**Scottish Parliament Region: Lothian**

## Case 200602124: Lothian NHS Board

## Summary of Investigation

### *Category*
Health: Continuing Care Funding

### *Overview*
The complainant raised a concern that her mother (Mrs A) had been refused NHS Continuing Care Funding by Lothian NHS Board.

### *Specific complaint and conclusion*
The complaint which has been investigated is that Mrs A was unreasonably refused NHS Continuing Care Funding (*not upheld*).

### *Redress and Recommendations*
The Ombudsman has no recommendation to make.

### *Further Action*
This and other complaints to the Ombudsman indicated an urgent need to review the guidance on NHS Continuing Care Funding which was issued more than 11 years ago. This is not a matter which an individual Health Board is able to address so cannot be resolved within this report. The Ombudsman has previously drawn this matter to the attention of the (then) Scottish Executive Health Department[1] and has now been informed that a review of this policy is underway with the intention that it will report in January 2008. In light of this action this office has formally suspended consideration of any further complaints raised with us on this matter pending the outcome of the review by the Scottish Government Department of Health and Wellbeing.

[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive. The latter term is used in this report as it applied at the time of the events to which the report relates.

## Main Investigation Report

### Introduction

1. On 13 October 2006 the Ombudsman received a complaint from the complainant (Mrs C) that her mother (Mrs A) had been refused NHS Continuing Care Funding by Lothian NHS Board (the Board). Mrs C had first raised a complaint with the Board on 22 March 2006 when she complained that Mrs A, who suffers from Alzheimer's, had been wrongly charged for her care in her Nursing Home (the Nursing Home) since her admission in September 2004 when she should be entitled to full NHS Continuing Care Funding. Mrs C received a response in October 2006 advising that there were no grounds for the NHS to pay for Mrs A's care. Mrs C was not satisfied with this response and complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that Mrs A was unreasonably refused NHS Continuing Care Funding.

3. As the investigation progressed, I identified issues concerning the clarity, accessibility and transparency of the process for assessing eligibility for NHS Funded Continuing Care. These issues have also been identified in other investigations previously conducted by the Ombudsman's office (200500976, 200502634, 200501504). The Ombudsman will, therefore, also be forwarding a copy of this report to the Scottish Executive Health Department (SEHD) to consider its implications for two reviews currently being undertaken by SEHD (see paragraphs 29 to 31).

*Background Legislation, Case Law and Guidance*

*Scottish Guidance, Legislation and Case Law*

4. The National Health Service (Scotland) Act 1978 (the 78 Act), section 1, outlines the general duty of the Secretary of State (now the Scottish Ministers) to promote a comprehensive and integrated health service and to provide or secure the effective provision of services for that purpose. Section 36 of the 78 Act relates specifically to the provision of nursing and other services considered necessary to meet all reasonable requirements (see Annex 3). The duty placed on local authorities in Scotland by the Social Work (Scotland) Act 1968 (the 68 Act) is to promote social welfare by making available advice, guidance and assistance as appropriate (this will include the provision of residential and other establishments). Both the 68 Act and the 78 Act are relevant to the decisions in this case.

5. Each NHS Board in Scotland has a duty to meet the health care needs of people in its geographical area who require continuing health care. This care is commonly referred to as NHS Funded Continuing Care and can be provided in a number of settings but is paid for entirely by NHS Boards.

6. Each NHS Board also has a duty to ensure any necessary arrangements are in place for in-patients prior to discharge. Responsibility for making these arrangements will vary according to the particular needs of each patient. The decision to discharge is made by the doctor responsible for the patient's care and is a clinical decision. In some cases it will also involve joint working between hospital staff, the GP and social services staff (in fulfilment of their obligations under the 68 Act). Where there are costs involved in meeting the particular needs identified these can be met in a number of ways including self-funding by the patient (or the patient's family), local authority funding (which will vary according to need and circumstance) or NHS Funded Continuing Care as appropriate.

7. A circular was issued in 1996 by the then Scottish Office Department of Health (MEL 1996(22)) (the MEL) setting out both the responsibilities of the NHS to arrange discharge and the criteria for NHS Funded Continuing Care. Annex A of the MEL states that (Health Boards) should arrange and fund an adequate level of service to meet the needs of people who because of the 'nature, complexity or intensity of their health care needs will require continuing inpatient care…in hospital…or in a nursing home'.

8. The MEL sets out in greater detail a number of criteria which all Health Boards must cover for their locality. Paragraph 16 of the MEL sets out the nature of the assessment of health needs which is to be carried out. Paragraph 20 sets out the eligibility criteria for NHS Continuing Care. Paragraph 5 of Annex A to the MEL sets out similar general principles. As relevant to Mrs A's situation the conditions can be summarised as applying to those circumstances where either: a patient needs ongoing and regular specialist clinical supervision on account of the complexity, nature or intensity of his or her health needs; a patient requires routine use of specialist health care equipment or treatments requiring the supervision of NHS staff; or a patient has a rapidly degenerating or unstable condition which means they will require specialist medical or nursing supervision.

9. At the time the MEL was issued, similar guidance was issued for England and Wales. The situation in England and Wales has developed significantly since 1996 as a result of a number of important judgements by the Court of Appeal and the High Court in England including the Coughlan Judgement (see Annex 3) and reports issued by the Health Services Ombudsman for England in January 2003 and December 2004 (see Annex 3). These developments attracted considerable media attention as a result of which the NHS in Scotland received a number of complaints about Continuing Care Funding. The SEHD Directorate of Service Policy and Planning issued a letter (DKQ/1/44) to all NHS Chief Executives on 13 June 2003, outlining the process for handling such complaints. In summary the current position with regard to guidance issued by SEHD on NHS Funded Continuing Care in Scotland remains limited to that set out by the MEL (see also 'Further Action', page 1).

10. The Board also issued local criteria (the Local Criteria) and guidance in April 1999 which gives a greater level of detail to the types and mix of care which the NHS and the local authority will provide in their area (see Annex 3). These criteria are intended, in part, to give local guidance on the MEL rather than extend eligibility beyond that of the MEL.

**Investigation**

11. Investigation of this complaint involved obtaining and reviewing Mrs A's clinical and Nursing Home records and the NHS Complaints File. I have also sought the view of a clinical adviser to the Ombudsman (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

**Complaint: Mrs A was unreasonably refused NHS Continuing Care Funding**

12. Mrs A was first admitted to the Nursing Home in May 2004 having suffered from Alzheimer's for a number of years. Her condition deteriorated and she was admitted to the nursing unit of the Nursing Home in September 2004. Mrs C later became aware of the Coughlan Judgement (see Annex 3) and considered that Mrs A's medical condition was such that she met the criteria for both the MEL and the tests used by the judges in Coughlan. Mrs C applied to the Board for assessment of Mrs A's eligibility for NHS Continuing Care Funding in March 2006. The Board treated this as a complaint in accordance with DKQ/1/44 (see paragraph 9).

13. A complaints officer at the Board (the Complaints Officer) discussed the case with the Development Manager for Older Peoples Services (the Manager) and it was decided that as Mrs A had been admitted from the community the way forward would be to seek the views of Mrs A's GP (GP 1) as to whether or not Mrs A currently met the eligibility criteria of the MEL. The Board wrote to GP 1 and asked her to consider whether Mrs A met the local assessment criteria for patients with dementia set out in the Local Criteria (see Annex 3). GP 1 responded by letter on 26 June 2006 and noted that she had attended Mrs A since January 2005. GP 1 described Mrs A as having recently become slightly verbally aggressive requiring a change in medication and that staff had commented that communication with Mrs A was quite difficult as she appeared not to understand and had difficulty in expressing herself. GP 1 concluded that Mrs A required 24 hour care in a nursing home.

14. The Complaints Officer discussed GP 1's response with the Manager on 7 August 2006. The Manager noted that NHS Continuing Care would only be funded in an NHS facility. The Complaints Officer contacted GP 1 again by telephone on 9 August 2006 and confirmed that in GP 1's view Mrs A did not require an NHS bed as she could be cared for adequately by the Nursing Home. It was noted in all these conversations that Mrs A was receiving Free Personal and Nursing Care (FPC) funding from social services (£210 per week).

15. At this point there was also considerable discussion about whether and where Mrs C could appeal any decision that Mrs A was not eligible for NHS Funded Continuing Care. The Complaints Officer spoke with staff at SEHD who were also unclear as to whether there was any appeal mechanism for an individual admitted to a nursing home from the community rather than by hospital discharge, but confirmed that referral to this office was appropriate under the NHS complaints procedure. The Complaints Officer also confirmed with the manager of the Nursing Home that in her view Mrs A did not require NHS Funded Continuing Care because she could be managed by them in the Nursing Home.

16. Mrs C was notified on 22 August 2006 that the Board did not consider Mrs A eligible for NHS Funded Continuing Care and noted the criteria of the MEL and referred to the Local Criteria. The letter also noted that the Coughlan Judgement was merely persuasive in Scotland and not binding on the Scottish Courts or the Scottish Executive. The letter noted that Mrs A received the FPC

allowance and that 'Consequently, there would appear to be no grounds on which the NHS should pay the balance of the cost of her care'.

17. Mrs C contacted this office and told me that Mrs A had advanced Alzheimer's and was unable to communicate any of her needs. Mrs A required assistance with all activities of daily living and relied entirely on staff input to perceive and act on her needs. Mrs C complained that Mrs A had to pay for her nursing home care which Mrs C considered should be provide free at the point of delivery by the NHS. Mrs C believed Mrs A had significant needs and accordingly was entitled to NHS Funded Continuing Care. Mrs C raised the Coughlan judgement (see Annex 3) and complained that the Board had not provided any evidence to her of the assessment tools used in their process and that consequently the process followed was not fair or proper.

18. Mrs C was critical that the situation in Scotland was apparently different to that in England. In particular she noted that the Board had raised Mrs A's entitlement to FPC and stated that 'there are no grounds on which the NHS should pay the balance of the cost of [Mrs A]'s care.' Mrs C was concerned that this showed a lack of understanding on the part of the Board as NHS Continuing Care entitles a claimant to full funding not top-up funding. Mrs C concluded that she considered it to be unacceptable that in one part of the country a person with a specific set of care needs would be assessed as qualifying for fully funded NHS Continuing Care, while a person with identical needs living in a different part of the country would be deemed ineligible.

19. The Adviser reviewed Mrs A's GP records from 2004 onwards and psychiatric reports for 8 July 2004 and 22 September 2004 as well as recent care plans from the Nursing Home from 23 June 2006. The Adviser noted that it was extremely difficult to reach a conclusion on Mrs A's eligibility for NHS Continuing Care because she had never been the subject of a multi-disciplinary assessment and there were very few clinical records available. The Adviser noted that there was no record of any discussion of Mrs A's actual heath care needs by the Manager and how these might meet the criteria of the MEL or the Local Criteria. There was a clear presumption that anyone who could be cared for in a nursing home would not have the level of need which entitled them to NHS Continuing Care Funding and that since, in GP 1's view, Mrs A could be cared for in this way she was not eligible for NHS Continuing Care Funding. The Adviser also noted that there was no discussion with Mrs C until the response letter of 22 August 2006 was sent with the decision already reached.

The Adviser expressed the view that Mrs C had made a request for funding but the review process adopted by the Board was fundamentally flawed and unfair to Mrs A because there was no multi-disciplinary assessment of Mrs A's health needs and no input from Mrs A's family.

20. In response to the draft of this report Mrs C told me that she was disappointed that her complaint had not been upheld but understood that the guidance was wholly unclear. She noted that her mother should have been entitled to a multi-disciplinary assessment whether or not she was admitted from hospital and that there was an incorrect assumption that because her mother was in a nursing home she did not need NHS Continuing Care funding.

21. In response to the draft of this report the Board noted that they were pleased to note the implications of this case were being raised with SEHD and looked forward to the clarity that revised guidance will provide in this matter.

*Conclusion*

22. In considering any complaint about the NHS this office has to reach a view on whether the person on whose behalf the complaint is made has been caused injustice or hardship by clinical failings, maladministration or service failure. I have seen no evidence of clinical failings in the Board's dealings with Mrs A.

23. If, in considering Mrs A's eligibility for NHS Funded Continuing Care, the Board had failed to act in accordance with the MEL or the Local Criteria, that would constitute maladministration which might have caused injustice or hardship to Mrs A. The Complaints Officer sought clinical in-put from GP 1 but the response did not detail how or why Mrs A did not meet the MEL or the Local Criteria. I am very concerned that there was considerable reliance placed on a presumption that because Mrs A was being cared for adequately by the Nursing Home she would not be eligible for NHS Funded Continuing Care as the MEL specifically states that care can by funded by the NHS in a nursing home environment. In practical terms I acknowledge that the Board are not saying that they would never fund care in a nursing home only that their current practice is to provide NHS Continuing Care in an NHS facility. However, in this case, I note that there has been no complete clinical review and assessment and an unjustified reliance on the views of GP 1, which did not seek to address the MEL criteria, and those of the Nursing Home Manager, who is not a clinician and is not responsible for making such a judgement.

24. I also note the Adviser's view of the lack of adequate assessment and family input. Unfortunately the current system for assessing NHS eligibility addresses only those being discharged from NHS care. As such the MEL process only applies to challenges to the clinical decision to discharge while still in NHS care and DKQ/1/44 only refers to challenges to decisions made after discharge from NHS care; neither covers Mrs A's situation where she has never been an NHS in-patient.

25. Mrs A's circumstances (being admitted to a nursing home from the community) are not unusual. The lack of provision in the MEL for assessment in such cases caused difficulties for Mrs C and the Board. Other complaints to this office also indicate that the lack of a mechanism for clinical consideration and appeal has caused confusion and distress for others. The Board cannot be held responsible for a lack of provision in the MEL as this can only be addressed by the SEHD. In this respect I do not consider that there has been any maladministration by the Board.

26. Was there service failure? Section 5(2) of the Scottish Public Services Ombudsman Act 2002 defines service failure as any failure in a service provided by an authority or 'any failure of the authority to provide a service which it was a function of the authority to provide'. If someone has needs which are complex, intense and of a nature that would be beyond what a local authority ought to provide under its duties in terms of the 68 Act, then the relevant Health Board has a responsibility under the 78 Act to provide (in the individual's home or elsewhere) such medical, nursing and other services as they consider necessary to 'meet all reasonable requirements' (see Annex 3). It is not the role of this office to determine what services are necessary to 'meet all reasonable requirements'. However, if the interpretation and application of the 'specialist' input criterion in the MEL acted as an impediment to the provision of self-evidently 'necessary services' through NHS Funded Continuing Care, it would be reasonable for this office to conclude that there had been service failure. On the evidence available to me in this case I cannot reach such a conclusion and, therefore, cannot conclude that Mrs A was entitled to NHS Continuing Care Funding. I, therefore, do not uphold this complaint.

27. I would also note that Mrs C raised the question of the application of the Coughlan Judgement in Scotland as this case considered a similar argument in the English courts based on English legislation and guidance. However, as Mrs C was correctly advised by the Board the Coughlan case is not binding on

courts in Scotland and cannot be considered as a statement of the law in Scotland. Mrs C also raised an issue about the confusion between the application of the NHS Continuing Care policy and the FPC policy. Mrs C is correct in saying that NHS funding is for 100% of costs and does not operate as a 'top-up' as the Board response implies.

28. While I do not have prima facie evidence of service failure, the reliance on the residence in a nursing home as a factor in determining eligibility in this case is a concern as is the misleading view of the interaction with the FPC policy. This case and a number of others with this office suggest the MEL may be being applied in a way which potentially means patients who have a sufficiently high level of health care need are excluded from NHS Continuing Care because their overall care needs are never properly assessed because they are deemed to be met within a nursing home environment. This would potentially prevent a Health Board from doing something it ought to do under the 78 Act. The Board consider they are correctly applying the MEL but this case begs the question of whether the MEL guidance alone is adequate since it addresses those affected by a clinical decision to discharge rather than consideration of those admitted to care form the community (although this group are not specifically exclude neither are they specifically addressed). The added complexity of the FPC policy appears to be increasing the potential for injustice. Any such potential omission and/or injustice is not a question that this office can determine but does lead me to conclude that unremedied injustices may be caused by the need to apply the MEL in situations it was not intended to cover and in circumstances which did not exist at the time it was written.

29. The concern and belief that unremedied injustice exists is raised in a number of the complaints about Continuing Care brought to this office. This continues to cause distress and anxiety for vulnerable individuals and their families and to take up a considerable amount of NHS time and resources in addressing these. This office will, in turn, continues to receive complaints which we are unable to determine. Further to the core concern about the legitimacy of the application of the MEL, Annex 4 sets out a number of other concerns about the operation of the MEL.

*Recommendation*

30. Based on the conclusion that there has been no injustice or hardship caused by clinical failings, maladministration or service failure on the part of the Board the Ombudsman has no recommendation to make to the Board.

However, the Ombudsman is pleased to note that an urgent review of this policy area is now being undertaken by the Scottish Government (see also 'Further Action', page 1) and will be writing to the SEHD asking them to consider the implications of this case for their review of this matter (see paragraphs 31 and 32).

*Summary of the Wider Policy Issues*

31. This and a number of other cases currently with this office raise issues about whether recent decisions by English Courts might be expected to have had a bearing on policy and practice in Scotland. While the English decisions themselves do not have direct application, the legal principles which they established and the developments which have flowed from them in England demonstrate that clarification on the issues of provision, assessment and decisions on NHS Continuing Care is necessary and important in terms of the Scottish guidance. The Ombudsman has raised this issue with SEHD who have indicated that they will be considering the implications of these judgements carefully as part of the review of NHS Continuing Care currently being undertaken by them.

32. These cases have also illustrated the need for a clearer, more accessible and a more transparent process for assessing eligibility for NHS Continuing Care Funding. This office has also raised these concerns with SEHD who have advised us that they acknowledge the procedural gaps identified in the current guidance and are seeking to address this issue in draft revised guidance which they are in the process of developing.

33. In light of both the review of the guidance and the implications of the English developments the Ombudsman will be sending a copy of this report to the SEHD for consideration of the impact of the current guidance in individual cases.

24 October 2007

**Annex 1**

**Explanation of abbreviations used**

| | |
|---|---|
| Mrs C | The complainant (Mrs A's daughter) |
| Mrs A | The aggrieved |
| The Board | Lothian NHS Board |
| The Nursing Home | The nursing home where Mrs A is resident |
| SEHD | Scottish Executive Health Department |
| The 78 Act | The National Health Service (Scotland) Act 1978 |
| The 68 Act | The Social Work (Scotland) Act 1968 |
| The MEL | The Scottish Office Department of Health (MEL 1996(22)) |
| The Local Criteria | Issued by the Board to give a greater level of detail to the types and mix of care which the NHS and local authority provide in their area. |
| The Adviser | The Clinical Adviser to the Ombudsman |
| The Complaints Officer | The Complaints Officer at the Board |
| The Manager | The Development Manager for Older Peoples Services |
| GP 1 | Mrs A's GP since January 2005 |
| FPC | Free Personal and Nursing Care |

**Annex 2**

## Glossary of terms

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| Alzheimer's | A neurological disorder characterized by slow, progressive memory loss due to a gradual loss of brain cells. Alzheimer disease significantly affects cognitive (thought) capabilities and, eventually, affected individuals become incapacitated |
| Dementia | Symptoms, including changes in memory, personality and behaviour, which result from a change in the functioning of the brain |

**Annex 3**

**Summary of legislation, policies, case law and reports considered**

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| National Health Service (Scotland) Act 1978 | Section 36 states:<br>(1) It shall be the duty of the Secretary of State to provide throughout Scotland, to such extent as he considers necessary to meet all reasonable requirements, accommodation and services of the following descriptions -<br>(a) hospital accommodation, including accommodation at state hospitals;<br>(b) premises other than hospitals at which facilities are available for any of the services provided under this Act;<br>(c) medical, nursing and other services, whether in such accommodation or premises, in the home of the patient or elsewhere. |
| Social Work (Scotland) Act 1968 | Under section 12 A (which was inserted by the National Health Service and Community Care Act 1990) a local authority has a duty to promote social welfare by making available advice, guidance and assistance as appropriate (this will include the provision of residential and other establishments) |
| FPC – Free Personal and Nursing Care policy | A policy introduced by the Community Care and Health (Scotland) Act 2002 which was intended to provide funding for personal and nursing care need by those over 65 |
| MEL 1996(22) | Sets out the responsibilities of the NHS to arrange discharge and the criteria for eligibility for NHS Funded Continuing Care. Issued by the then Scottish Office Department of Health (now SEHD) |

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| SEHD Circular<br>No. SWSG10/1998 | Scottish Office: Community Care Needs of Frail and Older People (Integrating Professional Assessments and Care Arrangements) |
| SEHD Circular<br>No. CCD 8/2—3 | SEHD Circular: Choice of Accommodation – Discharge from Hospital |
| SEHD Letter<br>DKQ/1/44 | Directorate of Service Policy and Planning letter to all NHS Chief Executives on 13 June 2003, outlining the process for handling Continuing Care funding complaints |
| The Health Service Ombudsman for England | HC399 (2002 – 2003) & HC144 (2003 - 2004) Reports on NHS funding for long term care |
| The Local Criteria | Policy and Eligibility Criteria for the provision of health services to meet continuing health care needs. Lothian Health Board April 1999 |

**List of Case Law (and brief summary conclusions)**

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| R v North and East Devon Health Authority ex parte Pamela Coughlan [2000] 2 WLR 622 (the Coughlan Judemgent) | The court found that a local authority can provide nursing services but that this is limited to such services which are provided as ancillary to the accommodation provided by the local authority in fulfilment of a statutory duty.<br>The court also considered the eligibility criteria for NHS funded care and noted that Health department guidance could not alter a legal responsibility under the National Health Service Act 1977. In particular it drew attention to a danger of excessive reliance in the Health department guidance on the need for specialist clinical input.<br>The court concluded that whether it is lawful to transfer care from NHS to local authority responsibility depends generally on whether the nursing services are incidental/ ancillary to the local authority provision and of a nature which the local authority can be expected to provide. |
| R (on the application of Maureen Grogan) v Bexley NHS Care Trust and Others [2006] EWHC 44 | The court ruled that the eligibility criteria for NHS Continuing Care were unlawful as they contained no guidance as to the test or approach to be applied when assessing a person's health needs in determining eligibility. |

**Annex 4**

## Procedural difficulties and confusion arising from MEL 1996(22)

1. The MEL was issued on 6 March 1996, more than 11 years ago. Much has changed in that period in terms of how the NHS is organised, how care is provided and the surrounding statutory and policy context. To take just one example, the coming into force of the Human Rights Act 1998 places a positive duty on public authorities to act in a way that is compatible with the rights conferred under the European Convention. The NHS Continuing Care cases reviewed in this office suggest that this Act may potentially have implications for the MEL beyond the procedural.

2. Given this background it is not surprising that complaints received in this Office show common themes of dissatisfaction associated with the process of being assessed for and obtaining NHS Funded Continuing Care.

3. The lack of a formalised process for Continuing Care assessment means the public are often unable to obtain clear information about the qualification criteria for NHS Funded Continuing Care. There is a lack of clarity about when a patient should be the subject of a multi-disciplinary assessment under the MEL. This assessment generally occurs at the time of a patient's discharge from hospital. Not every patient discharged will require to be assessed under the MEL but there is no clear guidance on how the decision on whether or not to assess is made. Decisions about whether patients need to be assessed for eligibility for NHS Continuing Care are properly made by consultants as part of the process of deciding whether they can be discharged from hospital. There is no formal requirement for such decisions to be documented and where documentation exists it tends to be sparse. This results in a lack of transparency and potential inconsistency in the decisions made.

4. The lack of a formalised process for NHS Funded Continuing Care assessment also results in a lack of clarity about how somebody who is not being discharged from hospital can access the Continuing Care assessment process under the MEL. The NHS has moved to work more closely with local authorities on assessment of care needs. The MEL does not reflect any role for such activities in assessing the potential eligibility of those currently living in the community (rather than this being carried out by hospitals as part of their discharge procedures).

5. The fact that certain patients are not considered eligible to be assessed without being given any formal assessment results in confusion about the reasons for refusal of funding. The way in which the MEL functions is not always clearly communicated to families and they are often not provided with details on how to appeal and request a review of the decision to refuse funding. Furthermore, if somebody has not been considered as eligible to be assessed under the MEL, there is no automatic right of appeal and no formal way in which the family or the patient can request an official assessment.