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

Report Reference: 202002939

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the South Eastern Health and Social Care Trust's (the SEHSCT) consideration of the complainant's late mother's (the resident) eligibility for continuing healthcare (CHC)[1] during the period 18 August 2020 to 26 November 2020, and its communication with the resident's family in that respect.

My investigation found that the SEHSCT did not make a determination in respect of the resident's eligibility for CHC, or conduct any reviews, assessments or reassessments of the resident's needs for that specific purpose. However, my investigation established the Trust did not do so because neither the resident, nor her family, applied to the SEHSCT for it to make this determination. In the absence of such an application, the SEHSCT had no reason, obligation or responsibility to make a determination on primary need for the purposes of considering CHC eligibility. In addition, my investigation found that whilst the SEHSCT has an obligation under the 2010 Circular to inform older people and their families of care management options for that older person, this does not extend to a specific obligation to inform those parties of their ability to apply to the SEHSCT for it to consider an older person's eligibility for CHC. I therefore did not uphold this complaint.

In investigating this complaint, however, I made some observations for the Trust to consider. These related to the resident's involvement in discussions about her care, record-keeping, as well as assessments for nursing care and for needs following a change in the resident's status from temporary to permanent care home resident. These matters were outside the scope of this investigation. However, the Trust's consideration of them may lead to improvements in its future practice.

[1] At the time the complainant submitted his complaint to my Office (June 2022), 'Continuing Healthcare' (CHC) was the term used in Northern Ireland to describe the practice of the health service meeting the cost of any social need which was driven primarily by a health need. Essentially, this meant that if an individual's primary need was for healthcare, rather than for social care (also known as personal social services), they did not have to pay for the care they received, irrespective of where that care was provided. A new policy for determining eligibility to CHC was introduced in Northern Ireland in February 2021. However, that 2021 Policy was quashed by a High Court Judicial Review judgement on 30 June 2023, citation no: [2023] NIKB 72. The High Court reinstated the original approach.

THE COMPLAINT

1. This complaint is about the actions of the South Eastern Health and Social Care Trust (the SEHSCT). The complainant made the complaint on behalf of her late mother, who is referred to in this report as 'the resident'.

Background

2. In April 2020 the resident was diagnosed with advanced endometrial cancer[2]. On 28 July 2020 the resident went into hospital to receive palliative radiotherapy[3] for three weeks. This hospital was under the jurisdiction of the Belfast Health and Social Care Trust (BHSCT). Prior to this, the resident had been living in her own home with the support of family and a package of care[4].

3. On 14 August 2020 the BHSCT completed a NISAT Initial Assessment/Short Term Intervention Form[5] in relation to the resident's needs. The BHSCT determined the patient was medically fit for discharge, but not sufficiently fit to return to her own home with a package of care at that time. The BHSCT decided to discharge the resident to a nursing home for '*respite care*[6]' and short-term rehabilitation[7], with the intention of her ultimately returning to her own home with a package of care when fit to do so.

4. On 18 August 2020 the resident transferred sums of money from bank accounts in her name to her family. Also on this date, the BHSCT discharged the resident into a nursing home (the nursing home) under the SEHSCT's jurisdiction.

5. Regarding the resident's nursing home fees, the complainant completed an Agreement to Pay/Financial Assessment and commenced making payments for the resident's care. She subsequently completed a declaration of means form.

[2] Cancer affecting glandular cells found in the lining of the womb.
[3] Treatment using radiation to slow down the growth or cancer or to reduce symptoms. However, it does not aim to cure cancer. It aims to improve a patient's quality of life and is considered comfort care.
[4] A mixture of services put together to meet somebody's needs after they've received a needs assessment by a social care professional.
[5] Northern Ireland Single Assessment Tool – designed primarily in the context of older people's needs and provides a validated assessment framework. It is designed to capture the information required for holistic, person-centred assessment to support the exercise of professional judgment in the care management process.
[6] temporary care of a sick, elderly, or disabled person, providing relief for their usual carer.
[7] Used for patients who have been released from the hospital following a serious illness, injury or surgery, but need more time to recover before safely returning home.

6. On 27 August 2020 the resident returned to the hospital under the BHSCT's jurisdiction suffering from an ulcerated tumour[8]. The hospital discharged the resident back to the nursing home on 29 August 2020.

7. On 2 September 2020 the complainant contacted the Trust to raise concerns about the resident's mental, emotional and physical health, her appetite and her rehabilitation progress. She also asked the Trust to consider whether there were any viable alternatives to the nursing home at that time that may allow the resident to enjoy a better quality of life. On 7 September 2020 the SEHSCT, the nursing home and the resident's family met to discuss the resident's needs. The outcome was the resident was not fit to return home at that time to live with a package of care in place as initially planned. They decided it was in the resident's best interests to remain in the nursing home at that time. In the event, the resident sadly never recovered sufficiently to enable her to return to her own home.

8. On 6 October 2020 the SEHSCT informed the complainant about the outcome of its interim assessment of the resident's means in respect of her nursing home fees, which the complainant accepted. It also sought additional information from the complainant about the sums of money the resident transferred on 18 August 2020, which complainant provided.

9. The resident sadly passed away on 26 November 2020.

10. On 8 February 2021 the SEHSCT informed the complainant it had included the sums of money the resident had transferred on 18 August 2020 in its financial assessment of the resident's means. It provided the complainant with its final invoice for the resident's nursing home fees. The complainant appealed against the SEHSCT's decision. However, the SEHSCT upheld its original decision.

11. The complainant was dissatisfied with the SEHSCT's decision and raised a complaint in May 2022. The complaint related to the Trust's financial decisions. It also related to the SEHSCT's assessment and review of the resident's needs

[8] Tumour due to complications from cancer. This skin can start bleeding or weeping fluid, and the tumour can cause the skin to die and get infected, resulting in a foul smell and an open wound.

and the associated financial implications, as well as its communication with the resident's family about this.

12. The SEHSCT responded to the complaint on 30 May 2022. The complainant was dissatisfied with this response and lodged a complaint with my Office.

Issue of complaint

13. The issue of complaint accepted for investigation was:

Whether the Trust appropriately considered the resident's eligibility for continuing healthcare during the period 18 August 2020 – 26 November 2020 in accordance with relevant policies, procedures and guidelines?

INVESTIGATION METHODOLOGY

14. In order to investigate this complaint, the Investigating Officer obtained from the SEHSCT all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process. I also obtained the resident's records and notes from the BHSCT, the resident's GP and the nursing home she lived in during the relevant period.

Independent Professional Advice

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

- **Registered Nurse** – with over 40 years' experience, including 20 years' experience in NHS continuing healthcare.

16. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided '*advice*'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

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

18. The general standards are the Ombudsman's Principles:[9]

    (i) The Principles of Good Administration

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

20. The specific standards relevant to this complaint are:

    - The Health and Personal Social Services (NI) Order 1972 ('the 1972 Order')
    - Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance; issued by the (then) Department of Health, Social Services and Public Safety on 11 March 2010 (the 2010 Circular);
    - Circular ECCU1/2006, HPSS Payments for Nursing Care in Nursing Homes, issued by the issued by the (then) Department of Health, Social Services and Public Safety on 10 March 2006 ('the 2006 Circular');
    - Continuing Healthcare in Northern Ireland: Introducing and Transparent and Fair System, Consultation Document, issued by the Department of Health on 19 June 2017 (CHC Consultation Document); and
    - Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a Fair and Transparent System, issued by the Department of Health on 12 May 2021 ('the 2021 Circular').

21. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered

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

relevant and important in reaching my findings.

22. I shared a draft copy of this report with the complainant and the SEHSCT for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Whether the Trust appropriately considered the resident's eligibility for continuing healthcare during the period 18 August 2020 – 26 November 2020 in accordance with relevant policies, procedures and guidelines?

Detail of complaint

23. The complainant raised the following concerns in this respect:

    - The complainant said there was a '*lack of transparency*' on the SEHSCT's part regarding its role in the resident's discharge from hospital, and its assessment of her needs following that discharge. In particular, the SEHSCT's determination of the resident's primary need. She said this prevented the Trust from '*exploring*' the patient's eligibility for continuing healthcare;

    - The SEHSCT failed to consider the resident's eligibility for continuing healthcare on an ongoing basis by keeping her needs under review as they '*intensified*' and her '*condition rapidly deteriorated*'.

24. The complainant said if the SEHSCT had correctly considered the resident's eligibility for continuing healthcare, the resident may not have incurred the nursing home fees the SEHSCT has charged her estate with.

Evidence Considered

Legislation, Policies and Guidance

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

- The 1972 Order;
- The 2010 Circular;
- The 2006 Circular;
- CHC Consultation Document; and
- The 2021 Circular.

The SEHSCT's response to investigation enquiries

26. The SEHSCT stated: it '*assumed responsibility*' for the resident's '*ongoing care needs*' following her arrival at the nursing home on 18 August 2020.

27. The SEHSCT stated it applied the relevant guidance from the Department of Health to determine the resident's needs could be '*properly met*' in the nursing home, and her needs were subsequently '*provided for*' in that setting. The resident was '*subject*' to the '*relevant charging policy*' and charged according to her means.

28. The SEHSCT stated: it reviewed, monitored and reassessed the resident '*as appropriate*' during the relevant period. Its '*multidisciplinary team*' visited the resident in the nursing home to '*review and assess*' her '*physical needs*'. This included a tissue viability nurse on 1 October 2020 and a physiotherapist on 20 October 2020. On 18 November 2020 a palliative physiotherapist '*reassessed and reviewed*' the resident, and from 13 November 2020 the resident's GP '*visited*' the resident '*weekly*'.

29. The Trust explained it would have conducted a '*formal review*' of the resident's needs, but that unfortunately she '*sadly passed away*' before this took place.

Documentation and records examined

30. I completed a review of the copy documentation the SEHSCT provided in response to my investigation enquiries, and the records I obtained from the complainant, the BHSCT, the resident's GP and the nursing home.

Independent Professional Advice

31. I considered the advice I obtained from the IPA. In her advice the IPA, at times, made reference to the actions of the BHSCT. The BHSCT is not subject to this complaint or investigation. However, the IPA's advice in this respect is contextually relevant to the subsequent actions of the SEHSCT when it assumed responsibility for the resident's care.

32. I enclose the IPA's full advice report is at Appendix three to this report.

Analysis and Findings

Context of CHC in Northern Ireland

33. Before I set out my findings, I should highlight that in February 2021, the Department of Health published the outcome of a public consultation it launched in June 2017 on future arrangements for CHC in Northern Ireland. Later, in May 2021, the Department issued guidance[10] on a new policy for determining eligibility for CHC on the basis of applying a single eligibility criterion. This criterion was whether an individual's care needs can be properly met in any setting other than a hospital. If the answer to this question was 'yes', then the individual was not be eligible for CHC and was subject to the relevant charging policy for the care they received. However, the High Court in Northern Ireland quashed that policy in its Judicial Review decision[11] issued on 30 June 2023. In doing so, the High Court, in practice, reinstated the previous approach, as set out in the 2010 Circular, issued in March 2010.

34. In this instance, the events in question took place prior to February 2021. Therefore it is the policy reflected in the 2010 Circular that is relevant to my consideration of this complaint, that is, that an individual's eligibility for CHC is determined on the nature of their primary need. I will therefore refer to this policy in setting out my findings on the complaint.

[10] Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system ('the 2021 Circular')
[11] Citation no. [2023] NIKB 72

35. In considering this complaint, I am mindful that the 1972 Order (the main legislation governing the provision of health and social care services in Northern Ireland) does not provide an explicit statutory framework for the provision of CHC, nor does it expressly require that CHC be provided to people in Northern Ireland. That said, I am aware that the 2010 Circular (which sets out the Department of Health's guidance on charging for social care [also known as personal social services] provided in residential care homes and nursing homes) states at paragraph 63, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential or nursing home accommodation arranged by a [Health and Social care] Trust.* ***There is no such requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home'*** (the 2010 Circular's emphasis). There is therefore a clear, and important, difference between healthcare and social care, in terms of a HSC Trust's legal authority to charge for the care it provides to an individual who has moved into a residential care or nursing home.

36. The (then) Minister of Health reinforced this distinction when he responded in September 2013 to an Northern Ireland Assembly Question[12] about CHC. The Minister stated, *'… an individual's primary need can either be for health care – which is provided free – or for social care for which a means tested contribution may be required.'*

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

[12] Assembly Question AQW 25318/11-15

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

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

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

40. The IPA highlighted that a definition of personal care (or social care) was provided in the 2010 Circular. This states that personal care *'includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on alcohol or drugs; or past or present mental disorder …'.* The IPA also pointed out that a further definition of personal care was provided in the Department of Health's 2006 publication, 'Payments for Nursing Care'.[13] This states that personal care is *'care you need to help you in the activities of daily living; for example, help with toileting and other personal needs like bathing, dressing and undressing, getting in and out of bed, moving around and help with feeding. It might also cover advice, encouragement and supervision in these activities. Care assistants rather than registered nurses will usually see to your personal care needs.'*

Findings

41. Upon review of the documentation, I note the complainant was in regular communication with the SEHSCT and the nursing home regarding the resident's care needs. However, I also note there is no record of the resident,

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

the complainant, or the wider family requesting, or applying to, the SEHSCT to consider the resident's eligibility for CHC specifically during the relevant period. I note the complainant considers the SEHSCT had a proactive obligation to consider this eligibility.

42. She considers that had the SEHSCT determined the resident's primary need following her discharge to the nursing home, it may have concluded this was healthcare. Alternatively, if the SEHSCT had proactively kept this determination under review, it may have concluded the resident's primary need became healthcare at some point during the relevant period as her health deteriorated. She considers that had the SEHSCT done so, the resident may have been entitled to CHC. The complainant's position is that if, at any point, the SEHSCT had determined the resident's primary need was healthcare, it would therefore have met the cost of the resident's nursing home placement from that point onwards, instead of her estate being held liable.

43. The SEHSCT denied it had any such proactive obligations, stating its focus is on ensuring an older person's needs can be met in the best environment.

44. *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*'.

45. The complainant considers this paragraph placed a specific and proactive obligation on the SEHSCT to make a determination about the resident's primary need for the purposes of her eligibility for CHC.

46. I can appreciate why the complainant formed this perspective when viewing this paragraph in isolation. I note the Judge in the abovementioned Judicial Review judgment referred to paragraph 17 as '*somewhat opaque*' as a CHC policy. I agree with this position. On careful review, I consider this paragraph explains

how the Trust can make a determination of primary need for the purposes of CHC eligibility, but is silent, or at best unclear, on how such a determination is initiated in the first place.

47. Upon a careful and considered review of all relevant standards and associated documentation, I am satisfied that, on balance, it is more likely than not a HSC Trust must receive a specific application from a party in order to initiate a determination of a specific older person's primary need for the purposes of CHC. I cannot reasonably conclude the SEHSCT had a specific, proactive obligation to initiate such a determination for every older person in their care, in the absence of an application from that older person, their family or carer. I have reached this conclusion, on balance, having considered the following:

    - Paragraph 5 of Annex A to the 2021 Circular deals primarily with the eligibility criteria adopted from 11 February 2021 (albeit, now quashed by the High Court, as set out above). However, it also refers to '*any applications for continuing healthcare already in the system prior to this should be assessed in line with previous guidance or policies*'. This demonstrates to me that, under the system in place under the 2010 Circular, the SEHSCT must receive an application from a party before it must make a determination of CHC eligibility. The SEHSCT is not the applicant, as it is the recipient of the application. Therefore another party must be the applicant. Paragraph 7 of Annex A also refers to '*any applications for continuing healthcare already in the system prior to 11 February 2021*'.

    - The CHC Consultation Document discussed the CHC framework in Northern Ireland under the 2010 Circular. Paragraph 17 of this document states '*it would appear that one of the key drivers for HSC Trusts receiving a request for continuing healthcare assessments is once an individual needs to, or has, moved into a nursing home*'. It goes on to state that HSC Trusts responsible for '*making a determination on continuing healthcare applications*' have found it challenging under the system set out in the 2010 Circular. This further demonstrates the SEHSCT must have received a specific request or application for CHC

eligibility to be determined from another party before doing so. It demonstrates the SEHSCT does not have specific, proactive obligation to initiate such a determination, as a default position, for all older people in its care, in the absence of a specific request.

- Paragraph 42 of the CHC Consultation Document appears under the heading '*Existing and Pending Continuing Healthcare Applications*'. It makes several references to how HSC Trusts ought to handle existing '*applications*' for CHC. I consider this further demonstrates the need for the SEHSCT to receive a specific request or application before it was obligated to determine primary need for the purposes of CHC eligibility.

- I also refer to Judgment [2023] NIKB 72 of the High Court, discussed above. In this judgment the Judge made frequent references to '*applications*' for a consideration of CHC eligibility under the system in place in the 2010 Circular. Whilst this is not a relevant standard to hold to the SEHSCT to, it nonetheless indicates the prevailing understanding in place at the time regarding the need for the SEHSCT to receive a specific request or application before it was obligated to determine primary need for the purposes of CHC eligibility.

48. On this basis, I find the SEHSCT did not have a specific, proactive obligation to determine the resident's primary need for the purposes of considering her eligibility for CHC. The SEHSCT would only have been required to make such a determination if the resident or her family had made a specific application or request for the SEHSCT to do so. The SEHSCT did not receive such an application, and so was not obligated to do so.

49. I note the complainant's position in her comments that under the 1972 Order and the 2010 Circular the SEHSCT needed to establish the authority to charge before doing so, and in this case the SEHSCT failed to do so. In this respect, I refer to Judgment [2023] NIKB 72 of the High Court, discussed above. In this judgment the Judge found Trusts are '*obliged to charge a service user for accommodation provided by way of social care (subject to the user's means)*'. The Judge then found '*Para 64 of the 2010 Circular does not, in my view, have*

the effect asserted by the applicants of depriving the Trust of authority to charge for care or nursing home fees until a CHC assessment has been made. Legal authority for the charging of those fees is to be found in Articles 36 and 99 of the 1972 Order'. On this basis, I am satisfied SEHSCT did not need to establish the authority to charge before doing so.

50. I note the complainant's position that she considers the SEHSCT should have been more transparent with the resident and her family about the overall care management process, to include the opportunity to request the SEHSCT consider the resident's eligibility for CHC. The SEHSCT denied it had a specific, proactive responsibility to explain this, reiterating its focus is ensuring an older person's needs are met in the best environment.

51. The 2010 Circular emphasises the importance of the SEHSCT providing service users and their families with information about their care management. It is outside the scope of this investigation to comment on the Trust's transparency about the care management process generally. However, it is within its scope to examine transparency as it pertains to applications for CHC eligibility. I am satisfied there nothing in the 2010 Circular to impose a specific obligation on the SEHSCT to proactively disseminate information to individual residents and their families about their ability to request or apply for a determination of primary need for the purposes of CHC eligibility. Furthermore, I refer to the abovementioned Judicial Review judgment. In it the Judge directed criticism to the Department of Health, rather than individual HSC Trusts, for '*plain dereliction of duty*' as regards promoting public awareness of the possibility to apply for a CHC eligibility determination.

52. I sympathise with the complainant's position that if the resident or her family had been aware they could ask the SEHSCT to consider the resident's eligibility for CHC they would have done so. Unfortunately, because they did not know they had the option to do so, they never made such a request. However, I cannot reasonably conclude that in not informing the resident or her family about this, the SEHSCT acted inappropriately, or contrary to relevant standards.

53. I refer to the complainant's concerns regarding the SEHSCT's role in the patient's discharge from hospital on 18 August 2020, its review and reassessment of the resident's needs during the relevant period, and the potential, consequential impact on the resident's CHC eligibility. The complainant said the SEHSCT should have conducted a NISAT Complex assessment[14] to determine the resident's primary need, but did not do so.

54. I am mindful of the IPA's view that were the SEHSCT to determine the resident's primary need for the purposes of CHC eligibility, she would have expected the SEHSCT to complete a NISAT Complex Assessment to demonstrate a '*co-ordinated*' multi-disciplinary approach. She explained this would help inform a determination of primary need for the purposes of CHC eligibility. She advised the information contained in the assessment the SEHSCT received from the BHSCT was not sufficient to determine primary need for this purpose. However, she also advised that was not the purpose of the BHSCT's assessment. The purpose of that assessment was to determine where the resident's needs could best be met at the point of discharge. She advised the outcome of the assessment was the resident's needs could best be met in a nursing home. She further advised this was a reasonable decision based on the resident's healthcare, nursing and personal social care needs at the time. The SEHSCT then acted upon that assessment when it assumed responsibility for the resident's care on discharge. I note the complainant considered the SEHSCT's communication with the resident and her family could have been better in respect of step-down care options. However, on foot of the IPA's advice, I am satisfied it was reasonable and appropriate for the SEHSCT to act on the BHSCT's assessment of need as of the point of discharge.

55. Upon review of all relevant documentation, I consider the SEHSCT did not conduct or co-ordinate a NISAT Complex assessment for the resident. It did not conduct any reviews, assessments or reassessments for the specific purpose of determining the resident's CHC eligibility. However, as established above,

[14] Complex assessment involves collation of information gathered through screening, core assessment and, where appropriate, specialist assessment summaries, carer's assessment and input from the GP and medical practitioners. Summaries of any assessments carried out will need to be co-ordinated, drawn together and interpreted by a professional in this role – Paragraph 16 of the 2010 Circular.

the SEHSCT did not receive an application from the resident or a party on her behalf regarding the resident's primary need for the purposes of CHC eligibility. I am therefore unable to determine what reviews, assessments or reassessments it may have conducted had it received such a request, which may have included a NISAT Complex assessment. In the absence of a specific request or application for the SEHSCT to determine the resident's CHC eligibility, I cannot reasonably conclude that the SEHSCT's actions were contrary to relevant standards in that context.

56. I can determine, however, the SEHSCT did take steps to monitor the resident's evolving needs from a care management perspective. The IPA advised '*the patient was assessed by a number of health professionals during her time at the nursing home*'. This included input from physiotherapists, a tissue viability nurse and dietetics. The resident's GP also attended the nursing home to see the resident. The SEHSCT also reviewed the resident's needs at meeting on 7 September 2020 with the nursing home and the resident's family. At this meeting it was determined it was in the resident's best interests to remain in the nursing home at that time.

57. Regarding the review meeting, I note the resident did not attend that meeting, and there is no record of the SEHSCT seeking or discussing her views at it. The IPA observed the Trust should have included the resident in that meeting, as there is no evidence in the records to suggest she lacked capacity at the time to have input into her own care. She also observed the name and designation of SEHSCT employee conducting the meeting should have been apparent from the record of the meeting, but it was not. Whilst is it outside the scope of this investigation to make a finding about these matters, I nonetheless encourage the SEHSCT to reflect on the IPA's advice in its practice going forward.

58. As the resident's care needs evolved her status changed from a temporary resident in the nursing home to a permanent resident. I note the SEHSCT's position that it did not conduct a formal review of the resident's needs during the relevant period because the resident sadly passed away before it could do so. The 2010 Circular states that the Trust should complete a NISAT Complex

Assessment where it is considering a temporary or permanent change in living arrangements or accommodation for an older person. In addition, the 2006 Circular requires the SEHSCT to complete a nursing needs assessment for its residents in receipt of nursing care. On foot of the IPA's advice, there is no evidence to demonstrate the SEHSCT commenced these assessments, or at least considered doing so, at the point the resident's status changed. The 2006 and 2010 Circulars indicate it should have done so. It is outside the scope of this investigation to make a finding about this because this investigation relates specifically to the Trust's consideration of the resident's eligibility for CHC. I also acknowledge the SEHSCT may have commenced these assessments in the future had the resident not sadly passed away. Nonetheless, I encourage the SEHSCT to reflect on my observations in its practice going forward.

IPA's Observation

59. As established above, I am satisfied the Trust did not receive an application or request to consider the resident's eligibility for CHC. I am also satisfied the Trust did not have a specific, proactive responsibility to make such a consideration in the absence of a specific application or request to do so.

60. I cannot be certain what the outcome would have been had the resident, or her family applied to the SEHSCT to consider her primary need for the purposes of eligibility for CHC. As previously established, I also cannot be certain what additional assessments and/or reviews the SEHSCT may have conducted or co-ordinated as part of considering such a request. I am in no doubt that the resident's records demonstrate that she had a range of social care needs, nursing needs and healthcare needs during the relevant period. However, that comprehensive range of care needs does not in itself mean that the resident's primary need during that time was healthcare.

61. In this context, I am mindful that the IPA's considered view, based on her detailed examination of the resident's records was that the resident did not have a primary healthcare need during the relevant period. I should stress this is the IPA's view and not those of this Office. Nor is its inclusion in this report designed to establish what I, or this Office, considers the SEHSCT would or

should have determined. It is, however, the opinion of a suitably qualified and experienced professional in this field, which I include to provide further context to the issue I have investigated.

62. With that in mind, the IPA advised the resident's records showed she had a combination of health, nursing and social care needs. However, in the IPA's consideration, the resident's '*predominant care needs*' were '*mainly for nursing and personal social care services*'. In the IPA's consideration, whilst the resident's physical condition sadly '*declined*' over the relevant period, her '*core personal care needs did not significantly change*'. The IPA advised that, in her opinion, the resident's nursing needs increased over the relevant period, '*but not to the extent that her primary need became a health need*'.

Summary

63. The issue of CHC in Northern Ireland was complex and vague under the system in place in the 2010 Circular, which impacted greatly on those trying to navigate the system. The position remains uncertain at present, due to the High Court's recent decision to quash the system set in place under the 2021 Circular, and reinstate the previous system. In addition, that Court decision is currently subject to appeal. I therefore sympathise with the complainant's position.

64. However, on foot of the above findings, I am unable to reasonably conclude that the SEHSCT's actions regarding a determination of the resident's eligibility for CHC were contrary to relevant standards. In the absence of a specific application or request from the resident, or by a party on her behalf, the SEHSCT had no reason or obligation to commence the process to make such a determination.

65. I therefore do not uphold this complaint.

66. However, the complainant has the ability presently to request or apply to the SEHSCT to retrospectively consider the resident's eligibility for CHC, under the system set out in the 2010 Circular. Should the complainant make such a

request or application to the SEHSCT, I expect the SEHSCT to handle it in line with relevant standards in place at the time of such an application.

CONCLUSION

67. I received a complaint about the SEHSCT 's consideration of the resident's eligibility for CHC during the period 18 August 2020 to 26 November 2020, and its communication with the resident's family in that respect. The complainant considered had the SEHSCT considered the resident's eligibility in line with the 2010 Circular, it may have determined a primary healthcare need, and thus eligibility for CHC. She believed had the SEHSCT done so, it may have been liable to pay for the care the resident received in the nursing home, instead of the resident's estate.

68. My investigation found that the SEHSCT did not make a determination in respect of the resident's primary need for the purposes of eligibility for CHC. It did not do so because neither the resident, nor her family, applied to the SEHSCT to make this determination. In the absence of such an application or request, the SEHSCT had no reason, obligation or responsibility under the 2010 Circular to make a determination on CHC eligibility.

69. In addition, my investigation found that whilst the SEHSCT has an obligation under the 2010 Circular to inform older people and their families of care management options for that older person, this does not extend to a specific obligation to inform those parties of their ability to apply to the SEHSCT consider an older person's eligibility for CHC.

70. I therefore do not uphold this complaint.

MARGARET KELLY
Ombudsman

27 March 2024

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.