Investigation Report

Investigation of a complaint against the Southern Health & Social Care Trust

NIPSO Reference: 17262

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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.

TABLE OF CONTENTS

Page

SUMMARY

I received a complaint about the how the Southern Health and Social Care Trust (the Trust) had responded to requests the complainant made to it for a determination of whether his mother (referred to in this report as 'Mrs A') was eligible for continuing healthcare (CHC)[1]. The complainant said that the Trust failed to make such a determination. He was also dissatisfied with the Trust's handling of complaints that were made to it about its failure to determine Mrs A's CHC eligibility.

I obtained all relevant documentation from the Trust, together with the Trust's comments on the issues the complainant had raised. I also obtained Mrs A's records and notes from her private nursing home, and I sought the advice of an independent professional adviser.

I established that the Trust had not dealt appropriately with repeated requests that were made to it for Mrs A's CHC eligibility to be determined. I found that the Trust had not considered the requests in accordance with the policy direction that the Department of Health had provided to Health and Social Care Trusts in 2010,[2] and that it had failed to determine Mrs A's eligibility for CHC in response to her family's requests. I also established that the Trust had failed to put in place the local administrative arrangements it needed to allow it to fulfil its obligations in relation to the determination of CHC eligibility. I was satisfied that the failings I identified had caused the complainant, and the other involved members of Mrs A's family, to experience frustration, uncertainty and distress, and also meant they had been denied the opportunity to have Mrs A's CHC eligibility determined in a timely manner.

My investigation also found evidence of a series of failings on the part of the Trust in relation to how it had handled the numerous complaints that were made to it, on behalf

[1] In Northern Ireland, 'Continuing Healthcare' (CHC) is the term used to describe the practice of the health service meeting the cost of any social need which is driven primarily by a health need. Essentially, this means that if an individual's primary need is for healthcare, rather than social care (personal social services), they do not have to pay for the care they receive, irrespective of where that care is provided.
[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.

of Mrs A's family, by two MLAs and by the Office of the Commissioner for Older People NI. I concluded that these failings had caused the complainant, and the other involved members of Mrs A's family, to experience frustration, distress and uncertainty, and also meant that they had been put to an unreasonable degree of time and trouble over a prolonged period.

I recommended that the Chief Executive of the Trust apologise to the complainant and make a payment of £1000 to him. I also recommended that the Trust take action to ensure that all Trust staff involved in the handling of complaints are reminded of the requirements, standards and good practice set out in the HSC Complaints Procedure.[3] The Chief Executive of the Trust accepted both these recommendations.

I further recommended that the Trust discontinue its routine practice of not making determinations of CHC eligibility in cases where the individual concerned had been placed in a residential care or nursing home; that it take action to ensure that it has in place all the administrative arrangements that are necessary to enable it to deal appropriately with requests for CHC determinations in the future; and that, having established those administrative arrangements, the Trust make a retrospective determination of Mrs A's CHC eligibility. The Chief Executive informed me that the Trust would contact the Department of Health, the Health and Social Care Board and the other HSC Trusts to agree collectively how these recommendations could be actioned.

[3] *'Complaints in Health and Social Care - Standards & Guidelines for Resolution & Learning'*, published by the (then) Department of Health, Social Services and Public Safety on 1 April 2009.

THE COMPLAINT

1. I received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). The complainant said that he considered his late mother (referred to in this report as 'Mrs A') was eligible for funded continuing healthcare (CHC) during the time she had been resident in a private nursing home. He complained that the Trust did not appropriately consider requests that were made to it for Mrs A's eligibility for CHC to be determined. He also complained about how the Trust had complaints that John McCallister MLA, the Commissioner for Older People NI (COPNI) and Sinead Bradley MLA, made to the Trust, on behalf of Mrs A's family, about its response to their requests for a CHC assessment.

Issues of complaint

2. The issues of complaint that were accepted for investigation are:

   Issue 1: Whether the Trust failed to follow the Department of Health's guidance in relation to the CHC assessment the complainant and his family requested for Mrs A; and

   Issue 2: Whether the Trust's handling of the complaints that were submitted to it, on behalf of Mrs A's family, was appropriate.

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation, together with the Trust's comments on the issues the complainant had raised. The Investigating Officer also obtained Mrs A's records and notes from her private nursing home.

4. 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 complainant and the Trust both submitted comments in response. In finalising my report, I gave careful consideration to the matters they raised.

Independent Professional Advice

5. I obtained independent professional advice from a continuing healthcare independent professional advisor (the IPA). How this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

6. I should also explain that the independent professional advice included at Appendix 4 is not the advice that was initially obtained during investigation of this complaint, and which informed the findings that were proposed in the first draft report. In commenting on that first draft report, the complainant and the Trust both raised issues regarding the initial independent professional advice that had been obtained (which was included at Appendix 3 to the first draft report). Consideration of their comments required further detailed review of the advice obtained from the first IPA. On reflection, it was decided to set aside the first IPA's advice and to obtain fresh advice from a second IPA. While it is not usual for this Office to take such action during the course of an investigation, the decision to do so was made in accordance with Section 30(6) of the Public Services Ombudsman (NI) Act 2016, which provides that *'…the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in circumstances of the case'.* The findings I have recorded in this report have taken account of the second IPA's advice only.

Relevant Standards

7. 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.

8. The general standards are the Ombudsman's Principles:[4]

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

(i) The Principles of Good Administration;

(ii) The Principles of Good Complaint Handling; and

(iii) The Public Service Ombudsmen Principles for Remedy.

9. 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.

10. The specific standards relevant to this complaint are:

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

(ii) 'Complaints in Health and Social Care - Standards & Guidelines for Resolution & Learning', published by the Department of Health, Social Services and Public Safety on 1 April 2009.

11. I did not include in this report all of the information 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.

THE INVESTIGATION

Issue 1: Whether the Trust failed to follow the Department of Health's guidance in relation to the CHC assessment the complainant and his family requested for Mrs A

Detail of Complaint

12. The complainant's mother, Mrs A, was a resident of a private nursing home ('the Nursing Home') from 8 August 2011 until her passing on 3 October 2016. In submitting his complaint to my Office, the complainant stated that at the time Mrs A became a resident of the Nursing Home, *'all accept that nursing care was not her primary need'*. The complainant said that he believed Mrs A's health declined rapidly in December 2011, to a point where her needs *'had changed to being primarily nursing, and medical intervention was required much more often'*. He said that it was following this decline in Mrs A's health that he, and other

members of her family, first became aware of what he referred to as 'the Continuing Healthcare Framework', and that they considered that this applied to Mrs A because *'her needs had become more nursing and less social care … therefore resulting in the Trust having a responsibility to fund the full cost for [Mrs A's] nursing care and home'.* The complainant also said that it was during a meeting with the Trust in February 2012 that he and his sister, Mrs A's daughter, (who was also Mrs A's next of kin), first asked the Trust to carry out a CHC assessment for Mrs A.

13. The complainant further complained that the Trust did not follow guidance issued by the Department of Health in relation to the CHC assessment that was requested for Mrs A, and that it therefore failed to determine her primary care need. He was also aggrieved that the he and the other involved members of Mrs A's family did not receive any explanation as to why the Trust would not complete a CHC assessment for her.

Evidence Considered

(i) Relevant legislation, policy and guidance

The Health and Personal Social Services (NI) Order 1972

14. The main legislation governing the provision of health and social care services in Northern Ireland is the Health and Personal Social Services (NI) Order 1972 (the 1972 Order). The 1972 Order does not provide an explicit statutory framework for the provision of CHC in Northern Ireland, nor does it require that CHC be provided to people in Northern Ireland. However, Article 98 of the 1972 Order requires that all services provided under that statute (which includes the provision of residential and nursing home care placements) and under the Health Services (Primary Care) (NI) Order 1997 are provided free of charge, except where there are provisions to the contrary in either piece of legislation. Where an individual is placed in residential care by a Health and Social Care Trust (HSC Trust), the relevant HSC Trust has a statutory obligation to charge the individual for their placement, if they have the financial means to pay for, or to make a contribution towards, the cost of that placement.

Circular HSC (ECCU) 1/2010 - Care Management, Provision of Services and Charging Guidance

15. Circular HSC (ECCU) 1/2010, 'Care Management, Provision of Services and Charging Guidance' (the 2010 Circular), issued by the Department of Health[5] (the Department) provides guidance on:
    - the care management process, including the assessment and case management of health and social care needs;
    - the provision of services, including placement of service users in residential care homes and nursing homes; and
    - charging for personal social services provided in residential care homes and nursing homes.

16. Paragraph 17 of the 2010 Circular states, *'… the distinction between health and social care needs is complex and requires a careful appraisal of each individual's needs. In this context, it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services. In the latter case, the service user may be required to pay a means tested contribution.'*

17. Paragraph 63 of the 2010 Circular states, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential care or nursing home accommodation arranged by a HSC 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).

18. In addition, paragraph 88 of the 2010 Circular 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 under [the Health and Personal Social Services (Assessment of Resources) Regulations (NI) 1993].'*

19. The 2010 Circular also refers to the means by which an individual's health and

[5] Department of Health, Social Services and Public Safety at the time the 2010 Circular was issued (March 2010)

social care needs are to be assessed. Specifically (on page 4), the 2010 Circular advises that the Northern Ireland Single Assessment Tool (NISAT) '*has been developed and validated, primarily in relation to assessing the needs of older people'*, and that the NISAT *'supports the exercise of professional judgement in the care management process'*. The 2010 Circular further states, *'NISAT is designed to capture the information required for holistic, person-centred assessment. It is structured in component parts and using domains which will be completed according to the level of health and social care needs experienced, from non-complex to complex.'* There is further reference to the NISAT in paragraph 15 of the 2010 Circular, which states, *'The NISAT, developed primarily in the context of older people's needs, provides a validated assessment framework.'*

20. The 2010 Circular also explains the position in Northern Ireland in relation to costs associated with the provision of nursing care in nursing homes. In this regard, paragraph 74 of the 2010 Circular advises, '*In October 2002, the Northern Ireland Assembly introduced a weekly HSC contribution towards the cost of nursing care provided in nursing homes. This flat weekly payment is intended to pay for the professional care given by a registered nurse employed in a nursing home. For individuals with assessed nursing needs who pay privately, the flat weekly rate is payable by HSC Trusts to homeowners. Alternatively, it is discounted from the charges raised by HSC Trusts for people who are required to refund HSC Trusts the full rate.'*

Circular ECCU1/2006 - HPSS Payments for Nursing Care in Nursing Homes

21. The Department's Circular ECCU 1/2006, 'HPSS Payments for Nursing Care in Nursing Homes' (the 2006 Circular) provides guidance on the responsibility of HSC Trusts to make payments for the cost of nursing care provided in nursing homes, on behalf of individuals who pay for their nursing home care. Paragraph 2 of the 2006 Circular explains that since the Health and Personal Social Services Act (NI) 2002 came into operation on 7 October 2002, HSC Trusts have been '*responsible for paying the nursing care of residents who otherwise pay the full cost of their nursing home care.'* Paragraph 10 of the 2006 Circular advises that HSC Trusts *'should encourage Nursing Homes to explain to [residents] that a nursing needs assessment is a requirement to determine eligibility for [HSC] payments.'* Paragraph 12 of the 2006 Circular advises of the availability of the Nursing Needs

Assessment Tool (NNAT), which was *'developed specifically to establish nursing needs…'*

Health Minister's Response to Northern Ireland Assembly Question on Continuing Healthcare in Northern Ireland

22. In September 2013, the then Minister of Health (the Health Minister) provided a written answer to a Northern Ireland Assembly question about CHC. The Minister's answer explained the legislative position regarding CHC in Northern Ireland.[6] The Minister stated, '*Legislation governing the provision of health and social care in Northern Ireland differs significantly from that in England. This is a result of Northern Ireland benefitting from a fully integrated system of health and social care, with services delivered by [HSC Trusts]. [The 2010 Circular] provides HSC Trusts with direction on the assessment process to be undertaken to identify both health and social care needs. As set out in the circular an individual's primary need can be either for health care – which is provided free – or social care for which a means tested contribution may be required. My Department sought confirmation from all HSC Trusts in October 2012 that they were compliant with this circular. All HSC Trusts confirmed that this was the case.'*

Department of Health's Public Consultation on Continuing Healthcare in Northern Ireland

23. In June 2017, the Department launched a public consultation on the future of the continuing healthcare system in Northern Ireland. The consultation document, *'Continuing Healthcare in Northern Ireland: Introducing a Transparent and Fair System'*,[7] explained that 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. It was also explained that *'Eligibility for continuing healthcare depends an individual's assessed needs, and not on a particular disease, diagnosis or condition'*, and that *'If an individual's needs change, then their eligibility for [CHC] may also change.'* The Department's consultation document further advised that in Northern Ireland, HSC Trusts *'are responsible for ensuring that an assessment of need is carried out for individuals in a timely manner and with appropriate multidisciplinary professional and clinical input as required'*. The

[6] AQW25318/11-15
[7] https://www.health-ni.gov.uk/consultations/continuing-healthcare-northern-ireland-introducing-transparent-and-fair-system

document also explained, however, that *'So as not to interfere with professional and clinical judgement, the Department has to date, refrained from drafting administrative guidance on a specific healthcare assessment.'*

24. The Department's public consultation document on CHC further explained that the assessment process *'covers both health and social care needs'*, and that should the outcome of such an assessment *'indicate a primary need for healthcare, the [the relevant HSC Trust] is responsible for funding the complete package of care in whatever setting. This is what is known as [CHC] in the local context. Alternatively a 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 that the HSC Trusts to levy a means-tested charge.'* It was also explained in the Department's consultation document that if an assessment identified that nursing home care was appropriate and the individual was responsible for meeting the full cost of their nursing home care, the relevant HSC Trust was responsible for making a payment of £100 per week directly to the nursing home provider to cover the cost of the nursing care.

NI Direct Website

25. The NI Direct website, the official government website for Northern Ireland citizens, provides advice on the *'HSC contribution towards the cost of nursing care provided in nursing homes'*. In doing so, it refers to CHC in Northern Ireland. When he submitted his complaint to my Office, the complainant provided a print-out of the relevant NI Direct webpage, as at 1 March 2013. The webpage,[8] which remains largely unchanged at the date of this report, states, '*If you live in a nursing home and have assessed nursing needs, the local trust will pay £100 per week towards the cost of the nursing. If your assessment indicates that your primary need is for health care, your Trust will pay for all your care. This is called "continuing health care".'*

(ii) The Trust's response to investigation enquiries

26. In response to investigation enquiries about the matters the complainant had raised, the Trust commented on its alleged failure to follow Departmental guidance

[8] https://www.nidirect.gov.uk/articles/paying-your-residential-care-or-nursing-home-fees

when it was requested to carry out a CHC assessment for Mrs A. The Trust stated, *'…the position of the Trust is that it has applied the assessment schedules available to it. These assessments include the Northern Ireland Single Assessment Tool (NISAT) and the Nursing Needs Assessment Tool (NNAT). These assessment tools are those referenced in [the 2010 Circular]. While I acknowledge that these tools do not start with a presumption of a continuing healthcare need, they do test if the presenting need can be addressed in a variety of care provision settings.'*

27. In relation to the complainant's contention that he and Mrs A's family did not receive any explanation as to why the Trust would not undertake a CHC assessment for Mrs A, the Trust commented that it had *'advised [the complainant] that [Mrs A's] continuing care needs would be assessed through the application of the NISAT and NNAT.'* The Trust also commented, *'[The complainant] has in the past been facilitated to input to these assessment processes. The Trust has also advised that the outcome of reviews of these assessments indicated that [Mrs A's] needs were being appropriately met within the Private Nursing Home'.*

28. In addition, the Trust referred to correspondence that had been exchanged between it and this Office in 2017 in relation to the issues faced by HSC Trusts in seeking to establish the administrative arrangements required to consider requests for CHC, in accordance with the 2010 Circular. The Trust acknowledged the need to put such administrative arrangements in place. However, it also highlighted that, when my Office had considered a previous (unrelated) complaint about the Trust's actions in relation to CHC, the (then) Ombudsman had (in March 2017) accepted there was a need to develop CHC policy on a Northern Ireland-wide basis. The Trust expressed the view that '*until such a regional position can be achieved [the Trust] is unable to move forward in relation to undertaking assessments for [CHC] needs or granting CHC status.'* (I will address this matter later in this report.)

29. Enquiries were also made of the Trust as to whether Mrs A had received payment from the Trust towards the cost of the nursing care that was provided to her at the Nursing Home. The Trust advised that Mrs A had been in receipt of the £100 per week payment for her nursing care since 31 October 2011, the date on which she had become a self-funding client at the Nursing Home, until the date of her

passing, 3 October 2016.

30. During the course of my investigation, it became apparent that certain assessments of Mrs A's care needs, which the Trust had carried out in January 2016 using the NISAT and the NNAT, were relevant to the matters the complainant had raised in his complaint. Enquiries were made of the Trust as to the assessor's understanding of the scope and purpose of those assessments. The Trust responded that it had no written record of the direction that had been provided to the Older People Specialist Nurse who had carried out the January 2016 assessments, advising, *'It would not be usual to provide a written brief along with a verbal request to complete an assessment'.* The Trust further stated in its response that the Older People Specialist Nurse had advised that '*she was requested to complete a fresh NNAT and NISAT assessment for [Mrs A]'*, and that '*she was made aware that [the complainant] [Mrs A's] son was in correspondence with the Trust seeking [CHC] status for his mother.'* The Trust also advised that the other member of Trust staff who had been involved in the January 2016 assessments, its Nurse Consultant for Older People, had since retired. The Trust stated it was not therefore in a position to ascertain the Nurse Consultant for Older People's recollection of events relating to the January 2016 assessments.

(iii) Department of Health's response to investigation enquiries

31. The public consultation on the review of CHC in Northern Ireland, which was launched by the Department on 19 June 2017, closed on 15 September 2017. During the course of the investigation of this complaint, enquiries were made of the Department to establish the current position on the review. In April 2019, the Department advised that a consultation response report had been drafted and would be published following consideration by a future Health Minister. In February 2020, following the end of the suspension of the Northern Ireland Assembly that had been in place since January 2017 , the Department advised that the consultation response report was yet to be submitted to the Health Minister and a decision taken on the way forward. In October 2020, the Department provided a further update on its review of CHC. At that time, it advised that there was no indicative timescale in relation to the publication of the public consultation response report and the implementation of new CHC arrangements in Northern Ireland.

32. The Department also advised me, as recently as October 2020, that HSC Trusts had been reminded that until such time as any revision to the current CHC arrangements had been agreed and implemented, the existing Departmental policy direction and guidance, as set out in the 2010 Circular, continued to apply. It further advised that *'it would be the Department's understanding/ expectation that each HSC Trust has in place policies/protocols/procedures and/or guidance to enable it to fulfil its responsibilities in relation to [CHC], in accordance with the [Department's] policy position set out in the 2010 Circular'.*

(iv) Review of documentation obtained

33. A review was completed of the documentation the complainant had provided in support of his complaint and of that provided by the Trust in response to investigation enquiries. Records provided by the Nursing Home were also examined. The following paragraphs reflect the findings of the documentation review that are relevant to this issue of complaint.

34. The resident profile record provided by the Nursing Home confirms that Mrs A became a resident on 8 August 2011. A Professional Visitor's Record notes that on 23 December 2011, Mrs A was seen by her GP. The reason for the GP's visit is recorded as *'Turn this p.m. TIA? Now has come around…'*

35. A Professional Visitor's Report dated 20 January 2012 records that Mrs A's Social Worker attended a review of her care needs at the Nursing Home. It is recorded that Mrs A's '*Current needs have increased due to TIA's Dec + Jan'*. The report further notes, *'[The complainant] very keen to establish these changes as he wishes to pursue a "continuing care assessment" through the Trust. Review arranged 18/4/12 @ 2.30pm…'*

36. In a document provided to the Investigating Officer during the course of the investigation,[9] the complainant stated, *'[Mrs A's daughter] and [Mrs A's son-in-law] and I attended a meeting in Daisy Hill Hospital on Wednesday 1st February 2012 at 2pm. I … spoke with [the Trust's Locality Manager] whom I understand is the direct line manager for mum's Social Worker. He admitted that he had seen the*

[9] Provided in the complainant's email of 10 March 2018 to the Investigating Officer

care plans and the last assessment prepared by the Social Worker and it was accepted that Mum's condition had deteriorated drastically since her review in November 2011. I explained that the underlying issue in this case concerns who should pay for the accommodation and care of [Mrs A] … The family and nurses in the home feel that mum's primary need is now a health need so is entitled to Continuing NHS Health Care paid for by the HPSS. [The Locality Manager] stated that he was totally unaware of this provision and that he would need to take our request back to his Director and possibly to the Board. [The Locality Manager] stated that we did not need to put our request for funding in writing as he felt that our position is clear. He stated that he would get back to us as quickly as he could.'

37. On 17 April 2012, a review of Mrs A's care needs took place at the Nursing Home. The record of the review, *'Minute of* [*Older People Primary Care] Review – Nursing/Residential Care'* states, *'[Mrs A] requires 24 hours nursing care and attention.'*

38. On 24 September 2012, the Department's Director of Mental Health, Disability and Older People Policy wrote to the Health and Social Care Board (HSCB). The purpose of the Department's correspondence (which is included at Appendix 6 to this report) was to obtain information from HCS Trusts about their approach to CHC. In its response, which is also included at Appendix 6, the Trust stated: *'Within the Southern Trust, the Northern Ireland Single Assessment Tool (NISAT) is used by professionals to assess need. The Trust works within the context of [the 2010 Circular].'*

39. On 20 February 2013, the Trust's Assistant Director of Primary Care wrote to the Mrs A's daughter, in response to her and the complainant having raised of the matter of a CHC assessment for Mrs A at their meeting with the Trust on 1 February 2012. In his letter, the Assistant Director of Primary Care stated, *'Thank you for contacting the Trust and for your enquiry in relation to [Mrs A's] eligibility for assessment for NHS Continuing Healthcare. I apologise for the delay in responding to your request for further information. I would now advise as follows: The Trust manages charging arrangements for individuals in residential and nursing home placements, in line with [the 2010 Circular]… I can advise that*

there is no policy framework for the full abatement of charges for those clients for whom a care home placement is considered as appropriate to their needs.'

40. A further review of Mrs A's needs took place on 29 August 2013. The Trust's record of the review, *'Minute of OPPC Review – Nursing/ Residential Care'* notes, *'Is very settled. Requires 24h nursing care.'*

41. On 5 September 2013, Mrs A's daughter wrote to the Trust, highlighting that the 29 August 2013 review had '*indicated that [Mrs A's] primary need [was] for health care, and as such the Trust should be funding the full cost of this care.'*

42. Subsequently, on 18 November 2013, the Trust carried out a Nursing Needs Assessment and a Memory Service Specialist Nursing Assessment for Mrs A at the Nursing Home. The Nursing Needs Assessment was undertaken using the NNAT, as referenced in the 2006 Circular. The NNAT assessment documentation notes that Mrs A had 'actual' nursing needs[10] in each of the 18 'assessed 'domains' of need. It also records, *'… [Mrs A's] condition is progressive and she requires 24 hour care and supervision to ensure her needs are met adequately'*. The section, '*Summary of Assessment,* noted*, '[Mrs A] has a 5 year history of Alzheimer's type Dementia. Her physical and mental health condition has been in gradual decline over the years. She…requires the consistency of the nursing care which she receives daily in [the Nursing Home]… She requires nursing home care given the complexities of her physical and mental health needs, to which she is totally dependent…'*

43. On 20 November 2013, the complainant and Mrs A's daughter attended another review of Mrs A's needs at the Nursing Home. The record of that review, '*'Minute of* [*Older People Primary Care] Review – Nursing/Residential Care'* notes that Mrs A '*Needs long term nursing care.'* It also records, '*It is evident when observing [Mrs A] that she is content and happy in [the Nursing Home]. Family state that she does seem to be safe and happy.'*

44. The Trust wrote to Mrs A's daughter on 2 December 2013 to inform her, as Mrs A's next of kin, of the outcome of the NNAT that had been completed on 18 November

[10] The NNAT methodology requires that an individual's nursing needs are assessed as 'none'; 'actual'; supervisory/management'; or 'directive'

2013. This was that Mrs A required *'Nursing care which needs to be provided in a nursing home.'* The Trust's letter also confirmed the payment of the Trust's contribution of £100 per week towards Mrs A's nursing care at the Nursing Home.

45. On 24 March 2014, John McCallister MLA wrote to the (then) Health Minister regarding Mrs A, and her family's requests for a CHC assessment to be completed for her. Mr McCallister pointed out that the family's requests remained unmet by the Trust. He asked that the Minister '*direct that the Trust carries out the Continuing Health Care Assessment in accordance with the [2010 Circular] …'*

46. The Health Minister responded to Mr McCallister on 9 April 2014, outlining the Northern Ireland policy framework for CHC, as set out in the 2010 Circular. Specifically, the Minister advised, '*…HSC Trusts are responsible for carrying out assessments of health and social care needs. As part of this assessment, as outlined in paragraph 17 of [the 2010 Circular], it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine whether an individual's primary need is for healthcare or for personal social services. In the latter case, the service user may be required to pay a means tested contribution.'*

47. The Minister also forwarded Mr McCallister's letter of 24 March 2014 to the Trust, asking that it consider and respond directly to the MLA in relation to Mrs A's case. (The Trust indicated to this Office that Mr McCallister's letter of 24 March 2014 was *'considered and responded to through the complaint's* [sic] *procedure'.* The Trust's handling of the Mrs A's family's complaint will be addressed later in this report.)

48. On 12 May 2014, Mrs A's daughter wrote to the Trust's Finance Department. She stated, *'…On the 1st February 2012, I along with my husband and my brother … attended a meeting in Daisy Hill Hospital where we met with [the Trust's Head of the Financial Assessment Unit], [the Trust's Financial Assessment Manager] and [the Trust's Locality Manager]. At this meeting we stated that the family and all the medical staff in the nursing home feel that mum's health had deteriorated to such an extent that we all felt her that her Primary need was now Health and as such she was entitled to [CHC] fully funded by the HPSS… We accept that there is a small debt on the account for her care up to and including the 23rd December 2011 the total which was to be agreed at a further meeting…'*

49. The Trust's (then) Chief Executive wrote to Mr McCallister on 21 May 2014, having received, on 14 April 2014, a copy of the MLA's letter of 24 March 2014 to the Health Minister. The Chief Executive stated, *'In cases where it is agreed that an individual's needs would be best met in a Nursing Home, the Trust manage[s] charging arrangements within the context of [the 2010 Circular]*.' The Chief Executive also advised that recent reviews had indicated that *'[Mrs A's] needs were being appropriately met'* in the Nursing Home's General Nursing Unit. (Further detail of the Chief Executive's response to Mr McCallister, along with my findings in relation to it, is provided later in this report, within the context of my consideration of the Trust's handling of Mrs A's family's complaint.)

50. Mr McCallister wrote again to the Health Minister on 26 June 2014. He pointed out that the complainant and his family maintained that in December 2011, Mrs A's care needs had *'changed from being primarily social to primarily medical'*.
Mr McCallister also stated that her family had been requesting a CHC assessment for her since February 2012 but that '*despite repeated requests … this has still not happened.'* He asked the Minister to '*give an undertaking that [he] would ensure that [the CHC assessment was] carried out as soon as is practicably possible and in any event before the end of August 2014 to enable the family to move forward with settling finances.'*

51. Mr McCallister's letter of 26 June 2014 to the Health Minister was referred to the Trust, where it was treated as a complaint about the provision of services to Mrs A. On 30 July 2014, the Trust's Chief Executive responded to the Health Minister, advising that her letter of 21 May 2014 to Mr McCallister *'clearly states the Trust's position in respect of how the Trust manages assessment for [CHC] placements'*. The Chief Executive further stated in her letter to the Minister that at the most recent review of Mrs A's needs on 20 November 2013 with family members, *'all present agreed that [Mrs A's] needs [were] being met in [the Nursing Home]. Therefore, the Trust position [was] that [Mrs A's] needs for a continuing care placement [were] being appropriately met within the context of the [2010 Circular]'*.

52. Mrs A's care needs were again reviewed at the Nursing Home on 3 September 2014. The complainant and Mrs A's daughter both attended the review, the record of which notes, '*Family have issues with the level of care their mother has been*

assessed as needing …Family report they are happy with the level of care provided in [the Nursing Home]'. The complainant referred to this review in the document[11] he provided to the Investigating Officer during the course of the investigation. Specifically, he stated, *'[Mrs A's Key Worker] said she was unaware of the on-going issues re funding for mum's care in the home … I also gave her a letter re written request for a [CHC] assessment as per [the 2010 Circular] to be carried out. She stated she would pass this to her direct line manager [the Trust's Nurse Consultant for Older People].'*

53. The letter the complainant and Mrs A's daughter passed to Mrs A's Key Worker on 3 September 2014 referred to the family's belief that Mrs A's primary need had become healthcare on 23 December 2011, and to no information having been provided to the family *'to show that she has been assessed for [CHC] since needing this full time care'*. The letter further stated, *'I believe that [Mrs A] is being charged for care that the Trust has a legal duty to provide free of charge. Her needs are beyond the remit of social care so should not be means tested.'* The letter also highlighted the family's concern that no determination for CHC '*as per paragraph 88 of the [2010 Circular]'* had been carried out and it asked that Trust advise when it would be arranging a CHC assessment *'as per paragraph 17 [of the 2010 Circular]'.*

54. On 28 October 2014, the Chief Executive of the Commissioner for Older People for Northern Ireland (COPNI) wrote to the Trust on behalf of the complainant and his family. The COPNI Chief Executive referred to the family's contention that '[Mrs A's] *primary need is health care and that due to her current medical condition is entitled to qualify for free nursing care'.* She also pointed out that the complainant had requested a CHC assessment on a number of occasions and had made a written request on 3 September 2014, to which he had yet to receive a response. The COPNI Chief Executive further advised that the family had not been *'presented with any information to confirm that a [CHC] assessment [had] taken place'*. She asked the Trust's Chief Executive to *'ensure that a full [CHC] assessment takes place without further delay.'*

55. On 4 November 2014, the Trust's Assistant Director of Primary Care wrote to the

[11] Provided in the complainant's email of 10 March 2018 to the Investigating Officer

complainant and Mrs A's daughter in response to the letter they had given to Mrs A's Key Worker on 3 September 2014, and in which they had requested a CHC assessment to be carried out. The Assistant Director of Primary Care stated, *'…In your letter you advised that you are concerned that "no determination for NHS Continuing healthcare as per paragraph 88 of circular (ECCU)' has been carried out". You also detailed a number of questions, which I will respond to:*

Question 1: Why is this the case?

Response:…the Trust manages charging arrangement for individuals in residential and nursing home placement, in line with [the 2010 Circular] …As advised previously, there is no policy framework for the full abatement of charges for those clients for whom a care home placement is considered as appropriate to their needs. The Trust's position is that [Mrs A's] continuing care needs have been consistently and appropriately met within a nursing home placement. Also that the [NNAT] has identified that [Mrs A] should receive the allowance allocated to ensure that the nursing needs element of her care does not attract any financial charge to [Mrs A].

Question 2: When will you be arranging an assessment as per paragraph 17?

Response: The Trust can advise that [Mrs A] has been assessed within the context of both the Northern Ireland Single Assessment Tool (NISAT) and the nursing Needs Assessment (NNAT) as specified in paragraphs 15, 16, 18 and 75 of [the 2010 Circular].'

56. Also on 4 November 2014, the Department's Director of Mental Health, Disability and Older People wrote to HSC Trusts to inform them of a planned review of CHC in Northern Ireland. The Department's correspondence, which is included at Appendix 6 to this report, explained that to inform the review, all Trusts were being asked to provide information on their current CHC practice. The Department's correspondence made it clear that '*until such time as this [review] is complete … **the current Departmental guidance on [CHC], specifically paragraph 17 of [the 2010 Circular] remains applicable*** [the Department's emphasis]*… It is the responsibility of HSC Trusts to ensure that appropriate assessments of needs for individuals are carried out, including those with continuing healthcare needs.'*

57. In its response to the Department's request for information on its CHC practice,

which is also at Appendix 6, the Trust stated that it understood that *'the concept of [CHC] refers to the categorisation, through a comprehensive assessment of need, whether an individual's primary need is for healthcare or for personal social services'.* In responding to the Department's enquiry about the process the Trust followed *'when assessing a client's eligibility for [CHC]',* the Trust advised that it assessed the needs of an individual *'though the application of the DHSSPSNI recommended [NISAT] and/or the [NNAT]'*. The Trust's response to the Department further indicated that assessments were *'carried out by suitably trained Health & Social Care professionals, usually on a multi-disciplinary basis'*, and that if a decision was reached that an individual's needs *would 'be best met within a continuing care placement (eg Residential Home or Nursing Home) the placement [was] managed in keeping with [the 2010 Circular]'*. The Trust also stated that it did not have any Trust-specific policies, protocols or guidance in place for clinicians to use in the determination of CHC eligibility; rather, the Trust ensured that staff used the NISAT and, where appropriate, the NNAT. The Trust noted that it would *'welcome definitive [Departmental] policy in relation to this issue'*. In response to the Department's enquiry as to whether the Trust was following the approach set out in the 2010 Circular, the Trust advised, *'…whilst the Trust manages any individual service user's needs for access to nursing care in keeping with the Circular's recommendations as they pertain to being assessed via the [NNAT] and being awarded free nursing care, no determination is made in relation to eligibility for [CHC] within continuing care placements.'*

58. On 26 November 2014, the Trust's Chief Executive wrote to the COPNI Chief Executive, in response to her letter of 28 October 2014. In relation to the complainant's written request of 3 September 2014 for a CHC assessment, the Trust's Chief Executive referred to the Trust's Assistant Director of Primary Care's response of 4 November 2014 to the complainant and Mrs A's daughter. With regard to the family's contention that Mrs A's primary need was healthcare, the Trust's Chief Executive advised, *'the Trust assesses individuals continuing placement requirements through the application of [the NISAT] and [the NNAT].* She further stated, *'Following the identification that the individual needs to be managed in a permanent placement, the Trust manages charging arrangements in the context of [the 2010 Circular], as well as through other associated guidance.'*

The Chief Executive did not directly address the COPNI Chief Executive's specific request that a CHC assessment be carried out for Mrs A. (Further detail of the Trust's Chief Executive's response to the COPNI Chief Executive, and my findings in relation to it, is provided later in this report, within the context of my consideration of the Trust's handling of Mrs A's family's complaint.)

59. On 26 June 2015, the COPNI Chief Executive wrote to the Trust's Chief Executive (Interim), reiterating Mrs A's family's '*wish for their mother to be subject to a full [CHC] assessment that involves the family and appropriate medical practitioners, with full disclosure of the relevant notes and records once the assessment has been completed.'*

60. The Trust's Older People and Primary Care Directorate's Clinical and Social Care Governance Office (the Governance Office) acknowledged the COPNI Chief Executive's correspondence on 6 July 2015. The Trust's Chief Executive (Interim) provided a substantive response to the COPNI Chief Executive on 10 August 2015, advising that the Trust's position on CHC was as stated in the Assistant Director of Primary Care's letter of 4 November 2014 to the complainant and Mrs A's daughter. The Chief Executive (Interim) reiterated the Trust's position on the management of '*requests for individuals to be assessed for continuing care placement'*, which was that '*individuals have their requirements assessed through the application of [the NISAT] and [the NNAT]*', and that where it was identified that '*the individual requires to be managed in a permanent placement, the Trust manages charging arrangements within the context of [the 2010 Circular], as well as through other associated guidance'*. The Chief Executive (Interim) further stated, *'All assessments to date have shown that [Mrs A] assessed care needs are being appropriately met in her current placement'.*

61. On 16 October 2015, a Person Centred Review of Mrs A's care needs was completed at the Nursing Home. The record of the review notes, *'[Mrs A's] general health has deteriorated since last review'.*

62. Following a meeting between COPNI and the Trust in early November 2015, the COPNI Chief Executive wrote to the Trust's Assistant Director of Primary Care on 9 November 2015. In relation to the assessment of Mrs A's needs, the COPNI Chief Executive wrote, '*The Trust has indicated that the most recent assessment of*

[Mrs A's] needs was carried out on 16th October 2015. The family wish to see a review of this assessment carried out by a suitably senior and experienced staff from an independent Health and Social Care Trust. Such a review would help to give confidence to the family and ensure that a full NISAT assessment has taken place, with the full engagement of the family. The family remain of the view that their mother's primary need is healthcare and have not seen evidence from the Trust that supports a contrary view. Please confirm when this review will be undertaken and by whom…'

63. The Trust's Assistant Director of Primary Care responded to the COPNI Chief Executive on 30 November 2015. He stated, *'…the Trust is proposing that in the first instance, a NISAT review will be performed by one of the Trust's Older People Specialist Nurses [who] will not have been involved in [Mrs A's] care previously and will be able to provide an independent opinion in relation to [Mrs A's] assessed needs.'* The Assistant Director of Primary Care also stated, *'Once the assessment is completed, it will then be reviewed by the Trust's Consultant Nurse for Older People'*.

64. The COPNI Chief Executive wrote again to the Trust's Assistant Director of Primary Care on 16 December 2015, advising that the complainant's family was '*keen to see a comprehensive health care assessment undertaken as quickly as possible'.* The COPNI Chief Executive requested the Trust to *'confirm a date for the assessment [and] the identity of the Older People Specialist Nurse who will be conducting the assessment as soon as possible.'*

65. On 20 January 2016, a Trust Older People Specialist Nurse undertook two assessments of Mrs A's needs, completing the NISAT and NNAT assessment documentation on that date. The 'NISAT Core/Complex Assessment' record states in the 'Assessors Analysis and Summary' section, *'[Mrs A] requires nursing home placement to meet her current assessed needs. This is reflected by person centered nursing assessments and care planning. [Nursing Home] Nursing staff are supported as and when required by [Trust] Professionals.'* The NNAT assessment documentation notes that Mrs A had 'actual' nursing needs[12] in 15 of

[12] The NNAT methodology requires that an individual's nursing needs are assessed as 'none'; 'actual'; supervisory/management'; or 'directive'

the 18 'assessed domains of need, and 'supervisory/ management' needs in one other domain. The record also notes in the 'Summary of Assessment' section, '[*Mrs A's] nursing needs are highly complex and require frequent intervention and regular assessment...'*

66. The Trust's Assistant Director of Primary Care wrote to the COPNI Chief Executive on 16 February 2016. He stated, *'…it is important to restate that the Trust have previously carried out assessments of [Mrs A] and based on these the Trust is supporting her continuing care placement in [the Nursing Home] where her care needs are fully met. The family of [Mrs A] have acknowledged during their input to previous reviews that her needs are being met.'* The Assistant Director also stated, *'the Trust position is that [Mrs A's] needs are being fully met within the Private Nursing Home placement, costed at the regional tariff and that the Trust is managing this placement in keeping with [the 2010 Circular].*

67. On 15 April 2016, the complainant and Mrs A's daughter attended a meeting with the Trust's Older People Specialist Nurse who had undertaken the NISAT and NNAT assessments on 20 January 2016. The Trust's Nurse Consultant for Older People also attended the meeting. The NNAT assessment documentation records that an amendment was made at that time to include *'issues identified since 20/1/16'*, which related to a wound on Mrs A's left breast; advice from an occupational therapist that the use of wheelchair for transferring Mrs A should discontinue; and a change of Mrs A's chair.

68. There is also reference to the meeting on 15 April 2016 in documentation the complainant provided to the Investigating Officer during the investigation.[13] In it, the complainant stated, *'[The Nurse Consultant for Older People] indicated that she had been asked by [the Assistant Director of Primary Care], to whom she reports,[14] to assess Mum's Nursing Needs as a self-funding resident in [the Nursing Home] and not a Healthcare assessment.'*

69. The Trust's Director of Older People and Primary Care again wrote to the COPNI Chief Executive on 25 April 2016. She advised that the NISAT and NNAT

[13] The complainant's email of 10 March 2018 to the Investigating Officer
[14] In commenting on the draft of this report, the Trust advised, *'The Nurse Consultant [for Older People] was not in a reporting or Line Management relationship with the Assistant Director of Primary Care.'*

assessments *'with family members present on Friday 15 April 201[6]'* had been completed by the Trust's Nurse Consultant for Older People and its Older People Specialist Nurse *'with [Mrs A's daughter] and [the complainant] present.'* The Director further advised, *'In keeping with previous assessments, the reassessments have identified a range of nursing needs in respect of [Mrs A]. The outcome of the reassessments show that [Mrs A's] care needs are well met within [the Nursing Home] … and that the Trust position is that the management of charging arrangements are appropriately dealt with in keeping with [the 2010 Circular]. Therefore, the Trust position is that all outstanding queries have been addressed by the Trust and that the debt owed is now due for immediate settlement.'*

70. Records provided by the Nursing Home indicate that Mrs A's health continued to decline following the January 2016 NISAT and NNAT assessments. A care plan in relation to '*End of Life Care – Active Palliative Care (end stage)'* dated 15 June 2016 records, *'[Mrs A] has reached the end stages of life she needs to be kept comfortable and provided with all aspects of care to maintain [her] dignity and consider her wishes…'*

71. COPNI's Legal Officer wrote to the Trust's Assistant Director of Primary Care on 22 June 2016 to request information on *'What conclusion [had] been reached as to what [Mrs A's] primary need is'*. The Legal Officer also asked, *'If [Mrs A's primary need is not considered healthcare can you outline the basis for this conclusion'* and *'If Mrs A's primary need is considered to be personal social services can you outline the basis for such a conclusion.'*

72. On 27 July 2016, the Manager of the Nursing Home prepared a letter addressed, '*To whom it may concern'.* The letter stated*, 'This is to confirm that [Mrs A] is in our care and her healthcare needs have changed since admission. At present she is receiving end of life care.' …*

73. The complainant and Mrs A's daughter met with the Trust's Nurse Consultant for Older People on 22 August 2016 to discuss the January 2016 NISAT assessment, to which they had provided input on 15 April 2016. The Trust's note of the meeting records, *'NISAT assessment reviewed in detail. The following actions were*

agreed: - Add in medical condition not noted; Amend typing errors; Clarify Y/N boxes. Update and send by post to [the complainant].' The NISAT core assessment documentation was updated, as agreed at the meeting, and a copy of the documentation was forwarded to the complainant and Mrs A's daughter on 26 August 2016.

74. The Trust's Assistant Director of Primary Care wrote to COPNI's Legal Officer on 8 September 2016, in response to the Legal Officer's correspondence to him of 22 June 2016. The Assistant Director advised that following the Trust's '*reassessments of [Mrs A]',* her family had requested further meetings with Trust staff, which had concluded on 22 August 2016. He stated that Trust's position remained that Mrs A's needs had been assessed in keeping with NISAT and NNAT, and that these did not *'provide, as an outcome, a determination in respect of whether the primary need is one of healthcare or personal social services'*. The Assistant Director of Primary Care further advised, *'the assessments have consistently identified that Mrs A has a range of nursing needs that have been well met with the Private Nursing Home environment at the regional tariff rate, without recourse for any particularly complex arrangements to be put in place.'*

75. On 25 October 2016, the Department's Director of Mental Health, Disability and Older People wrote to HSC Trusts to provide an update on the Department's review of CHC, as referred to in his previous correspondence to them of 4 November 2014. The Director of Mental Health, Disability and Older People advised that the Department's review had *'identified an apparent lack of understanding across a range of groups and inconsistent application of Departmental Guidance and [CHC] practice across HSC Trusts'*. He also advised that the Department had therefore concluded that *'there was a need for further clarity and revision to the local [CHC] policy'*. The Director of Mental Health, Disability and Older People went on to advise that a number of options were being explored by the Department and that a public consultation was planned, once a determination had been made on the most appropriate way forward. He further advised Trusts, '*…until such time as any revision to the current arrangements have been agreed and implemented, HSC Trusts are reminded that the extant Departmental guidance as set out in [the 2010 Circular] continues to apply.'* The Director of Mental Health, Disability and Older People went on to refer specifically

to the content of paragraphs 17 and 88 of the 2010 Circular.

(v) Independent Professional Advice

76. The Investigating Officer sought independent professional advice from a continuing healthcare independent professional advisor (the IPA). The IPA, a Registered Nurse (Adult), Specialist Practitioner (District Nursing) and Nurse Prescriber, has 35 years' experience working within NHS continuing healthcare. The IPA's full report is at Appendix 4 to this report.

77. It was pointed out to the IPA that the Trust had stated that it had undertaken a number of assessments of Mrs A's needs during the time she was resident of the Nursing Home. These assessments included a number of reviews of Mrs A's care needs; the NNAT assessment and the Memory Service Specialist Nursing assessment completed on 18 November 2013; and the NISAT and NNAT assessments undertaken on 20 January 2016. The IPA was asked which, if any, of these assessments were appropriate for determining Mrs A's eligibility for CHC. The IPA advised, *'The Trust have completed assessments using the recommended assessment tools - NISAT and NNAT - in accordance with the guidance as set out within [the 2010 Circular]. The NISAT assessment is the appropriate tool in Northern Ireland for determining [Mrs A's] health and social care needs. When the assessment is completed by the Multi-disciplinary Team (MDT), the assessment should provide sufficient information to determine if [Mrs A's] primary need is for health or social care, and therefore determine her eligibility for CHC.'*

78. The IPA was asked at what point in the chronology of the assessments completed for Mrs A, the Trust would have gathered sufficient information about her care needs to enable it to determine her eligibility for CHC. The IPA responded that *'Following the completion of a core NISAT assessment and if identified, any necessary specialist assessments, the Trust should then have sufficient information about [Mrs A's needs to enable a determination of her eligibility for CHC to be made.'* Although the IPA highlighted that *'OPPC reviews were completed on a number of occasions and NNAT and the Memory Service Specialist Nursing Assessment was completed in August 2013'*, she also pointed out, *'An assessment using the NISAT tool was not completed until January 2016.'*

79. Advice was sought from the IPA as to whether the assessments the Trust completed of Mrs A's care needs were, in themselves, sufficient to determine her eligibility for CHC, and, if not, what further action by the Trust would have been required to enable such a determination to be made. The IPA advised that the assessments completed by the Trust were not sufficient in themselves to determine Mrs A's eligibility for CHC. The IPA went on to highlight, *'Neither [the 2010 Circular] nor NISAT guidance[15] specifically sets out the process by which Trusts should determine eligibility for Continuing Healthcare funding'.* The IPA advised, *'The Trust, following an assessment or review process using NISAT, would have sufficient information in relation to [Mrs A's] needs to determine if further consideration should take place in relation to CHC eligibility. However, the Trust did not have mechanisms in place to make this determination for individuals placed in nursing care homes (continuing care placements). This is evidenced by the Trust's response to the Department of Health's 2014 questionnaire in its reply to Question 7. This stated "no determination is made in relation to eligibility for Continuing Healthcare within continuing care placements".'*

80. The IPA commented further, *'To enable a determination of [Mrs A's] eligibility, the Trust would need to put in place a local policy to make a determination of [Mrs A's] CHC eligibility. The policy would need to set out the Trust's interpretation of [the 2010 Circular] and the process to be used by the Trust's staff to determine if an individual's need was a primary need for healthcare or personal social services. To ensure the level of assessment was proportionate, the local policy would need to include a threshold criteria to 'trigger' a NISAT assessment. This is the most appropriate assessment tool within NI to determine if an individual has a "primary need for healthcare or personal care services"…'*

81. The Trust's responses to the Department's requests of September 2012 and November 2014 for information about its CHC practice (included at Appendix 6) were shared with the IPA. The IPA was asked whether the Trust assessed Mrs A's eligibility for CHC in the manner it had described in its responses to the Department.

82. The IPA advised that she was satisfied that, as it had stated in its responses to the

[15] The Northern Ireland Single Assessment Tool (NISAT) Procedural Guidance, version 3, January 2011

Department, the Trust had assessed and reviewed Mrs A's needs using OPPC, NISAT and NNAT assessment tools. However, the IPA also pointed out that *'… as the Trust [had] responded [to the Department], no determination was made in relation to [Mrs A's] CHC eligibility … as she was placed within a continuing care placement (eg residential home or nursing home)'.*

83. The IPA was also asked whether, notwithstanding the Trust's September 2012 and November 2014 responses to the Department on its CHC practice, the action it had taken in Mrs A's case was in keeping with the approach set out in the 2010 Circular. The IPA responded*, 'the Trust's position "no determination is made in relation to CHC eligibility … within continuing care placements" is not in line with the approach set out in the 2010 Circular.'* The IPA explained, *'To determine CHC eligibility, clinicians together with other health and social care professional colleagues … and in consultation with the service user, his/her family and carers, determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services. This process is described within Paragraph 17 of [the 2010 Circular] … Therefore, although the Trust completed assessments and reviews in accordance with the Circular, no local policies or processes were in place to support professionals in identifying if [Mrs A's] primary need was for health or social care within continuing care placements. Therefore, the Trust's practice is not in accordance with the approach set out in the 2010 Circular.'*

84. Advice was sought from the IPA on the appropriateness of the Trust's stated position that the NISAT and NNAT assessments completed for Mrs A in January 2016 did not "*provide as an outcome, a determination in respect of whether the primary need is one of healthcare or personal social services."*[16] The IPA advised that the Trust's stated position was '*not an appropriate response to the requests for [Mrs A's] CHC eligibility to be determined as this is not in accordance [with] Paragraph 17 [of the 2010 Circular].'* The IPA continued, *'To be in accordance with [the 2010 Circular], the Trust would need to establish if [Mrs A's] primary need was for healthcare or for personal social services to determine if she may be required to pay a means tested contribution towards her care.'*

[16] As stated in the Assistant Director of Primary Care's letter of 8 September 2016 to the COPNI Legal Officer

85. The IPA was also asked to comment on the appropriateness of the Trust's stated position that Mrs A's nursing needs were being *"well met with the Private Nursing Home environment at the regional tariff rate, without recourse for any particularly complex arrangements to be put in place".*[17] Specifically, the IPA was asked whether this was an appropriate and reasonable response to the Mrs A's family's request for her CHC eligibility to be determined. In her response on this matter, the IPA noted that on the basis of the records available to her, including GP and care home, and the NISAT and NNAT assessments completed for Mrs A, *'it appeared that [Mrs A's] care was well met and managed at [the Nursing Home] without any specialist arrangements being put in place',* and that *'the records also evidence that [Mrs A's] needs could have been met within any similar nursing care home establishment'.* The IPA acknowledged that in this respect, the Trust's stated position was appropriate and reasonable. The IPA was also clear, however, that the Trust's response was lacking in that it '*did not address the family's request for [Mrs A's] eligibility for [CHC] to be determined as the Trust maintained the position that "no determination is made in relation to eligibility for [CHC] within continuing care placements".'* [18]

86. The IPA was referred to paragraph 63 of the 2010 Circular, which states that *'the [1972 Order] requires that a person is charged for* ***personal social services*** [my emphasis] *provided in residential care or nursing home accommodation arranged by a HSC Trust [but that there is] no such requirement, or authority, to charge for* ***healthcare*** [my emphasis] *provided in the community*, *either in the service user's own home or in a residential care or nursing home.'* It was pointed out to the IPA that in submitting his complaint to this Office, the complainant had stated that following a deterioration in Mrs A's health on 23 December 2011, nursing staff at the Nursing Home and Mrs A's GP had '*felt that her needs had changed to being primarily* ***nursing****'* [my emphasis]. It was also highlighted to the IPA that subsequently, in submitting further documents to this Office in support of his complaint, the complainant had stated that, *'all accept that* ***nursing*** [my emphasis] *care was not [Mrs A's] primary need'* at the time she became a permanent resident

[17] As stated in the Assistant Director of Primary Care's letter of 8 September 2016 to the COPNI Legal Officer

[18] As stated in the Trust's response to the Department's November 2014 request for information on CHC practice.

of the Nursing Home. The IPA was asked to explain the difference, if any, between 'nursing care', as referred to by the complainant and 'healthcare', as referred to in paragraph 63 of the 2010 Circular.

87. In response, the IPA advised that the term 'nursing care' is used in the 2006 Circular. The IPA also advised that a definition of 'nursing care' is provided in the Department's guidance document, 'Payments for Nursing Care', published in June 2006[19], as follows: *"Nursing care means care by a registered nurse in providing, planning and supervising your care in a care home providing nursing care … It is different from personal care – 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'.* In relation to 'healthcare', as referred to in paragraph 63 of the 2010 Circular, the IPA advised that this *'relates to not only the care of a Registered Nurse but also the care provided by a range of other health care professionals and services required to meet the totality of an individual's health care needs, for example in the community, GPs, therapists, dieticians, audiologists etc.'*

88. The IPA was asked whether, on the basis of the available records and documentation, she considered Mrs A's primary need became more than social care (personal social services) at any time after she became a permanent resident of the Nursing Home in August 2011. The IPA responded, *'The care [Mrs A] required, as described within NISAT, NNAT and [the Nursing Home] care plans and records, was not beyond that defined as nursing and personal care services within the information produced by [the Department] to support [HSC] funding nursing care for people going into nursing homes, their families and their carers'.*[20] The IPA continued, *'The records evidence that [Mrs A] had a range of both health (including nursing) and social care needs on admission to [the Nursing Home] and*

[19] https://www.nidirect.gov.uk/sites/default/files/publications/%5Bcurrent-domain%3Amachine-name%5D/hpss-payments-for-nursing-care-information-leaflet.pdf
[20] https://www.nidirect.gov.uk/sites/default/files/publications/%5Bcurrent-domain%3Amachine-name%5D/hpss-payments-for-nursing-care-information-leaflet.pdf

throughout the time she was resident there - 8/08/2011 - 03/10/2016 … [Mrs A] required both social and health care to meet and manage her assessed and presenting care needs.' The IPA set out, at Appendix 1 to her report, extracts from care records, GP records and Trust documents that she considered illustrate the range of Mrs A's needs during the period 2011 to 2016.

89. The IPA was also asked whether, on the basis of the available records and documentation, she considered Mrs A's primary need became healthcare at any time after she became a permanent resident of the Nursing Home in August 2011. The IPA responded, *'After careful consideration and whilst acknowledging that [Mrs A] had a range of both health and personal care needs throughout the 24 hour period, I have concluded that interventions [Mrs A] required to meet her needs, in themselves or in combination, were not such to be considered indicative of a "a primary need for healthcare" according to Paragraph 17 [of the 2010 Circular] and based upon the information provided to me. However, "a primary need for healthcare" [as referred to in paragraph 17 of the 2010 Circular] should be determined by a MDT. Therefore for this to be confirmed, it would require the Trust to put in place a process for a MDT to consider if [Mrs A] had "a primary need for healthcare". This would need to be completed retrospectively as [Mrs A] has now passed.'*

90. The IPA set out in her report a detailed rationale for her opinion in relation to the nature of Mrs A's primary need.

91. The IPA was asked for any further comments she considered may assist in my consideration of the complainant's complaint. In response, the IPA advised, '*On review of the information within the NIPSO file, correspondence from the Trust, [the complainant] and others it is evident that the concept and determination of "primary need for health care" requires greater clarification in Northern Ireland in order to assist Trusts in the application of Continuing Healthcare.'* The IPA went on to highlight that the Department's public consultation on future arrangements for CHC in Northern Ireland, which had launched in June 2017. The IPA commented, '*On 15/04/2019, [the Department] provided an update to NIPSO about the 2017 public consultation on CHC in Northern Ireland. It advised that a consultation response report had been drafted and would be published following consideration*

by a future Health Minister. The Department further advised that HSC Trusts had been reminded that until such time as any revision to the current CHC arrangements had been agreed and implemented, the extant Departmental guidance, as set out in the 2010 Circular, continued to apply. Therefore, until such a time when the consultation response is published, the Trust needs local policies and processes setting out the Trust's approach for determining if an individual's primary need is for health or social care.'

92. The IPA concluded her advice by recommending that the Trust should consider the following service improvements:

    i. *'Develop[ing] local policy and protocols in relation to [the 2010 Circular] so that clear guidance is available to staff and the public in the response to requests for Continuing Healthcare assessment.*

    ii. *Develop[ing] local processes and protocols regarding the use of [the NISAT] in relation to establishing [CHC} eligibility as set out within [2010 Circular].*

    iii. *Develop[ing] local processes and protocols to include a question in the NNAT review template with regard to any changes in need for individuals in nursing homes which would warrant an assessment as to whether [CHC] could apply.*

    iv. *Set[ting] expectations regarding the Trust's position regarding [CHC] eligibility and assessment for individuals through literature, website etc.*

    v. *Ensur[ing] that Trust staff involved in the assessment of individuals with complex health and social care needs are adequately trained in the use of NISAT and NNAT covering the processes used in determining whether an individual's primary need is for healthcare or for personal social services.'*

(vi) The Trust's comments on the Independent Professional Advice

93. The Trust was invited to comment on the advice obtained from the IPA. In its response, and before commenting specifically on the IPA's advice, the Trust referred to previous correspondence between it and this Office regarding the

issues HSC Trusts faced in seeking to establish the administrative arrangements that are required to consider requests for CHC, in accordance with the 2010 Circular. (I have referred already to this correspondence, in recording the Trust's response to investigation enquiries about this issue of complaint.) The Trust reiterated that it was not in a position to put in place the necessary administrative arrangements to enable it to consider requests for CHC assessments in accordance with the 2010 Circular, or to provide a mechanism through which the outcome of CHC assessments could be reviewed. The Trust advised that its position remained as communicated to this Office in February 2017, which was that such administrative arrangements in relation to requests for CHC assessment, had to be *'agreed on a Northern Ireland basis, as accepted by [the (then) Ombudsman] in her letter dated 03 March 2017'.* (As I have noted above, I will address this matter later in this report.)

94. The Trust went on to comment on the advice that had been obtained from the IPA. The Trust's full response to the IPA's advice is at Appendix 5 to this report. The following paragraphs reflect those elements of the Trust's response, in which it had indicated that it did not agree with the IPA's opinion.

95. The Trust referred to the IPA's view that following the completion of a core NISAT assessment, and any required specialist assessments, the Trust ought to have had sufficient information about Mrs A's needs to enable a determination of her eligibility for CHC to have been made. The Trust challenged this view, on the basis that the '*absence of a regional definition and the associated decision support tools relating to CHC within Northern Ireland'* meant it was not in a position to make such a determination.

96. The Trust pointed out that the IPA had highlighted that the NISAT and NNAT *'in themselves were not sufficient to determine [Mrs A's] eligibility for CHC'*, and that neither the 2010 Circular nor the NISAT guidance *'specifically sets out the process by which Trusts should determine eligibility for [CHC] funding'*. The Trust again referred to *'the absence of a regional definition and the associated decision support tools relating to CHC within Northern Ireland'.*

97. The Trust also referred to the IPA's view that the Trust's stated position that Mrs A's nursing needs were being '*well met within the Private Nursing Home*

Environment at the regional tariff rate, without recourse to any particularly complex arrangements to be put in place', did not address the Mrs A's family's request for her CHC eligibility to be determined. The Trust again referred to impact the *'the absence of a regional definition of CHC within Northern Ireland and an agreed assessment process'* had had on its ability to make a determination of Mrs A's CHC eligibility. It also contended that this lack of *'regional definition of CHC, an agreed assessment process and decision support tools within Northern Ireland'* meant that its response to Mrs A's family's request for a CHC eligibility determination had been *'appropriate and reasonable'*.

98. In addition, the Trust referred to the IPA's advice that *'until such a time when the [Department's public consultation on CHC] response is published, the Trust needs local policies and processed setting out the Trust's approach for determining if an individual's primary need is for health or social care.*' The Trust advised that its position on this matter remained unchanged: administrative arrangements such as these *'need to be agreed on a Northern Ireland basis, as accepted by [the (then) Ombudsman] in her letter [to the Trust] dated 03 March 2017.'* (Again, I will address this point later in this report.)

Analysis and Findings

99. The complainant stated that the Trust did not follow Departmental guidance in relation to the CHC assessment that was requested for his mother, Mrs A, and that it therefore failed to determine her primary care need. He also complained that he and Mrs A's family did not receive any explanation as to why the Trust would not carry out an assessment of Mrs A's eligibility for CHC.

100. In submitting his complaint to this Office, the complainant said that when Mrs A became a resident of the Nursing Home, *'all accept that nursing care was not her primary need'*. He also said that it was after Mrs A's health declined rapidly in December 2011, to a point where her needs *'had changed to being primarily nursing, and medical intervention was required much more often'*, that he and his sister, Mrs A's daughter, and her next of kin, first asked the Trust to carry out an assessment of Mrs A's eligibility for CHC.

101. I noted that the 1972 Order does not provide an explicit statutory framework for the

provision of CHC in Northern Ireland, nor does it expressly require that CHC be provided to people in Northern Ireland. That said, I also noted that paragraph 63 of the 2010 Circular, states *'[The 1972 Order] requires that a person is charged for personal social services provided in residential care or nursing home accommodation arranged by a HSC 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 difference between healthcare needs and social care needs, in terms of the legal authority for a HSC Trust to charge for the care provided to an individual who has been placed in a residential care or nursing home.

102. I noted this distinction was reinforced by the Health Minister's written response to Assembly Question AQW 25318/11-15, which was that '*an individual's primary need can be either for health care – which is provided free – or social care for which a means tested contribution may be required',* and by the Department's June 2017 public consultation document on future arrangements for CHC in Northern Ireland, which stated that where an assessment of needs *'indicate[s] a primary need for healthcare, the [the relevant HSC Trust] is responsible for funding the complete package of care in whatever setting. This is what is known as [CHC] in the local context. Alternatively a 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 that the HSC Trusts to levy a means-tested charge.'*

103. I further noted that paragraph 88 of the 2010 Circular states that, *'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 under [the Health and Personal Social Services (Assessment of Resources) Regulations (NI) 1993]'*. I was mindful, however, the 2010 Circular also places a clear responsibility on HSC Trusts to determine whether the individual's primary need is social care or healthcare, where it is appropriate to do so (for example, where it appears that there may have been a change in an individual's care needs). Specifically, paragraph 17 states,'… *it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a*

comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services. In the latter case, the service user may be required to pay a means tested contribution.'

104. My investigation established that requests for Mrs A's eligibility for CHC to be assessed were made to the Trust on a number of occasions over a period spanning more than four years.

105. Mrs A's eligibility for CHC was first formally raised with the Trust by the complainant and Mrs A's daughter at a meeting on 1 February 2012. However, it was not until more than a year later, on 20 February 2013, that the Trust provided its response to the complainant's and Mrs A's daughter's enquiry about Mrs A's CHC eligibility. I noted that that response, provided by the Trust's Assistant Director of Primary Care, advised that the Trust *'manages charging arrangements for individuals in residential and nursing home placements in line with [the 2010 Circular]'*. The response also advised, *'… there is no policy framework for the full abatement of charges for those clients for whom a care home placement is considered as appropriate to their needs'*. It is evident from this response that despite the complainant and Mrs A's daughter having stated at their meeting with the Trust on 1 February 2012 that they considered Mrs A's primary need was healthcare and that she was therefore entitled to have the cost of her care met by the Trust, the Trust did not carry out a comprehensive assessment of Mrs A's needs at that time in order to determine her primary need, in accordance with the 2010 Circular.

106. I also consider it was inaccurate and misleading for the Trust to have stated in its response of 20 February 2013 to the complainant and Mrs A's daughter that there was '*no policy framework for the full abatement of charges'* for individuals whose needs make it appropriate for them to be placed in a residential care or nursing home. The statement is at odds with paragraph 63 of the 2010 Circular, which emphasises, '*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 particular paragraph of the 2010 Circular makes it clear that an individual's placement in a residential care or nursing home does not necessarily preclude their eligibility for CHC; if an individual's primary need has

been assessed as healthcare, then there is no requirement or authority for the relevant HSC Trust to charge for the care provided to them, irrespective of the setting in which that care is provided.

107. It is not possible for me to say, on the basis of the evidence available to me, whether the Trust's inaccurate and misleading response of 20 February 2013 to the complainant and Mrs A's daughter was due to a genuine misunderstanding or misinterpretation on its part of the provisions of the 2010 Circular in relation to CHC eligibility. That said, I noted there was no indication in the Trust's response to the Department's September 2012 request for information on its CHC practice (Appendix 6) that it (the Trust) was unaware of its responsibility to determine whether an individual's primary need was healthcare or social care, or that it was only in the latter case that the individual may be required to pay a means-tested contribution to the cost of their care. In commenting on the draft of this report, the Trust said that *'there was no deliberate intention to provide inaccurate information or to mislead [in its response of 20 February 2013]'*. It also stated that '*during 2012 the Trust was seeking clarity in respect of CHC policy from a number of sources, specifically in relation to CHC definitions, assessment schedules and eligibility criteria.'* I will return to this matter later in this report.

108. Furthermore, I was not presented with any evidence that justified the delay of more than a year in the Trust having provided a response to that first request for a CHC assessment for Mrs A, although I noted that the Assistant Director of Primary Care did offer an apology for the delay when he wrote to the complainant and Mrs A's daughter on 20 February 2013. The Trust again apologised for the delay when it commented on the draft of this report, acknowledging that '*it's response times to communication from [the complainant's] family was outside of acceptable timeframes.'*

109. I am conscious that in response to investigation enquiries, the Trust referred to the impact the absence of *'Departmental Guidance and a Regional position in relation to [CHC]'* had had on its ability to respond to the CHC matters that Mrs A's family had raised. The Trust reiterated this point when it commented on the draft of this report. It stated, *'… the request for [Mrs A] to be considered for CHC status was among the first received by the Trust and the Trust found it difficult to secure clarity*

in relation to how to deal with such requests in the absence of a regional definition, eligibility criteria and specific schedules/tools and processes.' The Trust again referred to attempts it had made in 2012 and 2013 to obtain clarity in respect of CHC policy (and, as stated above, I will address this point later in this report). Notwithstanding the Trust's comments, I noted that when it responded to the Department's September 2012 request for information about its practice in relation to CHC (Appendix 6), the Trust gave no indication that the lack of *'Departmental Guidance and a Regional position in relation to [CHC]'* was impeding its ability to assess individuals' CHC eligibility. At that time, the Trust confirmed to the Department that it was following the approach to CHC that was set out in the 2010 Circular and that decisions on CHC eligibility were determined by clinicians and other health and social care professionals. The Trust also provided the Department with details of the process it followed when '*assessing a client's eligibility for continuing healthcare'.* Furthermore, even if the Trust did need clarity about CHC eligibility to be able to respond to Mrs A's family's request in February 2012, it ought to have made that known to the family, by way of explaining the reason for the delay in responding to their request. There is no evidence of the Trust having done so.

110. My investigation established that in March 2014, John McCallister MLA, on behalf of Mrs A's family, made a further request, via the Health Minister, for the Trust to carry out a CHC assessment for Mrs A. Specifically, in his letter of 24 March 2014, Mr McCallister asked the Health Minster to '*direct that the Trust carries out the Continuing Health Care Assessment in accordance with [the 2010 Circular].* I noted that when the Trust's (then) Chief Executive wrote to Mr McCallister on 21 May 2014 (having received a copy Mr McCallister's letter of 24 March 2014 to the Minister) she advised that where it is considered that an individual's needs would be best met in a nursing home, '*the Trust manage[s] charging arrangements within the context of [the 2010 Circular].*

111. Despite the assurance provided to Mr McCallister, I consider that in Mrs A's case, the Trust did not adhere to all applicable provisions of the 2010 Circular. Paragraph 17 of the 2010 Circular provides that an individual may be required to pay a mean tested contribution towards the cost of their residential care or nursing home placement, where their primary need has been determined as personal

social services (social care). I am satisfied that this aspect of the charging arrangements set out in the 2010 Circular was appropriately applied to Mrs A when she became a resident of the Nursing Home in August 2011 because at that time, as accepted by the complainant, Mrs A's primary need was social care.

112. Importantly, however, paragraph 63 of the 2010 Circular 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'.* The complainant is convinced that Mrs A's care needs changed significantly in December 2011, to the extent that he considered she had become entitled to have the cost of her care in the Nursing Home met by the Trust. He therefore requested that Mrs A's eligibility for CHC be assessed. Paragraph 17 of the 2010 Circular places a clear responsibility on HSC Trusts '*to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services.* The Trust did not carry out such an assessment, in response to Mr McCallister's direct request of 24 March 2014. As such, it is my view that on this occasion, the Trust again failed to apply all applicable provisions of the 2010 Circular. Consequently, I also consider that the reference in the Chief Executive's letter of 21 May 2014 to Mr McCallister – that for individuals whose needs are best met in a nursing home, the Trust manages charging arrangements in the context of the 2010 Circular – was not an accurate and appropriate explanation as to why the requested CHC assessment was not going to be carried out.

113. A third request for a CHC assessment for Mrs A was made to the Trust in Mr McCallister's further letter of 26 June 2014 to the Health Minister. I noted that Mr McCallister stated, *'[Mrs A's] family maintain that from December 2011 her care needs have changed from being primarily social to primarily medical'*, and that he asked the Minister to '*give an undertaking that [he] would ensure that [the CHC assessment was] carried out as soon as is practicably possible'.*

114. I noted too that when the Chief Executive responded to the Health Minister on 30 July 2014, she indicated that her letter of 21 May 2014 to Mr McCallister *'clearly states the Trust's position in respect of how the Trust manages assessment for [CHC] placements'*. The Chief Executive also referred to the outcome of recently

completed reviews of Mrs A's care needs being that *'her needs [were] being met in [the Nursing Home]'*.

115. As I have already pointed out, the 2010 Circular places a clear responsibility on Trusts '*to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services'.* The Circular also confirms that there is no authority or requirement under the 1972 Order to charge for healthcare provided in the community, including in a residential care or nursing home. It is evident that Mr McCallister had explained the context of the CHC assessment that was being requested for Mrs A. The request was not made in response to a concern that Mrs A's needs were unmet at the Nursing Home: rather it was made in response to Mrs A's family's firm belief that in December 2011, Mrs A's needs had '*changed from being primarily social to primarily medical'*. However, the Trust took no action, in response to Mr McCallister's June 2014 correspondence, to determine whether Mrs A's primary need had changed since the time she had become a resident of the Nursing Home, in accordance with its responsibility under the 2010 Circular. Furthermore, I am satisfied that the Trust's response to the requested CHC assessment, that is, the reference to recently completed reviews of Mrs A's care needs having indicated that *'her needs [were] being met in [the Nursing Home]',* was not an appropriate explanation as to why the requested CHC assessment was not going to be carried out.

116. I established that on 3 September 2014, the complainant and Mrs A's daughter again raised the issue of a CHC assessment for their mother. I noted that in their written submission to the Trust, they asked, *'… when will you be arranging [a CHC] assessment as per paragraph 17 of [the 2010 Circular]'.* I noted too that their request again highlighted Mrs A's family's belief that Mrs A's primary need had become healthcare on 23 December 2011, and it made clear the family's view that Mrs A was *'being charged for care that the Trust has a legal duty to provide free of charge [as] her needs are beyond the remit of social care so should not be means tested.'*

117. I noted that the Trust's response to that particular request for a CHC assessment was provided on 4 November 2014 by the Assistant Director of Primary Care. As

on previous occasions, the Trust did not meet Mrs A's family's request that it carry out an assessment to determine her CHC eligibility, thereby again failing to meet its obligations under the 2010 Circular. I noted too that in his letter, the Assistant Director reiterated, '*there is no policy framework for the full abatement of charges for those clients for whom a care home placement is considered as appropriate to their needs.'* I have already recorded that I consider this statement was inaccurate and misleading, and was not in accordance with the provisions of the 2010 Circular. The reasons for my view are set out in paragraphs 105 and 106 of this report.

118. The Assistant Director of Primary Care also referred in his correspondence of 4 November 2014 to Mrs A having been '*assessed within the context of both [the NISAT] and [the NNAT]'.* I found no evidence of any NISAT assessment having been completed for Mrs A by that stage. Rather, the available evidence demonstrated that a NISAT assessment was not carried out until January 2016. I have therefore concluded that this statement by the Assistant Director was a further instance of the Trust having provided inaccurate and misleading information to Mrs A's family in response to their request for Mrs A's CHC eligibility to be assessed. In commenting on the draft of this report, the Trust accepted and apologised that its response of 4 November 2014 to the complainant and Mrs A's daughter had been inaccurate. The Trust said that this had occurred '*as a result of a communication error'.*

119. I noted that the Assistant Director of Primary Care further advised in his letter of 4 November 2014, '*The Trust's position is that [Mrs A's] continuing care needs have been consistently and appropriately met within a nursing home placement.'* In my view, this comment focused on the type of environment in which Mrs A's care needs could be best met. The Trust disagreed with this view when it commented on the draft of this report, stating that this line of the Assistant Director's letter *'was not intended to be a reference to the environment within which [Mrs A] was cared for'.* Whatever the Trust's intention in referring to the environment in which Mrs A's needs had been appropriately met, I found no evidence of Mrs A's family having indicated to the Trust that they considered that Mrs A's needs were not being met at the Nursing Home; rather, they had made it clear that they considered her care needs had changed to the extent that she had become entitled to have the cost of

that nursing home placement met by the Trust. The Assistant Director's response failed to address this specific matter. I consider, therefore, that the reference to Mrs A's needs having '*been consistently and appropriately met within a nursing home placement'* was an inappropriate response to the request for a CHC assessment to be completed for her.

120. My investigation found that on 28 October 2014, an explicit request was made to the Trust, for a fifth time, that an assessment of Mrs A's CHC eligibility be completed. That request was put to the Trust by the COPNI Chief Executive, on behalf of Mrs A's family. She asked the Trust to *'ensure that a full [CHC] assessment takes place without further delay'.* I noted that in making the request, the COPNI Chief Executive highlighted the family's contention that '[*Mrs A's] primary need is health care and that due to her current medical condition is entitled to qualify for free nursing care.'*

121. I noted too that in responding to the COPNI Chief Executive on 26 November 2014, the Trust's Chief Executive did not directly address the request that a CHC assessment be carried out for Mrs A. Rather, in relation to the family's contention that Mrs A's primary need was healthcare, the Trust's Chief Executive reiterated that *'the Trust assesses individuals continuing placement requirements through the application of [the NISAT] and [the NNAT]. Following the identification that the individual needs to be managed in a permanent placement, the Trust manages charging arrangements in the context of [the 2010 Circular], as well as through other associated guidance.'* I have already recorded my view that in Mrs A's case, the Trust did not adhere to all applicable provisions of the 2010 Circular because it failed, in response to the representations her family made following a deterioration in her condition, to determine her primary care need, in order to be certain that the charges being applied for her care remained appropriate. Consequently, this comment in the Trust's Chief Executive's letter was not an accurate and appropriate response to the COPNI Chief Executive's request that a *'full CHC assessment takes place without further delay'.*

122. Furthermore, I noted that the Trust's Chief Executive's comment about the Trust managing charging arrangements in accordance with the 2010 Circular reflected, in part, its response to the Department's November 2014 request for information on

its CHC practice (Appendix 6). However, the Trust's Chief Executive did not point out in her letter to the COPNI Chief Executive that, as had been advised to the Department, the Trust's practice was that '*no determination is made in relation to eligibility for [CHC] within continuing care placements'.* I was satisfied, therefore, that in relation to the October 2014 request for a CHC assessment for Mrs A, the Trust not only failed to consider the request in accordance with the provisions of the 2010 Circular but also failed to provide a complete explanation of its practice in relation to the determination of CHC eligibility for individuals who had been given residential care or nursing home placements.

123. I established that on 26 June 2015, the COPNI Chief Executive again wrote to the Trust, highlighting that Mrs A's family was seeking *'a full [CHC] assessment'* for Mrs A. As previously, the Trust did not agree to carry out the requested assessment. I noted that in responding to the request on 10 August 2015, the Trust's (then) Chief Executive (Interim) explained how the Trust '*manages requests for individuals to be assessed for continuing care placement'*, which as the Trust had stated on previous occasions,[21] was that '*individuals have their requirements assessed through the application of [the NISAT] and [the NNAT]*', and that *'Following identification that the individual requires to be managed in a permanent placement, the Trust manages charging arrangements within the context of [the 2010 Circular]*'. As I have already recorded in this report, it is my view that this was not an appropriate response to the request for a CHC assessment to be carried out for Mrs A because it is evident that, that in Mrs A's case, the Trust did not act in accordance with all applicable provisions of the 2010 Circular.

124. It was not until after COPNI met with the Trust in early November 2015 that the Trust agreed to carry out an assessment of Mrs A's needs using the NISAT, the specific comprehensive assessment tool referenced in the 2010 Circular. That NISAT assessment, along with a NNAT assessment, was carried out by a Trust Older People Specialist Nurse on 20 January 2016, almost four years after an assessment of Mrs A's CHC eligibility had first been requested by the complainant and Mrs A's daughter. When it commented on the draft of this report, the Trust said that this delay had been '*due to misinterpretation of information from clinical*

[21] The Trust's Chief Executive's letter of 21 May 2014 to John McCallister MLA and her letter of 26 November 2014 to the COPNI Chief Executive

staff.' The Trust provided no further detail of this 'misinterpretation of information'. The Trust also sought to provide *'an assurance that [Mrs A's] needs were comprehensively assessed during the time period using other recognised assessments.'* It contended that the NISAT is not *'the only way of comprehensively assessing an individual's needs'*, and stated, *'Prior to early 2016 [Mrs A's] needs were subject to comprehensive assessment'.* I accept that Mrs A's needs were assessed prior to the January 2016 NISAT. However, the important consideration is that Mrs A's needs were not assessed with a view to determining her eligibility for CHC - the 2010 Circular is clear that the NISAT is the appropriate means of assessing needs for that purpose.

125. I noted that when the Trust's Director of Older People and Primary Care wrote to the COPNI Chief Executive on 25 April 2016, she referred to the outcome of the January 2016 NISAT and NNAT assessments. The Director advised, '*The outcome of the reassessments show that [Mrs A's] care needs are well met within [the Nursing Home] and that the Trust position is that the management of charging arrangements are appropriately dealt with in keeping with [the 2010 Circular. Therefore the Trust position is that all outstanding queries have been addressed by the Trust and that the debt owed is now for immediate settlement.'* In my view, these comments indicate that, having completed the NISAT and NNAT assessments in January 2016 and having concluded that Mrs A's care needs were being met at the Nursing Home, the Trust considered that it had taken all necessary steps to address the Mrs A's family's request for her CHC eligibility to be assessed. However, for the reasons recorded below, I am not satisfied that this was the case.

126. As the IPA pointed out in her advice, having carried out the NISAT assessment for Mrs A in January 2016, the Trust would have had sufficient information about Mrs A's needs to determine whether there should be further consideration of her eligibility for CHC. I found no evidence, however, that the Trust gave any such further consideration to Mrs A's CHC eligibility, focusing instead on the fact that the assessments had indicated that Mrs A's needs were being appropriately met in the Nursing Home. There was no reference in the Director of Older People and Primary Care's letter of 25 April 2016 to whether the NISAT assessment had

indicated whether Mrs A's primary need remained social care or it had become healthcare. This would appear to support the contention the complainant made, in documentation he provided in during the investigation, that the Trust staff who had completed the NISAT and NNAT assessments in January 2016 informed him at a meeting on 15 April 2016 that they had been asked to assess Mrs A's nursing needs as a self-funding resident of the Nursing Home rather than to carry out a CHC assessment. It is not possible to be certain about the content of the complainant's conversation with Trust staff on 15 April 2016, although I noted the Trust was unable to present any evidence that would dispute his recollection of it.

127. Also in relation to this particular matter, I should record that in commenting on the draft of this report, the Trust said, *'… the language of Continuing Healthcare status is not widely used or recognised within clinical staff in Northern Ireland. Therefore, to have asked the Specialist Nurse to complete a Continuing Healthcare assessment was not appropriate given that there is no such assessment schedule or process agreed.'* In my view, this comment is a clear indication that the Specialist Nurse who carried out the NISAT assessment in January 2016 had not been asked to assess Mrs A's needs to inform the determination of her CHC eligibility, yet it was such a determination that the COPNI Chief Executive had explicitly requested, on behalf of Mrs A's family, when she wrote to the Trust on 9 November 2015. As I have already recorded, the Trust failed to respond appropriately to that request.

128. I acknowledge that the Trust completed a number of reviews and assessments of Mrs A's care needs during the years she was a resident of the Nursing Home, and I found no evidence that the complainant or other members of Mrs A's family ever indicated to the Trust they considered that Mrs A's needs were not being appropriately met in the Nursing Home. However, it is clear that despite having completed further assessments of Mrs A's needs in January 2016 (including the comprehensive NISAT assessment referenced in the 2010 Circular) in response to her family's repeated representations, the Trust still failed to determine whether her primary need remained social care or whether, as Mrs A's family contended, that it had changed to healthcare after her condition had deteriorated in late 2011.

129. I noted, as the IPA also highlighted, that when the Trust responded to the Department's November 2014 request for information about its CHC practice (Appendix 6), it advised that *'no determination is made in relation to eligibility for [CHC] within continuing care placements'.* In my view, this is clear evidence that the Trust's approach to CHC was that while an individual's care needs were being appropriately met in a nursing home placement, no determination of their primary need and, consequently, their eligibility for CHC, would be made. The basis on which the Trust continued to levy charges for Mrs A's placement in the Nursing Home, once the issue of a possible change in her primary need had been raised, is therefore unclear. As the IPA highlighted in her advice, the Trust's approach to CHC for nursing home residents is contrary to the Department's policy position on CHC, as set out in the 2010 Circular, in particular, paragraph 63, which states, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential care or nursing home accommodation arranged by a HSC 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'*, and paragraph 17, which states, '… *it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services'*.

130. Consequently, in cases like that of Mrs A, where it was previously accepted that an individual's primary need was social care, and not healthcare (and the Trust therefore had the authority to charge for care provided to that individual in their residential care or nursing home) but a possible change in the individual's primary need is subsequently highlighted to the Trust, either by the individual themselves or a third party acting on their behalf, the Trust must be satisfied that the primary need has not become healthcare, rather than social care, if it is to continue to have the legal authority to charge for the care being provided. The Trust's current position of routinely not determining CHC eligibility in cases where the individual concerned has been placed in a residential care or nursing home, while continuing to levy charges, is not in keeping with the 2010 Circular and is, therefore, unsustainable.

131. I was mindful that the IPA commented that '*the Trust did not have the mechanisms in place to make [a determination of CHC eligibility] for individuals placed in nursing care homes (continuing care placements)'*. I noted too that the Trust, in commenting on the IPA's advice, stated repeatedly that *'the absence of a regional definition of CHC in Northern Ireland and an agreed assessment process'* had meant it was *'unable to make a determination on CHC eligibility'* in Mrs A's case. The Trust made the same points when it commented on the draft of this report, insisting that a lack of definition of CHC, policy framework, decision-making tools and assessment schedules meant it was unable to determine CHC eligibility. I do not accept that these factors ought to have prevented the Trust from fulfilling its responsibilities under the 2010 Circular. The reasons for my view are set out below.

132. Firstly, I do not agree that there is an '*absence of a regional definition of CHC in Northern Ireland*' or a lack of clarity as to the meaning of CHC. The NI Direct website, in advising on the *'HSC contribution towards the cost of nursing care provided in nursing homes'*, explains the meaning of 'continuing healthcare' in Northern Ireland. It states, '*If you live in a nursing home and have assessed nursing needs, the local trust will pay £100 per week towards the cost of the nursing. If your assessment indicates that your primary need is for health care, your Trust will pay for all your care. This is called "continuing health care".'* In addition, when the Department launched its 2017 public consultation on future arrangements for CHC in Northern Ireland[22], it advised that 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. It was also explained that *'Eligibility for continuing healthcare depends an individual's assessed needs, and not on a particular disease, diagnosis or condition'*, and that *'If an individual's needs change, then their eligibility for [CHC] may also change.'* Furthermore, I note that in responding to the Department's November 2014 request for information on its CHC practice (Appendix 6), the Trust advised that it understood the concept of CHC in Northern Ireland to refer '*to the categorisation, through a comprehensive assessment of need, whether an individual's primary need is for healthcare or for personal social services'.*

[22] https://www.nidirect.gov.uk/articles/paying-your-residential-care-or-nursing-home-fees

133. Secondly, I acknowledge there is a lack of regional administrative guidance in relation to the determination of CHC eligibility, and I accept that this may well have impacted on the Trust's approach to the assessment of CHC eligibility. However, in my view, the absence of such guidance from the Department is not acceptable justification for the Trust having failed to put in place, either individually or collectively with other HSC Trusts and organisations, the local administrative arrangements that are necessary to enable it to fulfil its responsibilities under the 2010 Circular, and to ensure that all charges applied for placements in residential care and nursing homes comply with the provisions of the 1972 Order. The Trust did not accept my view on this matter when it commented on my draft report. Rather, it suggested that *'…while the outcome of the [Department's] Consultation is awaited … it is not appropriate to expect a Trust either individually or collectively with other HSC Trusts and organisations, to create new local administrative arrangements.'*

134. Although I noted that the Trust, in responding to the Department's November 2014 request for information on its CHC practice, highlighted that it *'would welcome definitive [Departmental] policy in relation to [the assessment of CHC eligibility'*, I found no evidence of the Trust having indicated to the Department before that time that the absence of regional guidance was preventing it from determining individuals' CHC eligibility. When it commented on the draft of this report, the Trust said that it had '*made a series of repeated efforts to seek clarity [in relation to CHC eligibility] through a number of sources.'* The Trust went on to list a number of meetings and discussions with the Department and other HSC organisations during the period 30 May 2012 to 14 June 2013, by way of example of the occasions on which it had sought such clarity. The Trust was invited to provide copies of discussion notes and/or relevant extracts of the minutes of meetings that evidenced that it sought clarity regarding the determination of CHC eligibility on the occasions it had highlighted. The Trust did not respond to this request so I was unable to give any further consideration to its comments on this matter.

135. Furthermore, I found no evidence of the Trust ever having indicated to Mrs A's family or their representatives, that the lack of guidance from the Department meant it was not possible for Mrs A's CHC eligibility to be assessed. I noted too

that the Department confirmed to this Office, in response to investigation enquiries, that it was its understanding/expectation that each HSC Trust had in place policies, protocols, procedures and/or guidance to enable it to fulfil its responsibilities in relation to CHC, in accordance with the Department's policy position set out in the 2010 Circular.

136. Having considered the evidence relating to this issue of complaint, I have found a number failings on the part of the Trust. The Principles of Good Administration are the appropriate standards against which the administrative actions of public bodies that are the subject of complaints made to this Office are to be judged. The 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. In particular, 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 provided is accurate and complete. The failings I have recorded above indicate that in its handling of the numerous requests for a CHC assessment for Mrs A that were put to it by, and on behalf of, her family during the period 2012 to 2016, the Trust did not always meet the standards required by the Principles. I consider this is maladministration on the part of the Trust. When it commented on this paragraph of the draft of this report, the Trust said it '*acknowledges failings in the management of the complaints raised by and on behalf of [Mrs A's family] and apologises for the distress and inconvenience that this caused.'*

137. I am satisfied that the maladministration I have found caused the complainant, and the other members of Mrs A's family who were involved in the pursuit of a CHC assessment for her, to sustain the injustice of frustration, uncertainty and distress over a protracted period of time. This injustice resulted not only because the Trust did not respond to their repeated requests for a CHC assessment, in accordance with the direction provided by the Department in the 2010 Circular, but also because the complainant and the other family members were not provided with appropriate, accurate and complete explanations as to why the specific assessment they had requested would not be completed. Mrs A's family members were also put to an unreasonable degree of time and trouble, both in pursuing the

issue with the Trust themselves, and in securing the support of other parties to make representations to the Trust on their behalf.

138. Importantly, I consider that the complainant and the other involved members of Mrs A's family had a reasonable and fully justifiable expectation that the Trust would respond to the request for a CHC assessment, in accordance with the policy direction provided by the Department in the 2010 Circular. It is clear that the unacceptable actions of the Trust meant that their expectation was not met, and that the complainant and the other family members, having formed the view that her primary need had become more than social care, were denied the opportunity to have Mrs A's primary need determined in a timely manner, and thereby be assured whether the charges being applied for her care in the Nursing Home remained appropriate.

139. It is not possible for me to be certain of what the outcome would have been had the Trust responded appropriately to the requests that were made to it for Mrs A's CHC eligibility to be determined, in accordance with the 2010 Circular. The IPA's considered view, based on her detailed examination of records provided by the Nursing Home, the Trust and Mrs A's GP, was that although Mrs A '*had a range of both health and social care needs throughout the 24 hour period … interventions [she] required to meet her needs, in themselves or in combination, were not such to be considered indicative of "a primary need for healthcare" according to Paragraph 17 [of the 2010 Circular]…"* I accept the IPA's conclusion that, on the basis of the available evidence, Mrs A's primary need was not healthcare at any time she was a self-funding resident of the Nursing Home.

140. I should also point out that the IPA made it clear in her advice that there is a difference between 'nursing care' and 'healthcare'. It is important that I highlight this distinction because I note that in making his complaint to this Office, the complainant stated that when Mrs A became a resident of the Nursing Home, *'all accept that **nursing care*** [my emphasis] *was not her primary need'*. He also stated that Mrs A's health declined rapidly in December 2011 to a point where her needs *'had changed to being primarily **nursing*** [my emphasis] *and medical intervention was required much more often'*.

141. There is no doubt that Mrs A's records demonstrate that she had a range of complex nursing needs. The fact that she was in receipt of the £100 weekly payment for the cost of the nursing care she received at the Nursing Home confirms this. However, 'nursing care', which is described in the Department's 2006 publication, 'Payments for Nursing Care',[23] as *'care by a registered nurse in providing, planning and supervising your care in care home providing nursing care"*, is not the same as 'healthcare', as referenced in paragraph 63 of the 2010 Circular, which the IPA advised, *'relates to not only the care of a Registered Nurse but also the care provided by a range of other healthcare professionals and services required to meet the totality of an individual's healthcare needs, for example in the community, GPs, therapists and dieticians'.* CHC eligibility is predicated on an individual's primary need being for healthcare, not for nursing care. In this regard, I accepted the IPA's view that *'The care [Mrs A] required, as described within NISAT, NNAT and [the Nursing Home] care plans and records, was not beyond that defined as nursing and personal care services within the information produced by [the Department] to support [HSC] funding nursing care for people going into nursing homes, their families and their carers'.*

142. That said, I noted that the IPA also highlighted that the question of whether an individual's primary need is for healthcare should be determined by a multidisciplinary team, and that, as such, confirmation of Mrs A's primary need by a multidisciplinary team *'would need to be completed retrospectively as [Mrs A] has now passed'*.

143. I will return to this aspect of the IPA's advice later in this report. However, having found a number of instances of maladministration on part of Trust in relation to its handling of the requests put to it for Mrs A's CHC eligibility to be assessed, and being satisfied that this maladministration caused the complainant to sustain an injustice, I uphold this issue of his complaint.

[23] https://www.nidirect.gov.uk/sites/default/files/publications/%5Bcurrent-domain%3Amachine-name%5D/hpss-payments-for-nursing-care-information-leaflet.pdf

Issue 2: Whether the Trust's handling of the complaints submitted to it, on behalf of Mrs A's family, was appropriate

Detail of Complaint

144. The complainant complained to my Office about how the Trust handled complaints that John McCallister MLA, the Commissioner for Older People NI (COPNI) and Sinead Bradley MLA, on behalf of Mrs A's family, made to the Trust about its actions in relation to the requested assessment of Mrs A's eligibility for CHC. He complained that the Trust *'failed deal with [the family's] complaint effectively and expeditiously by failing to reply to letters or disclose information in a timely manner'.* He also said that the information the Trust provided in responding to the complaint *'was neither fairly considered, coherent nor transparent'.*

145. The complainant contended that the first complaint, which was raised by John McCallister MLA on behalf of Mrs A's family, was closed by the Trust *'without any resolution or satisfactory conclusion having been received by Mr McCallister or the family'*. The complainant also stated that the Trust failed to inform either Mr McCallister or Mrs A's family in writing that the complaint had been closed. He further stated that the complaint was later reopened at the request of COPNI but that it was still not resolved to the family's satisfaction. He also referred to Sinead Bradley MLA having contacted the Trust subsequently, requesting that the Trust *'review and consider the case in its entirety'*, but that the Trust had stated that a formal response to each complaint had been issued and that *'it would not reconsider the family's request regarding outstanding debt'*.

Evidence Considered

(i) Relevant policy, procedure and guidance

HSC Complaints Procedure

146. The document, 'Complaints in Health and Social Care, Standards and Guidelines for Resolution and Learning', published by the Department on 1 April 2009 (the HSC Complaints Procedure), provides guidance on how HSC organisations should deal with complaints raised by those who use, or are waiting to use, their services. It deals with complaints about care and treatment, and about issues relating to the provision of health and social care.

147. Section 2 of the HSC Complaints Procedure, '*Making a Complaint'*, defines a complaint as*, 'an expression of dissatisfaction that requires a response'.* Paragraph 2.3 lists the type of individual that may make a complaint, which includes, '*any appropriate person in respect of a patient or client unable by reas on of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin'.* Paragraph 2.4 refers to the requirement for complaints made by a third party to have '*the written consent of the individual concerned*, unless this is not possible, for example, if the individual is deceased or is incapable.

148. Section 3 of the HSC Complaints Procedure sets out arrangements for the handling of complaints, including the actions to be taken by the HSC organisation on receipt of a complaint; in acknowledging a complaint; in investigating a complaint; in responding to a complaint, and in concluding the 'local resolution'[24] of the complaint.

149. In relation to the receipt of a complaint, paragraph 3.17 of the HSC Complaints Procedure states, *'A complaint should be acknowledged in writing within 2 working days of receipt'.* It is then stated in paragraph 3.19, *'It is good practice for the acknowledgment to be conciliatory, and indicate that a full response will be provided within 20 working days.'*

150. Paragraph 3.38 of the HSC Complaints Procedure sets out the timescales within which a response to the complaint is to be provided. It states, *'A response must be sent to the complainant within 20 working days of receipt of the complaint … or where that is not possible, the complainant must be advised of the delay…'*. Paragraph 3.37 states that where it is not possible to respond within target timescales, the complainant should be provided with *'an explanation with the anticipated timescales'*.

151. Paragraph 3.25 of the HSC Complaints Procedure deals with the investigation of a complaint. It states, '*Whoever undertakes the investigation should seek to understand the nature of the complaint … Complaints must be approached with an*

[24] The HSC Complaints Procedure defines 'local resolution' as 'the resolution of a complaint by the [HSC] organisation, working closely with the service user'.

open mind, being fair to all parties.'

152. In relation to the content of a response to a complaint, paragraph 3.42 of the HSC Complaints Procedure states, '*The [complaint] response should be clear, accurate, balanced, simple and easy to understand … The letter should … address the concerns expressed by the complainant and show that each element has been fully considered and fairly investigated … indicate that a named member of staff is available to clarify any aspect of the letter [and] advise of their right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.'*

(ii) The Trust's response to investigation enquiries

153. In response to investigation enquiries about this issue of complaint, the Trust provided a chronology of its handling of Mrs A's family's complaints, along with a copy of its related complaints file. The Trust's chronology of the complaints handling is at Appendix 7 to this report.

154. The Trust commented, *'… communication expressing dissatisfaction was initially received on 09 April 2014 in a letter from [the Health Minister], which enclosed a copy of correspondence from and to Mr McCallister MLA. The correspondences … were considered and responded to through the complaint's* [sic] *procedure. However, the Trust acknowledges that [the complainant] had expressed his concerns that [Mrs A] was not accessing [CHC] arrangements prior to April 2014. At that time the Trust dealt with the request for CHC status as an enquiry.'*

155. The Trust further stated that it had *'also received correspondences from [Mrs A's] family and their elected representatives, including from John McCallister MLA and Sinead Bradley MLA and [COPNI].'* The Trust advised that it had *'responded to all issues raised within the correspondences',* adding that *'It has been difficult to respond to these issues expeditiously as the Trust was awaiting further Departmental Guidance and a Regional position in relation to [CHC]. In the absence of such direction the Trust has responded to [the complainant] in line with the guidance available at the time.* The Trust expressed its disagreement with the complainant's contention that it had '*failed to reply to letters or that the information was neither fairly considered, coherent nor transparent.'* It also stated, however,

'*The Trust acknowledges delays in responding to [Mrs A's] family and apologises for failings in this regard.'*

156. The Trust also pointed out in its response to investigation enquiries that, *'In [the Director of Primary Care's] letter to [the complainant] dated 21 March 2017, the Trust confirmed there were no issues open for investigation under the complaint's* [sic] *process and advised [the complainant] of the Ombudsman's details if he wished to contact [this Office] in relation to his complaint.'*

(iii) Review of documentation

157. A review was completed of the documentation the complainant provided in support of his complaint, and of the Trust's complaints file. The following paragraphs reflect the findings of the documentation review that are relevant to this issue of complaint.

158. On 24 March 2014, John McCallister MLA wrote to the Health Minister about Mrs A and her family's requests that her eligibility for CHC be assessed. Mr McCallister pointed out that those requests remained unmet by the Trust. He asked that the Minister *'direct that the Trust carries out the [CHC] Assessment in accordance with [the 2010 Circular]'.*

159. As well as responding directly to Mr McCallister, the Health Minister referred Mr McCallister's letter of 24 March 2014 (along with his (the Minister's) response of 9 April 2014) to the Trust's (then) Chief Executive, asking that she '*consider and respond to Mr McCallister directly'* in relation to Mrs A's case.

160. The Trust's Chief Executive wrote to Mr McCallister on 21 May 2014, informing him that on 14 April 2014, she had received a letter dated 9 April 2014 from the Health Minister *'advising [her] of [Mr McCallister's] correspondence to him dated 24 March 2014 in relation to [Mrs A]'.* The Chief Executive went on to set out the Trust's position on the use of the NISAT to assess individuals' needs; its management of charging arrangements within the context of the 2010 Circular; and the financial support available to an individual to meet the cost of nursing care in nursing homes. The Chief Executive also stated that *'[Mrs A's] last review was undertaken on 29 August 2013',* and that her nursing needs were reassessed on 18 November 2013 by Memory Services staff. The Chief Executive advised that the outcome of

the reviews was that *'[Mrs A's] needs were being appropriately met'* in the General Nursing Unit of the Nursing Home.

161. Mr McCallister wrote to the Health Minister again on 26 June 2014. He stated, *'Since February 2012 [Mrs A's family] has been asking for the requisite "Continuing Health Care Assessment" as outlined in paragraph 17 of [the 2010 Circular] in order to determine the true need of their mother's care but despite repeated requests and indeed a promise from [the HSCB], this has still not happened'.* Mr McCallister continued, *'I am therefore asking you to give an undertaking that you will ensure that the Continuing Healthcare Assessment is carried out as soon as it is practicably possible and in any event before the end of August 2014 to enable the family to move forward with settling finances.'*

162. Mr McCallister's letter of 26 June 2014 to the Minister was passed to the Trust. The Trust's complaints file indicates that the Trust treated the correspondence as a complaint. On 30 June 2014, the Trust's Older People and Primary Care Directorate's Clinical and Social Care Governance Office (the Governance Office) wrote to Mr McCallister referring to '*the complaint [he had] made to [the Trust] regarding the provision of services to [Mrs A].'* The Governance Office asked Mr McCallister to arrange for Mrs A's next of kin to provide written consent for him, members of Mrs A's family and the Health Minister to make a complaint to the Trust on Mrs A's behalf. The Governance Office also informed Mr McCallister that on receipt of the written consent, '*it is the Trust's intention to advise you of the findings of the investigation within 20 working days'.* It continued, '*If for whatever reason we are unable to provide you with a full response within the timeframe above, I will contact you to advise of progress.'*

163. The Trust's Governance Office wrote to Mr McCallister again, on 22 July 2014, as the Trust had not received the written consent requested on 26 June 2014. The complainant attempted to email the written consent form, signed by Mrs A's next of kin, to the Trust on 8 July 2014. However, due to a spelling error in the email address used, the email was not delivered. The written consent was forwarded subsequently to the Trust by Mr McCallister's office on 29 July 2014.

164. The Trust's Chief Executive wrote to the Health Minister on 30 July 2014 in relation Mr McCallister's letter of 26 June 2014. The Chief Executive stated, *'I trust that my letter of 21 May 2014 to Mr McCallister clearly states the Trust's position in respect of how the Trust manages assessment for [CHC] placements'*. She added, *'… for clarity, I would advise that [Mrs A's] placement in [the Nursing Home] continues to be managed within the context of [the 2010 Circular].'*

165. The Chief Executive also stated in her letter of 30 July 2014 to the Health Minister that at the most recent review of Mrs A's needs on 20 November 2013, with family members in attendance, *'all present agreed that [Mrs A's] needs [were] being met in [the Nursing Home]. Therefore, the Trust position [was] that [Mrs A's] needs for a continuing care placement [were] being appropriately met within the context of the [2010 Circular]'*. The Chief Executive continued, *'In light of this, the Trust believes that there are no obstacles to [Mrs A's] family resolving any outstanding financial issues.'*

166. On 4 September 2014, Mr McCallister's office contacted the Governance Office to seek an update in relation to the Trust's anticipated response to Mr McCallister's letter of 26 June 2014 to Health Minister (which the Trust was treating as a complaint). In its emailed response of 5 September 2014, the Governance Office advised Mr McCallister's office that '*This case remains closed on our system following the last correspondence issued to [the Health Minister], dated 30 July, which was shared with your office on 01 August at 13:40 by way of email (attached for your reference).'*

167. Mr McCallister wrote again to the Trust's Chief Executive on 16 September 2014, referring to her letter to him of 21 May 2014, which he stated, he had not received until 5 August 2014, having just become aware of '*its existence when referenced in a response from the Trust's Complaints Department a few days earlier'.*
Mr McCallister pointed out that Mrs A's family was *'satisfied that [Mrs A's] needs were being met by [the Nursing Home]'* but that they were dissatisfied that *'despite many requests dating back as far as February 2012 for a [CHC] assessment to be carried out, they only discovered by chance that an assessment was carried out on 18 November 13 using the [NNAT]. This assessment identifies [Mrs A's] requirements under all 18 descriptors listed as being nursing yet the Trust is still*

refusing to accept that her needs are now primarily medical/nursing as opposed to social care.' Mr McCallister also asked the Chief Executive to confirm *'whether the assessment carried out on 18 November 2013 is indeed the correct [CHC] assessment required in accordance with Paragraph 17 of [the 2010 Circular]'*.

168. On 19 September 2014, Mr McCallister's office sent an email to the Trust's Governance Office, in response to its email of 5 September 2014, which had advised that Mrs A's family's complaint had been closed following the issue of the Chief Executive's letter of 30 July 2014 to the Health Minister. Mr McCallister's office advised that *'… as far as [Mrs A's family is] concerned that the matter has not been resolved to their satisfaction at all.'* The Trust was informed that Mrs A's family *'still have a serious issue with the fact that some form of assessment was carried out without the family's involvement, despite repeated complaints and assurances given that the Trust would ensure family involvement throughout the process … I would be grateful if you could investigate why the assessment carried out on 18 November 2013 took place without a family member being present and come back to me with a response.'*

169. On 22 September 2014, the Trust's Governance Office wrote to Mr McCallister, referring to '*the reopened complaint [he had] made to the [Trust] regarding the provision of services to [Mrs A]'* The letter advised Mr McCallister, *The Trust will investigate the issues which you have raised and respond to you in due course.'*

170. The Trust's Governance Office again wrote to Mr McCallister, on 16 October 2104, referring to the *'reopened complaint'* he had made about the Trust's actions in relation to Mrs A, and advising, *'Unfortunately there has been a delay in responding to the issues you have raised as the investigation is still ongoing. Please accept my apologies for this delay. It is now anticipated that you will receive a response within the next 19 working days.'*

171. The Trust's Chief Executive wrote to Mr McCallister on 20 October 2014, referring to his letter of 16 September 2014 and his office's subsequent email of 19 September 2014. The Chief Executive reiterated the Trust's position that '[*Mrs A's] needs are being very well met within [the Nursing Home]'* and that *[Mrs A's needs] could be equally met within a range of other [private nursing*

homes] and payments for the same managed within the context of [the 2010 Circular]. The Chief Executive also referred to Mr McCallister having highlighted the provisions of the 1972 Order in relation to authority to charge for healthcare provided in the community. She stated, '*The Trust would advise it is for this very reason that following a NNAT, it was identified that [Mrs A] should be awarded the NNAT payment, so ensuring that she is not contributing towards the nursing element of her care.'* The Chief Executive further advised in her letter of 20 October 2014 to Mr McCallister (in relation to his request for confirmation of whether the NNAT was the appropriate CHC assessment tool) that *'when assessing [Mrs A] [the Trust] has made use of the NISAT and NNAT documentation, which is the only documentation supplied by [the Department] to the Trust for use in the assessment process'*.

172. On 28 October 2014, the COPNI Chief Executive wrote to the Trust's Chief Executive, on the behalf of Mrs A's family, about Mrs A. The COPNI Chief Executive pointed out that the complainant had requested a CHC assessment for Mrs A on a number of occasions and had made a written request on 3 September 2014, to which he had yet to receive a response, and she asked the Trust's Chief Executive to *'ensure that a full [CHC] assessment takes place without further delay.'*

173. The Trust's Governance Office acknowledged receipt of the COPNI Chief Executive's correspondence on 7 November 2014, referring to '*the complaint you have made to [the Trust] regarding the provision of services to [Mrs A]*'. The Governance Office asked the COPNI Chief Executive to arrange for Mrs A's next of kin to provide written consent for her to make a complaint to the Trust on Mrs A's behalf. The Governance Office also informed the COPNI Chief Executive that on receipt of the written consent, '*it is the Trust's intention to advise you of the findings of the investigation at an early date'.* It continued, '*If for whatever reason we are unable to provide you with a full response within the timeframe above, I will contact you to advise of progress.'* COPNI provided the written consent to the Trust on 14 November 2014.

174. On 26 November 2014, the Trust's Chief Executive provided a substantive response to the COPNI Chief Executive's letter of 28 October 2014. In relation to

the lack of response to the complainant's written request of 3 September 2014 for a CHC assessment, the Trust's Chief Executive advised that the Trust had issued a response on 4 November 2014. With regard to Mrs A's family's contention that Mrs A's primary need was health care, the Trust's Chief Executive advised, *'the Trust assesses individuals continuing placement requirements through the application of [the NISAT] and [the NNAT]*.' She further stated, *'Following the identification that the individual needs to be managed in a permanent placement, the Trust manages charging arrangements in the context of [the 2010 Circular], as well as through other associated guidance.'*

175. On 6 January 2015, Mr McCallister's office again emailed the Trust's Governance Office, stating that a response to its email of 19 September 2014 had not been provided. The email also stated, *'It is our understanding that this case is not closed and would be grateful if you would come back to me as a matter of urgency.'* On 7 January 2015, the Governance Office contacted the Office of the Trust's Chief Executive, which confirmed that the Chief Executive's letter of 20 October 2014 had been posted to Mr McCallister on 23 October 2014. A copy of the Chief Executive's letter was emailed to Mr McCallister's office on 8 January 2015.

176. The COPNI Chief Executive sent a further letter to the Trust's Chief Executive on 9 March 2015, referring to the Chief Executive's correspondence to her of 26 November 2014, and seeking confirmation of '*the current status of the family's complaint to the Trust regarding the applied assessment process for NHS [CHC].'* The COPNI Chief Executive asked, *'Has this complaint been fully reviewed and adjudicated upon?'*

177. The Trust's (then) Chief Executive (Interim) responded to the COPNI Chief Executive on 6 May 2015. In relation to Mrs A's family's complaint, the Chief Executive (Interim) advised that *'any issues raised by [Mrs A's] family, or others on their behalf … [had] been responded to by the Trust.'* The Chief Executive (Interim) also highlighted that *'the last letter from the Trust to [the complainant and Mrs A's daughter] [was] dated the 4th November, 2014.'*

178. On 26 June 2015, the COPNI Chief Executive wrote again to the Trust's Chief Executive (Interim), advising that Mrs A's family had '*re-iterated their wish for their*

mother to be subject to a full [CHC] assessment that involves the family and appropriate medical practitioners, with full disclosure of the relevant notes and records once the assessment has been completed.'

179. The Trust's Governance Office wrote to the COPNI Chief Executive on 6 July 2015 advising *'… the complaint is 'now reopened regarding [Mrs A]. The Trust will investigate the issues which you have raised and respond to you in due course.'*

180. On 10 August 2015, the Trust's Chief Executive (Interim) provided her response to the COPNI Chief Executive's letter of 26 June 2015. In relation to the family's request for a CHC assessment for Mrs A, the Chief Executive (Interim) reiterated the Trust's position on the management of '*requests for individuals to be assessed for continuing care placement'*, which was that '*individuals have their requirements assessed through the application of [the NISAT] and [the NNAT]*'. She continued that where it identified that '*the individual requires to be managed in a permanent placement, the Trust manages charging arrangements within the context of [the 2010 Circular], as well as through other associated guidance'*. The Chief Executive (Interim) further stated, *'All assessments to date have shown that [Mrs A's] assessed care needs are being appropriately met in her current placement'.*

181. Following a meeting between COPNI and the Trust in early November 2015, the COPNI Chief Executive wrote to the Trust's Assistant Director of Primary Care on 9 November 2015. The COPNI Chief Executive stated, '…*Mr John McCallister's office had previously raised a complaint with the Trust on behalf of [Mrs A's] family. This complaint was subsequently closed by [the Trust]. Information regarding the conclusion of the complaint was not received by Mr McCallister's office at the time. On the assumption that the complaint is considered closed the family seek to have the substantive case re-opened to allow for a review to be carried out into actions taken at the time. The family remain dissatisfied at the handling of this particular complaint raised by Mr McCallister's office. The family wish to obtain clarity regarding their complaint and, where appropriate, lessons learned should be outlined.'*

182. Mr McCallister's office wrote to the Assistant Director of Primary Care on 10 November 2015. The letter referred to the recent meeting between COPNI and

the Trust and to Mr McCallister not having received the Trust's Chief Executive's letter to him of 21 May 2015 until after he had become aware of it, having received a copy of the Chief Executive's letter of 30 July 2014 to the Health Minister.

183. On 30 November 2015, the Trust's Assistant Director of Primary Care provided a response to the COPNI Chief Executive's letter of 9 November 2015. In relation to Mrs A's family's complaint, the Assistant Director of Primary Care advised that the Trust had dealt with Mr McCallister's letter of 24 March 14 as a complaint, and had closed the complaint on issue of its response dated 21 May 2014.

184. The COPNI Chief Executive wrote again to the Trust's Assistant Director of Primary Care on 16 December 2015, advising, *'in relation to the overall complaint [Mrs A's family] indicate that their complaint was closed by the Trust without any contact from the investigating officer, either with the family or Mr John McCallister MLA. The family seek to have the whole complaint process reviewed in this case …'*

185. By 20 January 2016, the COPNI Chief Executive had not received a response from the Assistant Director of Primary Care so she wrote to him again, asking for his comments in response to her letter of 16 December 2015.

186. The Assistant Director of Primary Care responded to the COPNI Chief Executive on 16 February 2016. In relation to Mrs A's family's complaint, the Assistant Director of Primary Care advised, *'… the complaint raised on [Mrs A's] family's behalf by Mr J McCallister (MLA), in his letter dated 24 March 2014, to [the Health Minister], was responded to by the Trust's Chief Executive on 21 May 2014. The Trust continues to engage with COPNI in response to [Mrs A's] family's ongoing concerns and therefore considers the complaint investigation to be ongoing.'*

187. The COPNI Chief Executive wrote to the Trust's Chief Executive (Interim) on 15 March 2016. The COPNI Chief Executive referred to Mrs A's family's previously raised '*concerns regarding the management and response to complaints they outlined to the Trust through the Offices of Mr. John McCallister MLA.'* She advised, '*…a number of concerns relating to [Mrs A]'s outstanding healthcare assessment as well as the substantive complaint handling and response have yet to be adequately addressed.'*

188. On 23 March 2016, the Trust's Director of Older People and Primary Care responded to the COPNI Chief Executive. The Director of Older People and Primary Care explained the chronology of the Trust's handling of Mrs A's family's complaint. She stated, '*Mr J McCallister (MLA) first corresponded with [the Health Minister] in his letter dated 24 March 2014, which was shared with the Trust by Minister on 09 April 2014. The Trust replied to Mr J McCallister in 21 May 2014… however Mr J McCallister subsequently advised that he did not receive this response until it was shared with him by [the Health Minister] on 05 August 2014. This resulted in the Trust sending a second copy of the 21 May 2014 response to Mr McCallister on 19 September 2014, in response to his phone call and correspondence. The Trust also received a letter on 19 September 2014 directly from Mr J McCallister dated 16 September 2014. This was dealt with as a re-opened complaint and was formally responded to on 20 October 2014 … The complaint was regarded as closed once the response dated 20 October 2014 was sent.'*

189. Subsequently, on 25 November 2016, Sinead Bradley MLA wrote to the Trust's Chief Executive having been contacted by the complainant '*with a view to sharing information on a complaint with the Trust which dates back to 2012.'* Ms Bradley pointed out, '*On initial inspection of the case, it appears that any referencing to the formal internal complaints process appears very light with no communications from the Trust advising at what stage in the process the case is being considered. I, like my constituent, remain hopeful that an opportunity remains whereby the Trust will reconsider the case in its entirety with a view to reaching a conclusion that is satisfactory to my constituent.'*

190. The Trust's Governance Office wrote to Ms Bradley on 30 November 2016, asking that she arrange for Mrs A's next of kin to provide written consent that confidential information relating to Mrs A could be disclosed to her and her office. Ms Bradley was informed that on receipt of the written consent, '*it is the Trust's intention to advise [her] of the findings of the investigation within 20 working days.* The Trust continued, '*If for whatever reason we are unable to provide you with a full response within the timeframe above, I will contact you to advise of progress.'*

191. On 8 December 2016, Ms Bradley wrote to the Governance Office, providing the required written consent. She also clarified that that neither she nor her office were making the complaint; rather *'The complaint has been made by [Mrs A's] family.'* Ms Bradley further advised, '*My aim is to establish when the current complaint was made and what stage of the complaints process it is at.'* The Governance Office acknowledged receipt of Ms Bradley's email that day.

192. The Trust's Director of Older People and Primary Care provided a substantive response to Ms Bradley on 13 December 2016. She stated, *'… I can advise that the Trust has provided a formal response to each complaint raised to by the representatives of [Mrs A's] family. Therefore, the Trust is not aware of any current active complaints. However, the Trust does continue to engage with [Mrs A's] family with respect to the recovery of outstanding debt.'* In relation to Ms Bradley's request that the Trust '*reconsider the case in its entirety with a view to reaching a conclusion that is satisfactory to [her] constituent',* the Director responded, '*I will assume that the issue relates to the outstanding debt owed to the Trust, in lieu of client contributions associated with [Mrs A's] placement. As a publicly funded body the Trust has a duty to recover any outstanding debt owed.' Therefore, the Trust is not in a position to reconsider the requests issued in lieu of this outstanding debt.* The Director concluded her letter by advising Ms Bradley to contact the Trust's Governance Office, within the following three months *'if [she was] unhappy with any aspect of [the] response'* in order that the Trust can '*attempt to resolve any outstanding issues.'* She also signposted Ms Bradley to this Office *'should [she] remain dissatisfied at the end of the complaints process'.*

193. The Trust's complaint file shows that on 1 March 2017, the complainant telephoned the Trust to request information about the status of the family's complaint. (By that stage, the complainant had submitted his complaint about the actions of the Trust to this Office, and this Office had informed him in a letter dated 27 February 2017 that the Trust had indicated that the complaints procedure was not yet exhausted.)

194. The Trust's Director of Older People and Primary Care wrote to the complainant on 21 March 2017 confirming that the Trust *'has no complaints process open in*

relation to your late mother. All complaints raised by you or your representatives have been responded to and you have raised no further new issues'.

(iv) Independent Professional Advice

195. In concluding her advice on the Trust's actions in relation to the requested assessment of Mrs A's eligibility for CHC, the IPA commented on the Trust's response to Mrs A's family's complaint. The IPA advised, *'The Trust has made considerable efforts to answer [the complainant's] complaint but due to a lack of local policy and clear national Northern Ireland guidance in relation to [CHC], the Trust has been unable to satisfactorily resolve the complaint.'*

Analysis and Findings

196. The complainant complained to my Office that the Trust did not deal appropriately with the complaint that John McCallister MLA first submitted to it, on behalf of Mrs A's family, about how the Trust had responded to their requests that Mrs A's eligibility for CHC be assessed. The complainant contended that the Trust closed the complaint without satisfactorily resolving it, and that it failed to inform Mr McCallister or Mrs A's family that the complaint had been closed. He also complained that the Trust failed to reply to letters or to disclose information in a timely manner, and that its response to the complaint was not '*fairly considered, coherent or transparent'*

197. I noted that Mr McCallister first wrote to the Health Minister about Mrs A on 24 March 2014. The Health Minister forwarded Mr McCallister's correspondence to the Trust on 9 April 2014, asking the Trust to *'consider and respond to Mr McCallister directly'*. I noted also that the Trust received the copy of Mr McCallister's letter on 14 April 2014, and that the Chief Executive wrote to Mr McCallister on 21 May 2014. The Trust stated, in its response to investigation enquiries, that it considered and responded to Mr McCallister's correspondence *'through the complaint's* [sic] *procedure'*.

198. Paragraph 3.17 of the HSC Complaints Procedure requires HSC organisations to acknowledge receipt of a complaint within 2 working days. There was no indication in the Trust's complaint handling chronology, or its complaints file, that the Trust

provided any acknowledgement of its receipt of Mr McCallister's correspondence of 24 March 2014. Furthermore, paragraphs 3.37 and 3.38 of the HSC Complaints Procedure require that the response to a complaint is provided within 20 working days of its receipt and, where that is not possible, that the complainant is provided with an explanation for the delay, and the anticipated timescale for response. It is evident that the Trust did not respond to Mr McCallister's correspondence within the required 20 working day timescale. However, I found no evidence that the Trust wrote to Mr McCallister to explain the delay in responding to the matters he had raised on Mrs a's family's behalf, or to inform him when he might expect to receive a response.

199. I noted that paragraph 3.42 of the HSC Complaints Procedure sets out the standards expected with regard to the content of a response to a complaint. These include that '*the letter should address the concerns expressed by the complainant …'.* Mr McCallister had made it clear in his letter to the Health Minister that an assessment to determine Mrs A's eligibility for CHC '*in accordance with [the 2010 Circular]'* was being requested. Although the Chief Executive acknowledged this request in her response of 21 May 2014 to Mr McCallister, she referred to Mrs A's *'last review'* on 29 August 2013 and further assessments of '[*Mrs A's] nursing needs'* on 18 November 2013 having indicated that her needs *'were being appropriately met in [the Nursing Home] on the General Nursing Unit'.* In my view, this comment did not address either Mr McCallister's explicit request that a CHC assessment in accordance with the 2010 Circular be carried out, or the concern he had expressed that there was a lack of clarity as to whether Mrs A's eligibility for CHC had yet been assessed. Furthermore, I noted that the Chief Executive's statement that *'[Mrs A's] last review was undertaken on 29 August 2013'* was factually incorrect as a more recent review of Mrs A's care needs had been completed on 20 November 2013.

200. A further requirement of paragraph 3.42 of the HSC Complaints Procedure is that the complaint response letter '*… indicate that a named member of staff is available to clarify any aspect of the letter [and] advise of [the complainant's] right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure'.* The Chief Executive's letter of 21 May 2014 to Mr McCallister did not meet either of those requirements.

201. I noted that Mr McCallister later informed the Trust (in his letter of 16 September 2014 to the Chief Executive and in his letter of 10 November 2015 to the Assistant Director of Primary Care) that he did not receive the Chief Executive's letter of 21 May 2014 until 5 August 2014, and that he had only become aware of it *'when referenced in a response from the Trust's Complaints Department a few days earlier'.*[25] When it commented on the draft of this report, the Trust asked me to note that it '*contends that this letter was sent to Mr McCallister's Offices.'* I noted the Trust's contention. Nevertheless, it remains the case that is not possible to be certain whether the Trust sent the Chief Executive's letter of 21 May 2014 to Mr McCallister at that time, nor is it possible to explain why, if the Trust did so, Mr McCallister did not receive the letter. It is clear, however, for the reasons set out above, that the letter was not an appropriate response to Mrs A's family's complaint, as set out in Mr McCallister's correspondence of 24 March 2014 to the Health Minister.

202. The investigation established that Mr McCallister's subsequent letter of 26 June 2014 to the Health Minister about Mrs A was also forwarded to the Trust. I noted that the Trust again treated the MLA's correspondence as a complaint. I noted too that the Trust acknowledged receipt of the complaint on 30 June 2014. On this occasion, and in contrast to its actions in dealing with Mr McCallister's correspondence of 24 March 2014, the Trust required that Mrs A's next of kin provide written consent for Mr McCallister to complain to the Trust about its actions in relation to Mrs A, which is in keeping with the requirements of paragraph 2.4 of the HSC Complaints Procedure. I noted that the Trust advised Mr McCallister that it was anticipated that a response would be provided to him within 20 working days of its receipt of the written consent. I noted also that the Trust received the required written consent on 29 July 2014.

203. The Trust's Chief Executive wrote to the Health Minister the following day, 30 July 2014, referring to Mr McCallister's letter of 26 June 2014, and setting out the Trust's position with regard to the assessment of Mrs A's care needs. The Chief Executive's letter to the Minister did not address Mr McCallister's explicit request

[25] Mr McCallister was referring to the Trust's Chief Executive's letter of 30 July 2014 to the Health Minister, which the Trust copied to Mr McCallister's office on 1 August 2014.

that a CHC assessment for Mrs A be carried out.

204. I noted that when Mr McCallister's office contacted the Trust on 4 September 2014 to seek an update on the anticipated response to Mrs A's family's complaint, the Trust advised that the complaint had been closed after the Chief Executive had written to the Health Minister on 30 July 2014. Although it has been established that the Trust, on 1 August 2014, emailed to Mr McCallister's office a copy of the Chief Executive's letter of 30 July 2014 to the Health Minister, I found no evidence that the Trust ever wrote directly to Mr McCallister, providing him with a substantive response to his letter of 26 June 2014, despite it having indicated to him on 30 June 2014 that it would do so. As such, there was no way for Mr McCallister, and therefore Mrs A's family, to know at the time that the Trust had concluded its consideration of the complaint.

205. It was established that Mr McCallister wrote to the Trust's Chief Executive on 16 September 2014, advising of Mrs A's family's continuing dissatisfaction with the Trust's response to their request for a CHC assessment to be carried out. Mr McCallister's office also emailed the Trust on 19 September 2014, expressing Mrs A's family's dissatisfaction with the actions of the Trust, and requesting specific information as to why family members had not been invited to be present when the nursing needs assessment and the memory service specialist nursing assessment had been completed for Mrs A on 18 November 2013.

206. I noted that, in response, the Trust wrote to Mr McCallister on 22 September 2014, referring to '*the reopened complaint [he had] made to the [Trust] regarding the provision of services to [Mrs A]'* and advising that a response would be provided '*in due course'.* I also noted that on 16 October 2014, the Trust informed Mr McCallister that it was anticipated that a response would be provided to him '*within the next 19 working days'.* I am satisfied, therefore, that on that occasion, the Trust kept Mr McCallister updated in relation to when he might expect to receive a response to the issues raised in his letter of 16 September 2014 and his office's email of 19 September 2014. However, for the reasons set out below, I consider that the Chief Executive's letter of 20 October 2014 to Mr McCallister was not an appropriate response to the 'reopened complaint'.

207. Firstly, in response to Mr McCallister's request for confirmation of '*whether the assessment carried out on 18 November 2013'* was the correct CHC assessment required in accordance with Paragraph 17 of the 2010 Circular, the Chief Executive advised that the Trust had used both the NNAT and the NISAT to assess Mrs A's needs. This statement was factually incorrect as the NISAT had not yet been used at that stage to assess Mrs A's needs. When the Trust commented on the draft of this report, it acknowledged that this reference to a NISAT having already been completed had been an error on its part. The Trust apologised for *'this inaccuracy, which was not intentional.'* Rather, it was not until 20 January 2016 that the Trust first carried out a NISAT assessment in relation to Mrs A. In my view, the Trust's reference to the NISAT in its letter to McCallister was also misleading, in that it implied that the specific comprehensive assessment of need referenced in the 2010 Circular had already been completed when, clearly, that was not the case.

208. Secondly, the statement in the Chief Executive's letter that '*The Trust would advise … that following a NNAT, it was identified that [Mrs A] should be awarded the NNAT payment, so ensuring that she is not contributing towards the nursing element of her care'* was also factually inaccurate and misleading because, as the Trust confirmed in response to investigation enquiries, Mrs A had been in receipt of the £100 per week nursing care payment since October 2011; she was not therefore *'awarded'* this payment following the NNAT assessment, first completed in November 2013. In commenting on the draft of this report, the Trust disagreed with my view on this matter, contending that *'it was not being suggested [in the Chief Executive's letter of 20 October 2014] that [the nursing care payment] was something new to the 2013 period and not having been in place before that time.'* I do not accept the Trust's position. The language used in the Chief Executive's letter made a clear link between the 'award' of the nursing care payment with a NNAT assessment (in November 2013) having identified that Mrs A had nursing needs, and was therefore entitled to receive the nursing care payment).

209. Thirdly, despite the Chief Executive having indicated that she was responding to Mr McCallister's letter of 16 September 2014 and to his office's email of 19 September 2014, her letter failed to address the specific request made in the email of 19 September 2014 for information about the non-involvement of Mrs A's

family in the 18 November 2013 assessments.

210. Finally, the Trust treated Mr McCallister's correspondence as a 'reopened complaint'. However, the Chief Executive's response to Mr McAllister did not meet the requirements of paragraph 3.42 of the HSC Complaints Procedure, which states that a complaint response letter must '*… indicate that a named member of staff is available to clarify any aspect of the letter [and] advise of [the complainant's] right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure'.*

211. My investigation also established that COPNI became involved in Mrs A's case in October 2014, with the COPNI Chief Executive making written enquiries of the Trust's Chief Executive, on Mrs A's family's behalf, on 28 October 2014. I note that the Trust acknowledged receipt of the COPNI Chief Executive's correspondence on 7 November 2014, referring to '*the complaint [she had] made to [the Trust] regarding the provision of services to [Mrs A]*. The Trust also indicated that it was necessary for Mrs A's next of kin to provide written consent for the COPNI Chief Executive to complain to the Trust on Mrs A's behalf, and it advised that on receipt of the written consent, the Trust would provide a response *'at an early date'*. This inexact timescale for response is not in keeping with the good practice set out in paragraph 3.17 of the HSC Complaints Procedure, which is that complaint acknowledgment letters should '*indicate that a full response will be provided within 20 working days'.*

212. I noted that COPNI provided the required written consent to the Trust on 14 November 2014, and that the Trust's Chief Executive provided a substantive response to the COPNI Chief Executive's letter on 26 November 2014. Although the Trust's Chief Executive commented in her letter on most of the issues the COPNI Chief Executive had raised, she did not address the specific request that '*a full [CHC] assessment takes place without further delay.'*

213. Furthermore, there was no indication in the Trust's Chief Executive's response of 26 November 2014 that the Trust had handled the COPNI Chief Executive's correspondence of 28 October 2014 as a complaint, despite the Trust having referred in its acknowledgement letter of 7 November 2014 to '*the complaint [the*

COPNI Chief Executive had] made to [the Trust] regarding the provision of services to [Mrs A]'. As such, there was no direction provided to the COPNI Chief Executive as to what action Mrs A's family could take, should they be dissatisfied with the Trust's response, which, as I have already highlighted, is a requirement under paragraph 3.42 of the HSC Complaints Procedure. I have no doubt that this lack of clarity regarding the status of Mrs A's family's complaint may well have led to the need for the COPNI Chief Executive to write to the Trust's Chief Executive again on 9 March 2015, asking whether the complaint had been '*fully reviewed and adjudicated upon'.*

214. I also noted that when the COPNI Chief Executive wrote subsequently to the Trust's Chief Executive (Interim) on 26 June 2015, reiterating the request for a CHC assessment for Mrs A, the Trust's Governance Office advised, on 6 July 2015, *'the complaint is now reopened regarding [Mrs A]'.* The Governance Office also indicated that a response would be provided '*in due course'.* As recorded previously, in relation to the Trust's acknowledgement of the COPNI Chief Executive's earlier correspondence of 28 October 2014, an imprecise response timeframe such as this is not in keeping with the standard required by 3.17 of the HSC Complaints Procedure, which is that complaint acknowledgment letters should *'indicate that a full response will be provided within 20 working days'*

215. The Trust's Chief Executive (Interim) did not provide her substantive response to the 'reopened complaint' until 10 August 2015. Clearly, that response was not provided within the 20 working day timescale required by paragraph 3.38 of the HSC Complaints Procedure, nor is there any evidence of the Trust having provided a holding response to the COPNI Chief Executive in the meantime.

216. Furthermore, having considered the content of the Chief Executive (Interim)'s letter of 10 August 2015, it is my view that it was not an appropriate response to all the issues the COPNI Chief Executive had raised. The reason for my view is that the COPNI Chief Executive had clearly stated in her letter of 26 June 2015 that Mrs A's family were seeking a *'full [CHC] assessment'* to be carried out for Mrs A. However, the Chief Executive (Interim)'s response to this issue was simply to reiterate the Trust's position on its management of '*requests for individuals to be assessed for continuing care placement',* which was that '*individuals have their*

requirements assessed through the application of [the NISAT] and [the NNAT]', and that where it is identified that '*the individual requires to be managed in a permanent placement, the Trust manages charging arrangements within the context of [the 2010 Circular], as well as through other associated guidance ...All assessments to date have shown that [Mrs A's] assessed care needs are being appropriately met in her current placement'.* I consider the focus of this response by the Chief Executive (Interim) was the assessment of Mrs A's needs in terms of the setting, or 'placement', in which those needs could be best met, rather than the specific assessment that had been requested by her family, which was an assessment of her primary need, in order to determine whether she was entitled to receive CHC, and consequently whether she was required to meet the cost of her nursing home placement. Consequently, it is my view that the Chief Executive (Interim)'s letter did not meet the standards required by paragraph 3.42 of the HSC Procedure, which include that a complaint response '*address the concerns expressed by the complainant and show that each element has been fully considered and fairly investigated'.*

217. In addition, the Chief Executive (Interim)'s response of 10 August 2015 to the COPNI Chief Executive failed to '*… indicate that a named member of staff is available to clarify any aspect of the letter [and] advise of [the complainant's] right to take their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure'*, which is a further requirement of paragraph 3.42 of the HSC Complaints Procedure

218. I noted that the COPNI Chief Executive wrote to the Trust's Assistant Director of Primary Care on 16 December 2015, advising that Mrs A's family had indicated that the Trust had closed their complaint without them, or Mr McCallister, having been advised of that action. It was not until 16 February 2016 that the Assistant Director of Primary Care responded to the COPNI Chief Executive, but there is no evidence that he acknowledged, or apologised for, the delay in providing that response. I noted also that the Assistant Director advised that Mrs A's family's complaint, as raised by Mr McCallister in his letter of 24 March 2014 to the Health Minister, had been responded to by the Trust's Chief Executive on 21 May 2014. The Assistant Director made no reference to Mr McCallister's subsequent letter of 26 June 2014 to the Health Minister, his correspondence of 16 September 2014 to

the Trust's Chief Executive, or the COPNI Chief Executive's letters of 28 October 2014 to the Chief Executive and 26 June 2015 to the Chief Executive (Interim), which this investigation has established were also treated as complaints made on behalf of Mrs A's family.

219. In my view, this is an indication that the Trust did not have a clear understanding of the full chronology of the family's complaint or the Trust's handling of it. When it commented on the draft of this report, the Trust said that it considered this was '*an unfair statement in light of the extensive documentation'* it had provided to my Office in response to the complainant's complaint. It also said that complaint correspondence of 26 June 2014, 16 September 2014, 28 October 2014 and 26 June 2015 had not been referenced in the Assistant Director's letter to the COPNI Chief Executive because '… *the Assistant Director had attended a meeting with COPNI on 06 November 2015 … during which [he] had answered any questions posed in respect of complaints responses at that time.'* It is clear, however, that when the COPNI Chief Executive wrote to the Assistant Director of Primary care on 16 December 2015, she advised that Mrs A's family wanted to have *'the whole complaint process reviewed …'* This shows that the family's concerns about the complaint handling process was not limited to how the Trust had responded to the initial complaint submitted by Mr McCallister in March 2014. Consequently, the Trust ought to have provided a more comprehensive response to the COPNI Chief Executive, referring also to the Trust's handling of the further complaint correspondence it had received from Mr McCallister and COPNI. Furthermore, it is evident that the meeting with COPNI on 6 November 2015, to which the Trust has referred, took place prior to the date of the COPNI Chief Executive's letter (16 December 2015). This indicates to me that whatever information the Trust provided at the meeting on 6 November 2015 did not satisfactorily answer the family's questions about the Trust's handling of their complaint.

220. My investigation established that the COPNI Chief Executive again wrote to the Trust's Chief Executive (Interim) on 15 March 2016, referring to Mrs A's family's previously raised '*concerns regarding the management and response to complaints they outlined to the Trust through the Offices of Mr. John McCallister MLA.'* I noted that on 23 March 2016, the Trust's Director of Older People and Primary Care responded to the COPNI Chief Executive. The Director explained the chronology

of the Trust's handling of the family's complaint, as follows: '*Mr J McCallister (MLA) first corresponded with [the Health Minister] in his letter dated 24 March 2014, which was shared with the Trust by Minister on 09 April 2014. The Trust replied to Mr J McCallister on 21 May 2014… The Trust also received a letter on 19 September 2014 directly from Mr J McCallister dated 16 September 2014. This was dealt with as a re-opened complaint and was formally responded to on 20 October 2014 … The complaint was regarded as closed once the response dated 20 October 2014 was sent.'* I note the Director did not refer to Mr McCallister's letter of 26 June 2014 to the Minister, which had also been treated as a complaint by the Trust. Again, I consider this omission from the complaint handling timeline provided in the Director's letter demonstrates that the Trust did not have a clear grasp of the full chronology of Mrs A's family's complaint and the Trust's response to it.

221. I noted that subsequently, on 25 November 2016, Sinead Bradley MLA wrote to the Trust's Chief Executive (Interim) about the Trust's handling of Mrs A's family's complaint, highlighting that '*…any referencing to the formal internal complaints process appears very light with no communications from the Trust advising at what stage in the process the case is being considered'.* I noted too that the Trust treated Ms Bradley's correspondence as a complaint, advising on 30 November 2016 that a substantive response would be provided *'within 20 working days'* of receipt of written consent from Mrs A's next of kin for the Trust to release confidential information to Ms Bradley.

222. The Trust met that 20 working day timescale, with a response from the Trust's Director Older People and Primary Care being provided to Ms Bradley on 13 December 2016. I noted that on that occasion, the Director's response satisfied the requirements of paragraph 3.42 of the HSC Complaints Procedure to provide details of who Ms Bradley and/or Mrs A's family should contact, should they be dissatisfied with the response, and to advise of their right to bring a complaint to this Office. In addition, I was satisfied that the Director's letter explained the Trust's position on status of the family's complaint, advising *'the Trust has provided a formal response to each complaint raised by representatives of [Mrs A's family]'* and *'… the Trust is not aware of any current active complaints'.* However, I consider the response was lacking in relation to the other matter Ms Bradley had

raised, that is, the family's request for the Trust to '*reconsider the case in its entirety with a view to reaching a conclusion that is satisfactory to [them]'.* In my view, the Director's statement, *'I will* ***assume*** [my emphasis] *that the issue relates to the outstanding debt owed to the Trust …'* is not indicative of the Trust having considered Ms Bradley's correspondence in accordance with the requirement of paragraph 3.25 of the HSC Complaints Procedure to '*seek to understand the nature of the complaint'*, and to approach a complaint '*with an open mind, being fair to all parties.'*

223. Having considered the evidence relating to this issue of complaint, I have found a significant number of failings in the Trust's handing of the complaints that were made to it by Mr McCallister, Ms Bradley and COPNI on behalf of Mrs A's family. The Ombudsman's Principles of Good Complaint Handling are reproduced in Appendix 3 to this report. Good complaint handling by public bodies means getting it right; being customer focused; being open and accountable; acting fairly and proportionately; putting things right; and seeking continuous improvement. The failings I have identified above are evidence that in dealing with the complaints submitted to it about its response to requests for Mrs A's CHC eligibility to be assessed, the Trust did always not meet the standards required by these Principles.

224. I am mindful that the IPA has expressed the view that '*the Trust has made considerable effort to answer [the complainant's] complaint but due to a lack of local policy and clear national Northern Ireland guidance in relation to [CHC], the Trust has been unable to satisfactorily resolve the complaint.'* I am also mindful that when it commented on the draft of this report, the Trust expressed the view that *'the issues of complaint in this case are very complex and interlinked with policy decisions on a Northern Ireland wide basis.'* I acknowledge that the determination of CHC eligibility is a complex matter. In addition, as I have already recorded in this report, I acknowledge that the lack of regional administrative guidance from the Department on the determination of CHC eligibility may well have impacted on the Trust's response to Mrs A's family's requests. However, I do not accept that an absence of such guidance ought to have hindered the Trust's ability to deal appropriately with the complaints that were made to it, on Mrs A's

family's behalf, in accordance with the HSC Complaints Procedure and the Principles of Good Complaint Handling.

225. Consequently, I consider the complaint handling failings identified above to be maladministration on the part of the Trust. I am satisfied that this maladministration caused the complainant, and other members of Mrs A's family, to sustain the injustice of frustration, distress and uncertainty, as well as being put to an unreasonable degree of time and trouble over a protracted period in pursing their complaint and in securing the support and representation of others with a view to have their concerns satisfactorily addressed. Consequently, I uphold this issue of complaint.

CONCLUSION

226. I received a complaint about the actions of the Trust in relation to how it responded to requests that were put to it for the care needs of the complainant's mother (Mrs A) to be assessed in order to determine her eligibility for CHC. The complainant was also aggrieved about how the Trust handled the related complaints that were submitted to it, on his family' behalf, by John McCallister MLA, COPNI and Sinead Bradley MLA.

227. The investigation of this complaint has found evidence of a series of failings on the part of the Trust, which I consider constitute maladministration. The failings, which relate to both issues of complaint that were accepted for investigation, and which have been set out in detail in this report, may be summarised as follows.

228. In relation to the Trust's response to the requests that were put to it for Mrs A's CHC eligibility to be assessed:

    i. The Trust failed to consider the requests of 1 February 2012; 24 March 2014; 26 June 2014; 3 September 2014; 28 October 2014; and 26 June 2015 for Mrs A's CHC eligibility to be assessed, in accordance with the Department's policy direction set out in the 2010 Circular;

ii. The Trust failed to provide appropriate and/or complete responses to the requests of 24 March 2014; 26 June 2014; 3 September 2014; 28 October 2014; and 26 June 2015;

iii. The Trust provided inaccurate and misleading information in its written responses to the requests of 1 February 2012 and 3 September 2014;

iv. There was an unacceptable delay of more than a year in the Trust providing a response to the 1 February 2012 request;

v. There was an excessive and indefensible delay of more than four years in the Trust carrying out the specific assessment that would inform a determination of Mrs A's CHC eligibility, that is, the NISAT assessment referenced in the 2010 Circular;

vi. Having carried out the NISAT assessment in January 2016, the Trust failed to then determine Mrs A's primary need, and therefore her eligibility for CHC, in accordance with the 2010 Circular; and

vii. The Trust failed to put in place the necessary local arrangements to enable it to fulfil its responsibilities under the 2010 Circular, in accordance with the Department's expectation in that regard.

229. I am satisfied that these instances of maladministration on the part of the Trust caused the complainant, and the other members of Mrs A's family who were seeking a CHC assessment for Mrs A, to experience the injustice of frustration, uncertainty and distress over a prolonged period of time. They also experienced the injustice of a loss of opportunity to have Mrs A's primary need determined in a timely manner, and thereby be assured about the appropriateness of the charges being applied for her care in the Nursing Home.

230. In relation to the Trust's handling of the related complaints that were made to it on behalf of Mrs A's family, the failings disclosed by the investigation are:

i In responding to John McCallister MLA's letter of 24 March 2014 to the Health Minister, the Trust failed to:
a) acknowledge receipt of the complaint;

b) inform Mr McCallister that there would be a delay in providing a response to the complaint, and give an indication of when that response could be expected;
c) address Mr McCallister's explicit request that an assessment of Mrs A's CHC eligibility be carried out in accordance with the 2010 Circular;
d) address Mr McCallister's concern about a lack of clarity as to whether Mrs A's eligibility for CHC had been assessed;
e) provide accurate information in relation to the date of the most recent assessment of Mrs A's care needs; and
f) inform Mr McCallister of the action he and/or Mrs A's family could take, should they be dissatisfied with the Trust's response to the complaint.

ii. In responding to Mr McCallister's letter of 26 June 2014 to the Health Minister, the Trust failed to:
a) address Mr McCallister's further direct request that an assessment of Mrs A's eligibility for CHC be assessed; and
b) provide a written response to the complaint directly to Mr McCallister, in accordance with the undertaking provided to him on 30 June 2015.

iii. In responding to Mr McCallister's letter of 16 September 2014 to the Trust's Chief Executive, and his office's email of 19 September 2014 to the Governance Office, the Trust failed to:
a) provide accurate information in relation to the nature of the assessments of Mrs A's needs that had already been completed;
b) provide accurate information in relation to Mrs A's receipt of the HSC nursing care payment;
c) address the request for information about the non-involvement of members of Mrs A's family in the assessments of Mrs A's needs that were completed on 18 November 2013; and
d) inform Mr McCallister of the action he and/or Mrs A's family could take, should they be dissatisfied with the Trust's response to the complaint.

iv. In responding to the COPNI Chief Executive's letter of 28 October 2014 to the Trust's Chief Executive, the Trust failed to:

a) stipulate a specific timescale within which a substantive response would be provided;
b) address the COPNI Chief Executive's specific request that *'a full [CHC] assessment takes place without further delay';* and
c) inform the COPNI Chief Executive of the action she and/or Mrs A's family could take, should they be dissatisfied with the Trust's response to the complaint.

v. In responding to the COPNI Chief Executive's letter of 26 June 2015 to the Trust's Chief Executive (Interim), the Trust failed to:
a) stipulate a specific timescale within which a substantive response would be provided;
b) provide a substantive response to the COPNI Chief Executive within the required 20 working day timescale, or explain the delay in the response;
c) provide an acceptable response to the COPNI Chief Executive's request that an assessment of Mrs A's eligibility for CHC be carried out; and
d) inform the COPNI Chief Executive of the action she and/or Mrs A's family could take, should they be dissatisfied with the Trust's response to the complaint.

vi. In responding to the COPNI Chief Executive's letter of 16 December 2015 to the Trust's Assistant Director of Primary Care, the Trust failed to:
a) provide a timely response, or to acknowledge, and apologise for, the delay; and
b) demonstrate a clear understanding of the chronology of Mrs A's family's complaint and the Trust's handling of it.

vii. In responding to the COPNI Chief Executive's letter of 15 March 2016 to the Trust's Chief Executive (Interim), the Trust again failed to demonstrate a clear understanding of the chronology of Mrs A's family's complaint and the Trust's handling of it.

viii. In responding to Sinead Bradley MLA's letter of 25 November 2016 to the Trust's Chief Executive (Interim), the Trust made an assumption about the

nature of one of the issues the MLA had raised, rather than seeking to understand the nature of the complaint and approaching it with an open mind.

231. I am satisfied that these instances of maladministration caused the complainant, and other involved members of Mrs A's family, to experience the further injustice of frustration, distress and uncertainty, as well as being put to an unreasonable degree of time and trouble over a protracted period in pursing their complaint, and in securing the support and representation of others, with a view to have their concerns satisfactorily addressed.

232. Having found maladministration on part of Trust in relation to each of the matters the complainant raised with this Office and, being satisfied that this maladministration caused the complainant to experience injustice, I uphold both of the issues of complaint that were accepted for investigation.

Recommendations

233. I recommend that, within one month of the date of this report, the Trust provide a written apology, made in accordance with NIPSO's Guidance on Issuing an Apology' (Appendix 8), and a payment of £1000 to the complainant for the injustice caused to him, and the other involved members of Mrs A's family, as a result of the failings identified in this report.

234. I also recommend that, with immediate effect from the date of this report, the Trust discontinue its practice of not determining CHC eligibility in cases where the individual concerned has been placed in a residential care or nursing home. This practice by the Trust is clearly contrary to the Department's policy direction, as set out in the 2010 Circular and as clarified further in the Department's 2017 public consultation document, ''*Continuing Healthcare in Northern Ireland: Introducing a Transparent and Fair System*.[26] It also causes me to be concerned about the basis on which the Trust continues to levy charges for a nursing home resident where the issue of a change in their primary need has been raised. The 2010 Circular is clear that a HSC Trust has no authority to charge for healthcare, irrespective of the setting in which that healthcare is provided. Consequently, for the Trust to apply a

[26] https://www.health-ni.gov.uk/consultations/continuing-healthcare-northern-ireland-introducing-transparent-and-fair-system

charge, in accordance with the 2010 Circular, it must be satisfied that the individual's primary need is not for healthcare but, rather, is for social care. The Trust's current position of routinely not determining CHC eligibility in cases where the individual concerned has been placed in a residential care or nursing home, and continuing to levy charges, even when a possible change in the individual's primary need has been brought to its attention, is, therefore, unsustainable.

235. I further recommend that the Trust, either individually or collectively with other HSC Trusts and organisations, take action to ensure that it has in place the administrative arrangements that are necessary to enable it to consider all future requests for a determination of CHC eligibility in a timely, consistent and transparent manner, and in accordance with the Department's policy direction, as set out in the 2010 Circular. In particular, the Trust should:
    i. Develop a local policy on the implementation of the provisions of the 2010 Circular;
    ii. Develop and implement local protocols and procedures in relation to the determination of an individual's primary need and consequently, their CHC eligibility;
    iii. Deliver training on the provisions of the 2010 Circular, and the related local CHC policy, protocols and procedures to be implemented, to staff involved in the assessment of individuals' complex health and social care needs; and
    iv. Publish details of the Trust's position on the determination of primary need and CHC eligibility.

236. In making this particular recommendation, I am conscious that during my investigation, the Trust contended, in responding to investigation enquiries, in commenting on the IPA's advice and in commenting on the draft of this report, that it was not in a position to put in place the administrative arrangements that are necessary to enable it to consider eligibility for CHC, in accordance with the 2010 Circular, because CHC policy and the related operating protocols and procedures need to be developed and implemented on a Northern Ireland-wide basis. In this regard, I acknowledge that in March 2017, this Office, in its consideration of a previous complaint relating to CHC, accepted that position. However, it is important to note that at that time, the Department's review of CHC in Northern Ireland was already underway; the Department had, in November 2014, informed

HSC Trusts about the planned review, which was to consider the need for further guidance on CHC, and subsequently, in October 2016, the Department had informed Trusts that a number of options on the way forward were being considered and that a public consultation was to be carried out. It was therefore not unreasonable, in March 2017, to anticipate that a new CHC framework, and associated regional guidance from the Department, might be developed and implemented within a relatively short period of time. There was no way of knowing at that time that the suspension of the Northern Ireland Assembly from January 2017 to January 2020, resulting in the absence of a Health Minister for a prolonged period, coupled with subsequent competing priorities for the Minister and the Department, would mean that almost four years later, the Department's review of CHC would still not have concluded.

237. I consider it is not sustainable that the Trust maintains that it is unable to make determinations of CHC eligibility because there is an absence of regional administrative arrangements. The Department has made it clear to all HSC Trusts that until such time as any revision to the current Northern Ireland CHC arrangements has been agreed and implemented, the provisions of the 2010 Circular continue to apply. The Department has also informed this Office, most recently in October 2020, that it is its expectation that each HSC Trust has in place the necessary administrative arrangement to enable it to fulfil its responsibilities and obligations under the 2010 Circular. The recommendation I have made in paragraph 235 is therefore in keeping with the Department's policy direction to HSC Trusts.

238. The Trust should implement an action plan to incorporate the service improvements I have recommended above and provide me with an update within six months of the date of this report, supported by evidence to confirm that appropriate action has been taken.

239. In addition, having reflected on the IPA's comments as to whether Mrs A's primary need became healthcare at any time while she was a resident of the Nursing Home, I recommend that, having put in place the necessary administrative arrangements for determining CHC eligibility, the Trust establish a multi-disciplinary team to be tasked with reviewing the NISAT assessment documentation completed

for Mrs A in January 2016, along with all other available records pertaining to her care needs, and making a retrospective determination of her primary care need, and therefore her eligibility for CHC. The Trust should make the necessary arrangements to ensure that the complainant is kept informed about the retrospective determination of Mrs A's CHC eligibility and that he is notified of the outcome in a timely manner. I further recommend that having made the retrospective determination of Mrs A's primary need and her eligibility for CHC, the Trust makes any necessary adjustment to the outstanding monies owed from Mrs A's estate for the cost of her placement in the Nursing Home.

240. Finally, I recommend that the Trust take appropriate action, within two months of the date of this report, to ensure that all staff involved in the handling of complaints are reminded of the requirements, standards and good practice set out in the HSC Complaints Procedure.

241. The Trust was asked to confirm whether it accepted my recommendations. In response, the Trust advised that it accepted the recommendations made in paragraphs 233 and 240 of this report. In relation to the recommendations made in paragraphs 234, 235, 238 and 239, the Trust said it would *'make contact with [the Department], [the Health and Social Care Board] and other Trusts to collectively agree how these recommendations can be actioned'.*

MARGARET KELLY **10 December 2020**
Ombudsman

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.

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.