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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY (1) ROBIN McMINNIS AND (2) THE COMMISSIONER FOR OLDER PEOPLE FOR NORTHERN IRELAND FOR JUDICIAL REVIEW

AND IN THE MATTER OF DECISIONS OF (1) THE BELFAST HEALTH AND SOCIAL CARE TRUST AND (2) THE DEPARTMENT OF HEALTH

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Fiona Doherty KC and Bobbie-Leigh Herdman (instructed by the Legal Office of the Commissioner for Older People for Northern Ireland) for the applicants
Neasa Murnaghan KC and Gordon Anthony (instructed by the Directorate of Legal Services) for the first respondent
Tony McGleenan KC and Terence McCleave (instructed by the Departmental Solicitor's Office) for the second respondent

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SCOFFIELD J

Introduction

[1] This application relates to a concept known as 'continuing healthcare' (CHC). It has been defined by the Department of Health (in its 2017 consultation document, discussed further below) as "the term used for the practice of the health service meeting the cost of any social care need which is driven primarily by a health need."

[2] There are two applicants in the proceedings: first, Mr Robin McMinnis, who applied for CHC but whose application has been refused by the first respondent, the Belfast Health and Social Care Trust ("the Trust" or "the Belfast Trust"); and, second, the Commissioner for Older People for Northern Ireland (COPNI) ("the Commissioner"), who principally challenges a decision of the second respondent, the Department of Health for Northern Ireland ("the Department"), to introduce a new policy in relation to CHC in 2021.

[3] There are also two separate policies relating to CHC which are at issue in these proceedings. The first is set out in a Departmental Circular from 2010, Circular HSC (ECCU) 1/2010 entitled 'Care Management, Provision of Services and Charging Guidance' ("the 2010 Policy" and "the 2010 Circular" respectively). The second is the new policy which has been introduced in 2021 and which is challenged by the Commissioner. For reasons which appear below, Mr McMinnis' case is being dealt with under the 2010 Policy; and his challenge relates principally to the operation of that policy.

[4] Both applicants in the proceedings were represented by Ms Doherty KC, who appeared with Ms Herdman. Ms Murnaghan KC appeared with Mr Anthony for the Trust; and Mr McGleenan KC appeared with Mr McCleave for the Department. I am grateful to all counsel for the assistance provided by their impressive written and oral submissions. In addition, the Northern Ireland Human Rights Commission (NIHRC) was permitted to intervene in the case by way of written submissions, which were provided by Lara Smyth BL, for which I am also grateful.

Relevant statutory provisions

[5] Northern Ireland has an integrated system of health and social care. The over-arching structures and duties involved in that system are now largely set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the 2009 Act"). Section 2(1) of the 2009 Act imposes upon the Department a general duty in the following terms:

> "The Department shall promote in Northern Ireland an integrated system of—
>
> (a) health care designed to secure improvement—
>
> (i) in the physical and mental health of people in Northern Ireland, and
> (ii) in the prevention, diagnosis and treatment of illness; and
>
> (b) social care designed to secure improvement in the social well-being of people in Northern Ireland."

[6] The obligation to promote a system designed to secure these improvements in health and well-being is supplemented by a further general duty, which is more operational in nature, at section 2(2):

> "For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory

> provision, whenever passed or made, which relates to health and social care."

[7] Section 2(3) provides a list of yet more concrete actions which the Department must undertake in order to meets its general duty. These include obligations to "develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland"; to "allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way"; to "formulate the general policy and principles by reference to which particular functions are to be exercised"; and to "monitor and hold to account the… HSC trusts in the discharge of their functions." By virtue of section 2(4), the Department must "discharge its duty under this section so as to secure the effective co-ordination of health and social care."

[8] Apparent from these provisions is the dichotomy between, on the one hand, health care and, on the other, social care. Although in Northern Ireland there is to be an integrated system for the provision of each of these types of care, the legislative scheme treats them as legally and conceptually distinct. Section 2(5) of the 2009 Act defines "health care" as meaning "any services designed to secure any of the objects of subsection (1)(a)", that is, the improvement in the *physical and mental health* of people in Northern Ireland and the prevention, diagnosis and treatment *of illness*. It defines "social care" as meaning "any services designed to secure any of the objects of subsection (1)(b)", that is, the improvement in the *social well-being* of people in Northern Ireland.

[9] Section 21 of the 2009 Act imposes on HSC Trusts a similar duty, in respect of those for whom they provide health and social care, as the Department's general duty under section 2(1) which it owes in relation to people in Northern Ireland as a whole. More detailed provision as to Trusts' functions, powers and duties are contained in other statutory provisions.

[10] The second key piece of legislation which is relevant for the purpose of these proceedings is the Health and Personal Social Services (Northern Ireland) Order 1972 ("the 1972 Order"). It adopts the meanings of "health care" and "social care" which are set out in the 2009 Act: see Article 2(2A). It makes provision for both types of care and services to be provided in a variety of ways.

[11] Article 15 of the 1972 Order deals with the general social welfare and provides for a variety of functions and facilities which form part of the system of social care. These facilities can include the provision, or arranging the provision, of residential or other accommodation; and can involve arrangements for third party providers to provide the social care in question (see Article 15(1) and (1A)). I return to Article 15 in a moment.

[12] Article 98(1) of the 1972 Order is also of relevance in relation to the issue of charging for services. It deals with services which should be free of charge and provides as follows:

> "The services provided under this Order or the 1991 Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 or the 2009 Act shall be free of charge, except where any provision contained in or made under this Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 or the 2009 Act expressly provides for the making and recovery of charges."

[13] The general rule, therefore, is that services (whether health or social care services) provided under the 1972 Order should not be charged for, unless that is expressly provided for. As we shall see shortly however, there is a general power to charge for social care services; and what appears to be an obligation to charge for accommodation which is provided by way of social care. In addition, the 1972 Order permits charges to be made for other services in various respects. Article 98(2) provides that Schedule 15 shall have effect in relation to the making and recovery of certain charges, amongst other things; although it is not necessary to consider that Schedule for present purposes.

[14] Although further amendments have been made to Article 15 of the 1972 Order by the Health and Social Care Act (Northern Ireland) 2022, at the time material to these proceedings, it provided in relevant part as follows:

> "(4) … the Ministry [the Department] may recover in respect of any assistance, help or facilities under this Article such charges (if any) as the Ministry considers appropriate.
>
> (5) In so far as it relates to the provision of accommodation, this Article is subject to Articles 36… and 99."

[15] The basic position was that the Department (and a Trust) may recover the expense of social care provided to a service user. It was and is not obliged to; but it is in principle permissible to charge for social care. Where the assistance provided relates to the provision of *accommodation*, however, Articles 36 and 99 are relevant and, indeed, Article 15 is expressed to be subject to those provisions. Article 36 relates to the provision of accommodation maintained by a third party provider (such as the owner of private nursing homes) and Article 99 relates to provision of accommodation provided by the Department itself. Both of those articles relate to the making of arrangements under Article 15, that is to say, where accommodation is provided by way of social care.

[16] Article 36 and Article 99 of the 1972 Order have a number of common features. Where a third party provider is involved, the Department must pay them the appropriate rates for the accommodation they provide. The Department will then recover the appropriate amount from the service user (see Article 36(3)); although there is a facility for the service user to agree simply to pay the third party accommodation provider directly (see Article 36(7)). Where the Department itself provides the accommodation, the service user simply pays it directly (see Article 99(1)). In each instance, the service user is ultimately liable for the cost of providing the accommodation *except for* "any amount in respect of nursing care by a registered nurse" (see Article 36(4)(a) and Article 99(2) respectively). That liability can be reduced if the Department is satisfied by virtue of means-testing that the service user is unable to make a refund or payment, as the case may be, at the full or standard rate (see Article 36(5) and Article 99(3)). Assessment of a person's means for that purpose may be made by way of regulations (see Article 36(6) and Article 99(5)). Regulations have been made in that regard in the form of the Health and Personal Social Services (Assessment of Resources) Regulations (Northern Ireland) 1993 ("the 1993 Regulations").

[17] A basic summary of the position as set out above may be said to be as follows: (1) the Department or Trusts may charge a service user for social care services, although they are not obliged to; except that (2) they *are* obliged to charge a service user for accommodation provided by way of social care (subject to the user's means); provided always that (3) they cannot charge in that way for any nursing care provided by a registered nurse.

[18] It has been a tenet of these proceedings that no charge may be made for the provision of health care. I will come to the basis of that suggestion – which is set out in the 2010 Circular – in due course. However, it seems to me that this is not necessarily the case as a matter of law, for reasons which are outlined below.

[19] Article 5 of the 1972 Order, under the heading 'Provision of accommodation and medical services, etc.', requires the Department to provide throughout Northern Ireland, to such extent as it considers necessary, "accommodation and services of the following descriptions", including "hospital accommodation"; "premises, other than hospitals, at which facilities are available for all or any of the services provided under [the 1972] Order or the 2009 Act"; and "medical, nursing and other services whether in such accommodation or premises, in the home of the patient or elsewhere."

[20] Significantly, Article 7 of the 1972 Order, under the heading 'Prevention of illness, care and after-care', provides as follows:

> "(1) The Ministry [the Department] shall make arrangements, to such extent as it considers necessary, for the purposes of the prevention of

illness, the care of persons suffering from illness or the after-care of such persons.

(2) The Ministry may recover from persons availing themselves of any service provided by the Ministry under this Article, otherwise than in a hospital, such charges (if any) in respect of the service as the Ministry considers appropriate."

[21] Article 7(2) therefore authorises the Department to recover such charges as it considers appropriate from persons availing themselves of a service provided, otherwise than in a hospital, "for the purposes of the prevention of illness, the care of persons suffering from illness or the after-care of such persons." This appears to me to permit, at least in certain circumstances, charging for services which would or may represent health care. Nevertheless, as appears below, the wording of the 2010 Circular suggests that the Department has not at any stage considered it "appropriate" to charge for such services where they represent health care.

Factual background: CHC in Northern Ireland

[22] It may be helpful to set out something of an over-arching timeline in relation to CHC in this jurisdiction, before turning more particularly to what happened in Mr McMinnis' case:

(i) For present purposes, the starting point may be taken as the 2010 Circular – issued on 11 March 2010 – which set out the 2010 Policy in relation to CHC. This made more generous provision for CHC than the 2021 Policy which has more recently been introduced by the Department and which is under challenge by the Commissioner in these proceedings.

(ii) In 2014, Age NI published a report claiming that older people were being denied CHC in Northern Ireland, largely due to a lack of guidance having been published in relation to it. This was a cause for concern because nursing home fees can be very significant and can eat into, or entirely deplete, an older person's financial resources, including their life savings, where they are accommodated in such a home. If there were circumstances where some such older people would be entitled to have those fees met by the HSC system at public expense, because any social care they were receiving was driven primarily by a health need, that was obviously something that many in that position would be keen to explore.

(iii) Further to the report from Age NI, the Department carried out (what it has termed) "a comprehensive review" to examine the use and operation of CHC in the various HSC Trusts. This involved analysing existing practice across each Trust, reviewing CHC queries received and engaging with a range of stakeholders (including Age NI and the Commissioner).

(iv) On 19 June 2017, the Department issued a consultation document entitled, 'Continuing Healthcare in Northern Ireland: Introducing a Transparent and Fair System.' I discuss this in detail below.

(v) On 12 May 2021, the Department announced that a new policy would be applied to CHC, applicable from 11 February 2021 onwards ("the 2021 Policy"). This is set out in a further circular, Circular HSC (ECCU) 1/2021 entitled 'Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system' ("the 2021 Circular"). Eligibility for CHC is now determined by reference to a single eligibility criteria question, namely: "Can your care needs be met properly in any other setting other than a hospital?" If the answer to this question is 'yes', the individual will not be eligible for CHC. Effectively, CHC (such as it still exists) is now confined in this jurisdiction to those in hospital.

(vi) There is now something of a two-tier system because the 2010 policy continues to apply to all applications for CHC which were made before 11 February 2021. Applications received after that, if any, will be dealt with under the new single eligibility criteria question.

The 2010 Policy

[23] The 2010 Circular was issued by the Department in March 2010. It was to provide the Health and Social Care Board and the HSC Trusts with updated guidance on a range of matters, principally (i) the care management process, including assessment and case management of health and social care needs; (ii) provision of services, including placement of service users in residential care homes and nursing homes and the service user's right to a choice of accommodation; and (iii) charging for personal social services provided in residential care homes and nursing homes. The policy therefore does not deal solely, or even mainly, with CHC. However, the availability of CHC for certain individuals is obviously an important part of what is discussed in the 2010 Circular in terms of *charging* for personal social services. The 2010 Circular was expressly not intended to reflect any substantive change either to the pre-existing legislative or policy framework applicable at that time.

[24] The cover letter to the 2010 Circular from the Department's Director of Primary and Community Care outlined, amongst other things, the central objectives of community care services. These were (a) to help people remain in their own homes, or as near as possible, for as long as they wished and it is safe and appropriate to do so; (b) to provide practical support to carers; and (c) to ensure "that residential care, nursing home care and hospital care is reserved for those whose needs cannot be met in any other way."

[25] Much of the 2010 Circular is irrelevant for present purposes. Key provisions relating to the subject matter of these proceedings are paras 17, 63-64 and 88. Para 17

of the 2010 Circular – which first mentions the "primary need" test – is in the following terms:

> "Similarly, 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."

[26] Albeit in somewhat opaque terms, para 17 of the 2010 Circular is what effectively sets out the 2010 Policy as regards CHC. A determination is to be made of whether the individual's primary need is for health care or social care. In the latter case, the individual may be required to pay. It is not expressly stated what the charging arrangements will be in the former case; but it may be thought to be implicit that, in that case, the service user will not be required to pay a means tested contribution. That is supported by para 88 of the circular, set out further below.

[27] Part 3 of the 2010 Circular deals with charging for personal social services. Paras 63 and 64 are particularly important and are in the following terms:

> "63. The Health and Personal Social Services (Northern Ireland) Order 1972 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.** Consequently, all references to financial assessment and charging hereafter apply to the provision of personal social services in residential care or nursing home accommodation.
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> 64. A financial assessment should only commence **after** an assessment of the service user's health and social care needs has been completed. The financial circumstances of individuals **should never** be used as the reason for failing to offer assessment of need or, as appropriate, access to the care management process."
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> [bold emphasis in original]

[28] These two paragraphs of the relevant guidance were not amended or altered when the 2021 Policy was introduced. The applicants submit that they represent a correct statement of the legal position under the statutory provisions outlined above. As I have explained (see paras [20]-[21] above), it seems to me that the Department or a Trust may be able to charge for certain health care services but, for the time being, has determined that no such charge should be made.

[29] Paras 74 and 75 of the 2010 Circular are also of some, although lesser, relevance. They deal with the HSC system's contribution toward the cost of nursing provided in nursing homes. They explain that, 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." Where the service user pays for their accommodation privately, the HSC Trust simply pays the fee to the nursing home owner. Where an HSC Trust charges the service user, the nursing contribution is simply discounted from those charges. The payment is, however, subject to the outcome of a nursing needs assessment where the individual's nursing needs are identified (in order to ensure that they require nursing care). In this way, the Department and Trusts seek to ensure that they comply with the obligations in Article 36(4)(a) and 99(2) that they cannot charge "any amount in respect of nursing care by a registered nurse" which is provided in the course of the provision of accommodation which otherwise represents social care.

[30] "Continuing healthcare" is mentioned in para 88 of the 2010 Circular, in the following terms:

> "When contracting with homes, HSC Trusts should contract for the full cost of the placement, and, where there had not been a determination of continuing healthcare need, seek reimbursement under the 1993 Regulations. Residents can, however, seek the agreement of both the HSC Trust and the home to pay their assessed contribution directly to the home…"

[31] This paragraph is significant firstly because it uses the term "continuing healthcare" in a reference back to para 17 of the circular; but also because it makes clear that CHC under the 2010 Policy could apply where the service user was resident in a home (that is to say, a residential care home or, perhaps more likely, a nursing home).

[32] How then does the 2010 Policy fit within the basic statutory position in relation to charging which is summarised at para [17] above? First, it is clear that the Trust will pay for any nursing care which is provided, which it is prohibited from charging the resident in the course of recovering accommodation charges. Nursing care must be funded by the Trust. What then of any remaining accommodation charges? Where CHC applies, the Department or Trust *will* cover the cost of accommodation which is provided to the service user. In those circumstances, it seems to me either that the

nursing costs must be such as to equal or exceed the full or standard rate for the accommodation which would otherwise be payable; and/or that the provision of the accommodation is then viewed as *not* being provided by way of social care under Article 15 of the 1972 Order (in which case there is an obligation to pass on the charges to the user, subject to means testing). In those circumstances, because of the nature of the individual's primary need, the accommodation is provided as part of a package which is viewed *in its totality* as the provision of healthcare, even though it is or may be provided outside a hospital setting.

[33] In my view, it follows from Article 5 of the 1972 Order that health care *can* be provided in accommodation other than hospital accommodation and, indeed, that the Department *can* provide accommodation as a means of health care provision (rather than social care provision) and/or can provide a range of health care services (including, but not limited to, nursing services) in such accommodation or premises, or in the home of the patient or elsewhere. It has essentially been common case in these proceedings that there can be individuals who are not being cared for in hospital but who would meet the 2010 Policy's CHC eligibility test. (The dispute has really been about how many such people there are likely to be and how one is to apply the test to determine those who do, and those who do not, qualify, whether they receive healthcare in a domiciliary care setting or a nursing home.)

[34] In the Department's skeleton argument in these proceedings the matter is put in this way:

> "Importantly, the 2010 Circular recognises that there may be circumstances in which a person's care needs are driven by matters concerned directly with their health as opposed to personal social services. As highlighted by [para 63] of Part 3 of the 2010 Circular, this is an important distinction as the 1972 Order requires that a person is charged for personal social services provided in residential care or nursing home accommodation arranged by an HSC Trust…
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> … As such, in circumstances where a person's primary care need is for healthcare it is for the Trusts to meet the cost of that care. In contrast where the primary need is for social care, a person may be required to pay a means tested contribution. It is evident therefore that in the context of continuing healthcare, the 2010 Circular establishes a clear eligibility criterion which is predicated upon whether a person's primary need was for health care or personal social services. As expressly recognised by the 2010 Circular professional and clinical judgment was and continues to be integral in determining whether that criterion was satisfied."

[35] At this juncture it is appropriate to refer to another document which is helpful in understanding how the Department levied charges for accommodation at the time when the 2010 Policy was in force. It is entitled the 'Charging for Residential Accommodation Guide' (CRAG) ("the charging guide") and was issued under Article 17(1) of the 1972 Order. The version before the court was the version which had most recently been amended in April 2015. Much of this guide explains the details of the 1993 Regulations and how a resident's income and capital are calculated and taken into account (or left out of account, as the case may be). The detail of such financial assessments is not relevant for present purposes.

[36] The charging guide explains, consistently with what I have noted at paras [16]-[17] above, as follows:

> "The 1972 Order requires that a person is charged for residential accommodation i.e. accommodation in a registered residential care home or nursing home or in a Trust managed home, arranged under Article 15 of the 1972 Order. Article 36 provides for charging in an independent sector care home and Article 99 of charging in a Trust managed residential home."

[37] A lot more detail is given about this but there is minimal, if any, mention of the fact that nursing services cannot be charged for; and no mention of the concept of CHC. That might be thought to be consistent with the case made by the applicants in these proceedings that this was not a concept which the HSC sector was keen to publicise to potential beneficiaries.

The 2017 consultation paper

[38] The Department's 2017 consultation paper defined and described CHC in this way (at para 3):

> "Continuing healthcare, which is for adults, is the term used for the practice of the health care service meeting the cost of any social care need which is driven primarily by a health need. Eligibility for continuing healthcare depends on an individual's assessed needs and not on a particular disease, diagnosis or condition. If an individual's needs change, then their eligibility for continuing healthcare may also change. So as not to interfere with professional and clinical judgement, the Department has to date, refrained from drafting administrative guidance on a specific continuing healthcare assessment."

[39] The paper said this about the assessment for CHC (at paras 10-11):

> "10. Due to Northern Ireland benefitting from a fully integrated system, the assessment process covers both health and social care needs. At present, if the outcome of an assessment indicates a **primary need for healthcare**, then the HSC is responsible for funding the complete package of care in whatever setting. This is what is known as **continuing healthcare** in the local context. Alternatively a primary need for social care may be identified and where such a need is met in a residential or nursing home setting, legislation requires the HSC Trusts to levy a means-tested charge.
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> 11. If the assessment identifies that nursing home care is appropriate and the individual is responsible for meeting the full costs of their nursing home care, then the relevant HSC Trust is responsible for making a payment of £100 per week to cover the cost of providing the nursing care. This payment is made directly by the HSC Trust to the nursing home provider."

[40] The consultation paper then contained a section entitled 'The Need for Change.' It discussed the report published in 2014 by Age NI entitled 'The Denial of NHS Continuing Healthcare in Northern Ireland' ("the Age NI Report") which claimed that older people were being denied access to assessments for CHC, largely due to a lack of clear guidance. The Age NI Report contained nine recommendations, one of which was specifically that the Department draft and publish guidance on CHC to provide clarity on its operation, as well as requiring data to be collated and monitored in order to promote a better understanding of how and when CHC was used. It is a fair summary to say that the Age NI Report contended that the system was not working and that those who could or should be eligible to receive CHC were being deprived of this opportunity.

[41] As already mentioned, the Department then carried out its own review in order to ascertain how CHC was operating between the HSC Trusts and, in essence, to assist it in reaching its own view as to whether there was substance to the concerns raised in the Age NI Report. The findings of this review are summarised in the 2017 consultation paper and make for depressing reading in the context of this case. I summarise them as follows:

(i) "There is confusion about continuing healthcare and its applicability in Northern Ireland." Specifically, there was "a lack of understanding" that the Checklist Tool and Decision Making Tool used by authorities in England do not apply in Northern Ireland and are not part of the existing assessment process here.

(ii) Where an individual was moved into a nursing home, and was therefore required (in the absence of a grant of CHC) to contribute to the cost of their care, this was a key driver for a request for a CHC assessment.

(iii) There was "an apparent variance in the application of Departmental guidance and in continuing healthcare practice across the HSC Trusts." This led to inconsistency and a "postcode lottery" for individuals.

(iv) HSC Trusts had "indicated that they have found it challenging to apply Departmental guidance."

(v) In turn, multi-disciplinary panels which had been established by Trusts in order to make determinations on CHC applications "have found the decision making process extremely difficult." As a result, some Trusts had temporarily suspended the use of these panels, pending the outcome of the Departmental review.

(vi) All of the relevant Trusts confirmed that they were using the Single Assessment Tool (NISAT), which "is the standardised, multi-professional assessment tool providing a framework for holistic, person-centred assessment." A Nursing Needs Assessment Tool (NNAT) would also be undertaken when this was required.

(vii) Between April 2011 to September 2016, there had been 43 individuals who had been assessed as eligible for CHC in Northern Ireland. The Department acknowledged that this figure was "much lower" than corresponding numbers in England, Scotland and Wales, although pointed out that this figure did not include those individuals who may be eligible for CHC but received a care package in their home for which there was no charge (such that they had not been incentivized to seek a CHC assessment).

[42] At para 18 of the consultation paper, the Department noted that:

> "The outcome of the review has provided the Department with sufficient evidence that further clarity and revision to the local continuing healthcare policy is now required."

[43] In those understated terms, the Department accepted that there was an issue which required to be addressed. It then turned to the various options in that regard, expressing the aim that it wished to ensure a transparent and fair system for all individuals who may or may not have a continuing healthcare need. The four options identified were to do nothing (Option 1); to introduce a CHC Decision Support Tool Model (Option 2); to introduce a Single Eligibility Criteria Question (Option 3); or to develop Standalone Guidance and an assessment checklist specific to the HSC System in Northern Ireland (Option 4).

[44] Option 1 was discounted on the basis that it would not address the concerns which had been raised by Trusts, nor the issue of general lack of understanding about CHC in Northern Ireland. The consultation paper noted, "Importantly this option would not resolve the inequality issues for individuals which currently exist."

[45] Option 2 would have involved the introduction of the Checklist Tool and Decision Support Tool and associated guidance in terms either identical to or similar to that used in England. The Checklist Tool would then be used by HSC professionals to work out if an individual may have care needs which were of a level or type that may indicate eligibility for CHC. Subject to the findings of the initial assessment, a full assessment with the Decision Support Tool may be undertaken. This is the option which commended itself to the applicants in this case as being an appropriate remedy for the issues which had been identified in the Departmental review. However, the Department identified a number of issues with use of "these complex tools and the appropriateness of using them locally." First, it was said that this would unnecessarily add a further layer to the existing assessment process (NISAT) "which is considered to be sufficiently comprehensive for care assessment purposes." Second, it was noted that although the Decision Support Tool supports the process of determining eligibility, "it does not solely determine eligibility": clinical or professional judgement would remain necessary in all cases. It was considered, therefore, that Option 2 would not address the regional variance which appeared to exist in Northern Ireland.

[46] Option 3 was said to be similar to the arrangements introduced in Scotland in 2015. The applicants strongly dispute this. In any event, the consultation paper explained that, under this option, the Department would amend the current CHC policy by introducing a single eligibility criteria question in the following terms: "Can your care needs be properly met in any other setting other than a hospital?" If the answer to that question was 'yes', then the individual would be discharged to the appropriate care setting. This was the option identified as the Department's preferred option and which was ultimately selected and implemented by it. In terms of payment for social care, the position in this situation was explained (at paras 32-34 of the consultation paper), as follows:

> "32. If the individual required placement in a residential care home, then they would be subject to the same charging policy as other residents and would contribute to the cost of their care depending on their financial circumstances.
>
> 33. If the individual required placement in a nursing home, then they would be subject to the same charging policy as other residents and would contribute to their accommodation and personal care costs depending on their financial circumstances. HSC Trusts would still remain responsible for meeting the cost of providing nursing care to the individual in the nursing home. This payment,

which is currently set at £100 per week, would be paid directly by the relevant NHS Trust to the care provider.

34. For an individual discharged to return to their own home, they would if required, receive relevant support through a domiciliary care package which is not a chargeable service in Northern Ireland."

[47] The Department said that it considered this to be a workable option as it would provide "a clear and easily understood test." In addition, one of the main advantages of implementing this option was said to be "that it will ensure regional consistency in continuing healthcare outcomes across HSC Trusts, importantly addressing any existing inequality issues for individuals." It was further said that Option 3 would create a fairer system where all individuals needing to avail of residential or nursing home care services would be subject to the same charging regime.

[48] Option 4 was to develop standalone CHC guidance and an assessment checklist specific to the HSC system in Northern Ireland. It would require the Department, in conjunction with significant input from clinicians and practitioners, to develop guidance and an assessment tool specifically for this jurisdiction. This was considered to be a potentially very resource intensive exercise, noting that in England the guidance and associated tools took between 4 to 5 years to develop. The Department did not consider this to be a desirable option in light of the "pressing need for the Department to provide clarity" in the CHC policy in Northern Ireland in a much shorter timeframe. In addition, Option 2 would provide a similar outcome but involves much less time and expense.

[49] At para 41 of the consultation paper, the Department explained that, irrespective of which option was chosen, it was proposed that those individuals *already* in receipt of CHC would continue to receive it for as long as they remained eligible and therefore would not be disadvantaged as a result of new arrangements being introduced. For those individuals who were awaiting a decision by their Trust on an application they had made for CHC, there were two possible options: either Trusts could assess those applications in line with the then current (2010) policy, or they could put them on hold until the new arrangements were introduced and apply those.

[50] The consultation paper indicated that, although the Department had indicated that Option 3 was its preferred option, no final decision had been taken and views were being sought on the way forward. Consultees were told that the proposed amendments had been equality screened and a preliminary decision taken that a full equality impact assessment (EQIA) was not required. I return to that below. It was also said that the preliminary screening decision was subject to change following analysis of feedback received during the consultation. The consultation document was published on 19 June 2017 and responses were to be submitted by 15 September 2017.

[51] The outcome of the consultation was published on the Department's website several years later, on 11 February 2021. The preferred option which emerged from the consultation was Option 3. At the same time as publishing the outcome, the Department published a consultation analysis report. The majority of consultation respondents did not agree with the Department's proposed option.

The 2021 Policy

[52] The new policy introduced in 2021 was to use the single eligibility criteria question, which was to be applicable from 11 February 2021. The 2021 Circular was issued on 12 May 2021 by the Department's Elderly and Community Care Unit. It advised Trusts that its terms represented "an update to paragraphs 17 and 88 only, in relation to Continuing Healthcare" of the 2010 Circular. Accordingly, apart from those two paragraphs, all other aspects of the 2010 Circular remained operational. The 2021 Circular was to take effect, with an element of retrospective application, from 11 February of that year (the date when the Department's preferred outcome from the 2017 consultation had been announced).

[53] The introduction of the new single eligibility question was recognised as "a significant change to the policy" but was said to "provide a clear and easily understood test which will ensure a consistent and standardised approach in continuing healthcare outcomes across Northern Ireland" which would "importantly… help in addressing any existing inequality issues for individuals."

[54] Paras 5 and 6 of the 2021 Circular provide as follows:

> "5. The new policy of a single eligibility criteria question is applicable as of 11 February 2021. Any applications for continuing healthcare already in the system prior to this should be assessed in line with previous guidance or policies. New applicants from that date will be subject to the new policy of a single eligibility question.
>
> 6. Those individuals already in receipt of continuing healthcare, will continue to receive it for as long as they remain eligible to do so (as judged against the guidance and policies in place at the time they were awarded continuing healthcare) and therefore will not be disadvantaged as a result of the new arrangements."

[55] Para 7 of the 2021 Circular repeats that only paras 17 and 88 of the 2010 Circular were being updated; that any applications for CHC already in the system prior to 11 February 2021 should continue to be assessed in line with previous guidance; but that any new applications from that date should be considered under the new policy of a single eligibility criteria question. The Department committed to establishing a

working group with key stakeholders in order to develop guidance to support the new policy.

[56] Indeed, Departmental guidance on the 2021 Policy was in due course published on 18 May 2022. In the applicants' submission this guidance "confirms the feared impact of the 2021 Policy, i.e. narrowing of CHC into non-existence." It includes the following guidance:

> "If an individual's care needs can be properly met in any setting other than a hospital then the individual will be discharged to the appropriate care setting and depending on the type of care package, be subject to the relevant charging policy. The key aim for anyone that does need to be in hospital for a longer period of time is to get them well enough to return to whatever setting is most appropriate for them in the community…"

[57] It is now clear that only healthcare needs of a level of severity requiring hospitalisation will be covered by CHC. Healthcare needs which do not require hospitalisation will not be covered by CHC. In short, the previous facility for CHC funding of accommodation costs in a nursing home or residential care home has been brought to an end.

The Belfast Trust's 2015 review response

[58] An important piece of evidence in this case, in my view, is the response from the Belfast Trust to the Department in the course of the Departmental review of CHC following on from the 2014 Age NI Report ("the Belfast Trust 2015 review response"). As part of this review, Trusts were asked by the Department what they understood the concept of CHC to mean within the context of the HSC system in Northern Ireland. The Belfast Trust's response included the following:

> "… the BHSCT does not consider the concept of "continuing healthcare" relevant or easily definable within an integrated health and social care system. The term continuing healthcare is not referenced within the care management circular and pertains to GB where the health and social care systems are quite separate and was conceived to deal with financial responsibilities which it can be argued is a separate issue."

[59] Assuming the reference to the "care management circular" is a reference to the 2010 Circular, it is wrong to say that "continuing healthcare is not referenced." The *concept* is referred to at para 17 of that circular, although without using the phrase "continuing healthcare." That phrase *is* used in para 88 of the 2010 Circular in the context of a determination as to the level of reimbursement for residential care which

a Trust should seek under the 1993 Regulations. It has been common case in these proceedings that the 2010 Circular established the 2010 Policy in relation to CHC which is described above. Perhaps of more concern, however, is the impression that this concept is relevant to Great Britain but not Northern Ireland. That impression is, in effect, expressly stated in a later portion of the Belfast Trust's 2015 review response:

> "Requests for reassessments for retrospective refunds [of] nursing home fees are based on the GB systems which are separate jurisdictions. We do not receive requests for [continuing healthcare assessments] and where we do individuals are referred to their MDT or Care Manager. We do indicate that [for] anyone assessed for placement in a nursing home the primary need will be personal and social care not "continuing healthcare" as the concept does not apply in a [Northern Ireland] setting."

[60] I accept that the Trust response was provided in late 2015 and is not therefore necessarily reflective of the Trust's position when Mr McMinnis' case was specifically considered some years later. However, the response (consistent with some other evidence provided in these proceedings) indicates a high level of uncertainty as to how CHC eligibility should be dealt with, to say the least. Indeed, the Belfast Trust's 2015 review response was, in my view, a clear misdirection as to the applicability of CHC in Northern Ireland as set out in the 2010 Circular. Notably, there was no material assistance provided in further policy or guidance from the Department between that time and the relevant decisions which are the subject of these proceedings.

[61] When asked what policies or guidance it had in place in order to assess a client's eligibility for CHC, the Belfast Trust said this in its 2015 review response:

> "The BHSCT does not use specific policies / protocols or guidance to determine whether an individual's primary need is health care or for personal social care sources. These needs are indivisible and the central responsibility of the multi-disciplinary team is to ensure those needs are met. In a small number of cases patients will have complex fluctuating medical or behavioural issues which require regular access to specialist medical supervision and continuous high skill nursing interventions. These patients will often remain in hospital for long periods or may have intensive health and social care packages delivered at home. These individuals' needs are subject to frequent review."

[62] This explanation gives rise to a number of potential concerns, including that the threshold for the award of CHC in the Belfast Trust was treated as an elevated one, consistent with the earlier statement to the effect that it simply would not arise for a

service user accommodated in a nursing home. Further contents of the response are highly suggestive that the Belfast Trust considered CHC to arise only in respect of some patients who had to *remain in hospital* (including palliative and end-of-life patients), that is to say, reflecting what later became the 2021 Policy, notwithstanding the different terms of the 2010 Policy. The statement, however, that the two types of needs "are indivisible" – whilst possibly defensible as a matter of practice – indicates a failure to grasp the importance of the distinction made *as a matter of law* (and, indeed, in the Department's policies) for the purpose of decisions as to charging for the two types of service provision.

The position in other jurisdictions

[63] Continuing healthcare policy and practice varies across Northern Ireland, England, Scotland and Wales. The 2017 consultation paper notes that, in England, 'NHS Continuing Healthcare' is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health needs. In England, assessment decisions are made by reference to the Checklist Tool and Decision Support Tool. The test is whether the individual has a 'primary health need.' In order to determine this, there is a detailed assessment and decision-making process. This is described in a National Framework document ('National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (Revised), Incorporating the NHS Continuing Healthcare Practical Guidance'), which runs to some 167 pages. A more accessible public information leaflet is also available which acts as a guide to the operation of the scheme for members of the public. The scheme in England is not limited by reference to the care setting in which the individual is treated for their health need. The applicants submit that para 82 of the National Framework suggests that it is for medical practitioners to indicate who needs an assessment for CHC eligibility, rather than this onus falling upon the service user themselves.

[64] The Decision Support Tool (DST) which is used looks at eleven different types of need in terms of the nature, complexity, intensity and unpredictability of the individual's need. As the Department submitted, this is not an assessment of needs in itself but is addressed to particular care domains which are to be addressed. The domains are: Breathing; Nutrition, Food and Drink; Continence; Skin and Tissue Viability; Mobility; Communication; Cognition; Psychological and Emotional Needs; Behaviour; Drug Therapies; Altered States of Consciousness; and Other Significant Needs. Each domain is divided into levels of need, which are considered for complexity, intensity and unpredictability. Using these metrics, in each domain the need is classed as follows: No Needs; Low; Moderate; High; Severe; or Priority. Only certain care domains can qualify for severe or priority needs. The exercise is highly structured, albeit it requires judgement to be applied. The ultimate decision is also reached in a structured way (set out at para 58 of the DST), with the core guidance being in the following terms:

> "At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the individual's needs, along with the MDT's recommendation about eligibility or ineligibility. A clear recommendation of eligibility for CHC would be expected in the following two circumstances:
>
> - A level of priority needs in any one of the four domains that carry this level.
> - A total of two of more incidences of identified severe needs across all care domains.
>
> Where the following occur, this may also indicate a primary health need, requiring further consideration:
>
> - one domain recorded as severe, together with needs in a number of other domains, or
> - a number of domains with high and/or moderate needs."

[65] The 2017 consultation paper notes that, in Wales, 'Continuing NHS Healthcare' is a package of care provided by the NHS for those individuals with complex and primary health-based needs. In Wales, authorities use the DST used in England, although not the Checklist Tool. Again, the provision of a complete package of ongoing care arranged and funded by the NHS can be provided in any setting outside hospital. CHC in Wales co-exists alongside, and is in a different form from, 'NHS Funded Nursing Care', which is applicable to individuals in nursing homes. The decision on eligibility for NHS Funded Nursing Care is only to be taken when it is considered that the person does not fall within the eligibility criteria for CHC. The decision on eligibility for CHC is governed by the NHS Continuing Healthcare National Framework for Implementation in Wales, which is a guidance document running to 138 pages. Again, the applicants submit that, under this document, the onus is on practitioners to assess service users for eligibility, rather than the service users themselves being required to complete a formal application.

[66] As the Department observed in its submissions, there is a parallel between the position in Northern Ireland under the 2010 Circular and the position in England and Wales. In England the criterion for CHC is whether there is "a primary health need" and in Wales whether "an individual's primary need is a health need." There is thus, as the Department accepts, "no material difference in the central test to be applied in the 2010 Circular." That, however, underscores the applicants' point (they submit) that it is highly surprising that, in both England and Wales, there is a considerable amount of additional guidance setting out clearly and precisely how that over-arching criterion will be approached, with no equivalent guidance in this jurisdiction, nor anything approaching it.

[67] The 2017 consultation paper notes that, in Scotland, NHS Continuing Healthcare was replaced by 'Hospital Based Complex Clinical Care' in June 2015. This was following an independent review of NHS continuing healthcare in Scotland which was published in May 2014. From June 2015, hospital-based complex clinical care was based on the same single eligibility question which the Department was proposing to introduce in its 2017 consultation paper. Following assessment, if the question was answered positively (*viz* that the individual's care needs could properly be met in a setting other than hospital) the person will be discharged from NHS care to a suitable community setting, for example to their own home with support, a care home or supported accommodation. In a way, therefore, the Department can present the present position in Northern Ireland as being analogous to that in Scotland.

[68] However, the applicants take strong issue with the suggestion that the present (non-)provision of CHC in Northern Ireland is now similar to the arrangements in Scotland. This is because in Scotland Hospital Based Complex Clinical Care is supplemented by a policy of Free Personal and Nursing Care which provides both free personal and nursing services to individuals who have been assessed as requiring same by their local authority. This policy allows for various personal and nursing care to be provided free of charge, regardless of whether or not the service user is cared for at home or in a nursing or care home. No similar policy is in place in Northern Ireland, the applicants submit. In summary, they submit that it is still possible for care home charges to be funded at public expense in Scotland in a manner similar to the position under the 2010 Policy here, although no longer by means of a funding policy labelled as CHC.

[69] The 2017 consultation paper stated that, in the Republic of Ireland, there is no policy on continuing healthcare; but little or no information was provided there, or has been provided to me in the course of these proceedings, as to the arrangements in the Republic of Ireland. In any event, in this context, it seems that arrangements in the other jurisdictions within the United Kingdom are likely to be more relevant.

The contours of the challenge

[70] The first applicant, Mr McMinnis, challenges a decision of the Belfast Trust dated 28 May 2021 to refuse his application for CHC under the 2010 Policy. Relatedly, he challenges the lawfulness of that policy and the failure of the Belfast Trust and the Department to develop and implement guidance governing its application. Further, or in the alternative, Mr McMinnis challenges the decision of the Belfast Trust to charge him for his care and/or to seek a refund of the cost of his care for the period prior to the assessment of his application for CHC. This last aspect of the challenge relates to what charges if any should be made pending determination of a CHC application. The first applicant's challenge can be seen therefore to focus squarely on the operation of the 2010 Policy which, it is common case, applies to his application because of the time at which it was made.

[71] The challenge to the decision of 28 May 2021 ("the assessment decision") is mounted on two bases. First, it was reached in a procedurally unfair manner because the applicant had no advance notice of the procedure or process to be adopted; was deprived of an appropriately constituted multi-disciplinary panel with adequate experience of his care; was unable to make properly targeted representations in support of his application; and had a test applied which was essentially made up in an ad hoc fashion. Second, it is in breach of his rights under Article 1 of the First Protocol to the ECHR (A1P1) "in that it opens up an avenue for Mr McMinnis' property and assets to be utilised to meet his care costs." His challenge to the 2010 Policy overlaps almost entirely with his challenge to the assessment decision. He contends that the 2010 Policy operates "without a clear and consistent procedure, test or guidance of any kind" which is inherently procedurally unfair and accordingly operates in a way which is incompatible with A1P1 rights. His challenge in this regard is supported by the NIHRC, which focused its submissions on the human rights grounds but, since those grounds overlapped heavily with the applicant's common law complaints, were generally supportive of the first applicant's claim. He further contends that it was irrational for the respondents to fail or refuse to issue guidance on the operation of the policy.

[72] Mr McMinnis' challenge to the decision or approach of the Belfast Trust to charge him for his care (or seek a refund of the cost of his care from him in future) for the period after his CHC application had been made but before it had been assessed is contended to be unlawful on two bases also. First, he submits that the Trust can only lawfully levy such charges where there had been a determination that personal social services (rather than health care) were being provided. Given that no such determination had been made prior to the assessment decision on 28 May 2021, there was no lawful authority for these charges to be imposed. Second, and relatedly, it is again contended that the imposition of charges in this way is incompatible with his A1P1 rights, either by virtue of its procedural aspect (on the same grounds as the procedural unfairness challenge described above) or because there is a lack of adequate authority for the charges to be imposed in these circumstances. An originally pleaded challenge based on Article 14 of the Convention was not pursued.

[73] The Commissioner's challenge focuses on the legality of the 2021 Policy and the decision to adopt it. There were two grounds of challenge which were pursued in this regard. An irrationality challenge grounded upon the failure of the Department to issue guidance on the operation of the 2021 Policy was abandoned during the course of the proceedings when such guidance was published. As to the grounds which were pursued, first, it was contended that the Department has acted in a procedurally improper way in failing to conduct a full EQIA on the 2021 Policy, despite its obviously less favourable impact on older people. Second, it was contended that the 2021 Policy imposes or gives rise to charges which are simply unlawful, on the basis that there is no authority to charge for health care provided in the community and/or that the Department has failed to comply with Articles 36 and/or 98 of the 1972 Order.

Factual background: Mr McMinnis' case

[74] When these proceedings were commenced the first applicant was a 73-year-old man. He has multiple sclerosis, which first presented in 2006, at which point he retired. His diagnosis was confirmed in February 2011 following a lumbar puncture. Sadly, he has suffered a steady decline since that time. He is now a resident in the Somme Nursing Home, which he moved into when his care needs became too significant for his wife to manage at home, despite extensive efforts she had made in that regard. He made his first application for CHC in April 2017. He contends that he is still awaiting a fair and lawful consideration of the application.

[75] Mr McMinnis was formerly a high-level civil servant, at one stage acting as a Director in the Department for the Economy. In 2006 he was awarded an OBE in recognition of his work and contribution to Northern Ireland during his professional service. He suffers from a serious degenerative condition which causes his health to progressively deteriorate. He is essentially paralysed, retaining physical function in his head and eyes only. He is bed-bound. He is said to require specialist care with every physical aspect of his life. However, he retains full cognitive function. He can currently still speak but requires the aid of a voice amplifier and his voice tires easily. He uses specialist technology to type, through the use of his eyes. Prior to his engagement with COPNI, he himself communicated with the Trust and with the Northern Ireland Public Service Ombudsman (NIPSO) ("the Ombudsman") in this way about his CHC application, in a manner which cannot do otherwise than inspire respect.

[76] The Trust's evidence is that its engagement with Mr McMinnis dates back to 2012, from which point it has been closely involved in all aspects of his care. Where healthcare interventions have been required, these have been provided and have been provided, the Trust avers, without his having been charged for them. A number of such interventions are mentioned, including a specialist nursing home support team. At a point in time, however, Mr McMinnis felt it best that he move to a nursing home. He initially went to the Somme Nursing Home for respite care in mid-2016 but later moved there permanently in early 2017. The Trust contends that, at that point, it (the Trust) was not of the view that his social and healthcare needs could not be met in his own home; indeed it did not consider that his social care needs required residential accommodation but it did not oppose his move to the nursing home.

[77] The evidence before the court is that without CHC Mr McMinnis' nursing home costs are approximately £25,000 per year. Were he to be eligible for CHC under the 2010 Policy, the HSC system would be responsible for these costs. Mr and Mrs McMinnis sold their matrimonial home in order to allow Mrs McMinnis to downsize to a property of a more manageable size. Mr McMinnis was later advised that the Trust intended to seek recoupment of his share of the sale proceeds as part of a required contribution to his care costs, which were to be backdated to 2017. These proceeds had already been used by him to assist in the purchase and renovation of a new home for Mrs McMinnis, which was in very close proximity to the Somme Nursing Home where he now resides. The financial re-assessment in this regard has

been stayed pending the outcome of these proceedings but has been the cause of some considerable worry to both the first applicant and his wife. For him, this is what is at stake in relation to his CHC assessment.

[78] As noted above, Mr McMinnis made an application for CHC in April 2017. It set out in detail his own view of his conditions and care needs, which need not be described in the same level of detail here. As his condition had advanced, he considered that he met the 'primary healthcare need' test. The application was refused in February 2018 on the basis that the Belfast Trust does not place people with continuing healthcare needs in general nursing homes, as these facilities would not be able to meet such persons' clinical needs. The response also said that the Trust "does not provide continuing health care assessments for the purposes of abatement of nursing home fees." This was a refusal in fairly cursory terms, consistent with the approach described above in the Belfast Trust's 2015 review response but inconsistent with the acceptance inherent within the 2010 Policy that CHC *could* arise in a nursing home setting. Mr McMinnis initially declined the offer of a multi-disciplinary assessment in April 2018, on the basis that he did not think it would be a helpful use of time given the Trust's position (which amounted to, or was at least very close to, a view that CHC could only be provided in hospital). Nonetheless, in due course, essentially after the involvement of NIPSO, such an assessment was undertaken.

[79] Mr McMinnis is critical of the compete absence of any regional or local guidance from either the Department or the Belfast Trust as to how the 2010 Policy is to be applied in practical terms. For instance, he says that it is not even clear if a CHC assessment ought to take place automatically or if it is something which must be applied for. If it must be applied for, the process is not clearly outlined; and no information had been made available, at least easily or routinely, to permit people who may be eligible for CHC to know how to go about securing it. In his case, he learned of the policy through his own online research.

[80] After the initial refusal of his application, Mr McMinnis made a complaint to the Ombudsman about maladministration in the way in which his application for CHC had been dealt with. NIPSO investigated the matter and the Ombudsman promulgated an investigation report on 16 December 2020, finding three elements of maladministration on the part of the Belfast Trust in respect of its decision in February 2018, namely:

(i) Failing to implement a local procedure for the assessment of CHC applications in accordance with the 2010 Circular;

(ii) Failing to provide the complainant, Mr McMinnis, with the opportunity to have a timely and appropriate CHC assessment; and

(iii) Failing to have a CHC policy that was consistent with the principles set out in another HSC policy document entitled 'Transforming Your Care Review.'

[81] The NIPSO report is very detailed and contains much detail in relation to the findings mentioned above, which it is not possible to set out in full in this judgment. The thrust was that the Trust's determination that the complainant did not have a primary healthcare need simply because he was able to be cared for in a nursing home was not consistent with the relevant CHC standards. In the course of her investigation the Ombudsman was assisted by an independent professional adviser (IPA), a specialist nursing practitioner of 35 years' experience, including 15 years' experience within NHS CHC in England. Her findings included that the Trust's approach ignored the possibility of individuals with a primary healthcare need being cared for in settings other than hospital; that the 2010 Circular was not specific to the type of needs that would indicate whether an individual's primary need was for healthcare or personal social services; and that there was a lack of clarity in the Trust's position on CHC. The Ombudsman also made a number of recommendations to the Belfast Trust. These included that it should:

(a) Develop a local policy on the implementation of the provisions of the 2010 Circular;

(b) Develop and implement local protocols and procedures in relation to the determination of an individual's primary need and, consequently, their CHC eligibility;

(c) Deliver training on the provisions of the 2010 Circular, and the related local CHC policy, protocols and procedures which were implemented, to staff involved in the assessment of individuals' complex health and social care needs; and

(d) Publish the details of the Trust's position on the determination of primary need and CHC eligibility.

[82] In short, the Ombudsman accepted that the Trust needed to provide much clearer and more transparent guidance in relation to what CHC was and how eligibility for it (the assessment of 'primary need') was to be assessed. The details in relation to how these matters were then to be addressed should be published in a transparent way. She further recommended that the Trust offer Mr McMinnis a new multi-disciplinary assessment in order to determine his primary need within a period of two months from her report; and that the Trust issue an apology to him.

[83] The Trust accepted the NIPSO findings and therefore accepted that it ought not to have waited for the Department to issue guidance, but ought itself to get on and deal with Mr McMinnis' request for an assessment. In correspondence from the Trust to NIPSO which has been placed before the court (in particular, a letter of 17 September 2020 from the Trust's deponent Ms Traub when the Ombudsman's draft investigation reported had been provided), the Trust made clear its view that it was for the Department to issue guidance on CHC eligibility by way of regional policy. Indeed, this letter pointed out that the Ombudsman had herself in a previous report accepted

that regional policy would be the best way forward. In light of the political hiatus which had arisen, however, the Trust accepted the Ombudsman's view that the absence of policy and procedures for staff and service users could no longer continue and that the Trust (and other Trusts) must now remedy the matter.

[84] Nonetheless, the Trust continued to complain – with justification, in my view – that if it proceeded in this way there was a risk of local interpretation, and therefore confusion and a lack of equity, regarding how the issue would be managed across individual Trusts, giving rise to knock-on effects and concerns across the HSC sector. Its correspondence of 17 September 2020 expressed the following view:

> "Within your report, you note that it is the position of the Department of Health (NI) that they do not wish to issue policy that interferes with professional judgement at a local level. However, it is accepted across other parts of the United Kingdom that guidance is required and you refer to a range of tools that are available in other jurisdictions to support decision-making. Whilst we appreciate the intention of the Department, it is the consensus of professionals and decision-makers on the front line, that regional guidance would be very much required and welcomed. Regional policy, procedures and tools would enable us to understand the thresholds for CHC, and the presenting level of needs that would indicate a primary healthcare need…."

[85] In any event, after the NIPSO report into his case Mr McMinnis was offered a new multi-disciplinary CHC assessment, as recommended (although this was not undertaken within the recommended two-month timescale). He was also provided with a written apology on behalf of the Trust. However, he contends that the Trust has failed to follow any of the other recommendations, particularly in respect of the development, implementation and publication of local policies and procedures in relation to applications under the 2010 Policy. In short, he contends that the Trust has simply 'kept its head down' in respect of the maladministration the Ombudsman identified going beyond the very particular requirements as to Mr McMinnis' case personally.

[86] The new multi-disciplinary CHC assessment of Mr McMinnis' needs was carried out. The decision was taken by a panel of three medical and social care practitioners who were appointed after the Trust had liaised with NIPSO. On 23 April 2021 the Trust wrote to Mr McMinnis inviting his comments on the methodology/approach which he felt the panel should take when arriving at a determination. In my view, Mr McMinnis could have responded more helpfully to this correspondence. That said, there is also force in the submission made on his behalf that it was not for him to set out the methodology to be applied by the Trust; and that

the fact that he was being asked for views on it is illustrative of the fact that it was being adopted ad hoc.

[87] The outcome of the assessment was notified to him on 28 May 2021, when it was concluded that he was not eligible for CHC. It is this decision which is the primary focus of his part of this challenge. The decision was provided in the form of a report from the multi-disciplinary panel, all of whom have relevant expertise but, admittedly, "no previous experience in the assessment for Continuing Healthcare." I have been provided with quite some detail, both in evidence and submissions, about this decision and the particular assessment of Mr McMinnis' needs. I need not set that out extensively, or indeed in much detail at all, in this judgment. That is because the court's assessment is not concerned with the merits of Mr McMinnis' application for CHC, much less the detail of fine judgements made in the course of that assessment. Leave to apply for judicial review was refused on an originally-pleaded ground that the substantive outcome of the panel's assessment was irrational.

[88] It suffices to say, however, that there is a live debate between the parties about whether – particularly if the DST used in England governed eligibility in this case – Mr McMinnis should have been adjudged eligible for CHC. That is because the panel assessed him as having three domains with moderate needs (and a further with low to moderate) and one with severe needs. The Panel commented that he would not be eligible under the English approach "as he has one "severe" level of need and no "priority" levels of need." The applicant contends, applying the guidance at para [64] above, that he falls within a circumstances which *may* indicate a primary healthcare need, either on the basis that he has "one domain recorded as severe, together with needs in a number of other domains" or "a number of domains with high and/or moderate needs." That is before one gets into any debate about whether the panel under-assessed the severity or complexity of the need in any particular domain. It is also relevant to note that the NISAT tool (discussed further below) was used as part of the assessment of Mr McMinnis which led to the impugned decision.

[89] The first applicant wrote again to NIPSO on 12 June 2021, raising concerns about the determination of 28 May 2021. As it happens, in another case, the Trust sent the Ombudsman a letter, dated 19 July 2021, setting out the methodology it was using. This letter said that it was important to note that the Trust had recently been informed that the Department was actively developing regional advice in relation to the management of historical CHC requests, which pre-dated the implementation of the 2021 Policy. (I return to this issue below.) At that time, the regional guidance to be provided by the Department had not been received. The Trust said that "therefore there continues to be no regional framework to make a determination on historical CHC requests." Until such times as that guidance had been provided, the Trust had established its own methodology and said that it would "utilise a number of tools to inform decision-making." The letter then referred to a variety of documents which had been taken into account, including the 2010 Circular, the NIPSO report, the 2017 consultation outcome, the DST used in England, and Scottish guidance on Hospital Based Complex Clinical Care. The letter then purported to explain the methodology

which had been used. It explained again that there was not a CHC toolkit endorsed by the Department. Therefore, in addition to reviewing the NISAT and related assessments, the appointed panel would consider a number of physical and psychological domains of need. Not only would this involve consideration of the DST from England; it would also consider the Roper, Logan and Tierney Model of Activities of Daily Living ("the RLT Model").

[90] The Ombudsman replied on 5 August 2021, in a letter upon which the Trust places particular reliance. The investigating officer said that she was pleased to note the detail provided around the methodology the Trust planned to use and the engagement that there would be with the individuals affected. The investigator's view was that the proposal by the Trust to try to remedy the matter "was the best outcome we could achieve… at this time." It was considered that the proposed methodology which the Trust had established, along with engagement with the individual affected, was "a suitable remedy to bring this matter to a close."

[91] NIPSO replied to Mr McMinnis on 30 September 2021, noting the methodology which had been used by the Trust and accepting that the methodology was based on the correct question, namely whether his primary need was healthcare or personal social services. The letter thanked Mr McMinnis for his patience and bringing the complaint to the Ombudsman, notably commenting that his "complaint has helped bring to light many of the struggles faced by CHC applicants over the years."

[92] Mr McMinnis also made contact with the Commissioner, in order to seek assistance from his office, in July 2021. (He had originally sought to approach COPNI in February that year, before the impugned decision, but this came to nothing.) The Commissioner later assisted Mr McMinnis with the bringing of these proceedings. His interest is described below.

The attempt to formulate additional Departmental advice

[93] As noted at para [89] above, on 19 July 2021, the Trust told NIPSO that the Department was at that time actively developing regional advice in relation to the management of historical CHC requests, i.e. in relation to CHC applications which were still governed by the 2010 Policy. During the course of the hearing of this application I enquired about this and was later provided with some additional documentation from the Department about it.

[94] On 7 July 2021 – after the impugned decision in Mr McMinnis' case – an official within the Elderly and Community Care section of the Department provided a draft letter to Trusts "relating to outstanding cases" for CHC which arose before 11 February 2021. The draft letter was from the Director of Disability of Older People in the Department and was addressed to Trust Directors of Older People. It was provided "in order to facilitate consistency" in dealing with outstanding cases under the 2010 Policy and suggested things that Trusts should consider. These included "the use of NISAT, alongside any other relevant assessment options, to allow a clear

determination of primary need (healthcare or social care)"; and consideration of other issues including "the hours of healthcare delivered, versus hours of personal/social care delivered", "the setting in which care is delivered", and "the complexity and frequency of the healthcare need." The following considerations were also suggested, adapted from the National Framework document in England, namely that "an individual has a primary health need if, having taken account of all their needs through assessment, it can be said that the main aspects or majority part of the care they require is focused on addressing health needs"; and "having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality." The draft letter concluded: "I hope this information is helpful in clarifying the approach."

[95] This email and draft correspondence apparently elicited some responses and a further version was provided on 12 August 2021, which had been amended. Again, it remained in draft. The covering email on this occasion said, "It is worth bearing in mind that this letter is designed to provide a suggested approach and basis for decisions, without being prescriptive." The draft text of the letter said that the contents below should be referred to "for the suggested approach to follow when dealing with outstanding applications." Further comments were requested before the draft letter was finalised. The covering email noted that, "Ultimately the complexity and need for specialist intervention should be key to an assessment", although this text did not appear in the revised draft letter. Additional text, however, would now direct decision-makers to "the need for regular specialist clinical supervision of the patient" as a result of various issues which were listed. In addition, the bullet point referring to "the main aspects or majority part" of the individual's care being focused on addressing health needs was to be qualified by the addition of the words "beyond general nursing support." It appears that someone had suggested that a "bolt on" to NISAT may be necessary or useful. As to this, it was suggested that it was for Trusts to set up a group to consider and design this together to ensure consistency. The reference in the draft letter to considering the setting in which care was delivered had been removed.

[96] The Department disagreed with the characterisation of these exchanges by the Trust as being prescriptive regional guidance. In the event, the draft letter was not finalised and sent because, on 12 August 2021, the Commissioner sent pre-action protocol correspondence which preceded these proceedings. When that arrived, the Department shelved the development of this advice, emailing those involved on 27 August to advise them that the draft letter would not be moving forward and should be disregarded. It is difficult to avoid the conclusion, however, that this exercise demonstrated (i) continuing uncertainty and debate between Trusts and the Department about how the 2010 Policy should be applied, with the proposed approach constantly shifting; and (ii) an acknowledged need for consistency between Trusts, which would best be delivered by some guidance being issued by the Department.

The Commissioner's interest in these proceedings

[97] The second applicant in these proceedings is the Commissioner for Older People for Northern Ireland. His office is governed by the provisions of the Commissioner for Older People Act (Northern Ireland) 2011. His principal aim in exercising his functions under that Act is to safeguard and promote the interests of older persons. In his grounding affidavit in these proceedings, the Commissioner has averred that during his tenure an issue that has repeatedly been brought to his attention by and on behalf of older persons is the issue of continuing healthcare. His office is attending to at least 20 specific requests for assistance in respect of CHC from or on behalf of older people. Many of these requests have, in the Commissioner's view, illustrated the difficulty people have had in understanding how the 2010 Policy is intended to operate, how to apply for it effectively, and how their application will be assessed. Mr McMinnis was one such person.

[98] The Commissioner has highlighted in his evidence that he is conscious of the pressures faced by the health system in Northern Ireland, particularly financial pressures. However, his concern is that CHC is intended to ensure that individuals requiring what is effectively healthcare do not end up paying for that care, which ought to be provided to them free of charge in the same way that it would be if they were in hospital or some other form of healthcare setting. He has averred that:

> "In my view, this is an important part of our healthcare system and needs to exist in order to ensure that healthcare does not become inadvertently means tested for individuals whose healthcare needs are being met outside of hospital. It is in the best interest of the system as a whole for individuals to remain out of hospital where possible and there are clear social benefits to health care needs being able to be met at home, in a nursing or care home or other setting."

[99] The Commissioner has provided evidence that, in his experience, the 2010 Policy has been operated by different Trusts across Northern Ireland in various ways, using different methodologies and tests in assessing the eligibility of individuals for CHC. The Department has never issued guidance to Trusts on how the 2010 Policy should operate and, to the Commissioner's knowledge, none of the Trusts have issued their own local policies and guidance. This has resulted in a lack of consistency of application, delays in assessment and several Trusts being criticised by NIPSO for maladministration in respect of application of the 2010 Policy. He described the situation – whereby Trusts consider the issuing of guidance to be a matter for the Department and the Department considers it to be a matter for Trusts – to have led to a stalemate and "vacuum."

[100] The Commissioner's office submitted a response to the Departmental consultation on CHC. It outlined the Commissioner's concerns about adopting the Department's preferred option. In the Commissioner's view, the single eligibility

question has the effect of ending CHC in the community and renders it inapplicable to those requiring nursing or residential care in Northern Ireland, some of whom may have primarily healthcare needs. To make CHC 'venue specific' in this manner is, in the Commissioner's view, to render the policy "functionally pointless" because care in hospital is already provided free of charge in Northern Ireland under the NHS.

[101] The Commissioner is concerned that this marks part of a wider policy move to categorise more and more services as being in the nature of social care as opposed to healthcare, since social care services are often means tested and charged for accordingly, whilst healthcare cannot be charged for. The Commissioner has referred to the fact that he is aware that NIPSO has also had cause to deal with complaints in respect of the operation of CHC in Northern Ireland which has resulted in findings of maladministration against more than one HSC Trust. For these reasons he has taken the unusual step of litigating the issue.

[102] In an attempt to illustrate the widespread nature of the enquiries he has fielded and the issues arising with the application of the 2010 Policy, the Commissioner has given details of a number of case studies which have come to his attention. These cases have been anonymised in order to protect the privacy of those who have approached his office with concerns about CHC. The details are included in an affidavit from Aoife Colgan, COPNI's Head of Legal. I summarise them below (as at the time of the relevant evidence being filed):

(a) Client A is in his 70s and has a brain injury and other complex disabilities arising from a serious road traffic accident. His family has repeatedly sought additional care from the Trust but were unaware until recently that CHC existed as a policy. He had never been assessed for CHC.

(b) Client B suffered from COPD. She required a 24 hour additional oxygen supply. Her family requested a CHC assessment in 2013 before her admission to a care setting. This assessment was not completed. Subsequently, she was admitted to a care home and was charged over £1,800 per month over a period of three years. Her daughter was a qualified nurse and was therefore aware of CHC. However, Client B's health deteriorated and she passed away in April 2016 without ever having been assessed for CHC.

(c) Client C lives with multiple sclerosis and brain damage. She lives in a vegetative state. She is said to need complete nursing care and is fed by a nasogastric tube. Her son requested a CHC assessment in March 2018 and in February 2019. In July 2021 the Trust advised Client C's son that there was no specific CHC assessment tool. The family pay over £300 per week in nursing home fees. They must also pay some £52,000 to the nursing home from the sale of the family home in due course. In November 2021 the Trust advised that they would agree to conduct a further assessment of Client C's needs to determine if she is eligible for CHC and that a multidisciplinary approach

would be used, including use of NISAT. Client C was continuing to reside in a nursing home and paying nursing home fees pending assessment.

(d) Client D had experienced a ruptured aneurysm, which resulted in a subarachnoid haemorrhage followed by a severe stroke. On advice from Age NI, her husband contacted the Belfast Trust and requested an assessment for CHC in May 2015. In July 2015, the Trust advised that, in accordance with the 2010 Circular, Client D was assessed as being appropriate for nursing home care and admitted to the nursing wing of a care home. Client D then passed away and her husband is unsure if any CHC assessments were ever completed. Client D and her husband had previously lived in England but had returned to Northern Ireland assuming that CHC would be as readily available here as it is in England. She paid approximately £111,000 in nursing home fees over a five year period. Her husband continued to pay care home costs without a CHC assessment being undertaken.

(e) Client E was 86 years old when she initially entered a care home and had 24/7 assistance from a nurse assigned to her during that time. From 2021, the family made numerous requests for a CHC assessment; but one was never carried out. Correspondence from the Trust to COPNI in 2016 indicated that Client E's NISAT and NNAT assessments had consistently identified that she had a range of nursing needs that were well met within the nursing home environment at the regional tariff rate. Client E passed away in 2016 and the family had still never received a CHC determination. In April 2017, the Trust commenced litigation against a family member for unpaid care home fees in respect of Client E for the sum of £89,000. Evidence provided suggests that, at least for part of the relevant period, the care home fees paid by the family were in the region of £1,000 per month.

(f) Client F was a 72-year-old woman who lived with diabetes and dementia. The family assumed she could be assessed for CHC. However, the Trust sent her a letter in July 2017 stating this was not the case as such assessments did not exist in Northern Ireland. Client F's family requested a CHC assessment on two occasions but this was refused on each occasion. She passed away in June 2021. The family paid nursing home costs of approximately £110,000 over a four year period.

(g) Client G died waiting for an assessment under the 2021 Policy.

[103] I accept that this sample of cases shows that there is a degree of widespread concern amongst older people who wish to avail of CHC and contend that they should be considered eligible for it; and that there is evidence to suggest systemic issues about its operation over the last number of decades. Indeed, this seems to me to be entirely consistent with the Department's own findings in its 2015 review.

The respondents' positions

[104] A major theme of the Department's submissions was that, in Northern Ireland we benefit from an *integrated* system of health and personal social care and that this therefore renders any comparison with the position in England and Wales limited. The Department further submits that it was down to local Trusts to develop additional guidance on CHC and to ensure that appropriate assessments were undertaken, since the primary responsibility for such assessments rested with the clinicians. It operates at a strategic level and was not bound to descend into the detail of the application of the 2010 Policy.

[105] The Department's evidence in the case was provided by way of affidavit evidence from Mr Mark McGuicken, the Director of Disability and Older People. His affidavit addresses a number of the points highlighted above. It also summarises the consultation process which led to the 2021 Policy, including the delay in adopting that policy (which was affected by the absence of devolved government and Ministers from 2017 to 2020).

[105] On behalf of the Trust, an affidavit was submitted by Ms Gillian Traub, Director of Adult Community, Older People Services and Allied Health Professionals. This sets out in considerable detail the steps the Trust has taken to deal with Mr McMinnis' case. The Trust also submitted that it did expect some guidance from the Department in relation to CHC but that this was delayed, partly due to the political stalemate in the jurisdiction. As to the impugned decision of May 2021, it is submitted that this was a detailed and comprehensive clinical assessment about which no complaint can properly be made.

Procedural fairness in Mr McMinnis' case

The eligibility test and methodology/criteria

[106] A key feature of Mr McMinnis' claim is that the procedure to which his application was subject was unfair because of a lack of a clearly defined test or process governing when CHC would be granted. The panel's decision in his case records that the Department has not provided a definitive framework for determination of the eligibility for CHC in Northern Ireland and that the panel itself therefore "have had to develop its own methodology." As it explained in its decision:

> "In the absence of clear NI Guidance on the application for CHC, the panel has evaluated the NISAT against other established domains/criteria that are currently used in

> England and Scotland before the panel attempted to answer the question above."

[107] A preliminary issue is the extent to which a duty of procedural fairness applies in this context given the heavy overlay of medical assessment and clinical judgement which clearly exists. I have little hesitation in concluding that such a duty does apply, for a variety of reasons:

(1) First, although an assessment of eligibility for CHC is not, classically, the exercise of an administrative discretion, it is a decision which can and does have financial implications for individuals and also for the State, in terms of its liability to meet care charges at public expense. It involves an interface between the individual and a public authority which determines their respective rights and obligations, in circumstances where the medical assessment is not solely or mainly directed to the provision of treatment but, rather, who should pay for it. Some of the Trust's or Department's own documents refer to the decision-making process in terms which reflect this: for instance, the reference to a 'determination' in paras 17 and 88 of the 2010 Circular; and the reference to 'applicants' being 'awarded' CHC in the 2021 Circular.

(2) Second, the significance of the potential financial implications for the individual are such that a duty to permit effective participation in the decision arises, in my view.

(3) But third, and importantly, the 2010 Circular expressly envisages (at para 17) that the determination will be made "in consultation with the service user, his/her family and carers." In my view, this is not simply a reference to seeking information from the individual but to a process whereby they are entitled to be consulted on the question of whether, and why, they say they are eligible for CHC. Plainly this does not require the full panoply of procedural guarantees which the law might require in some circumstances; but it does require a basic understanding of how the relevant test operates and is to be applied. The *Grogan* case, discussed further below, suggests that a duty to act in a procedurally fair way arises (by reference to Charles J's acceptance that the unclear criteria in that case may amount to a failure to give adequate reasons).

(4) I reject the analogy drawn by the Department in its submissions with cases where a pure medical judgement about treatment is in issue (for instance, the decision in *R (YZ) v Oxleas NHS Foundation Trust* [2017] 1 WLR 3518); although it remains the case that the court will pay the highest regard to the bona fide professional judgement of responsible clinicians involved in the determination. For that reason, leave to apply for judicial review was refused in this case on a ground which sought to argue that the substance of the Department's eligibility decision was irrational in light of a variety of medical factors. The court could not begin to sensibly evaluate that issue, in my view. But the mere fact that the eligibility decision may have been left to clinicians by the Trust does not, in my

view, mean that procedural fairness does not or cannot apply. That is to be determined by the legal character of the decision and its effects. The approach followed in England & Wales demonstrates that a transparent and objective process can be adopted which allows clinical judgement its proper place. All manner of assessments, such eligibility determinations in respect of social security benefits, involve the exercise of clinical judgement to a greater or lesser degree. That does not mean that such assessments may not be subject to a requirement that the eligibility criteria (and how they are to be applied) are to be clearly set out; nor that they are immune from the usual requirements of procedural fairness. Indeed, in many such contexts there are elaborate arrangements for decision-making and onward reviews and appeals.

[108] On the key issue which lies at the heart of this element of Mr McMinnis' challenge, I am satisfied that there was no clear and accessible methodology applied to the question of CHC eligibility under the 2010 Policy for a variety of reasons:

(a) The 2017 consultation paper expressly noted (see para [38] above) that the Department had refrained from drafting guidance on a specific assessment to be used.

(b) The 2014 Age NI Report made the case that there was a lack of clarity as to how and when CHC would be granted, such that older people were being denied access to this facility.

(c) The Department's 2017 consultation paper accepted that it (the Department) had continued to receive queries from individuals, families, elected representatives and other stakeholders on the subject of eligibility for CHC.

(d) More importantly, the Department's own review found, candidly, that there was "confusion about continuing healthcare and its applicability" in this jurisdiction; and that there was variance between Trusts as to how they applied Departmental policy giving rise to a situation which could be described as a "postcode lottery." Elsewhere in the consultation paper, the Department referred both to a general lack of understanding about CHC in Northern Ireland and "the inequality issues for individuals which currently exist", arising from "a clear variance in practice across HSC Trusts."

(e) In the case of the Belfast Trust in particular, its own review response (see para [58] above) made clear its view that CHC was "not… easily definable" and suggested that it was applying a test which was higher than that envisaged in the 2010 Policy, if indeed it recognised the existence of CHC (outside the hospital setting) in this jurisdiction at all.

(f) Concerns in relation to the lack of proper guidance on the test were raised by a variety of other Trusts. The Northern Trust's response said there was "difficulty in determining eligibility due to lack of detailed guidance that goes beyond

statements in the 2010 Circular"; and that "the absence of specific criteria and guidance results in confusion for assessors, clients and relatives…." The Southern Trust said it would welcome "definitive… policy" in relation to this issue from the Department. The South Eastern Trust said the primary need criterion "would be easier to determine if there was a Regional threshold." It went on to explain that its panels determining CHC applications "found making decisions extremely difficult" such that "without clear policy direction there is a reluctance for staff to sit on these Panels."

(g) The review also found that some of the decision-making panels established for the purpose of determining CHC applications found the decision-making process difficult to such a degree that some Trusts simply gave up on the process (by way of 'temporarily suspending' it) until the Department provided additional assistance, which was not in the event provided.

(h) The fact that there was (as the Department accepted) a "much lower" number of individuals qualifying for CHC in Northern Ireland than one would expect when compared with the corresponding numbers in the rest of the UK also indicates to me that there was a problem here. Where the provision of CHC is potentially of such financial benefit to the individual, there is no reason to expect that applications for CHC assessment in this jurisdiction would be lower than in sister jurisdictions. Although the Department is correct that their figure did not include those who may be eligible but who received a care package at home, the likelihood of that number being high seems minimal (since, where the individual's primary need was for healthcare, it is unlikely that they would be content with a care package delivered at home, save for a small number of cases where very high levels of intensive nursing support are provided in that environment).

[109] I am extremely conscious that the assessment and classification of an individual's needs, where they have complex medical needs and perhaps a range of conditions, is not straightforward and is itself a complicated and specialist task. It is likely to be complicated further where the variety of needs or conditions with which an individual presents engage a range of medical specialties. I have therefore been careful to ensure that I do not simply read across the complexity of the task as equating to a lack of appropriate guidance so as to render the process unfair. Even accepting that the task is necessarily difficult, I have been clearly persuaded that not enough assistance was in place to allow the CHC system to operate rationally (that is, without arbitrary inconsistency) and fairly. In reaching this view, I have been highly influenced by the view from Trusts themselves, and those they charged with making the relevant assessments, that they simply did not know how to do it properly. The comparison with the high level of detail and guidance provided for the purpose of essentially the same assessment in the sister jurisdictions of England and Wales further underscores this point.

[110] In assessing what fairness requires in this context, I take into account the 2010 Circular's expressed aim that information about health and social care services and how to access them should be provided "in an accessible, informative and user-friendly manner which will assist those who may require support and/or services" (see para 10). That was clearly not the case in this instance.

[111] Moving from the general lack of clarity and guidance in this area which is described above to the particulars of Mr McMinnis' case, it is impossible to avoid the conclusion that the assessment panel in his case made the process up – both as to procedure and how his individual needs would be assessed against the primary healthcare criterion – as they went along. I emphasise that that is not in any way to doubt the professionalism, bona fides or conscientiousness of those involved: it is simply a reflection of what they did, doing their best, in the situation in which they found themselves. But from the perspective of fairness, it was not good enough.

[112] It is well known that the requirements of fairness are context-specific. In ascertaining what fairness requires in the present circumstances, it is by no means irrelevant to consider the following. First, the potential financial implications of a decision that an individual is, or is not, entitled to CHC may be huge for that person and/or their relatives. It can literally be the difference between losing a family home or life savings, or not. Second, decisions in relation to these matters are likely to be taken, as Ms Doherty submitted, at a time when the individual is particularly vulnerable, often having moved into residential care at a time of sadness and uncertainty, with added financial worry. Authority in this area establishes clearly that the requirements of procedural fairness are flexible, with what is required being tailored to the nature of the decision at issue and its context. Objectively speaking, however, the party affected should be afforded "a fair crack of the whip" (see *Spitfire Bespoke Homes Ltd v Secretary of State for Housing Communities and Local Government* [2020] EWHC 958 (Admin)). In my view, this involves knowing, to an appropriate level of detail, *why* your needs are not considered to amount to a primary healthcare need.

[113] The applicant relied upon the statement within the 2010 Circular (at para 12) that the assessment of an individual's need "should reflect the perceptions and wishes of service users and carers as well as their strengths and preferences." Plainly the wishes of service users cannot always be determinative, either in terms of service provision or indeed who will pay for any service. However, it is significant that para 17 of the 2010 Circular, which specifically concerns the determination of whether an individual's primary need is for healthcare or for personal social services (that is to say, the CHC eligibility assessment), envisages this decision being made by clinicians "in consultation with the service user" and/or his or her family and carers.

[114] Ms Murnaghan explained that the method adopted by the Trust had involved looking at all 12 areas of the RLT Model, considering the DST, and looking at a variety of other clinical assessments. It cannot be said that relevant considerations were left out of account; but what the Trust process amounted to was a mish-mash or amalgam

of a variety of different processes and assessments without any clear explanation or understanding of how the overarching question would be answered. The applicants contended, with some justification, that the RLT Model was a new introduction to the process (which was not referenced in the Trust's letter of 23 April 2021) and that they were not clear how it was used or how it fitted with the other tools or assessments to which the panel said it had regard. In addition, the panel had regard to the NIPSO IPA's report, which it said "did not find any evidence to support Mr McMinnis' primary needs being healthcare", which the applicants criticised since it was not the purpose of that report to carry out any such assessment.

[115] A discrete issue in relation to procedural fairness arose from the Trust having taken into consideration guidance issued by the Northern Trust in relation to CHC ("the Northern Trust CHC guidance"). This is a four page document which attempts to set out and clarify the eligibility test to be applied under the 2010 Policy. It draws on the NHS National Framework used in England and on the decision of the court in *R (Grogan) v Bexley NHS Care Trust* [2006] EWHC 44 (Admin) ("*Grogan*"). It includes the summary that, "CHCN can only apply where the service user's needs would normally have been met in a hospital environment and they require 1:1 supervision/interventions from a specifically trained Health Care Professional." The applicants contend that this is an erroneous statement of the legal position and/or one which has no basis in the 2010 Policy. It does appear to me to represent a fettering of the discretion set out in 2010 Policy; as does the later statement that "the task is to identify those service users who have needs much greater than what would be provided in a nursing home setting or by traditional nursing services." However, for present purposes, the more important point is that it was a further reference tool which was considered, without the applicant having been made aware of this in advance (it was not referred to in the correspondence of 21 April 2021 which preceded the decision), and which arguably required or proposed a different approach to that prescribed by some of the other tools (such as the DST) which the panel also said that it had taken into account.

[116] In summary, I accept the applicant's claim that his application for CHC was not determined fairly because, at the relevant time, the 'test' (such as it was) was so lacking in specificity or accompanying information or guidance as to result in a process in which the applicant could not effectively participate, as intended. That is *not* to say that the overarching test itself (whether he had a primary healthcare need) requires or required to be changed. Rather, it is simply to say that sufficient guidance had to be provided – but was not – to enable Mr McMinnis, and others, to meaningfully engage with the detail of the process and whether he met the eligibility requirement for CHC. This was required both as a matter of fairness to individuals seeking the benefit of CHC but also as a matter of rationality so as to avoid arbitrary and capricious outcomes as between individuals in materially similar circumstances.

[117] I would not characterise this – as the applicant did at points in his submissions – as an aspect of the requirement that the individual "know the *opposing* case." It is a basic aspect of fairness in a case such as the present, however, where an individual has

a right to participate in the decision-making, that they have a sufficiently clear understanding of the nature of the decision-making process in order to permit them to do so in an informed and meaningful manner. I do not accept the submission made on behalf of the Trust that the most the applicant could expect in this case was the chance to comment on the methodology that was to be used by the panel. I have already observed (see para [86] above) that this invitation might have been engaged with in a more collaborative spirit. But the fundamental point remains that the Trust was cobbling together a process – which ultimately involved having regard to a variety of different pieces of guidance, several of which did not speak with one voice – which was ultimately inscrutable for the individual most directly affected. That is not – I emphasise again – to suggest that the Trust or the MDT were acting otherwise than in good faith.

[118] I have been reinforced in this view by the *Grogan* case (*supra*) *v Bexley NHS Care Trust* [2006] EWHC 44 (Admin), in which a circular published in 2001 in England dealing with CHC was held to be unlawful in light of its failure to set out clearly "the test and approach to be applied." That circular itself followed on from the seminal case in this area of *R v North and East Devon Health Authority, ex parte Coughlan* [2000] 3 All ER 850, which deals with a number of the foundational concepts in this area. The claimant in the *Grogan* case, as here, was aggrieved at an assessment that he was not eligible for CHC. The guidance there was in much more detailed terms than the mere expression of the 'primary need' test in this case; but the key failing was that, whilst there were several criteria identified, overall there was a lack of clarity as to how the ultimate eligibility question should be answered. Charles J held at para [91] that "the Criteria gives effectively no guidance as to the test to be applied in determining whether the qualitative and quantitative factors referred to in it found a conclusion that the person falls within" a relevant category in which CHC was payable. He continued:

> "The decision maker is effectively left adrift on a sea of factors without guidance as to the test or tests he should apply to assess and weigh (in the words of the Criteria) *the nature or complexity or intensity of unpredictability and the impact* of an individual's health needs in determining the category into which the relevant person falls."

[119] The judge held, at para [94], that "by failing to give any effective guidance as to the test to be applied in making the required value judgment" the impugned criteria in that case were "fatally flawed." The position was not saved by reference to a variety of other materials relied upon or taken into account by the decision makers (see para [95]); nor by a variety of submissions about the complexity or nature of the task (see paras [96]-[97]). There still required to be a proper identification of the test or approach to be applied in reaching the judgements required. At para [101], the judge indicated that, to his mind, it did not matter whether the public law failing which he had identified was classified "as a failure to set proper guidelines, or a failure to apply the

correct approach at law, or a failure to give adequate reasons", the last of these of course being a species of procedural unfairness.

[120] The circular at issue in *Grogan* has since been replaced with the Decision Support Tool and guidance in England referred to above. Ms Murnaghan submitted that *Grogan* was not a case about procedural fairness, which is correct (with the qualification that Charles J would also have held that the approach there represented a failure to give adequate reasons). The issue in that case was about whether the criteria were so unclear as to be unworkable. But if a process of that nature is adopted, it is hardly likely to be fair to an individual who has a right to participate meaningfully in it. As is often the case, judicial review grounds may shade into each other. I was not persuaded that the respondents could meaningfully distinguish the *Grogan* case in a way which undermined the assistance which the first applicant can clearly draw from it.

[121] I also accept the applicants' submission that the integrated nature of the health and social care system in Northern Ireland does not have the significance the respondents ascribed to it in these proceedings. For present purposes, the CHC eligibility test (under the 2010 Policy) was the same as in England – namely that of "primary healthcare need" – and the question was asked for the same purpose, namely the question of where liability to fund the relevant care fell. The fact that, in England, this was a dispute between the NHS and a local authority, rather than between the NHS and a service user such as Mr McMinnis, is of no particular importance. It is true that there are elements of the guidance from other parts of the United Kingdom upon which the applicants rely which have no application or resonance here. But that does not apply to the fundamental nature of those documents, which is what is relevant for present purposes.

[122] The Trust has relied upon the fact that, after the impugned decision in May 2021, the Ombudsman was not persuaded that any further action on her part was warranted. In Ms Doherty's submission, having been dealing with this complicated issue for quite a while, and in the face of the Trust having not implemented her recommendation to adopt detailed guidance, the Ombudsman 'lost heart for the fight.' Experience of the Ombudsman's office may suggest that that is a rare complaint once the holder of that office has commenced an investigation. Whether or not that is so is of no moment, however, since NIPSO's view of the matter is not determinative as a matter of law. The Trust has also observed that Mr McMinnis has not pointed out, even in his case in the course of these proceedings, what additional submissions or representations he *would have* made if he had had a clear understanding of the eligibility and approach to be adopted. I do not consider that objection to carry the day. The onus is not on him to show that, had a fair procedure been adopted, the result would have been different.

[123] I should make clear, if it is not clear already, that nothing I have said in this judgment should be taken as any indication of whether or not Mr McMinnis is indeed eligible for CHC under the 2010 Policy. Ms Murnaghan took me to a number of pieces

of evidence in order to make good the suggestion that, although some of Mr McMinnis' conditions are distressing, they were matters which, with the correct support, could in fact be managed at home. Indeed, at one point, there was a suggestion that he was thinking about moving home, she submitted. This was designed to suggest that the substance of the decision in this case was sound. But that is not a matter for me, either in favour of or against the applicant. Certainly, I have not been persuaded to the high degree required that no relief should be granted to the first applicant because, if a fair and lawful process is followed, the outcome is bound to be the same. For the same reason, I express no view on the points made by Ms Doherty, which were said not to be exhaustive but illustrative only, of examples where it was argued that the assessment was obviously unduly unfavourable to Mr McMinnis in terms of recognising the complexity of his needs or applying the methodology set out in the DST (had that been considered determinative).

Further ancillary procedural complaints

[124] In addition, the first applicant complained that *his own carers* were not involved in the process of his CHC eligibility assessment. I do not consider this to have given rise to any illegality. It seems that the Trust took a decision not to involve anyone in Mr McMinnis' care in order to avoid pre-determination (or, one might suppose, a conscious or unconscious bias towards someone with whom they had developed a close relationship). That is an understandable concern, even if it might be considered to be overly cautious. The first applicant further complains that none of the panel who determined his case had any personal knowledge of his care and treatment; and that none were specialists in the areas of medicine most relevant to his conditions. In the English model, the DST states that the panel should "usually include both health and social care professionals, who are knowledgeable about the individual's health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual." Again, there is no specific legal requirement for this to be so; but the development of clear guidance for the decision-makers should reduce the scope for complaint in this area, provided they are sufficiently appraised of the individual's needs and circumstances, which can be achieved in a number of ways.

[125] Relatedly, the MDT also had no contact with Mr McMinnis in person, which in my view is very regrettable. Ms Murnaghan may have been strictly correct in her submission that the indication of the individual being "involved" or "consulted" does not necessarily mean that the decision-maker will meet them; and that this may be best practice but is not required. However, there may have been more faith in the process if the decision-maker(s) had actually had the opportunity to see Mr McMinnis and hear from him in relation to his own needs. In England, the DST (at para 5) provides that "the individual should be given a full opportunity to participate"; that they "should be given the opportunity to be supported or represented by a carer, family member, friend or advocate"; and that "the eligibility assessment process should draw on those who have direct knowledge of the individual and their needs." The guidance goes on (at para 14) to indicate that the individual should be invited to be present or represented wherever practicable. This is plainly best practice; and the more

engagement of this sort that there is the less likely the individual will be to feel that their case and circumstances have not been fully considered. I was not impressed by the contention that Mr McMinnis could (and should) himself have asked the panel to meet him, although again it may be strictly correct that he could have done so. In the redetermination which is required as a result of the quashing order to be made in this case, I strongly recommend that the decision-maker meet with Mr McMinnis.

[126] Insofar as the first applicant's case amounted to a submission (as in many respects it did) that the Trust was obliged to adopt precisely the same procedure as is envisaged in the English guidance documents, I do not accept it. There is no such legal obligation. The Trust is free to adopt whatever procedure it wishes provided that the resulting decision complies with public law principles, including that it is reached in a procedurally fair way, that all relevant considerations have been taken into account and that irrelevant considerations have been left out of account. In a decision of this type, where so much depends on the individual's needs, there will be a high burden to discharge that the case has been fully and properly considered where the decision-maker has not met with the individual or included carers familiar with their case, which is why I would recommend that such a meeting occur, at least in those cases which cannot readily be discounted as having no real prospect of establishing CHC eligibility under the 2010 Policy.

[127] The first applicant's submissions also touched upon the absence of any mechanism to review or appeal an adverse finding in relation to CHC eligibility. Interestingly, the Northern Trust guidance which was taken into account *does* suggest that there should be an appeal in relation to an unfavourable eligibility assessment. This discrete complaint was not pleaded, however. In any event, as with the matters addressed immediately above, I do not consider that the applicant has a legal right to any particular composition or identity of decision-maker, provided they act in a way which is consistent with usual public law principles. Nor does Mr McMinnis have a legal right to require the Trust to adopt the same decision-making structures as are set out in the English guidance. The procedure can still be fair even if this procedural model is not entirely replicated. I understand Mr McMinnis' concerns about the practicalities of the procedure being addressed on an ad hoc basis and as to the procedure adopted; but this, of itself, does not in my view give rise to any illegality.

The use of the NISAT

[128] A particular issue which has been raised in this case is the use of the NISAT assessment tool in the assessment of whether an individual qualified or qualifies for CHC. It is clear that the decision-making panel in Mr McMinnis' case did have regard to this – partly because it had been completed by practitioners who *were* personally very familiar with his case. In the 2017 consultation paper, the Department expressed the view that NISAT was "considered to be sufficiently comprehensive for care assessment purposes." The applicants are highly critical of this view, insofar as it is applied to CHC assessments, on the basis that NISAT is not designed to answer the key question of eligibility for CHC.

[129] NISAT is helpfully described and explained in the cover letter of 11 March 2010 to Trusts from the Department's Director of Primary and Community Care which enclosed the 2010 Policy. It is a tool which has been developed and validated, primarily in relation to assessing the needs of older people, to support the exercise of professional judgement in the care management process. It is said to be "designed to capture the information required for holistic, person-centred assessment." It is structured into component parts and uses domains which are completed according to the level of health and social care needs experienced, from non-complex to complex. There is obviously some overlap between the issues addressed for these purposes and, for instance, the domains addressed under the DST in England for the purpose of CHC eligibility assessment.

[130] There are three primary components to the NISAT assessment: the contact screening, the core assessment, and the complex assessment. The last two components have prompts to further specialist assessment, where necessary. There are also four additional components to be used in conjunction with the primary components: a specialist referral form, a specialist summary and recommendations form, a GP and medical practitioner report, and a carers' support and needs assessment. Some of these components are described in some further detail in the text of the 2010 Circular itself (see paras 15-16). This makes clear that the complex component of NISAT should only be used by professionals trained and supervised in complex assessment. A separate detailed guidance document, including a practitioner manual, on the operation of NISAT was also published.

[131] The applicants are concerned that NISAT is primarily directed towards the care management process. It is about assessing the services most appropriate to the person's needs and then seeking to ensure that those services are delivered. It supports the exercise of professional judgement in these spheres but is not directed towards the CHC eligibility question, nor does it direct practitioners to a structured analysis of the relevant information which is addressed to the nature of the *primary* need in the case. For instance, the Northern Trust's response to the Departmental review stated that, in its Trust area, "individuals are not assessed for eligibility for [CHC]." Rather, *needs* were assessed; and the assessment tool in use for that was NISAT.

[132] Central to the first applicant's complaint about the use of NISAT in this regard is correspondence between the Department and the Belfast Trust from September 2012 – which came to light during the NIPSO investigation – in respect of the use of the NISAT assessment tool in CHC assessments. In that correspondence, the Trust said this:

> "The Trust recognises that approaches to determining eligibility for CHC in England and Wales are very different and that there exists a range of specialist assessment tools in the area of continuing care eligibility. Locally our assessment tools *(NISAT) would not support this*

> *determination* nor are staff in a position to make this determination without definition or training."
>
> [italicised emphasis added]

[133] In the applicants' submission, this correspondence represents a 'smoking gun' as far as any continued reliance on NISAT is concerned as a tool for determining CHC eligibility. In their submission, it clarifies that NISAT is not capable of answering the eligibility question and is not therefore sufficient for the purposes of carrying out the assessment of CHC. In addition, they point to an averment in Ms Traub's affidavit to the effect that NISAT is a *general* assessment tool [the deponent's emphasis] which assists staff to establish what a person's assessed need is and what level of care and support they need. At no point does it direct the staff member completing it to record whether the individual's primary need is for personal social care or health care. The applicant submits that the NISAT assessment tool is not designed to answer the question of whether a person's primary need is for personal social care or health care. This seems to be a concern which was also shared by NIPSO.

[134] On the other hand, the Department appears to consider that the NISAT tool can be much more fundamental in this assessment. Its skeleton argument in these proceedings refers to the "presence of an assessment tool designed to assist the exercise of clinical judgement in the assessment of need" as a key feature in why there is (in its submission) a clear eligibility test, procedure and guidance (at para 26 of the Department's skeleton). This is plainly a reference to NISAT, as described in the 2010 Circular.

[135] My conclusion in relation to the use of NISAT is that it is certainly not unlawful per se to use that assessment tool in the course of a CHC eligibility assessment; nor to take into account the contents of a NISAT assessment. In Ms Murnaghan's phrase, it includes a significant amount of "raw data" which it can be useful to consider. The clinical input into a NISAT assessment is likely to contain a lot of information relevant to a CHC eligibility assessment. However, it would be unlawful to use NISAT as the sole or main tool for the purpose of determining CHC eligibility. This is because it is simply not designed as a tool for the answering of the key question and does not, of itself, contain sufficient guidance to allow that question to be answered in a way which is fair and rational (in the sense of ensuring consistency within and between Trusts), having regard to the requirements of procedural fairness in this context. That is, in effect, simply a further outworking of the conclusion I have already expressed at para [116] above.

The Department's responsibility for the lack of clear guidance

[136] The level of information and guidance provided by the Department in relation to CHC was minimal. There is evidence to suggest that some individuals *may* have qualified for CHC under the 2010 Policy but were either completely unaware of the concept or availability of CHC or, perhaps worse, were misinformed that it did not exist in this jurisdiction. The Belfast Trust's 2015 review response indicated that no

requests for CHC assessments had been received between 1 April 2011 to 30 September 2014. Given the size of the Trust's area of responsibility and the population within that area, this seems surprising.

[137] The applicant's case on procedural fairness was focused against the Trust, as it was the Trust which determined his application for CHC. The Ombudsman directed her finding against the Trust since it was the Belfast Trust which was the subject of Mr McMinnis' complaint of maladministration. It was her view that, in the absence of more clear Departmental guidance, or any prospect of it being developed soon, the Trust had to fill that gap. There is force in the applicants' submission that the Trust sought to remedy the position in Mr McMinnis' case but did not do so more generally in compliance with the Ombudsman's other recommendations; although, in the Trust's defence, it is able to point to the NISPO acceptance of the ad hoc process it had adopted (see paras [89]-[90] above). On one view, a finding that the Trust has acted with procedural unfairness in its assessment of Mr McMinnis' application is all that is required in order to dispose of his case, by means of requiring that assessment to be re-taken in a fair way, with a more transparent approach to how the eligibility question is assessed.

[138] But, in my judgement, that would be to unfairly lay sole or primary responsibility at the door of the Trust when, in reality, the Department has been responsible for a plain dereliction in its duty in this sphere. The Trust responses, in 2015, to the Department's own review were such as to show that there were huge problems with the administration and effectiveness of the 2010 Policy on CHC contained within the 2010 Circular. An overwhelming theme was that Trusts did not know how to address CHC or determine who was eligible for it. Remarkably, some Trusts (such as the Belfast Trust) went as far as to suggest that it did not apply in this jurisdiction. The Department's ultimate response was – some six years later – to scrap CHC in the form in which it existed from 2010. However, it did nothing in the meantime to address the obvious problems which had arisen which were giving rise to anguish on the part of many individuals and families who had (perhaps against the odds) become *aware* of CHC and how it might operate but who were denied any fair opportunity to access it (in the event that their case fell within the limited category of cases where CHC was to be afforded).

[139] This failing was pleaded as an instance of irrationality as well as procedural unfairness and, indeed, I consider that it could properly be characterised as a course which no reasonable Department would adopt: to stand by and decline to issue guidance when, as a result of its own review, it became clear that Trusts, both internally and as between each other, were in an utter state of disarray and inconsistency in seeking to apply the 2010 Policy. Some had given up on carrying out assessments pursuant to the Department's 2010 Policy. NIPSO further highlighted the hugely unsatisfactory state of affairs which had been permitted to come about. I am satisfied that the Department's resolute failure to seek to ameliorate the situation by way of providing regional guidance was unreasonable in the *Wednesbury* sense. There was no logical reason whatever why it would not seek to bring some clarity to the way

in which CHC eligibility was to be assessed and determined unless, unlawfully, it was pursuing an improper purpose of seeking to hide the potential entitlement to which the 2010 Policy gave rise. When it adopted the 2021 Policy, with the express aim (contained in the very title of the policy) of *introducing a fair and transparent system*, it effectively accepted that it had permitted an unfair system which lacked transparency to pertain up to that point. The 2021 Policy may have corrected matters going forward but did nothing to assist those who had made applications under the 2010 Policy.

[140] I am reinforced in this view when one considers the context of the important statutory obligations imposed upon the Department by section 2 of the 2009 Act. As noted above (see para [7]), these obligations expressly direct the Department to develop or formulate policies and principles at a strategic level with a view to reducing health inequalities, to guiding HSC Trusts in the discharge of their functions, and to securing effective co-ordination in the areas of health and social care. The Department's failure to act here was the antithesis of that.

[141] I have considered the cases relied upon by the respondents, particularly *R (BF (Eritrea)) v Home Secretary* [2021] UKSC 38, and accept that there is no general duty to give guidance at common law. In this instance, however, that general principle has been displaced by the particular statutory context discussed above, in which the Department was under express statutory obligations to produce policy at a central or strategic level. This is not a case where a Minister is being requested to issue policy guidance in an attempt to eliminate uncertainty in relation to the application of a stipulated legal rule, as in *BF*. Rather, it is a case where the Department was being requested to clarify its own policy for the very statutory purposes which those duties were designed to secure. An aggrieved applicant for CHC cannot apply to the court to enforce the correct application of the CHC eligibility test as it is not a matter of law (cf. para [52] of the *BF* judgment). The obligation to avoid the lack of certainty under which Trusts were labouring fell to the Department.

The interim charging issue

[142] A further strand of the first applicant's case – which I refer to as 'the interim charging issue' – was that the Trust should not be allowed to charge Mr McMinnis (or any applicant for CHC under the 2010 Policy) for personal social care between the time when they made a CHC application and the (lawful) determination of that application. The basis for this argument is that, unless and until the CHC eligibility assessment has been undertaken, it is not known whether the individual's primary need is for healthcare or social care; and that the Trust cannot simply proceed on the assumption that the primary need is social care without having properly determined that question. A cornerstone of this argument is the contents of paras 63 and 64 of the 2010 Circular (set out at para [27] above). The argument proceeds as follows: (1) there is no authority to charge for healthcare provided in the community; (2) a financial assessment can only be made after an assessment of the user's needs has been completed; and (3) that assessment must occur before charges can be made because, otherwise, a successful

CHC applicant may have been wrongly or unlawfully charged for healthcare pending the determination of their application.

[143] The first applicant draws support for this argument from the Ombudsman's report in his case. In the course of that report, she said this:

> "Without a process for determining whether they are eligible for CHC, applicants may be wrongly required to make significant financial contributions to their care… The Trust's ability to charge for care must be based on a determination that personal social services are being provided. There is an affirmative obligation on the Trust to make this determination when an applicant requests a CHC assessment, before charging the applicant for care."
>
> And later:
>
> "… I am concerned that the Trust continues to charge the complainant without having made a determination on the complainant's primary need – either for health, or personal social services – the Trust has no basis for determining the complainant's primary need is personal social services. The Trust has accepted that the necessary multidisciplinary assessments are a pre-requisite for determining primary need. Without these assessments, I can see no basis for the Trust to charge the complainant for care."

[144] There is a superficial attraction to this argument but, ultimately, I cannot accept it. This is for two important reasons. First, I accept the respondents' submission that the reference in para 64 of the 2010 Circular to "an assessment of the service user's health and social care needs" is not referring to a CHC eligibility assessment. Rather, it is simply referring to the normal assessment made in each individual's case, as part of the care management process, of how the individual's needs should be met and what services they require. (In this regard, I note that the word "assessment" is defined in the Glossary of Terms in Annex D to the 2010 Circular as the "process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated…"). As a matter of common sense, no financial assessment can be made until it is clear what services the individual will be accessing; and it makes sense to conduct a financial assessment (looking at the resident's means pursuant to the 1993 Regulations) *after* their care needs and a suitable placement have been considered, so that their means play no part in that assessment.

[145] Para 64 of the 2010 Circular is not specifically dealing with eligibility for CHC but is of much wider application. I consider this to be the ordinary and natural reading of that paragraph; but, in addition, I do not consider that it could have been the intention of this provision that no charges could be made in respect of care provided

in the community pending a CHC eligibility assessment. In many cases such an assessment will not be required. The evidence in this case established that these assessments can be very complicated and take lengthy periods of time. If the applicant's approach was correct, service users could potentially avoid the imposition of any charge simply by making and prolonging a CHC application, even where that application was entirely speculative or totally lacking any prospect of success.

[146] The second reason is that it seems to me entirely reasonable for the Department to proceed on the interim basis, where a CHC application is made, that it is social care which is being provided in the community (or, put another way, that the primary need is one of social care) unless and until it is established that the individual's primary need is one of healthcare. Even taking into account the fact that the numbers of those in receipt of CHC in Northern Ireland are comparatively lower than in sister jurisdictions, and that this may be a result of the absence of clarity or guidance discussed above, it is a matter of common sense that the significant majority of those receiving care in the community will not be persons whose primary need is for healthcare. Further, this assumption, which is implicit (if not explicit) in para 63 of the 2010 Circular, is also reflective of the basic requirement – in Articles 36(3) and 99(1) of the 1972 Order - that accommodation in a residential care home or nursing home should be paid for by the service user (subject to their means).

[147] It will be apparent from the discussion elsewhere in this judgment that I am not persuaded by the suggestion that only those being treated in hospital may have a primary healthcare need. Certainly, that was not the position which follows from the Department's 2010 Policy. For many years it has been recognised, both in this jurisdiction and others, that there will be those who are provided with care in the community (largely, although not necessarily exclusively, in residential nursing homes) whose primary need is one of healthcare. That position did not simply stop in 2021. However, Ms Murnaghan described the position as being that there is a presumption that, where an individual is accommodated in a nursing home, there is some nursing care (catered for by payment of the flat rate) but that the primary purpose of their being there is to receive social care rather than CHC. As an interim assumption, it is in my view reasonable for the Trust to take the view that a person receiving their care in the community does not have a primary healthcare need unless and until that has been determined to be the case. 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.

[148] However, where an application for CHC under the 2010 Policy has been determined in the individual's favour, the effect of para 63 of the 2010 Circular is that that individual should not be charged and should not *have been* charged for any care which is properly to be regarded as healthcare. In my judgement, that is not only prospectively from the date of the assessment but, rather, for all care which in light of the assessment is properly to be regarded as healthcare. What that may in practice

require is a refund to the individual where, pending the CHC eligibility assessment, they have been charged for social care services which (in light of the assessment) are properly to be viewed as representing CHC to meet a primary healthcare need. Just as it would be wrong for the Trust to view this only as applying at and after the date of the assessment, which might incentivise delay on the part of Trusts in making such assessments, it would also be wrong to treat this as necessarily applying from the date of the individual's application for CHC having been submitted. There may be cases where, in fact, once the CHC eligibility assessment is completed, it is clear that the individual's primary need was one of healthcare from a time pre-dating their application for CHC. In other cases, it may well be the case that the individual's primary need was not one of healthcare at the time of their application but, due to some deterioration in their condition before the assessment was completed, their primary need became a healthcare one at some time between the date of application and assessment.

[149] I am conscious that consideration of this issue might add a further level of complexity to what is already a difficult assessment. However, the nature of the statutory scheme and the Departmental arrangements is that an individual should not be charged for healthcare (or elements of social care which in light of the 2010 CHC Policy are properly to be viewed as an overall healthcare package) and it is therefore incumbent on those making such an assessment to seek to ascertain whether, and the extent to which, an individual has been wrongly charged for healthcare. Where that has occurred, a refund should be made. Insofar as the Trust has refused to accept the possibility of a refund in appropriate circumstances where eligibility for CHC has been established, I consider that to be unlawful. However, in the course of her submissions, Ms Murnaghan made the entirely proper concession that, where eligibility for CHC is established, there was a good case that the service user would then have to be given a refund of healthcare costs which they had been required to pay.

[150] It goes without saying that all of this points towards the need for speedy resolution of claims for CHC under the 2010 Policy. That is another reason why fairness – and indeed simply the principles of good administration – required more clear guidance as to how such assessments should be undertaken, which ought inevitably to expedite the process. In cases where, as the evidence suggests has occurred in some instances, an unreasonably long period of time passes without an eligibility assessment having been made where this has been requested, this may be unlawful, either representing a species of *Wednesbury* unreasonable behaviour or by virtue of giving rise to procedural unfairness. It also seems to me that where, as the evidence suggests has also occurred, an individual who has requested a CHC assessment sadly passes away before it is completed, it remains incumbent upon the Trust to conclude the assessment and make a determination under the 2010 Policy. Otherwise, the individual's estate may be improperly and unlawfully deprived of funds which had been expended on the individual's care in circumstances where, properly viewed, the individual ought not to have paid for that care since it ought to have been state-funded as continuing healthcare.

[151] It follows from the above that I do not accept that it was unlawful for the Trust to charge Mr McMinnis for his care as if he was not eligible for CHC up to 28 May 2021. In the event, however, that his application is successful (on foot of a further process adopted in view of the relief granted in these proceedings), he should be refunded the sums which, with the benefit of hindsight, he should *not* have been required to pay during that interim period.

[152] Nothing I have said above should be taken as imposing a requirement upon a Trust to so charge whilst a CHC application under the 2010 Policy is being considered. There may be cases where the application is so likely to succeed that the Trust chooses to adopt the contrary presumption; or some half-way house may be agreed, provided that once the position is authoritatively determined by the assessment process an appropriate reconciliation then occurs. I do not consider it unlawful, however, for a Trust to proceed on the basis that the primary need is one of personal social care until the contrary position has been assessed.

[153] This aspect of the first applicant's case is closely allied to his contention that his A1P1 rights have been violated. He draws attention to the fact that he has been required to pay over £110,000 in respect of his care to date due to his ineligibility for CHC. He does not contend that the levying of charges for personal social care is unlawful of itself; nor is the legality of the charging provisions under challenge. However, the applicant does submit that the charges imposed upon him are not in accordance with law by reason of the lack of clarity in the test and procedural unfairness in the process.

[154] This is not a classic case of deprivation of possessions by the state, in the form of a mere tax or by way of confiscation. Here, the charges levied are for the provision of services, in the form of personal care. There is no challenge to the governing statutory provisions, including those that mandate recovery of charges for accommodation provided by way of social care. Mr McMinnis has no A1P1 right to eligibility to CHC. The kernel of his A1P1 challenge ultimately boiled down to a complaint that it was unfair to charge him in the absence of a CHC eligibility process which complied with the Convention's 'quality of law 'requirements. I accept Mr McGleenan's submission that absolute certainty is not required in this regard (see, for instance, paras 141-143 of the Grand Chamber's decision in *Centro Europa 7 SRL and Di Stefano v Italy* (App No 38433/09)). There may often have to be tests applied which are, to some degree, vague and whose interpretation and application are questions of practice. I have found that, at common law, the procedure adopted in Mr McMinnis' case was unlawful. However, there is clearly statutory authority for the applicant to be charged for care accommodation (minus a contribution for nursing care); and I have also held above that it is not unlawful for the authorities to work from the starting point that accommodation in a care home in the community involves that accommodation being provided as a means of social care, *provided* decisions in relation to CHC eligibility are progressed within a reasonable period of time and a refund is available where, once that assessment has been made, it becomes clear that accommodation costs should have been borne at public expense though the 2010 CHC

Policy. I do not consider this to result in a situation where the Convention's human rights protections are breached.

The challenge to the 2021 Policy

[155] An originally pleaded challenge to the Department's failure to issue guidance in relation to the 2021 Policy fell away. As noted above (see para [56]), the Department has now issued guidance in relation to the new policy. There is, however, still a challenge to the legality of the 2021 Policy, mounted on two bases, by the Commissioner.

[156] In the first instance, the Commissioner mounts a frontal attack on the legality of the policy. In this regard, I have been directed to the decision of the UKSC in *R (A) v Secretary of State for the Home Department* [2021] UKSC 37 as setting out the approach which should be adopted by the court when asked to rule on the legality of the contents of a policy document. The key question is whether the policy authorises or approves unlawful conduct by those to whom it is directed. At para [46] of the judgment, the Supreme Court helpfully summarised the position:

> "In broad terms, there are three types of cases where a policy may be found to be unlawful by reason of what it says or omits to say about the law when giving guidance for others: (i) where the policy includes a positive statement of law which is wrong and which will induce a person who follows the policy to breach their legal duty in some way (i.e. the type of case under consideration in *Gillick*); (ii) where the authority which promulgates the policy does so pursuant to a duty to provide accurate advice about the law but fails to do so, either because of a misstatement of law or because of an omission to explain the legal position; and (iii) where the authority, even though not under a duty to issue a policy, decides to promulgate one and in doing so purports in the policy to provide a full account of the legal position but fails to achieve that, either because of a specific misstatement of the law or because of an omission which has the effect that, read as a whole, the policy presents a misleading picture of the true legal position."

[157] The Commissioner submits that the first and third prohibitions have been contravened in this case. It is said that the 2021 Policy authorises and approves decision-makers unlawfully by levying charges on those whose primary need is healthcare when they are resident outside hospital.

[158] The mainstay of the Commissioner's challenge to the substance of the policy is that it will result in individuals (many of them, older people) having to pay for care which represents *health* services, rather than *personal social* services. That is to say, there

will be cases where the individual's health needs go far beyond the £100 per week flat rate nursing contribution. Put another way, if, prior to May 2021, there were individuals whose primary need was for health care, albeit they were not in hospital, that category of person will now end up being charged for health care services which they would not have been required to pay for under the 2010 Policy. This, it is contended, is directly contrary to the legal position established by the statutory provisions analysed above, as correctly summarised (the Commissioner submits) in para 63 of the 2010 Circular. The definition of health care has not changed; but persons who previously were viewed as not having to pay towards their care, because it was health care, will now have to.

[159] It goes without saying that, within the bounds of legality (prescribed principally by statutory provisions which operate in this area), it is no part of the court's function to dictate or seek to influence the policy choices made by the Department, for which the Minister is responsible to the Northern Ireland Assembly. It is by now also well established that it is in principle permissible for different jurisdictions within the United Kingdom to adopt different approaches to issues of healthcare provision. That is in the nature of devolution: see generally *R (A) v Secretary of State for Health* [2017] UKSC 41.

[160] The Department's case is that the new single eligibility question is a policy choice which was open to it, and which is designed to facilitate a range of public interests. In its submission, the new approach "does no more than determine when care costs will be met in full, it does not authorise the levying of any charges for healthcare in Northern Ireland." In the Department's submission, healthcare remains free of charge.

[161] It is possible that all those with a primary health need (some of whom might previously have been discharged to care settings in the community) could be accommodated in hospital, if there were sufficient hospital beds and resources to permit this. It is also possible that the Department might lawfully change its policy to one which is less generous – no longer covering the personal care costs of those who might previously have been considered to have a primary health need but where, on more detailed analysis, *some* of the costs relating to their care could properly be determined to be for personal social services. The one absolute is that the individual should not, under the present arrangements set out in the 2010 Circular (even as amended by the 2021 Circular), be required to pay for healthcare. Although, as I have also pointed out above (see paras [12]-[13] and [20]-[21]), that position arises from the policy adopted by the Department (summarised in para 63 of the 2010 Circular) and *not* necessarily from a bright-line statutory prohibition. The position is complicated, however, by the fact that both Articles 36 and 99 and the 1972 Order do prohibit charging, through residential care charges, for registered *nursing* care.

[162] The true issue in this case is that the Department has changed its position on when it will fund certain personal social care. It remains the case, and the Department accepts, that it should not charge for healthcare provided outside a hospital setting.

That is the reason why, where healthcare is provided in a nursing home, the Department will continue to pay the flat rate mentioned within paras [39] and [46] above. That gives rise to the question – which might well be the other key issue brought into focus by the Department's change in position – of whether the flat rate really is appropriate to cover the cost of healthcare provided in the community in every case. To take a hypothetical case: if Patient A's needs are 49% healthcare needs and 51% social care needs, they may not have been eligible for CHC (ignoring for the moment the fact that the determination of primary healthcare need does not depend upon this type of simplistic arithmetical analysis) but it may be questionable whether the flat rate contribution truly covers that element of their care in the community which represents healthcare. To take another hypothetical case: if Patient B's needs are 75% healthcare needs and 25% social care needs, they might well have been eligible for CHC under the 2010 Policy. In certain circumstances, they might be able to have their healthcare needs met in a nursing home (since that will depend not merely on the extent of their healthcare needs but also on their complexity and severity). It is such a person to whom the Commissioner's challenge is, in my view, really directed. I have grave doubt that the flat rate contribution would in fact cover healthcare provision in such a case but do not have the evidence before me to begin to assess that in any given case, much less as a matter of generality. Indeed, the second applicant's case was not set up in that way. There would appear to be good sense, however, in the principle and level of the flat rate nursing contribution being reconsidered if the Department chooses to maintain the 2021 Policy.

[163] In principle, however, it is not necessarily unlawful for the Department to abandon its previous position that, where an individual's primary need was healthcare, it would meet *all* of their costs (treating any social care costs as being subsumed within an overall healthcare need). Provided the Department does not breach the prohibitions in Articles 36(4)(a) and 99(2) (now Article 99(2A)), it is free to seek a more accurate disaggregation of health care costs and social care costs; and, indeed, would also be entitled to charge for certain healthcare (which did not fall within the prohibition against charging for registered nursing provided in the course of residential care) under Article 7(2) of the 1972 Order.

[164] In short, the Department is not required as a matter of law to retain the same approach to CHC as was set out in the 2010 Policy. It is free to change its approach, within the limited legal constraints which operate upon it.

[165] In addition, the Department made an objection that this aspect of the Commissioner's case was the type of issue which can only properly be advanced against a concrete factual scenario, rather than in the abstract. I consider there to be force in that submission.

The section 75 issue

[166] The other aspect of the Commissioner's challenge to the adoption of the 2021 Policy was procedural in nature and is grounded on the Department's obligation,

under section 75 of the Northern Ireland Act 1998 (NIA), to have due regard to the need to promote equality of opportunity between persons with particular protected characteristics, including persons of different age.

[167] There is no procedural challenge in this case in relation to the legality of the consultation process which preceded the adoption of the 2021 Policy, notwithstanding that it might be said that the Department was not up front about the purpose and effect of its proposed preferred option. I also have considerable sympathy for the applicants' submission that Option 2 – use of the Decision Support Tool Model used in England – was rejected on a flawed, indeed irrational, basis (namely that it would not address the issue of regional variance because the exercise of clinical judgement would still be required, which seems to me to be illogical). However, these points were not pleaded grounds. The Commissioner's procedural challenge was confined to the section 75 issue.

[168] The Commissioner's evidence is that it is undoubtedly clear that the single eligibility question which forms the cornerstone of the 2021 Policy is more straightforward to understand "but the price to pay for the simplicity is the fact that it effectively limits CHC to a hospital setting, care in which is free of charge in any event." The effect "is equivalent to the revocation of the CHC scheme altogether." In the course of the Commissioner's consultation response, he outlined that his office considered that a full equality impact assessment should be carried out. It was his clear view that the proposal would potentially seriously adversely impact more upon older people than any other age group in society given that the ageing population in Northern Ireland are more likely to require assistance with health and social care needs, particularly in a nursing home setting, and also more likely to have accumulated savings (such as a mortgage-free home and/or a pension).

[169] These are not mere unevidenced assumptions. In response to consultation responses, the Department issued an updated equality screening document dated 4 February 2021. The document noted that, as at 30 June 2016, there were 12,368 residential and nursing care packages in effect. Of this, 10,077 (some 81%) of service users were in the Elderly Programme of Care. It was also noted that ageing of the population was set to continue. The screening document considered that:

> "Therefore, older people requiring residential or nursing home care may be impacted to a greater extent by the proposed revisions to the current policy."

[170] Similar observations were made about those with a disability. There was no evidence that there would be any differential impact on any of the other section 75 groups. When the likely impact on the equality of opportunity of those within the section 75 category of 'age' (and 'disability') was addressed, however, the screening document concluded that the policy was assessed as having a minor differential impact on older people, classifying this differential impact as positive. It further indicated that a decision was taken not to undertake a full EQIA as "… no evidence

has been identified to show that the proposal will have a differential impact on any of the Section 75 Groups." The impact of the policy was summarised as "no impact." The document went on to say:

> "Concerns were also expressed that the proposed policy would seriously impact the elderly more than any other age group in society. However, the policy will be based on assessed need and will be applied equally across all Section 75 categories."

[171] As the Commissioner's submissions pointed out, the fact that a policy may be applied equally to all is no basis for screening it out for equality-proofing, since one of the key purposes of such an exercise is to assess whether there is a disproportionate effect, which might amount to indirect discrimination, on one particular group, which is masked by the characteristic-neutral application of the policy. The second applicant contends that Mr McGuicken's evidence on behalf of the Department does not seek to explain the rationale for the conclusion that the impact on equality of opportunity for those falling within the section 75 'age' category was likely to be 'minor' and 'positive' in nature. The screening out of the new policy for full equality assessment has, the second applicant submits, meant that possible mitigations in respect of the disproportionate adverse impact the policy will have on older people have not been considered fully or at all.

[172] There are a number of authorities in this jurisdiction which hold that judicial review challenges based on section 75 of the NIA should not be permitted to proceed where they can and should be pursued by way of complaint to the Equality Commission under the enforcement procedures for non-compliance with an equality scheme under Schedule 9 to the NIA. The most significant, and seminal case in this regard, is that of *Re Neill's Application* [2006] NICA 5. The portion of that judgment upon which the Department relies is found at paras [27]-[29]. At para [30] the Court of Appeal went on to say this:

> "The conclusion that the exclusive remedy available to deal with the complained of failure of NIO to comply with its equality scheme does not mean that judicial review will in all instances be unavailable… It is not necessary for us to reach a final view on this argument since we are convinced that the alleged default of NIO must be characterised as a procedural failure. We incline to the opinion, however, that there may well be occasions where a judicial review challenge to a public authority's failure to observe section 75 would lie. We do not consider it profitable at this stage to hypothesise situations where such a challenge might arise. This issue is best dealt with, in our view, on a case by case basis."

[173] More recently, in *Re Stach's Application* [2020] NICA 4, the Court of Appeal recognised that the approach in *Neill* is a "strong general rule" (see para [117] of the judgment of McCloskey LJ). I granted leave to apply for judicial review on this ground, notwithstanding the case law referred to above, on the basis that it was arguable that the breach in this case was so egregious as to fall into the exceptional category where the court would be prepared to consider the claim. The second applicant claims that the breach of the section 75 obligation in this case is a "substantive" breach, rather than a procedural issue, falling within the residual category of case envisaged in *Neill* in which exceptionally judicial review will be appropriate.

[174] Regrettably, little guidance has been provided by the Court of Appeal, or even in first instance decision-making in the High Court, as to the type of cases where, notwithstanding the strong general rule against entertaining such claims in judicial review, the courts will proceed to examine a claimed breach of section 75. The single example where this appears to have been done is in the judgment of Maguire J in *Re Toner's Application* [2017] NIQB 49 (see, in particular, para [163] of that judgment). In that case, the judge considered that the underlying issue was "the substantive issue of the potential safety of a section of the public" (the blind and partially sighted). It was clearly appropriate that a careful consideration of their position was undertaken. The judge held that, unfortunately, the public authority concerned had "failed to comply with their section 75 duty in a far greater way than some simple technical omission or procedural failing", including after the matter had become one of "high controversy."

[175] Having considered the case-law, it seems to me that the following are broad principles which might be gleaned from the authorities on this issue:

(1) A court will rarely permit a section 75 claim to proceed by way of judicial review. The strong general rule is that such claims should be pursued by way of complaint to the Equality Commission under Schedule 9 to the NIA for failure to comply with the authority's equality scheme, which is the primary means by which provision is made for the discharge and enforcement of the section 75 duty.

(2) Nonetheless, the court retains a discretion – reflecting its discretion to hear and determine a case even where an effective alternative remedy exists – to allow a section 75 claim to proceed by way of judicial review. The governing principle expressed by the Court of Appeal in *Neill* is whether the alleged breach is procedural or substantive; but, in light of additional authority post-dating *Neill*, it is clear that something exceptional is required.

(3) The result is that a court will very rarely permit a section 75 claim to proceed by way of judicial review where the complaint is about the conduct of a full EQIA. Where a full EQIA has been carried out, it is likely that any complaint

about the content of that exercise will be a matter of detail better addressed by the Equality Commission.

(4) Different considerations *may* apply where the complaint is essentially that, by means of the approach taken to an equality screening exercise, or by not conducting a screening exercise at all, the public authority concerned has simply side-stepped any proper equality assessment of the policy or decision under consideration.

(5) Even then, this will often be a matter to be pursued with the Equality Commission. It may, however, be appropriate for the court to intervene in such a case where:

(a) the approach adopted, by which the impugned decision has been 'screened out' of equality assessment, is arguably irrational on its face or amounting to bad faith; *and*

(b) the impact on a protected group is likely to be particularly serious (for instance, giving rise to objectively very significant detriment to them, such as physical danger in the *Toner* case or other significant adverse impact, rather than something such as mere offence or inconvenience).

[176] Put another way, it may be appropriate for the court to intervene where there is a particularly egregious failure to equality-proof a decision, which can easily be addressed as a matter of legal argument without requiring detailed analysis, and where the consequences for a protected group are so serious as to merit action by the court, rather than requiring the complainant to proceed to the Equality Commission and then to the Secretary of State.

[177] *Toner* was, in my view, a case where the above approach – which ought still to be applied strictly – was evident. So too, in my view, is the present case. I do not accept the stark submission made on behalf of the Commissioner that it could not be said at all that the simplification of CHC policy had no positive impact whatever. It would, at least, remove much of the uncertainty about the parameters of CHC provision which previously pertained. Nonetheless, I do accept his submission that the Department's equality exercise, such as it was, failed to grapple in any meaningful way with the gravamen of the new policy, which was to remove any possibility of CHC funding where an individual was cared for in a non-hospital setting. The Department's focus was on simplifying the test, rather than recognising that this would (at least potentially) significantly alter the parameters of CHC provision.

[178] When that consequence is understood, it can properly be said to be irrational in my view to characterise the effect on older people as being only minor and positive. For older people who would or might lose out on CHC eligibility, it would have very significant financial consequences which might lead to the loss of life savings or a family home.

[179] It follows from the analysis above that it may well not be unlawful for the Department to adopt the new policy which it has in terms of CHC; but where it was effectively abolishing this type of funding arrangement in the community, it should have faced up to that fact and fully and fairly examined the implications and impact of it doing so. The centrality of a proper Departmental understanding of these issues is underscored by its obligation under section 2 of the 2009 Act to develop policies to reduce health inequalities between people in Northern Ireland. The equality exercise in this case was, in my view, such as to unlawfully evade the Department's section 75 duty.

Conclusion and relief

[180] For the detailed reasons given above:

(a) I propose to quash the Trust's decision of 28 May 2021 by which it determined that the first applicant was not eligible for CHC, on the basis that this was procedurally unfair to Mr McMinnis. I will remit determination of that issue to the Trust for reconsideration.

(b) I further propose to quash the decision of the Department to adopt the 2021 Policy on the basis that it was adopted in breach of its obligation to have due regard to the need to promote equality of opportunity between persons of different age under section 75 of the Northern Ireland Act 1998. The screening exercise undertaken in this case, regrettably, did not begin to properly consider the true impact of the new policy on older people.

[181] It follows from my conclusions and reasoning above that, before a lawful decision is made on Mr McMinnis' application, a clearer methodology will have to be set out, in advance, with which he (or his relatives or carers on his behalf) can meaningfully engage in the sense envisaged by para 17 of the 2010 Circular; and in accordance with the requirement of procedural fairness that an applicant with the appropriate capacity should be able to understand the methodology involved in the assessment of whether the overarching criterion of primary healthcare need is met.

[182] Although it primarily falls to the Trust to rectify this issue in Mr McMinnis' case in the first instance, I also propose to grant a declaration that, in failing to provide guidance to HSC Trusts in this regard, the Department acted unlawfully (for the reasons given at paras [138]-[141] above). Given that a number of Trusts may still have historic applications which require to be addressed under the 2010 Policy, urgent consideration should in my view be given to remedying this situation. Indeed, in light of the quashing of the 2021 Policy, there may be further historic, or more recent, applications which require to be addressed under the 2010 Policy, pending the adoption of a new policy which has been the subject of lawful consideration.

[183] For the reasons given in relation to the interim charging issue, I do not propose to grant any more intrusive relief in relation to the present charging arrangements for Mr McMinnis' care or the claim for damages. It should be obvious from what is said above that the redetermination in his case should be undertaken as soon as practically possible, consistently with the requirement to rectify the procedural fairness issue identified above. In the event that Mr McMinnis was ultimately adjudged to be eligible for CHC – about which this judgment says nothing – then a refund of costs which he has paid for care which was driven by a primary healthcare need should be provided to him, from the date (as best can be determined) of when his eligibility for CHC first arose.

[184] I will hear the parties on the issue of costs and the terms of the court's final order.