Scottish Parliament Region: Mid Scotland and Fife

Case 200501504: Fife NHS Board

Summary of Investigation

Category

Health: Hospital; NHS Funded Continuing Care

Overview

The complainants, a firm of solicitors (the Solicitors) raised a concern on behalf of their client, Mrs C, that her late husband, Mr C, had not been properly assessed by Fife NHS Board (the Board) and consequently had ceased to receive funding for NHS Continuing Care (Continuing Care). Mrs C was also concerned that during her appeal against the decision not to fund Mr C's care she had been subjected to undue pressure from the Board.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to properly assess Mr C's ongoing eligibility for Continuing Care *(partially upheld*); and

(b) exerted undue pressure on Mrs C by supporting the local authority in making an application to the Sheriff Court to be appointed Mr C's welfare guardian (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) make a formal, evidenced record of decisions to discharge and that this record is provided to the patient and/or family in a timely manner;

(ii) ensure that when a decision to discharge is reached such a decision is made known to the patient and/or family at the time the decision is taken and that where objections are presented the process for appealing against such a decision is clearly and fully explained;

(iii) act on the recommendation of the Fife report[1] to produce written information on ongoing eligibility for patients assessed as eligible for NHS

[1] Provision of NHS Continuing Care for Older People in Fife: Needs Assessment. July 2006 NHS Fife

funded Continuing Care. The Board should ensure that there is a single approach to such funding and that this is commonly understood by all relevant staff; and

(iv) make a written apology to Mrs C that the lack of clarity among staff about eligibility for Continuing Care led to miscommunication to Mrs C of Mr C's status and caused unnecessary distress.

Further Action

This and other complaints to the Ombudsman indicate an urgent need to review the guidance on NHS Funded Continuing Care 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 will instead draw this matter to the attention of the Scottish Executive Health Department.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 31 August 2005, the Ombudsman received a complaint from a firm of solicitors (the Solicitors) on behalf of the wife (Mrs C) of a man with early onset dementia, atypical Alzheimer's and cardiac problems (Mr C) about the assessment of the eligibility of Mr C for NHS funded Continuing Care by Fife NHS Board (the Board). The main events referred to in this complaint occurred between June 2003 and Mr C's death on 20 October 2005. Mrs C first raised the general matter with the Board, through the Solicitors, on 6 July 2005 having previously sought to appeal the decision to discharge Mr C to a nursing home without funding. That appeal was unsuccessful. A response to the complaint was sent on 24 November 2005 but Mrs C remained unhappy and asked the Ombudsman's office to investigate the matter.

2. The complaints from Mrs C which I have investigated are that the Board failed to:

(a) properly assess Mr C's ongoing eligibility for Continuing Care; and

(b) exerted undue pressure on Mrs C by supporting the local authority in making an application to the Sheriff Court to be appointed Mr C's welfare guardian.

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 conducted by the Ombudsman's office. The Ombudsman will, therefore, 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 38 to 40).

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 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) – referred to in this report as 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 in-patient 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 Mr C'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; or, 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 (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 the funding of Continuing Care. 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.

10. This case also raises a question about the Board's decision to support the local authority in applying to the Court to appoint a Welfare Guardian for Mr C. Applications for both Intervention and Guardianship Orders were considered by the Board. These orders are covered by Part 6 of the Adults With Incapacity (Scotland) Act 2000 (the 2000 Act). The 2000 Act states at Section 53(1) 'The sheriff may, on an application by any person (including the adult himself) claiming an interest in the property, financial affairs or personal welfare of an adult, if he is satisfied that the adult is incapable of taking the action, or is incapable in relation to the decision about his property, financial affairs or personal welfare to which the application relates, make an order (in this Act referred to as an 'intervention order')'. There is a similar statement in Section 57 of the 2000 Act in relation to Guardianship Orders.

11. The Mental Welfare Commission for Scotland has issued guidance on (amongst other things) the operation of Part 6 of the 2000 Act 'Authorising Significant Interventions for Adults who lack capacity. August 2004'. This document specifically refers to an application for a Guardianship Order being a possible necessary step for a local authority to take prior to an incapacitated person being moved form hospital and where there is a conflict over the working of the 2000 Act. It also refers to strongly expressed views that if public bodies don't apply for orders they may breach patients' human rights.

Investigation

12. Investigation of this complaint involved reviewing Mr C's relevant hospital and nursing home records, the Board complaint file, obtaining the opinion of a clinical adviser to the Ombudsman (the Adviser), reading the documentation provided by the Solicitors, identifying relevant legislation, reviewing policies and procedures and in particular a report into the Provision of NHS Continuing Care issued by the Board in July 2006 (the Fife report). In July 2006 the Ombudsman' office raised a number of the concerns identified in this complaint and a number of other cases being considered by this office, with the SEHD and subsequently sought legal advice on certain matters. A summary of terms used is contained in Annex 1. A glossary of medical terms is contained in Annex 2. A list and detailed summary of the Scottish legislation, policies and reports considered in this report is at Annex 3. A summary of the problems identified by the Ombudsman's office with the procedure for operating the MEL is contained in Annex 4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. The Solicitors and the Board were given an opportunity to comment on a draft of this report.

13. In the complaint to the Ombudsman's office (and in previous communications with the Board) the Solicitors raised issues about the relevant SEHD guidelines. These guidelines are the responsibility of the SEHD and cannot be addressed within this investigation which concerns the Board. However, this and other complaints currently with this office raise broader policy issues which the Ombudsman has drawn to the attention of SEHD.

(a) The Board failed to properly assess Mr C's ongoing eligibility for Continuing Care

14. Mr C was admitted voluntarily to Whyteman's Brae hospital (Hospital 1) early in 2003 and later detained under the Mental Health (Scotland) Act 1984, under the care of Consultant 1 who determined he should receive medium-term care. He was suffering from early onset dementia (and other underlying medical conditions). He transferred between hospitals and was eventually transferred to Stratheden Hospital (Hospital 2) on 6 June 2003. Mrs C was of the view that Mr C was at this time assessed as being a Continuing (long-term) Care patient. Mr C was later transferred to an assessment ward in the Hospital because he was considered to be a danger to others but subsequently the deterioration in his physical condition meant that this element was substantially removed. Rather than being transferred back to the Continuing Care ward (as

Mrs C had expected and considers she was promised) a decision was made prior to a meeting in August 2004 that Mr C did not qualify for NHS funded Continuing Care. Mrs C disputed this and involved the Solicitors following the meeting in August 2004.

15. The Solicitors wrote to Consultant Psychiatrist 2 on 18 August 2004 challenging the decision to discharge Mr C. A response was sent by Consultant Psychiatrist 2 on 11 October 2004 stating that in his view Mr C did not meet the criteria for NHS funded Continuing Care and accordingly care costs would no longer be met by the NHS. The response also indicated that it was Consultant Psychiatrist 2's recollection that Mrs C had not challenged Mr C's discharge in August 2004 but was disputing who funded his on-going care and this would be discussed shortly with Social Services. On 25 October 2004 Consultant Psychiatrist 2 received a letter from the Solicitors referring to a number of developments in English case law and the English Ombudsman's judgements and asking for the matter to be referred as a matter of law to SEHD's Central Legal Office. Consultant 2 wrote to the hospital manager on 27 October 2004 enclosing a copy of the solicitor's letter and requesting it be passed to the Central Legal Office. Consultant 2 advised the Solicitors of this by phone on 3 November 2004. However, no response appears to have been provided to the Solicitors from any party.

16. A discharge planning meeting was finally held on 7 April 2005 at which Mrs C was advised of her right to appeal against her husband's discharge from in-patient NHS funded Continuing Care. Mrs C lodged an appeal through the Solicitors on 13 April 2005. This appeal was not successful and concluded in a letter from the Board in June 2005. Following this the Solicitors complained to the Board on 6 July 2005. A further discharge planning meeting was held on 14 July 2005 at which the issue of appointing a Welfare Guardian was raised as no agreement could be reached (see complaint (b)). Mrs C then agreed to Mr C being discharged to the Nursing Home and he was discharged on 31 August 2005. The Solicitors also wrote to the Ombudsman's office on that day raising Mrs C's concerns about the withdrawal of NHS Continuing Care funding and the manner in which Mrs C's objections had been handled. Mrs C did not consider that Mr C should be moved from the Nursing Home but still felt that his care should be funded by the NHS. Mr C died in the Nursing Home on 20 October 2005.

17. In summary Mrs C said she had been told Mr C would receive NHS funded Continuing Care and she had expected this to be the case for the duration of his life. Mrs C also felt that Mr C's condition had not altered for the better and she considered that he met the MEL criteria. In particular she felt that the nature, complexity and intensity of his health needs combined with his rapidly degenerating and unstable condition meant he should be eligible for NHS funding of his care notwithstanding that it could be provided outwith the hospital setting.

18. In response to a draft of this report the Board noted the following account of events: A handwritten case conference note of 19 May 2003 (chaired by Consultant 1) at which both Mrs C and a further family member were in attendance, clearly indicates 'refer to Edenview Ward, [Hospital 2] with a review of long-term care needs in a few months time, i.e. refer for MEDIUM TERM CARE.' The Board further noted that the capitals are handwritten in the notes as if to emphasise the decision on the type of care and to avoid any misunderstanding). In the summary review from Hospital 2, dated 20 May 2003, the plan is noted as 'As discussed at the case conference on 19 May 2003 with his wife and sister in law, he will require mid-term placement in Hospital 2, which will be reviewed in a few months time.' This document was signed by the Senior House Officer (SHO 1) on behalf of Consultant Psychiatrist 1. The transfer summary (countersigned by Consultant Psychiatrist 1) to the patient's GP, indicated that the follow-up arrangements were 'Review of medium-term placement in Hospital 2 in a few months.' The handwritten admission note by SHO 2, dated 6 June 2003, indicated that Mr C was transferred from Hospital 1, for medium-term care. At the case conference meeting of 12 August 2004 chaired by Consultant 2, the multi-disciplinary team were in agreement that Mr A no longer required NHS care and that his level of care needs were appropriate for nursing home placement. Mrs C indicated she would be keen for her husband to be placed in a nursing home in their home area. The funding issue was raised during this meeting by Mrs C. This is described in a contemporaneous email sent by Consultant 2 on 12 August 2004. This email records that Mr C was now fit for discharge to nursing home but the patient's wife stated that her lawyer told her that she would not be responsible for a financial payment of her husband's continuing care as he had an irreversible neurological disease that required 24 hour care. A further email of 16 August 2004 from Consultant 2 confirmed that NHS MEL (1996) 22 regarding NHS responsibility for continuing healthcare had been

taken into account, and stated 'As noted, the team did not think he required ongoing NHS in-patient care'.

19. The Board concluded that 'the sequence of events indicates that the clinical and multi-disciplinary team were very clear that Mr C was receiving medium-term care in hospital and the notes indicate that Mrs C and her sister-in-law were informed of this on 19 May 2003, with the GP being informed shortly after, as well as the receiving ward. It, therefore, remains unclear how Mrs C could form a view that she had been given a promise in relation to NHS Continuing Care status for her husband given all the clear documentation. We do acknowledge, however, that, even after the 19 May case conference, one member of the nursing staff has confirmed that she was not clear about the admission status of Mr C.'

20. The MEL sets out guidance for decisions to discharge from long term NHS care as well as criteria for decisions about eligibility for NHS funded Continuing Care. It does not, however, distinguish between these two similar (and sometimes overlapping) situations making interpretation of the guidance confusing. The MEL makes no reference to any process for future review of a decision about eligibility for NHS funded Continuing Care – either where a person's condition deteriorates such that they might later become eligible or improves and they are no longer eligible. This lack of clear guidance again makes interpretation of the MEL difficult for service users. The Adviser told me that the relevant English guidance makes specific reference to the fact that NHS funded care is not provided 'for life' and eligibility may change from time to time.

21. The Board commented that the appeal is a two stage process. In Mr C's case the first stage entailed a detailed review of the process leading up to the decision to discharge and examined whether any undertaking for NHS Continuing Care had been made to Mrs C. The second stage entailed a clinical review of the patient by an independent consultant (Consultant 3) from another NHS Board area. It was the conclusion of Consultant 3 that Mr C did not at that time meet the criteria for NHS Continuing Care.

22. The Fife report notes that within the Board area there are different practices in operation and that a number of clinicians do inform relatives that a patient is eligible for life once so assessed, but that others do not refer to the matter while one clinician specifically provides written information that eligibility

is not for life. The report recommends that a leaflet is produced setting out in writing that eligibility is not for life.

23. The Adviser reviewed Mr C's medical, nursing and Nursing Home records from early 2003 to the time of his death in October 2005. The Adviser told me that Mr C's condition did alter throughout this time, notably his physical condition. The Adviser considered that Mr C had highly complex and intense care needs in relation to the management of his skin integrity and pressure areas; continence management; feeding regime to prevent choking; lack of cognitive functioning and resistive behaviours; and immobility. He required very careful management to ensure his safety and well-being were maintained. The Adviser concluded that while Mr C may not have required ongoing and specialist clinical supervision as set out in the criteria of the MEL (see paragraph 8 and 9) his care needs were complex and intense.

24. The Board commented that in their view Mr C clearly did not meet the criteria of the MEL

> 'the key issue here, we feel, is that the nature or intensity of a person's care needs are such that regular specialist care is required. Such specialist care input was not required by Mr C nor had it been for several months prior to his discharge from Hospital 2. We feel that our opinion on this point is supported by Consultant 3.
>
> Once a person has been designated as needing NHS Continuing Care, because they meet the criteria set out in the MEL, it is true to say that the MEL provides for the NHS to provide that care in a range of settings including Nursing Homes… [the Board] does not routinely contract with any nursing home to provide NHS continuing care for psychiatry of old age patients. Our policy for this group of patients is to provide NHS Continuing Care in hospital settings. Therefore, if Mr C actually needed that form of care in the nursing home, this would lead us to conclude that either Mr C met the criteria and was not receiving appropriate care to meet his needs or he did not meet the criteria and, therefore, did not need NHS Continuing Care.'

(a) Conclusion

25. In considering any complaint about the NHS the Ombudsman's 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 Mr C. Indeed, I note that the Adviser considers Mr C received a high standard of care and treatment in the Hospital and that this view was endorsed by Mrs C.

26. If, in considering Mr C's eligibility for NHS funded Continuing Care, the Board had failed to act in accordance with the MEL that would constitute maladministration which might have caused injustice or hardship to Mr C. The Adviser considers that the view of the Board that Mr C would not have qualified for NHS funded Continuing Care may be open to question. However, that does not necessarily mean that the Board's view is wrong or that there was fault in the process by which it was reached. The Board consider that the view they have reached is fully in accordance with the MEL and I am aware that the position they take, and the processes by which they have arrived at it, are in line with those taken by other NHS Boards in similar circumstances. The MEL did not require any formal assessment or record of why Mr C was not considered to meet the criteria for NHS funded Continuing care and I do not consider the lack of a formal record of an assessment by the Board to be otherwise maladministrative.

27. Much of the initial difficulty in this complaint arose from a miscommunication between some members of hospital staff and Mrs C. I do not consider that Mr C was originally clinically assessed for NHS funded Continuing Care but was for medium-term care. However, this effect of this decision was never adequately explained to Mrs C who on the contrary was led to believe by some members of staff that Mr C was eligible for funding and that this funding would be continued after his move to another ward. The fact that a number of different practices have been in operation within the Board did make it more likely that nursing staff may be misinformed about the correct position. The nursing staff would not have had the authority to make a determination about eligibility and although they were no doubt acting in good conscience their view cannot be regarded as binding on the Board. The lack of clarity in the MEL added to the confusion for Mrs C. I do not consider that Mrs C was made a binding promise of ongoing funding but it was not unreasonable of her to consider that this was the case. I consider that there was maladministration in this regard.

28. Was there service failure? Section 5(2) of the Scottish Public Services 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 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 2). It is not the role of the Ombudsman's 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, do not uphold this aspect of this complaint.

29. However, while I do not have prima facie evidence of service failure the reliance on the use of the word 'specialist' in the MEL is a concern. This case and a number of others with the Ombudsman's office suggest the MEL may be being interpreted in a way which means patients who have a sufficiently high level of health care need are potentially excluded from NHS Continuing Care because their overall care needs cannot overcome the hurdle of requiring 'specialist' input. This would potentially prevent a Health Board from doing something it ought to do under the 78 Act. If this is the case then the Health Board is obliged to follow its legal duty, which may override the guidance if the guidance fails to reflect the law. The Board consider they are correctly applying the MEL but this case begs the question of whether the MEL properly reflects the legal provenance for NHS funded Continuing Care. This is not a question that this office can determine but does lead me to conclude that unremedied injustice may be caused by the application of the MEL.

30. The concern and belief that this unremedied injustice exists is at the core of all the complaints about Continuing Care brought to the Ombudsman's office. This will continue to cause distress and anxiety for patients and their families at a time when they are especially vulnerable and to take up a considerable amount of NHS time and resources in addressing these. This office will, in turn, continue 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.

31. Overall I conclude there was no clinical or service failure but that there was an element of administrative failure. I, therefore, partially uphold this complaint.

(a) Recommendation

32. In light of these conclusions the Ombudsman recommends that the Board;

(i) make a formal, evidenced record of decisions to discharge and that this record is provided to the patient and/or family in a timely manner;

(ii) ensure that when a decision to discharge is reached such a decision is made known to the patient and/or family at the time the decision is taken and that where objections are presented the process for appealing against such a decision is clearly and fully explained;

(iii) act on the recommendation of the Fife report[2] to produce written information on ongoing eligibility for patients assessed as eligible for NHS funded Continuing Care. The Board should ensure that there is a single approach to such funding and that this is commonly understood by all relevant staff; and

(iv) make a written apology to Mrs C that the lack of clarity among staff about eligibility for Continuing Care led to miscommunication to Mrs C of Mr C's status and caused unnecessary distress.

In light of the conclusions in paragraph 28 and 29 the Ombudsman will be referring this report to the SEHD, once again stressing the urgent need for completion of the review of the MEL.

(b) The Board exerted undue pressure on Mrs C by supporting the Local Authority in making an application to the Sheriff Court to be appointed Mr C's welfare guardian

33. Mrs C complained to the Ombudsman's office about the way she and her husband were treated by the Board during the process of discharging Mr C from hospital as she considered that she was forced to agree to the move by the Board threatening legal action to appoint another party as her husband's welfare guardian.

[2] Provision of NHS Continuing Care for Older People in Fife: Needs Assessment. July 2006 NHS Fife

34. On 14 July 2005 the option of placing Mr C in a Nursing Home under a guardianship order was discussed at a discharge planning meeting attended by Mrs C and the Solicitors. The Solicitors advised me that Mrs C had not been informed officially about this meeting and only attended because of a passing remark about the meeting from a member of nursing staff. The Solicitor's the board advised me that Mrs C queried the plan for a meeting with the nurse and only subsequently to this did she receive notification from the Board about the meeting. The Solicitors sought, unsuccessfully, to delay the meeting pending the outcome of the complaint. The minute of the meeting records the view of Consultant Psychiatrist 2 that there were clinical concerns about Mr C remaining in hospital care and that an application under the 2000 Act might be needed to ensure Mr C's welfare. A solicitor for the Board also commented that such an order was necessary in any case where a change of location was contemplated. The meeting note records that all parties were of the view that as no compromise could be reached it would be necessary to apply to the Sheriff to have the matter decided. It was noted that Mrs C would co-operate with the legal process but not with the current discharge process or financial assessment requested by the local authority.

35. On 15 July 2006 Mrs C wrote to the Board advising that on consideration she would co-operate with Mr C being discharged from the Hospital and asking for confirmation that in this event the Board would no longer seek to support an application under the 2000 Act. It is interesting to note that despite the view of a solicitor for the Board that an application would be needed in any event, no such application was in fact made. The guidance issued by the Mental Welfare Commission refers to differing legal opinions and interpretations on this matter.

36. In response to the draft report Mrs C told me that she had no concerns about the level of care her husband received while an NHS in-patient but that she had very real concerns about the ability of any care home in the area being able to cope with his high level of need for care. Mrs C was particularly concerned that without immediate access to medical input, any change in her husband's condition would not receive a prompt response. Mrs C also told me that she feels that events have proved her correct as the care home did not contact a doctor to review her husband for several days after she raised a concern about a change in his condition.

(b) Conclusion

37. It is clearly in everyone's best interests in such cases that the way forward is agreed by all parties. However, this will not always be possible and where a stalemate is reached more formal action may be necessary to enable progress. I understand that some actions will have very broad implications beyond the immediate concern about discharge and accordingly will be a cause of considerable anxiety to relatives. Such steps should, therefore, only be taken as a last resort.

38. The full process for appeal against discharge had been followed and the view of clinicians was that Mr C should be discharged. In this circumstance I conclude that the Board acted reasonably in considering action to apply to the Sheriff for a Guardianship Order and I do not uphold this aspect of the complaint.

Wider Policy Issues

39. This and a number of other cases currently with the Ombudsman's 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 Free Personal and Nursing Care currently being undertaken by them.

40. 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. The Ombudsman's 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.

41. 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 (along with the other related reports) to the SEHD for consideration of the impact of the current guidance in individual cases.

20 June 2007

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved
Mrs C	The aggrieved's wife
The Solicitors	The Complainant (representing Mrs C)
The Board	Fife NHS Board
The Adviser	The Clinical Adviser to the Ombudsman
SEHD	Scottish Executive Health Department
NHS QIS	NHS Quality Improvement Scotland
The Nursing Home	The nursing home where Mr C was resident after his hospital discharge
Hospital 1	Whyteman's Brae Hospital
Hospital 2	Stratheden Hospital
Consultant 1	The consultant initially responsible for Mr C's care planning
Consultant 2	The psychiatrist who attended the discharge planning meeting in July 2005
Consultant 3	The Consultant from another health board area who reviewed Mrs C's appeal against refusal of NHS Continuing Care Funding

Annex 2

Glossary of terms

Dementia	Symptoms, including changes in memory, personality and behaviour, which result from a change in the functioning of the brain.
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

Annex 3

Summary of legislation, policies, case law and reports considered

National Health Service (Scotland) Act 1978
Section 36 states:
(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 -
(a) hospital accommodation, including accommodation at state hospitals;
(b) premises other than hospitals at which facilities are available for any of the services provided under this Act;
(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)

Community Care and Health (Scotland) Act 2002

Adults With Incapacity (Scotland) Act 2000

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).

SEHD Circular
No. SWSG10/1998
Scottish Office: Community Care Needs of Frail and Older People (Integrating Professional Assessments and Care Arrangements)

SEHD Circular
No. CCD 8/2—3
SEHD Circular: Choice of Accommodation – Discharge from Hospital

SEHD Letter
DKQ/Q44
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

List of Case Law (and brief summary conclusions)

R v North and East Devon Health Authority ex parte Pamela Coughlan [2000] 2 WLR 622
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.
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.
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 the Ombudsman's 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. Consultants can make discretionary and undocumented decisions that patients are not eligible to be assessed under the MEL and this results in a lack of transparency and 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.