the complainant's representations and in accordance with the Department of Health's policy direction and guidance that applied at the time, as set out in the 2010 Circular, it would have concluded that Mr A had a primary healthcare need. As such, I also unable to conclude that the Trust did not have the authority to charge for Mr A's placements in Nursing Home 1 and Nursing Home 2 .

69. Nonetheless, having found maladministration on the part of the Trust in relation to its handling of the complainant's representations about Mr A's eligibility for CHC and being satisfied that this maladministration caused the complainant to sustain injustice, I uphold this complaint.

CONCLUSION

70. I received a complaint about how the Trust applied charges for the care the complainant's brother, Mr A, received in nursing homes, following his discharge from RVH in November 2017. The complainant said he considered that Mr A's care needs are related to his medical condition and that he is eligible for CHC. As such, he believes the Trust should pay for the care Mr A received in the nursing homes.

71. My investigation found that the Trust undertook appropriate assessments of Mr A's needs both before and after his discharge from RVH in November 2017. However, the Trust failed to determine the nature Mr A's primary need and his eligibility for CHC, in accordance with the Department of Health's policy direction and guidance. I also found the Trust failed to provide accurate and complete responses to the complainant's representations about Mr A's eligibility for CHC. Rather, the Trust relied on its position that because the assessments it had undertaken of Mr A'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, it does not reflect the policy that applied at the time the complainant requested Mr A's eligibility for CHC to be assessed.

72. I consider the Trust's failure to determine the nature Mr A's primary need, in accordance with policy that applied at the time, and to respond appropriately to the complainant's representations about Mr A's eligibility for CHC, to be 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 Mr A's CHC eligibility to be dealt with appropriately. I uphold this complaint.

Recommendations

73. I recommend that within one month of the date of [the final version of] this report, the Trust provide the complainant with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[9] for the injustice caused to him as a result of the failings identified in this report. The Trust informed me that it accepted this recommendation.

74. In addition, in order that the complainant can be reassured of the basis for the Trust's charging for Mr A's nursing home placement beyond the period my investigation examined, I recommend that the Trust make a determination of Mr A's CHC eligibility since the date he became a resident of Nursing Home 3,

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

following his discharge from Holywell on 16 December 2020. The Trust should apply the relevant CHC eligibility policy to make that determination, and should ensure that the complainant is notified of the outcome in a timely manner.

75. The Trust informed me that it accepted this recommendation. It advised, however, that while it remained the Trust's *'absolute intention'* to complete an determination of Mr A's CHC eligibility from the date he became a resident of Nursing Home 3, it would not be in a position to do so until after the conclusion of ongoing legal action concerning the Trust's assessment of another individual's CHC eligibility.

76. I also recommend that the Trust implement the following service improvements:

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

    (ii) the Trust should take action to ensure that it has in place the necessary framework to enable it to consider all future 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 the 2010 Circular and the 2021 Circular. This should include the provision of guidance to relevant Trust staff to assist them in handling requests for assessments of CHC eligibility.

77. The Trust agreed to implement these recommended service improvements. In relation to establishing a framework to support the consideration of future requests for assessment of CHC eligibility, the Trust informed me that it had been working with the other Northern Ireland health and social care trusts, and with the Department of Health, in relation to the development of guidance for dealing with requests for assessment of CHC eligibility, under both the 2010 Circular and the 2021 Circular. The Trust said it would work to ensure that a framework and related guidance were developed and adopted within the Trust as soon as practicably possible after the conclusion of the ongoing legal action concerning its assessment of another individual's CHC eligibility.

78. I will be seeking an update from the Trust in due course in relation to its implementation of the recommendations made in this report.

MARGARET KELLY
Ombudsman **19 July 2022**

Appendix One

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.