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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint on behalf of
Mrs S against Cardiff and Vale University Health Board

A report by the Public Services Ombudsman for Wales

Case: 201101810

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 ("the 2005 Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs S and to her mother as Mrs W.

Summary
Solicitors complained on Mrs S's behalf that the Cardiff and Vale University Health Board had failed to administer matters in relation to her mother Mrs W's claim for continuing health care correctly. Mrs W had been in a nursing home since 2002 and was receiving funding for the nursing element of her care costs. Her home had been sold to pay for the remaining element of her care home fees.

The Solicitors submitted evidence which they said showed that there had been delay and error in dealing with Mrs W's assessments for continuing health care and that the Independent Review Panel had also not dealt with matters properly. They alleged that this situation had led to injustice to Mrs W through delay and financial loss.

The Ombudsman found that there had been significant maladministration in two assessments carried out by the Board and that there were failings on the part of the Independent Review Panel, although the second assessment had in fact found Mrs W to be eligible for continuing health care.

The Ombudsman recommended that his report should be brought to the attention of the Independent Review Panel, to consider what further training it needed and that a retrospective assessment of Mrs W's needs should be carried out under the supervision of an independent person nominated by the Welsh Government. He also recommended that the Board should revise its procedures and conduct a retrospective review of all cases that had been handled in the same way as Mrs W's in terms of the start date for funding.

The Ombudsman decided that the case raised matters of public interest.

The Complaint

1. The Solicitors complained on behalf of Mrs S that the Cardiff and Vale University Health Board ["the Board"] had failed to administer an application for continuing health care provision for her mother, Mrs W, correctly.

2. Mrs W has been in a nursing home for some years and was receiving funding for the nursing element of her care costs. The Solicitors complained that there had been a lengthy delay on the part of the Board in considering an application for NHS funded continuing health care ["NHSFCHC"] and that the process it had followed had been flawed in a number of aspects. Following an appeal, the matter had been referred to the Independent Review Panel and the outcome had been that Mrs W was not eligible for NHSFCHC.

3. The Solicitors had submitted a claim for retrospective consideration of NHSFCHC from the start of care in November 2002 to 15 August 2010 which was being dealt with under the "All Wales" review process being managed on behalf of the Welsh Government by the Powys Local Health Board.

4. The Solicitors complained to me about the Board's handling of matters and the outcome of the review process. It was agreed that the relevant period for consideration by my office was from 16 August 2010 onwards.

Investigation

5. I obtained comments and copies of relevant documents from the Board and considered those in conjunction with the evidence provided by the Solicitors. An independent clinical adviser considered the information and advised me of her views.

6. I have not included in this report every detail that has been investigated but I am satisfied that nothing of significance has been overlooked.

7. The Solicitors, Mrs S and the Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

8. I am issuing this report under s16 of the Public Services Ombudsman (Wales) Act 2005.

Relevant legislation and guidance

National Health Service (Wales) Act 2006

9. Section 1 of the National Health Service (Wales) Act 2006 ["the 2006 Act"] sets out the Welsh Ministers' overall statutory duty to provide or secure the provision of services for the prevention, diagnosis and treatment of illness and stipulate that the provision of such services must be free of charge except where specified otherwise by legislation. Section 3 of the Act sets out the duty to provide specified services. It sets out that the obligation of health boards in Wales is to provide a service to patients to the extent it considers necessary to meet all reasonable requirements. The wording of the 2006 Act therefore allows a health body to make its own decisions about the extent of what is necessary and about what requirements are reasonable. The above wording is identical to the predecessor statute in England which has been the subject of case law, which established that the duty under section 3 is neither absolute nor is it a duty which is owed to an individual.

10. Whilst the statutory duty is set out in the 2006 Act as a general duty, it also describes the statutory factors which the NHS body has to apply in making decisions. The process which health boards have to follow has to take account of case law, guidance material, normal principles of lawful administrative decision making and principles of good administration.

CHC processes in Wales

11. A process for retrospective claims for compensation in CHC cases was introduced by Welsh Health Circular WHC (2004) 054. This was subsequently amended by WGC 13/2011 in 2011. The 2011 Circular deals only with claims for the period from 1996 to 15 August 2010.

It sets out that claims after 15 August need to be considered in accordance with the Continuing NHS Health Care: New National Framework for Adults ["NF"], which was issued by the Welsh Government in May 2010. However the 2010 Circular offers no guidance on dealing with retrospective claims which postdate the NF. There is no Welsh circular dealing with retrospective claims after 15 August 2010 and none dealing with the question of what health boards should do about people with primary health needs who have been paying for their own care after 15 August 2010. I have seen anecdotal evidence which suggests that practice in relation to the commencement date for funding successful applications and the triggering of a retrospective consideration differs amongst health boards in Wales.

12. There is therefore no guidance in Wales about what should be done about refunds of any amounts paid by an individual patient while they have been waiting for a CHC decision. If a CHC assessment shows that the patient has had a primary health need which is likely to have been in existence at a time when the health board knew or should have known of the person's needs, and the person has paid themselves, then in the absence of formal guidance the health body has to follow principles of good administration. Public bodies' policies are required by law to retain appropriate flexibility to take account of relevant circumstances and to disregard those which are irrelevant.

The National Framework (NF)

13. As mentioned above, the NF sets out the Welsh Government's policy framework for assessments and decisions on eligibility. It should however be noted that the NF does not have any coercive statutory effect. Welsh Ministers did not issue statutory directions under the 2006 Act to require health boards to comply with its National Framework unlike in England. The NF does not define the extent of the liability of health boards in individual cases. It imposes an obligation to investigate individual health needs, to assess eligibility or to provide a service. Of particular relevance within the NF are paragraphs 4.13 which states that there should be no gap in the provision of care; Paragraph 5.44 which states that the NHS is responsible for ensuring that assessment of CHC

eligibility and provision is dealt with in a "timely and consistent fashion" and paragraph 5.45, which states that the time lag between the start of assessment and care package should not exceed 6-8 weeks. The NF does not imply that health boards can leave decision making for this or any other period as a matter of course. It is noted that paragraph 5.45 states that in some cases much speedier decisions should be made in the person's best interests. The NF includes scope for the health board to make a decision straight away in obvious cases. Paragraph 5.47 states unambiguously that there should be no delay in a full consideration of eligibility.

14. The NF does not specify what is to be done in obvious cases. It does not prevent health boards from making an immediate positive CHC eligibility decision. The NF does not require a health board to go through an extended process in every case. The NF does not refer to backdating of payments to a point before a formal decision or to the power to make a formal decision to backdate. It cannot therefore be taken to be a reason not to backdate; it simply does not deal with the issue.

The Board's procedures and approach

15. The Board's procedures make it clear that speedier decisions than 6-8 weeks should be made in some cases in the person's interests. However, the Board's procedure limits fast tracking to patients who are suffering from a terminal illness; these seem to be the only ones in which an immediate decision is made. The Board's procedure does not specify what date is to be taken as the start date of funding. The Board's procedures do not refer to any possibility of funding starting from the point at which a person has incurred expense in paying for a service which should have been provided as part of CHC. They seem by implication, to exclude this option. The Board seems not to fund any CHC service on an immediate or interim basis pending an extended process unless there appears to be a deteriorating end of life situation. Therefore it does not provide for provisional funding in cases where the person appears to need a CHC service but where a final decision can only be made after further investigation and assessment.

16. The Board's procedure appears to leave those who are already funding a care service in a position where they have to pay all costs without any possibility of a refund even if it becomes clear on fuller assessment that the person's health needs mean that they should have been provided with fully funded CHC from an earlier stage. This means that the person has had to pay for a service which fell within the NHS's responsibilities.

The relationship between legal obligations and the expectations of good administration

Legal obligations

17. NHS obligations in relation to CHC form part of the Welsh Ministers' statutory functions under section 3(1) of the 2006 Act. The functions are delegated to health boards. The functions cover the class of people who need the specified services. As mentioned previously, section 3(1) does not create an individual duty relating to individuals with health needs in advance of their having come to the attention of the NHS as people who may be in need of a service. Some degree of prioritisation of services and different persons is allowed by the 2006 Act.

18. Health boards have to discharge functions in a way that promotes the aims of the 2006 Act. This means that they must not create gaps in a service by inflexible procedures. They have to provide services which fulfill the goals set out in section 3(1). This means that if a person who may have a primary health need comes to the attention of the health board, then it has to deal with them. The health board also has to take a reasonable approach to identifying and dealing with those persons who may need to be considered for the provision of CHC. It must take a reasonable approach to assessment of health needs and for the provision of CHC services.

19. It is evident that a health board is not legally obliged by the 2006 Act to pay for CHC before it is aware of the possible need for funding. Its approach to CHC funding has to be consistent with its duties under section 3(1). It should not operate a procedure or take an approach which has the inevitable effect of leaving persons who have a primary health need and who are in need of CHC services without a service.

If it did so this would be unlawful because it creates a gap in service. It also follows that the approach to determining the date from which CHC funding starts must not create an intentional gap in service provision. It follows that once a health board has recognized that a person has a primary health need, then it must take steps to meet that need by the provision of services. At this stage its obligation moves beyond that of a general duty and becomes a specific duty which is owed to the individual.

20. The principles of administrative law give a legal entitlement to a person to demand (a) that a health board gives proper consideration to their individual case and needs, (b) that it acts consistently with the requirements of the statute and (c) that it takes account of relevant factors and disregards irrelevant factors, when it makes a decision or takes an action. Relevant factors in this case include individual health needs, available resources, applicable guidance or directions and what is reasonable. Legal entitlement therefore deals with what must be done.

Principles of good administration

21. The obligations of good administration are not restricted by strict legal requirements although there can be an overlap. Whilst legal entitlement deals with what must be done, good administration deals with what should be done. In a situation where there is a legal entitlement to be treated in a particular way, a health board's failure to meet its obligations is a failure to apply good administration principles and it is likely that an injustice will be the result. If the effect of this is to have caused unnecessary financial loss or other detriment then this will normally amount to hardship.

22. My predecessor issued statutory guidance on relevant administration and redress principles under the 2005 Act. Individual decisions are required to be based on the same principles. Therefore the principles of good administration mean that public authorities should:

- comply with the law and have due regard for the rights of those concerned. They should act according to their statutory powers

and duties and any other rules governing the service they provide. They should follow their own policy and procedural guidance, whether published or internal.

- in their decision making, listed authorities should have proper regard to the relevant legislation and guidance. Proper decision making should give due weight to all relevant considerations, ignore irrelevant ones and balance the evidence appropriately.

- should treat people with sensitivity, bearing in mind their individual needs, and respond flexibly to the circumstances of the case. Where appropriate, they should deal with customers in a co-ordinated way with other providers to ensure their needs are met; and, if they are unable to help, refer them to any other sources of help.

- putting things right may include reviewing any decisions found to be incorrect; and reviewing and amending any policies and procedures found to be ineffective, unworkable or unfair, giving adequate notice before changing the rules.

- listed authorities should operate effective complaints procedures which investigate complaints thoroughly, quickly and impartially; and which can provide an appropriate range of remedies to the complainant and any others similarly affected when a complaint is upheld. As a minimum, an appropriate range of remedies should include an explanation and apology from the listed authority to the complainant, remedial action by the listed authority, financial compensation for the complainant or a combination of these. The remedy offered should seek to put the complainant back in the position they would have been in if nothing had gone wrong. Where this is not possible - as will often be the case - the remedy offered should fairly reflect the harm the complainant has suffered.

23. These principles make it clear that failures of good administration are not restricted to legal errors and that injustice and hardship can be caused even if there has been no failure to meet legal obligations. It is key to those principles that the administrative body must act in a way

that avoids causing hardship or injustice. If it has done so, it should put things right. Where a statutory framework does not define the exact nature of obligations to individuals and where general principles of administrative law apply then there is an expectation that public bodies must act in an appropriate way in individual cases.

24. In overall terms therefore health boards should not have policies which cause avoidable gaps in funding and provision of CHC. The approach that should be taken with individuals who may possibly be in need of CHC, is to determine eligibility as quickly as possible and to avoid delays in the provision of any CHC. A health board procedure that means that funding cannot be provided as soon as there is a need for CHC creates a gap in service. The need to apply the principles outlined above has already been highlighted in a report by the then Health Service Commissioner for England issued in February 2003 entitled "NHS Funding For Long Term Care (HC399)". One of its recommendations to NHS bodies in England was that they should,

> "..make efforts to remedy any consequent financial injustice to patients where the criteria, or the way they were applied, were not clearly appropriate or fair. This will include attempting to identify any patients in their area who may wrongly have been made to pay for their care in a home and making appropriate recompense to them or their estates."

25. This recommendation, which placed an obligation on the NHS to identify those who lost out on NHS funding to which they were properly entitled, was accepted as also applying in Wales. Nothing in statute appears to have changed this position.

The background events

26. Mrs W first entered a nursing home in November 2002. She moved to another nursing home in 2005.

27. Mrs W had been receiving funding for her nursing care costs but her eligibility for NHSFCHC had not been established and the remainder of the care home fees were being funded privately, including from the proceeds of the sale of her home.

28. Mrs W was 91 years of age. She had vascular dementia and often appeared to be confused and unaware of her surroundings. She had type 2 diabetes and suffered from deep vein thrombosis. She had no mobility and was unable to communicate her needs. She was doubly incontinent and unable to make choices with regard to her own health and well being. Mrs W's skin integrity was at risk due to her immobility and incontinence. Her skin condition and blood sugar levels required regular monitoring. Sadly, Mrs W died shortly before this report was issued.

29. The Solicitors made a request to the Board for an assessment of Mrs W's eligibility for NHSFCHC in December 2009 and repeated the request in March 2010, but the assessment was not completed until August 2010. It should have been completed within six weeks according to guidance.

30. Believing that the assessment had not been conducted in line with the requirements, the Solicitors made a request for an Independent Review Panel ["IRP"] in March 2011. The IRP met on 9 August 2011 but should have met within two weeks of the request according to guidance.

31. In its complaint to me, the Solicitors outlined the flaws they perceived in the assessment process and submitted that although the IRP had acknowledged failings in the assessment process conducted by the multi disciplinary team, it had not requested a re-assessment. They also highlighted a number of concerns with regard to how the IRP had come to its view that Mrs W was not eligible and put it to me that the IRP decision was not sound as it was based on flawed evidence.

The Board's evidence

32. The Board submitted its records for scrutiny. My investigator asked whether in the light of the procedural failings the IRP had identified in the August 2010 assessment, it had considered asking the Board to re-assess the claim properly. The IRP responded, through the Board, saying that it believed that the failings were not of such severity that a re-assessment had been warranted. However, it said that as some time had elapsed since that assessment had been carried out, it had decided to suggest that re-assessment was done. The Board confirmed in November 2011 that this assessment was underway.

Professional advice

33. In December 2011, I received a report from my clinical adviser Jenny Williams who is a registered general nurse. She is the lead clinician in continuing health care for a primary care trust in England and is also a continuing health care assessor. In her advice to me, she endorsed the criticisms made in the submission from the Solicitors and said there had been a number of failings in the August 2010 assessment in terms of the statutory guidelines. These included:-

a. That there had been no assessment initiated in September 2009 when Mrs W's social worker raised the issue of her possible eligibility and made a referral for an assessment. Further, it was unacceptable that an assessment had not been initiated until the Solicitors' second request of December 2009.

b. That there was an unacceptable delay in the length of time taken to complete the assessment in August 2010 and it did not appear to her that the assessment had considered the preceding six months, which was a significant flaw.

c. That Mrs W's family had not been allowed to engage in the process as they should have been and had not been provided with relevant information.

d. That there was a failure to clearly identify the timescales being reviewed. Some of the evidence that had been included dated from 2006 and some time periods were not covered at all.

e. That no rationale had been provided for the differences of opinion as to eligibility between two of the professionals involved in the initial assessment or why one changed her mind during the process, to later agree that Mrs W was not eligible. Therefore the internal disputes resolution process had been flawed.

f. That the multi-disciplinary team's recommendation to the Board's panel, which makes decisions on eligibility, was unsigned and undated and this was unacceptable. In addition, the document did not adequately explain how Mrs W's needs did or did not relate to the indicators of a primary health need.

g. That the decision support tool matrix had been poorly completed on 21 July 2010. The responses were not evidence based and did not provide the necessary insight into Mrs W's care and needs; also, it made no recommendation on eligibility for NHSFCHC.

34. The adviser said that in the light of these factors, it was not clear that in reaching their final decision on eligibility, the Board had used the appropriate eligibility criteria or followed the requirements of the process; therefore the process itself and the decision on eligibility were not robust. She said that,

> "Given the amount and overall impact of the errors I would have expected the Chair of the IRP to have returned the case to [the Board] at this point with a request for a full retrospective review of Mrs [W's] needs clearly identifying the time frame under consideration."

35. The adviser thought it significant that the referral from the social worker in September 2009 was overlooked by both the Board and the IRP as the social worker had clearly identified that Mrs W's needs were at the higher end of what Social Services could legally provide.

36. The adviser concluded that in any future review the Board needed to:-

a) Define the period of time under review.

b) Confirm the data to be applied.

c) Gather relevant contemporaneous evidence.

d) Draw up full evidence based pen portrait and needs portrayal with the involvement of the family which covers the agreed review period.

e) Present it, if at all practical, to a neighbouring LHB for a decision.

f) Review the internal disputes process.

IRP Decision of January 2012

37. The Board conducted the re-assessment that had been promised (paragraph 32) before I received the above advice. The outcome of that process was that Mrs W was eligible for NHSFCHC from 20 January 2012 on the basis of changes in her health arising in December 2011. The letter to the family confirming this was dated 17 January 2012, which I presume was a typographical error. The letter said that funding would commence from 20 January 2012. When the investigator queried the reason for the start date being the 20 January 2012, the Board advised that its procedures specified that the start date for all successful claims would be the date the IRP made a decision on the case and that the IRP had been held on the 20 January.

38. The Board was asked to provide relevant documents in support of its position and from these, the following issues were noted by my investigator:-

a) The change in Mrs W's condition that led the Board to decide that she had a primary health need and was therefore eligible for NHSFCHC from 20 January 2012 was a condition of muscular seizures and choking which meant that she needed closer supervision. The care home records that the IRP had used in its deliberations showed that muscular seizures and choking had occurred in October, November and had become more frequent in December 2011.

b) The information on Mrs W's condition considered by the IRP appears to be drawn from different time periods, replicating a key failing of the previous assessment.

c) There was no record in the documentation of any consideration by the IRP of whether Mrs W's primary health need had arisen earlier than 20 January 2012.

d) The Board's procedures did not specify, as had been claimed, that the start date for funding a successful application should be the date that the IRP had made its decision; in fact it was silent on this matter.

Analysis and conclusions

39. My clinical adviser has set out numerous failings in both the processes followed by the Board in its August 2010 assessment and in the deliberations of the IRP in August 2011. Indeed, her level of concern was such that she suggested that another health board should oversee any further assessment conducted for Mrs W. I have rarely seen such a recommendation from a clinical adviser.

40. I note with concern the fact that the re-assessment conducted by the Board in January 2012 repeats some of the failings identified in the August 2010 assessment and that the Board has continued to depart from guidance. Consequently, I believed it was necessary for me to ask the Welsh Government to appoint a suitably qualified person to oversee the future handling of Mrs W's assessments by this Board. It has agreed to do so.

41. Therefore **I uphold the complaint and find maladministration** on the part of the Board in its conduct of the assessment of August 2010 and injustice due to delay in dealing with these matters, uncertainty to the family and because Mrs W had to pay for her care by the sale of her property. Although the Board found Mrs W to be eligible in January 2012, the conduct of the assessment process had replicated some of the failings of the previous assessment. I am satisfied that the failings lead inevitably to a recommendation that the Board should assess Mrs W's eligibility for continuing health care funding from 16 August 2010 up to and including the 19 January 2012. I expect and require that this will be done in full awareness of the shortcomings identified in this report and in compliance with its guidance.

42. I am concerned that the IRP failed to recognise in August 2011 that the assessment it was reviewing was so fundamentally flawed that it should have requested a re-assessment. **I therefore find maladministration** leading to injustice by virtue of the resultant delay and uncertainty to Mrs W and her family in waiting too long to have her case reviewed.

43. That a review body should have failed to act to ensure that a full and proper re-assessment was done in these circumstances is of concern. I fail to see how the IRP could be satisfied that its own decision was robust, when relying on information that it had said was flawed. That it did not recognise the flaws to be as extensive and significant as my adviser suggests is of further concern.

44. I turn now to the manner in which the Board considered whether Mrs W was entitled to CHC funding before 20 January 2012. I accept that the duty under section 3 of the 2006 Act is not absolute nor is it a duty which is owed to an individual. Therefore there can be no legal obligation for the Board to provide Mrs W with CHC funding from a date prior to 20 January 2012, even though she had a demonstrable primary care need before to this date. (I have addressed the requirement to observe the principles of good administration elsewhere in this report) However, once the Board reaches a positive conclusion (that is in context a conclusion that the person fulfills the requirements for CHC and that it is to be provided) then the obligation of the health board becomes a duty owed to that individual. At this point it can fairly be said that the obligation "crystallizes" so that it moves from being a general duty to an individual duty. Once it has been recognized that the person is eligible from this point there is a duty to meet the person's needs.

45. Once the health board is aware that a person is eligible for CHC then it cannot delay, for example by operating a waiting list, in providing it. Delay is maladministration as I have already concluded in earlier cases, including investigations 200700927 and 200800779, for example.

46. There is no Welsh circular dealing with retrospective claims after 15 August 2010 and none dealing with the question of what health boards should do about people with primary health needs who have been paying for their own care after this date. There is no Welsh guidance about what should be done about refunds of any amounts paid by individuals when they have been waiting for a CHC decision. I find the lack of such guidance both difficult to understand and unacceptable since the retrospective payments issue has been known for many years. In my view, if the assessment shows that a person has had a primary health need which is likely to have been in existence at a time when the health board knew, or should have known, of the person's needs, and the person has paid themselves for services to meet those needs, it is difficult to see how the health board can avoid giving active consideration to a refund.

47. In the absence of specific guidance the health board has to follow principles of good administration. If it does not do so then it faces the prospect of acting maladministratively, potentially leading to injustice and/or hardship. To fail to reimburse a person who should not have had to pay for their healthcare appears unfair. It also leads to a situation where it appears that the NHS expects a patient to pay for their own CHC even while they have had a primary health need.

48. In my view an absolute policy by a health board not to pay for the cost of any care which has been paid for by the person before the CHC decision is unreasonable. A health board's refusal to consider reimbursement in this situation is also in my view unreasonable. It is apparently unjust that a person should be denied the provision of a service that comes within the NHS's responsibility. Furthermore, it is unjust that a person should be expected to pay for a service which the state is obliged to supply free of charge. It is clear to me that nothing was done by the Board to carry out any retrospective examination of Mrs W's entitlement or to give any consideration to the question of the period over which the CHC should have extended.

49. It is clear that until my investigation the Board had not paid attention to the question of when Mrs W's need for CHC first arose and what consequences this might have for those who had been paying for a service that should have been available free of charge because of their condition. I have seen no evidence that the Board considered in this instance what should be done to address the question of the financial shortfall and non provision of CHC. It seems to me that the crucial point in terms of maladministration is whether it should have been apparent that injustice and hardship would be likely to result from its approach given the likelihood of it creating financial and service gaps in CHC provision. The Board's procedures do not refer to any possibility of funding starting from the point at which a person has incurred expense as a result of having to pay for a service which should have been provided by the NHS. They seem, by implication, to exclude this option. In reality it was self evident that the Board should have made a decision about retrospective funding. The delays in the Board's processes were excessive.

50. Where a statutory framework does not define the exact nature of obligations to individuals and where general principles of administrative law apply then there is an expectation that public bodies must act in an appropriate way in individual cases. Health boards should avoid policies which cause avoidable gaps in funding and provision of CHC. The overall approach to be taken with individuals who may possibly be in need of CHC, is to find out as quickly as possible if that is so and to avoid delays in the provision of CHC. A health board's procedure that funding cannot be provided as soon as there is a need for CHC creates such a gap.

51. I am drawn inevitably to conclude that the Board's failure to consider reimbursing Mrs W's care costs before 20 January 2012 was maladministrative and led to financial injustice to her. Furthermore, I consider the Board's reluctance to consider whether Mrs W paid for her care during a period during which the NHS may have had responsibility to provide her with a service is also maladministration which has resulted in an injustice to Mrs W. For those reasons, I **uphold** the complaint.

52. The Board's stated practice, albeit not reflected in its own procedures, not to retrospectively consider whether any individual patient has suffered an injustice as a result of having to pay for their healthcare costs is in my view indicative of a systemic failure which could conceivably result in a widespread financial injustice to patients in its area.

53. Such a systemic failing may extend to other parts of Wales because a lack of statutory guidance or indeed any guidance, from the Welsh Government on the processing of retrospective applications for CHC arising after 15 August 2010. Such guidance should include a clear and unambiguous statement on the need to provide CHC funding to patients with a primary health need and should emphasise a requirement to ensure there is no gap in service whereby a patient is expected to pay for a service the NHS is responsible for providing. That there is a need for such guidance is re-inforced by a certain amount of anecdotal evidence which suggests that practice in relation to the commencement date for funding successful applications and the triggering of a retrospective consideration differs amongst health boards in Wales.

54. My own preferred view is that if, at the time of assessment, the evidence is available to identify when the primary health need arose, the MDT should consider that date as the appropriate start date for funding. However such consideration should only be undertaken if it will not delay the commencement of current funding. If further historical evidence is required, then a separate retrospective process should be initiated immediately and without the need for external prompting.

55. Regrettably, I do not have the statutory power to extend any investigation to establish what practices are in place across Wales and I will look to the National Assembly to consider introducing such powers.

56. I will be bringing my report to the attention of the Welsh Government with a request that it issues interim, and, in due course, full and statutory guidance and takes appropriate action to ensure that health boards in Wales are operating consistently and in compliance with

its guidance and the legislative requirements. I believe it is in everyone's best interests, not least vulnerable claimants and their families, to avoid having a build up of historic claims arising from the current position.

Recommendations

57. That the Chief Executive of the Cardiff and Vale University Health Board makes a full and detailed apology to Mrs S for the delays and failings identified in this report and makes a payment to her in the sum of £750 for her time and trouble in bringing this complaint.

58. I recommend that the Cardiff and Vale University Health Board conducts a full and proper assessment of Mrs W's eligibility for NHS funded continuing health care from 16 August 2010 to 19 January 2012 with a freshly constituted multi-disciplinary team and under the supervision of a suitably qualified and independent person, nominated by the Welsh Government, who has not previously been involved in this case.

59. I recommend that the Board draws the attention of the members of the Independent Review Panel to my report and considers what further training or procedural guidance they require in the light of my findings.

60. I recommend that the Board revisits its procedure to ensure that once eligibility has been ratified, consideration is given to ensure that funding starts from the date that the primary health need arose and that in this and all other aspects, including timeliness, its procedures and actions comply with principles of good administration, legislation and national guidance.

61. I require that the recommendations outlined above are undertaken within three months of the date of issue of the final report and that the Board will supply me with documentary evidence of what it has done to comply with my recommendations.

62. I recommend that within six months of this report the Board conducts a review of its successful funding assessments to ensure that funding started from the date that the primary health need was evidenced rather than an arbitrary administrative date.

63. The Board has agreed to implement the recommendations as set out in paragraphs 57, 58 and 59 of this report. This means that the Board has agreed to apologise to Mrs S for the delays and failings identified in this report and make a payment in the sum of £750 for her time and trouble in bringing the complaint. The Board has also agreed to re-assess Mrs W's eligibility for funding from 16 August 2010 to 19 January 2012, with a fresh team and under independent supervision. The Board has also agreed to draw my report to the attention of the Independent Review Panel and will invite it to consider what additional training or procedural guidance they require.

Peter Tyndall
Ombudsman 24 April 2013