DRN-5102948

## The complaint

Ms P complains about the way Vitality Health Limited handled a claim she made on a group private medical insurance policy.

## What happened

The background to this complaint is well-known to both parties. So I've simply set out a summary of what I think are the main events.

Ms P is insured under her employer's group private medical insurance policy. The scheme includes mental health cover.

In January 2024, Ms P contacted Vitality to make a claim due to poor mental health. Vitality referred Ms P to its third-party provider, N, for a triage appointment. In February 2024, Ms P got back in touch with Vitality as she hadn't heard from N's therapist. Vitality contacted N which confirmed that it was ready to offer next steps to Ms P but hadn't been able to contact her.

On 7 May 2024, Ms P contacted Vitality to ask for further support with her mental health. She received an acknowledgement which stated it would reach out to her within 72 hours. However, it didn't do so. Therefore, Ms P made a complaint about the delays on 12 May 2024. Two days later, she sent through a referral request to see a psychotherapist.

Subsequently, on 20 May 2024, Ms P chased up Vitality by WhatsApp. During the conversation, she told Vitality that she didn't want to be contacted by phone – she wished to be contacted by email. Her referral request was escalated to Vitality's mental health team (MHT). Later that day, the MHT team emailed Ms P to let her know that while Ms P's preferred psychotherapist was registered with it, it couldn't take a direct referral to a psychotherapist. Instead, it said it would need a GP referral from either an NHS GP or its own GP to a psychiatrist or psychologist for an initial assessment.

On 21 May 2024, Ms P had an appointment with Vitality's GP, who issued a referral letter for Ms P to see a psychotherapist. Ms P sent this letter on to Vitality. But Vitality confirmed that it couldn't accept the referral as it wasn't to a psychiatrist or psychologist. Ms P felt Vitality was seeking to block her from accessing treatment. So Vitality tried to call Ms P to discuss things. It later emailed her to ask for a good time to talk. It seems Vitality also tried to call Ms P on 23 May 2024. And on 29 May 2024, Ms P emailed Vitality to confirm that she didn't want to speak to it on the phone. Vitality made a further call that day which Ms P did answer, although she was distressed during the conversation.

Vitality issued its final response to Ms P's complaint on 29 May 2024. The letter explained that another option available to Ms P was to go through N to access therapies. And, if Ms P's preferred therapist was suitable to provide support to Ms P and had availability, it could offer this support through N's network. It reiterated that if Ms P didn't want to go through N's panel, it would need a GP referral to a psychiatrist or psychotherapist for an initial assessment. It did recognise though that it hadn't handled Ms P's enquiries as quickly as it should have done and so it offered her £50 compensation.

Ms P was very unhappy with the way Vitality had handled her claim and she considered it had placed unreasonable blocks to her being able to access treatment. She was unhappy that Vitality had continued to contact her by phone, despite her vulnerabilities. She said this had caused her mental health to worsen and she'd needed to take some time off from work. Ms P told us that ultimately, her preferred psychotherapist had had no availability but that she'd arranged her own self-funded care through another therapist who met her needs. She considered Vitality should meet the costs of her self-funded treatment.

Our investigator thought Vitality had handled the claim in line with its policy terms. She also explained that we can't tell a financial business to change its processes or procedures. But she thought Vitality could have told Ms P about the option to speak to N to arrange therapies earlier than it did. And she thought this might have prevented the need for Ms P to speak to Vitality's GP. She didn't think it had been reasonable for Vitality to continue calling Ms P by phone after she'd clearly told it she wanted to be contacted by email. Taking together Vitality's service mistakes, the investigator thought Vitality should pay Ms P total compensation of £200. She also added that if Ms P provided Vitality with evidence of her therapy costs, she'd expect Vitality to consider whether the costs of Ms P's treatment were covered.

Vitality accepted the investigator's view but Ms P didn't. So the complaint's been passed to me to decide.

**What I've decided – and why**

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I agree with our investigator's findings and for broadly the same reasons. I'll go on to explain why.

First, I'd like to say how sorry I was to hear about Ms P's illness and the impact this has had on her. I don't doubt what an upsetting and worrying time this has been for her. I'd like to reassure her that while I've summarised the background to her complaint and her submissions to us, I've carefully considered all she's said and sent. In this decision though, I've focused on what I consider to be the key issues, as our rules allow me to do.

It's also important that I make clear that this decision will only consider Vitality's actions. While I appreciate Ms P has concerns about the care she received from N, which acted as Vitality's third-party provider, the policy terms make it clear that Vitality isn't responsible for the actions of its third-party providers. So I can't consider anything N did as part of this decision. If Ms P is still unhappy about the care she received from N, she'd need to make a separate complaint directly to it.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. I've taken those rules into account, amongst other relevant considerations such as regulatory principles, the policy terms and the available evidence, to decide whether I think Vitality has handled Ms P's claim fairly.

*The policy terms*

I've first considered the policy terms and conditions, as these form the basis of Ms P's employer's contract with Vitality. Ms P's cover includes cover for mental health and talking therapies. As Ms P made a claim for mental health treatment, I think it was reasonable and appropriate for Vitality to consider the claim in line with the 'Mental Health Treatment' section set out on page 16 of the policy handbook. This says:

*'If you have Mental Health Cover included on your plan then all treatment must be arranged by a psychiatric consultant, following a referral from your GP, except:*

*• out-patient consultations with a clinical/counselling psychologist who you were referred to by your GP*
*• treatment arranged by our mental health panel.*

*You can refer yourself for talking therapy, without a referral from a GP. The number of sessions you are eligible for is stated on your membership certificate. However, you must contact us before undergoing treatment, so we can arrange for you to see a mental health therapist on our panel.*'

I think the policy terms make it clear that mental health treatment must be arranged by a psychiatric consultant, following a GP referral, unless a member has been referred to a psychologist by their GP or treatment has been arranged by Vitality's mental health panel. I've listened to a call between Vitality and Ms P, which took place in January 2024, and I think the way the policy worked was explained to Ms P at that point. I appreciate that a member can self-refer for talking therapies but I think the policy makes it clear enough when approval will be necessary.

*Did Vitality fairly handle Ms P's claim?*

Vitality accepts that Ms P contacted it for support on 7 May 2024 and that it sent an acknowledgement which stated that it would contact her within 72 hours. But Vitality didn't get in touch with Ms P within its own stated timeframe. Indeed, Ms P had to contact Vitality again on 12 May 2024 to make a complaint about the lack of response. And it wasn't until she sent further messages on 20 May 2024 to ask for support that her claim for treatment with her preferred psychotherapist was escalated to the appropriate team. Given Ms P stated in the 12 May email that the lack of response was worsening her mental health and given the nature of the claim, I don't think Vitality responded to her queries as soon as it could or should have done. I also think this was likely to have caused Ms P additional, unnecessary upset at a time when she was suffering from poor mental health.

Once the claim was escalated to the right team, I can see that Vitality's MHT explained to Ms P that in order to look into supporting treatment with Ms P's preferred provider, there was a route it would need to follow. The MHT said:

*'We would need a GP referral either from your NHS or our Vitality GP to either a psychiatrist or a psychologist for an initial assessment as we are unable to take a referral directly to a psychotherapist. If you do have a referral, please do send this over for us to review. If this is something you do still need to obtain, then please send this over once you have received it.'*

I think the MHT clearly set out *part* of the process. In order for psychotherapist treatment to be approved, Vitality could have required GP referral to either a psychiatrist or psychologist for an initial assessment, to determine the most appropriate treatment. However, the MHT also ought to have highlighted to Ms P that instead of a GP referral to a psychiatrist or psychologist, she could alternatively discuss potential treatment with its own mental health panel via N.

Unfortunately, although Ms P did speak with Vitality's GP, the referral the GP issued was directly to a psychotherapist. So Vitality explained it couldn't accept this referral. I think its decision was in line with the policy terms and also with its own internal guidance. So I don't think Vitality acted unfairly in concluding that Ms P's referral to her preferred provider couldn't be approved at that point. I don't find it was trying to place deliberate barriers to Ms P accessing support – it appears it was trying to ensure that Ms P received the most

clinically suitable treatment. And based on the evidence, it seems that the same terms would have applied to any member in the same circumstances as Ms P, so I don't think she's been singled out in any way.

While I appreciate Vitality subsequently tried to contact Ms P to discuss these options, they weren't set out in writing until Vitality's final response letter of 29 May 2024. I think it would have been reasonable and appropriate for Vitality to set both options out to Ms P in writing on 20 May 2024. If Vitality had clearly set out to Ms P that she didn't necessarily need a GP referral and could instead potentially arrange treatment via N, she may well not have been put to the time and trouble of organising a GP appointment which ultimately didn't lead to the approval of her claim.

So I've gone on to think about whether this caused Ms P's treatment to be delayed. I don't think I could fairly find it did. That's because Ms P has told us that her preferred provider didn't have any availability. So even if she had been able to seek approval a few days earlier, it doesn't seem likely that she could have been seen by the psychotherapist she wished to receive treatment from.

I understand Ms P is incurring costs of self-funded treatment, which is a significant expense for her. I've thought about whether I could fairly direct Vitality to reimburse these costs. I don't think I could, based on the available evidence. That's because Vitality needs to be given a chance to assess whether the claim is covered – for example, to check whether it recognises Ms P's therapist and whether the treatment she's receiving is in line with the policy terms. It's open to Ms P to send Vitality information about her treatment so that it can consider whether or not the claim is covered. I'd remind Vitality of its regulatory obligations when assessing any further evidence Ms P may choose to send it.

*Customer service*

Like the investigator, I've looked carefully at the available call and communication records to decide whether I think Vitality took fair and appropriate steps when it communicated with Ms P. It doesn't appear to me that Ms P told Vitality she didn't want to be contacted by phone until 20 May 2024. At that point, I think she was sufficiently clear that she only wanted to be contacted by email.

However, Vitality tried to contact Ms P by phone on 21, 23 and 29 May 2024. While I can appreciate it wanted to discuss treatment options (and her complaint) with her, I don't think it was reasonable or appropriate for it to contact Ms P by phone. In the circumstances, I think it should have corresponded with Ms P in line with her communication preferences, especially knowing she was vulnerable. And, as the investigator said, while Ms P did answer the call of 29 May, this clearly caused her to become distressed. So I do think Vitality unnecessarily caused Ms P to suffer trouble and upset when it continued to call her.

And, as I've set out above, I also think Ms P was put to unnecessary time and trouble in organising a GP appointment which may have been avoided had Vitality clearly explained the route available to her through N. Again, I think this caused Ms P additional frustration and time.

*Fair compensation*

In the round then, I don't think Vitality's original offer to pay Ms P £50 compensation fairly reflects the trouble and upset its errors caused her between 7 and 29 May 2024. I don't think it took into account its failure to highlight both referral options to Ms P and its failure to adhere to her request to be contacted by email. In my view, total compensation of £200 is a fair, reasonable and proportionate award to reflect what I think is the likely impact of those

errors on Ms P.

I appreciate Ms P doesn't think this award goes far enough. I was sorry to hear that her condition worsened and she needed to be signed-off work. However, I haven't seen persuasive medical evidence that indicates that this was down to any service or claims handling failures on the part of Vitality.

Overall, I've decided that the fair outcome to this complaint is for Vitality to pay Ms P £200 compensation.

**My final decision**

For the reasons I've given above, my final decision is that I uphold this complaint.

I direct Vitality Health Limited to pay Ms P £200 compensation.

Vitality must pay the compensation within 28 days of the date on which we tell it Ms P accepts my final decision. If it pays later than this it must also pay interest on the compensation from the deadline date for settlement to the date of payment at 8% a year simple

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms P to accept or reject my decision before 20 March 2025.

Lisa Barham
**Ombudsman**