HEALTH SERVICE OMBUDSMAN
MILLBANK TOWER
MILLBANK
LONDON SW1P 4QP

TELEPHONE: 0845 015 4033
TEXT TELEPHONE: 020 7217 4066
FACSIMILE: 020 7217 4940
EMAIL: OHSC.Enquiries@ombudsman.gsi.gov.uk
WEBSITE: www.ombudsman.org.uk

Published by TSO (The Stationery Office) and available from:

Online
www.tso.co.uk/bookshop

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/General enquiries 0870 600 5522
Fax orders 0870 600 5533
E-mail book.orders@tso.co.uk
Textphone 0870 240 3701

TSO Shops
123 Kingsway, London WC2B 6PQ
020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
0121 236 9696 Fax 0121 236 9699
9-21 Princess Street, Manchester M60 8AS
0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
18-19 High Street, Cardiff CF10 1PT
029 2039 5548 Fax 029 2038 4347
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/General enquiries 020 7219 3890
Fax orders 020 7219 3866

TSO Accredited Agents
(see Yellow Pages)

and through good booksellers

THE HEALTH SERVICE OMBUDSMAN

NHS funding for long term care

HC 399

THE HEALTH SERVICE
OMBUDSMAN

NHS funding for long term care

2nd REPORT – SESSION 2002-2003

Presented to Parliament Pursuant to Section 14(4)
Of the Health Service Commissioners Act 1993

Ordered by
The House of Commons
To be printed on
13 February 2003

HC 399 London : The Stationery Office

THE HEALTH SERVICE OMBUDSMAN

Contents

THE HEALTH SERVICE
OMBUDSMAN

Foreword

NHS funding for long term care of older and disabled people

Over the last 18 months my office has been investigating a number of complaints about arrangements for long term NHS care (often referred to as continuing care) for older and disabled people. Similar concerns have been raised by many of the complainants, particularly about the local criteria used by health authorities between 1996 and 2001 to decide whether people were eligible for NHS funding for care in nursing homes. Four of the investigations, involving four different health authorities, are now complete. The complaints concerned were largely justified. Authorities were using over-restrictive local criteria which were not properly in line with Department of Health guidance nor with a crucial judgment by the Court of Appeal in 1999 (the Coughlan judgment). The effect was that in at least one case a patient had to pay for their own care when the NHS should have paid for it. The complaints I have seen also raise other concerns detailed in the report, about how the system for assessing eligibility for NHS funding has been working.

Although I have more similar investigations underway, the evidence from the first four suggests that it is in the public interest for me to publish the results of our work so far, by laying this report before Parliament in accordance with Section 14(4)(b) of the Health Service Commissioners Act 1993.

I do that for two reasons. First, because although as Health Service Commissioner I cannot investigate the actions of the Department of Health, in my view weaknesses in the Department's guidance have contributed to the difficulties. Health authorities and trusts will need further support and very clear guidance from the Department both to avoid similar problems in the future and to ensure that previous problems are properly identified and remedied. I look to the Department to provide that.

Secondly, I am concerned that all those who have suffered injustice from such failings should obtain redress. In the investigations completed, we have asked authorities to identify any other patients who may have been adversely affected by the over-restrictive criteria and to remedy any injustice caused. However identifying such patients is not easy, and a greater public awareness of the issue may assist in that. Also the findings of the initial investigations make me wonder if there were similar problems in other areas of the country. I hope that all NHS bodies concerned with such matters will review whether the criteria used since 1996 conformed to national guidance and, if they conclude that they did not, will act now to remedy any injustice caused.

Ann Abraham
Health Service Commissioner for England

February 2003

arrangements for Mrs R's placement were not handled as sensitively as they could have been. It says it is 'not sure of the value' of apologising about the unreasonableness of the criteria, since it is not convinced that the criteria and their application led to any injustice to Mrs S.

34. I therefore ask it to reconsider both the approach it is taking to a retrospective review and the fullness of the apology.

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
02/03 819899 19585 130371

5 October - The Secretary of the Health Authority informed Mrs S of this decision stating:

'It is the unanimous view … of all persons concerned … that [Mrs R] does not meet the criteria for NHS Continuing Care.

'It is the view of the [Health] Authority, having consulted the Independent Chairman, that the proper process has been followed in arriving at this conclusion. The [Health] Authority has therefore decided not to proceed with the continuing care review panel.'

The new Health Authority's response to the statement of complaint

29. On 19 April 2002 in his formal response to the statement of complaint the Chief Executive of the new Health Authority wrote:

'… In accordance with HSG (95)39 Paragraph 19 the Health Authority does have the right to decide not to convene a Panel in those cases where the patient falls well outside the eligibility criteria. Before taking such a decision, the [Health] Authority sought advice from the Independent Chairman of the Continuing Care Review Panel …

'In considering the request, the Chairman … [checked] that [the] proper procedures have been followed in reaching that decision about the need for Mrs R to receive NHS Continuing in-patient care, and to ensure that the Health Authority's eligibility criteria had been properly and consistently applied.

'… [The Chairman] … decided not to convene a Panel…

'Mrs S was informed of the decision on 5 October and was informed that if she was not satisfied, she could make a complaint through the NHS Complaints System.'

Findings (b)

30. I turn next to the complaint that the review process was not properly applied. HSG (95)39 clearly states that although the Health Authority does have the right not to convene a panel, this should be confined solely to those cases where the patient falls **well** outside the criteria. I interpret this to refer to those cases where the needs of the patient were such that there could be no doubt whatsoever that the eligibility criteria were not met. However when writing to explain the decision that no panel should be held the Health Authority did not suggest that Mrs R fell **well** outside the criteria, only that she did not meet them. I do consider that this was not an adequate reason for a refusal to hold a panel. It is not within the power of a panel to consider the criteria themselves: so, given the over-restrictive criteria being applied, Mrs R might still reasonably have been judged to be well outside the criteria and been denied a panel or would probably not have received funding even if a panel had been held. Therefore although the review procedures were not properly followed, that in itself probably did not affect the funding decision. The main problem lay with the criteria themselves and that was not a matter the review procedure was designed to address. I uphold the complaint only to the extent that inadequate reasons were given for refusal to hold a panel.

Conclusions

31. I have set out my findings in paragraphs 20-25 and 30. The new Health Authority has agreed to make sure that the new criteria used in its area are more precise and that they will deal more explicitly with compliance with the Coughlan judgment. It has agreed that, with the Birmingham PCTs, it will review the criteria in use since 1996, by seeking further legal advice as to their compliance with the guidance and the Coughlan judgment. It has also said that it will review against the new continuing care criteria those patients currently in nursing homes and funded in part or whole by social services. If this exercise identifies anyone who might meet the criteria, they will arrange an assessment and appropriate funding. If they find that there are 'considerable numbers' who meet the criteria, they will undertake a larger retrospective exercise.

32. I am pleased that the new Health Authority has accepted most of my findings and agreed to some of the recommendations. However I am disappointed that it is not prepared to adopt in full my recommendation about determining whether there were any patients who have been wrongly refused funding since 1996. What it proposes goes a considerable way towards that, but does not involve a retrospective review, unless they find there are 'considerable numbers' of patients still alive who have suffered an injustice. However the patients most at risk of having suffered an injustice, by being wrongly judged to be ineligible for NHS funding for their care, are those with the greatest health needs. They are probably also the patients most likely to have died during the period.

33. The new Health Authority has asked me to convey through my report - as I do - its apologies to Mrs S that the criteria were worded in such a way that they could have been misinterpreted and that

THE HEALTH SERVICE OMBUDSMAN

Introduction

1. I know that arrangements for funding long term care (also known as continuing care), particularly for dependent elderly people, are of general public concern. In the last 18 months my office has received and begun considering 13 complaints about NHS funding for such care, to add to three already under investigation at the start of that period. Many of the newer complaints have also raised concerns which required investigation. While each complaint is different, many raise similar issues. A pattern is emerging from the complaints I have seen of NHS bodies struggling, and sometimes failing, to conform to the law and central guidance on this issue, resulting in actual or potential injustice arising to frail elderly people and their relatives. Therefore I think it is important for me to report on the issues arising from these complaints as soon as possible, even though several of the investigations are not yet complete. The indications are that problems may be widespread. My hope is that action will be taken to remedy the situation, not just in respect of complaints I have received and upheld, but more widely. This report includes the full text of the reports of the first four completed investigations. Nothing in this report should be read as implying that I have pre-judged the outcome of others: as always each complaint will be considered on its own merits.

2. The people who have complained to me are not only concerned about what they see as the unfairness of the system for funding care, but about substantial financial injustice when it was applied to them. This arises because, if the NHS fully funds continuing care in a care home, the patient does not have to make any contribution to the cost of that care. If not, the patient funds much of the care him or herself; or it is funded by local authority social services departments, with patients being expected to contribute according to their means. That can mean some patients having to use virtually all their accumulated life savings and capital from the sale of their home, to pay for care: whereas other patients who are judged eligible for full NHS funding for care in a care home make no financial contribution at all, regardless of their means. It is not surprising therefore that the decisions made by NHS organisations about eligibility for NHS funding arouse strong feelings.

Legal and policy framework

3. The issue is not a new one for this office. Sir William Reid published reports on similar cases in 1994 and 1996 (HC 157 and HC 504). The first of those reports was titled 'Failure to provide long term NHS care for a brain-damaged patient' and referred to what is often known as the Leeds case. Following that, in February 1995, the Department of Health issued new guidance (HSG (95) 8) on NHS responsibilities for meeting continuing care needs, setting out a national framework within which health authorities were to develop their own eligibility criteria for continuing care. Sir William Reid's report (titled 'Investigations of complaints about long term NHS care') published in 1996 related to complaints that had arisen before then.

4. The Department of Health's 1995 guidance said that the NHS was responsible for arranging and funding inpatient continuing care, on a short or long term basis, for people:

> '…. where the complexity or intensity of their medical, nursing care or other care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team….

'…. who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff ….

'who have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.'

The in-patient care might be provided in a hospital or in a nursing home.

5. The Department issued further guidance (EL(96)8), in February 1996. That referred to the danger of eligibility criteria being over-restrictive and mentioned the risk of an over-reliance on the needs of a patient for specialist medical opinion when determining eligibility for continuing care. It said that there would be a limited number of cases where the complexity or intensity of nursing or other clinical needs might mean that a patient was eligible for continuing care even though they no longer required medical supervision.

6. In March 1999 a Royal Commission on Long Term Care reported. This had looked at a range of issues connected with funding of long term care for elderly people. It identified three principles behind its approach:

- Responsibility for provision now and in the future should be shared between the state and individuals - the aim was to find a decision affordable for both and one which people could understand and accept as fair and logical;
- Any new system of state support should be fair and equitable;
- Any new system of state support should be transparent in respect of the resources underpinning it, the entitlement of individuals under it and what it left to personal responsibility.

One of the Royal Commission's main recommendations was that the costs of long term care should be divided between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means. The Commission defined personal care as the care needs, often intimate, which give rise to the major additional costs of frailty or disability associated with old age. It was to include support from skilled professionals.

7. The Government responded in July 2000. It did not accept the recommendation about personal care, but accepted an alternative proposal to make **nursing** care in nursing homes free to users, by providing NHS funding (see paragraph 10).

8. Meanwhile, in July 1999, the Court of Appeal had given a crucial judgment (R v. North and East Devon Health Authority ex parte Coughlan) relating to funding for continuing care. This considered the issue of whether nursing care for a chronically ill patient might lawfully be provided by a local authority as a social service (in which case the patient paid according to their means) or whether it was required by law to be provided free of charge as part of the NHS. The judgment said that whether it was unlawful to transfer responsibility for the patient's general nursing care to the local authority depended, generally, on whether the nursing services were:

(i) Merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide; and

(ii) Of a nature which it could be expected that an authority whose primary responsibility is to provide social services could be expected to provide.

of Health, I **recommend** that the new Health Authority seeks advice from the Midlands and East Health and Social Care Directorate. Following this advice and to avoid any further delay, I **recommend** that the new Health Authority promptly sets out a clear plan for the implementation of its revised criteria for funding continuing care. Although the new Health Authority said that the revision was intended to provide clearer criteria for staff to use, if the criteria are to be applied consistently (and for that to be clear to patients and carers), guidance for staff (also made available to the public) on interpreting the criteria and assessing patients against them will also be needed. I **recommend** that the new Health Authority produce such guidance. I uphold the complaint.

Complaint (b): the review process was not properly applied

National guidance on Continuing Care Review Panels HSG (95)39 - Discharge from NHS Inpatient Care of People with Continuing Health and Social Care Needs - 'Arrangements for Reviewing Decisions on Eligibility for NHS Continuing In-patient Care'

26. In 1995, detailed guidance, HSG (95)39, was issued to health authorities and trusts on dealing with applications for review of decisions about eligibility for NHS continuing in-patient care. The review procedure did not apply where patients or families wished to challenge the content rather than the application of the eligibility criteria. The guidance included, as an appendix, a checklist of issues to be considered before referring a case to a review panel. It also included:

'4. The review procedure is intended as an additional safeguard for patients assessed as ready for discharge from NHS in-patient care who require ongoing continuing support from health and/or social services, and who consider that the health authority's eligibility criteria for NHS continuing in-patient care (whether in a hospital or in some other setting such as a nursing home) have not been correctly applied in their case …

'19. The health authority does have the right to decide in any individual case not to convene a panel. It is expected that such decisions will be confined to those cases where the patient falls well outside the eligibility criteria, or where the case is very clearly not appropriate for the panel to consider …'

In June 2001, the Department of Health issued new guidance HSC 2001/015, which cancelled previous guidance including, HSG (95)39. However, the review process detailed in HSG (95)39, remained largely unchanged.

Documentary evidence

The Health Authority's Guidance on Continuing Care Review Panels

27. The Health Authority's patient leaflet entitled 'How to ask for a review if you think decisions made about you or your relative are wrong' states:

'… whether your case is reviewed will depend on the reason for your request. If you are challenging the procedure that was followed or the fact that you are being denied continuing care even though you think you comply with the criteria, your case **will** normally be reviewed.

'… The panel will **not** review your case if you are challenging or complaining about:

- the criteria themselves
- the type or location of continuing health care which you have been offered;
- the care you have already received.'

Sequence of events

28. I set out below the principal events and correspondence relevant to the matters investigated.

11 September 2001 - Mrs S wrote to the Health Authority requesting that the decision to refuse her mother funding for continued in-patient care be reviewed:

'… It is obvious that no-one has spent time with my mother or they would see how anxious she is and continually needs reassuring that she will be getting out of hospital, where she has been for 3 months and at 91 years old she deserves care and consideration. She has substantial memory problems and not even recognises her own family frequently … [I] therefore, request an independent review panel to be arranged.'

An Independent Chairman reviewed the documentation and concluded that the process for deciding whether Mrs R qualified for NHS-funded continuing care had been properly applied and that a review panel should not take place.

She continued to be refused funding from then until December 2001 when she was discharged from hospital to a nursing home (where she died very soon afterwards). By this point, the Health Authority were obliged to fund the registered nursing element of her nursing home care, following the implementation of HSC 2001/17 in October 2001. At the time of her discharge to the nursing home the decision on full funding for NHS care continued to be based on the original over-restrictive criteria dating from 1996. However the Health Authority had been expected, by October 2001, to have ensured that continuing NHS care policies complied with the revised guidance (HSC 2001/015) which had been issued in June 2001, and by March 2002 they should have agreed new joint eligibility criteria for the respective responsibilities of meeting health and social care needs. Also from October 2001 some of the concerns raised by the Coughlan judgment about the funding of nursing care would not apply in quite the same way, as (following HSC 2001/17 - paragraph 13) health authorities were funding nursing care in homes for patients such as Mrs R who would otherwise have had to pay for it themselves. Although the deadline of March 2002 for agreeing joint eligibility criteria was postponed until October 2002, in this case the Health Authority had not revised their criteria since 1996, even in the light of the Coughlan case and the 1999 guidance. I criticise the Health Authority for that. I conclude that the Health Authority, in failing to revise their criteria and assessing Mrs R only against their, over-restrictive, 1996 criteria, acted unreasonably.

22. I am also concerned that the draft of the new eligibility criteria as outlined by the new Health Authority, paragraph 18, might still be more restrictive than the current guidance intends: though the way the guidance is drafted makes it difficult to be sure. The draft new Health Authority criteria requires a need for '**daily**' supervision or intervention by NHS staff, whereas the national guidance refers only to that being needed 'regularly'.

23. How have the Health Authority's failings affected Mrs R and Mrs S? The Health Authority's criteria were certainly significantly more stringent than could reasonably have been the case between April 1996 and October 2001. It seems likely therefore that some people who were entitled to NHS-funded continuing care in the Birmingham area from June 1996 were denied it. Had Mrs R been assessed against criteria which were in line with the then guidance and the Coughlan judgment, she might (though it is not possible to be certain) have been deemed eligible for NHS funding for her nursing home care. She might then have left hospital earlier in 2001 and continued to receive full funding for her nursing home care until her death in December. However she did in fact have full NHS funding for her care for virtually all of that period, as she was in hospital until a few days before her death. By the time she was discharged she was entitled to, and got, free nursing care for the short period she survived after admission to the home. I do not think therefore that there was any major financial injustice to her estate.

24. However Mrs S complained that as a result of the decision not to fund in-patient continuing care, her mother missed the opportunity of an early transfer to a nursing home closer to her family, and remained in hospital unnecessarily. Nothing prevented Mrs R's family from making arrangements to discharge her to a nursing home as soon as she was well enough. However that might have been at her own cost, and I can understand why her family did not do that while they were still disputing the assessment and criteria used for determining eligibility for NHS funding. Nevertheless, she could in my view have suffered an injustice, in that had the use of reasonable criteria led to her being considered eligible for funding, she probably would have moved to a nursing home closer to her family at a much earlier stage. Sadly there is nothing I can recommend now which could be done to remedy that situation. However I know that Mrs S was also keen to make sure that others did not suffer similarly. I too am concerned about that.

25. The organisation of the NHS has changed since these events. Birmingham Health Authority no longer exists. Responsibility for setting eligibility criteria now lies with the new Birmingham and The Black Country Health Authority, and the relevant budget for funding such care will be held by a Primary Care Trust (PCT). While I recognise that the new Health Authority played no part in these events, I must regard them as responsible for taking remedial action. I **recommend** that the new Health Authority should, with its associated PCT and local authority colleagues, review the eligibility criteria for funding continuing care that have been in operation **since April 1996** to ensure that they were in line with the Coughlan judgment and other relevant guidance at that time. I further **recommend** that the new Health Authority should, with its associated PCT and local authority colleagues, determine whether there were any patients who were wrongly refused funding for continuing care from April 1996 onwards, identify them and make the necessary arrangements for reimbursing the costs they incurred unnecessarily. To ensure that the revised continuing care policy and eligibility criteria to be used **in the future** appropriately reflect the intentions of the Department

9. In the light of that, in August 1999, the Department of Health issued guidance (HSC 1999/180) on action required in response to the judgment. It said that health authorities should satisfy themselves that their continuing and community care policies and eligibility criteria and other relevant procedures were in line with the judgment and existing guidance. Where health authorities revised their criteria, having involved and discussed the outcome with Primary Care Groups, they should consider what action they needed to take to re-assess the eligibility of current service users against the revised criteria. The guidance said that the Government would be reviewing continuing care policy and guidance, with a view to issuing revised guidance later that same year.

10. In March 2001 the Department of Health issued a National Service Framework (NSF) for Older People. That referred to the provision of free nursing care in nursing homes, but did not include any guidance on NHS funding for the full costs of continuing care for older people.

11. New guidance on continuing care was not issued until June 2001 (HSC 2001/015): nearly two years after the 1999 guidance. It replaced the previous guidance. It referred to the Coughlan judgment, saying that eligibility criteria for NHS arranged and funded nursing services in nursing homes should cover the following situations:

- Where all the nursing service is the NHS's responsibility because someone's primary need is for health care rather than accommodation;
- Where responsibility can be shared between the NHS and the council because nursing needs in general can be the responsibility of the council but the NHS is responsible for meeting other health care requirements;
- Where the totality of the nursing service can be the responsibility of the local council.

The Department's guidance listed issues which health authorities had to consider when establishing eligibility criteria for what it called continuing NHS health care, i.e. 'a package of care arranged and funded solely by the NHS' - I shall use that terminology from now. However, it included very little guidance on how exactly the listed issues should affect eligibility (see annex for relevant extracts from the guidance).

12. The Department's June 2001 guidance looked ahead to the introduction in October 2001 of NHS funding for nursing care in nursing homes (often referred to as 'free' nursing care). This meant that from that date the NHS would fund care in nursing homes by a **registered nurse** (but not by other staff) for people who would otherwise be funding the full cost of their care themselves. From April 2003 NHS funding will be provided for such care for all care home residents. (In April 2002 the previous distinction between nursing and residential homes ended, and all are now known as care homes, with or without nursing care.) A circular and practice guide on free nursing care was issued by the Department in August 2001. The amount of nursing care required (the Registered Nurse Care Contribution - RNCC) is assessed by an NHS nurse to determine which of three bands (levels) of nursing care is needed. Each band, high, medium and low, attracts a different level of NHS funding. The practice guide mentions specifically that the advent of free nursing care left responsibilities for continuing NHS health care (which it defined as being where service to meet the totality of the patient's care should be arranged and funded entirely by the NHS) unchanged.

13. In January 2002 the Department of Health issued a circular (HSC 2002/001) and guidance on the implementation of a single assessment process for older people, as heralded in the National Service Framework. The purpose of the process is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively. The process (which is still being implemented) is designed to ensure that agencies do not duplicate each other's assessments, and should provide information to support the determination of the RNCC for residents in care

homes which provide nursing care. The guidance does not suggest how, if at all, the single assessment process would contribute to assessment of eligibility for full NHS funding for care in a home. The guidance does not recommend the use of any particular assessment tool, but leaves it to bodies to develop and agree what to use locally.

Issues arising from complaints

14. The complaints I have received are about events that arose in the period 1997 to date (but mainly before October 2001), and raise several important issues. Those include:

- Informing and involving patients and their relatives;
- Developing eligibility criteria for NHS-funded care in line with guidance issued in 1995;
- Reviewing eligibility criteria in the light of the Coughlan judgment (July 1999);
- The national framework for NHS funded care;
- Assessment against criteria.

Involvement and information

15. Patients and relatives often complain about not being adequately involved in decisions about moving into a care home, about being given inadequate information about how decisions are reached, and the financial implications of those decisions.

16. Many patients move to care homes after a spell in hospital, for example following a stroke or a serious fall. While it is in no-one's interests for patients to remain in hospital longer than they need to, this means that there can be pressure to arrange a move quickly. Yet giving up one's own home and moving into a care home is a major event, with enormous emotional and financial implications. It is therefore essential that health and social services staff, who are involved jointly in such situations, work well together to make sure that patients and relatives have all the information and support they need to make the difficult decisions involved at such a stressful time. Too often I receive complaints of patients' and relatives' views not being taken into account in multi-disciplinary assessments, of little or no written information being provided and of criteria and procedures not being explained adequately.

17. A contributory factor in this seems to be inadequate communication between health authorities and NHS trusts. Within the NHS, primary responsibility for setting eligibility criteria rests with health authorities: but it is usually trust staff who carry out clinical assessments of patients' needs against the criteria, sometimes with little or no guidance on the practical application of the criteria. Also they are not always sufficiently well-informed to discuss the wider issues of eligibility, for instance the review procedure, with patients and relatives.

Developing eligibility criteria in line with the 1995 guidance

18. The Department of Health's 1995 guidance required, for the first time, that all health authorities developed eligibility criteria for access to NHS-funded continuing care. It laid down a broad national framework, leaving health authorities room to develop their own local criteria within that. It is not surprising, therefore, that criteria vary from authority to authority and that (as in one case published today, E.420/00-01) the same patient might be judged to be eligible by one authority but not another. Patients and their relatives find such differences hard to understand within a **national** health service but, without national criteria, such differences are almost inevitable and not in themselves evidence of maladministration.

'We do not anticipate that this revision will lead to a significant shift in the threshold for in-patient continuing care but it should produce clearer and more focussed definition …'

18. In further comments in October 2002, the Head of Corporate Affairs at the new Health Authority said:

'[The Health Authority] had some discussions with lawyers post-Coughlan, although I have not found any clear documentary evidence of advice received at the time. The recollection of those involved was that there were not any particular points of concern.

'This is borne out by some legal advice the [Health] Authority received … in September 2001, which states that "the existing criteria are, I believe, generally sound, although clearly not framed in language which is now common following the Coughlan judgment. In particular they do not expressly refer to the limitation on Social Services ability to purchase nursing care expressed in the Coughlan case, by reference to what is incidental and ancillary for the provision of accommodation The Court of Appeal gave no clear guidance on the interpretation of this although significantly they approved … guidance … that talked in terms of the general nursing care in nursing home being the responsibility of Social Services. Your existing criteria do have an approximation to the 'quantity' test in the second alternative for in-patient care." …'

19. In further comments in November 2002 the Chief Executive of the new Health Authority said:

'The former Birmingham Health Authority criteria were not intended to suggest that only patients who required a nurse to be with them and attending to them without a break 24 hours a day might meet the criteria but we accept that it is possible they could have been interpreted in that way …

' … [the former Authority's lawyers] concluded that the criteria were broadly in line with what was expected although they identified some areas where the language of the criteria did not reflect that being used after the Coughlan judgment. This view was reported to the West Midlands Regional Office [of the NHS Executive], which was the requirement at the time.

' … The criteria were designed to recognise a group of people whose needs for nursing care were greater than could be regarded as incidental or ancillary to the provision of accommodation: and indeed the Health Authority funded a number of nursing home placements for people who were judged to meet the continuing care criteria. We recognise however that the wording used in the … criteria was not the same as contained in the Coughlan judgment and that therefore it may not have been clear that this was the way in which the criteria were intended to operate …'

Findings (a)

20. The matter I will consider first is whether the Health Authority's criteria for eligibility for continuing in-patient care were unreasonable. The national guidance, as set out in paragraph 7, stated that health authorities should fund the costs of continuing care for those patients whose health care needs were so complex or intense as to require regular supervision/intervention of specialist and/or NHS staff. Health authorities have the discretion to determine their own eligibility criteria, provided that these appropriately reflect the national framework. The Authority's criteria required a need for either weekly input from a consultant or continual intensive skilled health care supervision on a 24 hour basis. While it is hard to be sure how the latter criterion would be applied in practice, there is a risk that it would have been interpreted as meaning that only patients who required a nurse to be with them and attending to them, without a break, 24 hours a day might be seen to satisfy the criterion. That would be more restrictive than the national framework. However my main concern about the criteria is how they measure up to the Coughlan judgment. Health authorities had been asked, following the Coughlan case in 1999, to review their criteria in the light of the judgment. The judgment, and subsequent guidance, clarified the point that health authorities could not expect social services to fund nursing services unless the services were merely incidental or ancillary to the provision of accommodation and of a nature which a social services authority could be expected to provide. The Health Authority's criteria do not appear to have been amended at that point, even though they do not reflect that position: in my view there would certainly be a group of people who do not need weekly review by a consultant or continual intensive skilled health care supervision on a 24 hour basis, but whose needs for nursing care are greater than could be regarded as merely incidental or ancillary to the provision of accommodation. Therefore, in the light of the Coughlan judgment, the Health Authority's criteria were certainly over restrictive. The judgment did not change the law, but clarified what the law had already been. The criteria had therefore been over restrictive since 1996.

21. Mrs R was first assessed as ineligible for full NHS funding for her nursing home care in June 2001.

transfers, in need of all personal care, but able to feed herself, needing occasional enemas, catheterised and with a sore left heel, a superficial sore on her sacrum and a healing burn on the left side of her chest. She is nursed on a Nimbus III mattress, but is fully alert though confused and can sit out of bed.

'Although her cardiac condition may from time to time need consideration, I do not believe she needs weekly Consultant supervision, nor do I foresee useful prospects of rehabilitation. In so far as the wording of the criteria is capable of precise interpretation, I do not think that she needs daily care incorporating continual intensive skilled care with health care supervision or intervention on a 24 hour basis, nor on the other hand is her prognosis foreseeably eight weeks or less. I do not therefore feel that she meets the [Health] Authority's Continuing Care Criteria for continued in-patient care.'

22 August - The Health Authority again advised Mrs S that following the second assessment Mrs R had not met the criteria for NHS Continuing care.

10 December - Mrs R was discharged to a nursing home, where she died six days later.

Mrs S' evidence

16. In her letter to the Ombudsman Mrs S complained that her mother had been in hospital for over five months unnecessarily and that as only her basic needs were being met, her quality of life was poor. Despite being unable to do anything for herself, her mother was unable to obtain NHS funding for continuing in-patient care in a nursing home.

The new Health Authority's response to the statement of complaint

17. On 19 April 2002, in his formal response to the statement of complaint the Chief Executive of the new Health Authority wrote:

'... The [Health] Authority's criteria were originally produced in response to the requirement to agree continuing health care criteria set out in HSG(95)8. This guidance identified a need to include a category for continuing in-patient care that covered patients with a level of complexity or intensity of the need that meant that they needed regular specialist skilled health care supervision. (Annex A, section E of the guidance).

'There is obviously a balance to be struck in producing criteria between providing sufficient clarity and consistency and ensuring that staff applying the criteria are able to relate them to the circumstances of any particular patient. The health authority's view, however, is that the criteria as currently produced:

- Identify a group of patients whose clinical needs are so complex that they require regular consultant review;
- Identify a group of patients whose need for care is so intensive that they need daily skilled health care supervision;
- Distinguish between patients who may be in need of care but whose needs could be met through the services normally available to, for example, residents of nursing homes and patients with higher dependency continuing health care needs.

'The [new Health] Authority is, also, in the process of reviewing our continuing health care criteria following the [Coughlan] judgment and recent guidance received from the DoH (HSC 2001/015). We are in the final stages of this review which has included seeking advice from the [Health] Authority's solicitors and are consulting with staff involved in applying the criteria in both health and social services. It is, however, likely that the relevant sections of the criteria will be revised to read:

"the person has such complex, unstable and/or unpredictable health care needs that s/he requires continual intensive skilled health care supervision and/or intervention on at least a daily basis. The level of care needed will be over and above the highest level of free nursing care provided in a nursing home

AND

has been assessed for rehabilitation and found to have no further capacity to benefit from such programmes."

'The revision is designed to:

- provide clearer criteria for use by staff
- focus more directly on the complexity, instability or unpredictability of care needs rather than the frequency of intervention by particular health care professionals
- provide a specific link between the criteria and the levels of need set out in the guidance from implementing NHS responsibility for nursing care in nursing homes.

19. However, some of the local criteria I have seen appeared to be significantly more restrictive than the guidance permitted. For instance: some explicitly say that only patients requiring continued consultant supervision, or on-site medical expertise, are eligible for NHS-funded care: others seem to suggest that in explanatory text, or to imply that only people requiring hospital care are eligible. Yet it is quite clear from the 1995 guidance, and reinforced by the additional guidance in EL (96) 8, that some other patients should be eligible.

Taking the Coughlan judgment into account

20. The Coughlan judgment provided a valuable analysis of some legal and policy issues connected with the funding of continuing care, and set out the basis for deciding whether it was reasonable for the NHS to refuse to fund the general nursing care of a patient in a care home. The Department of Health quite properly drew the judgment to the attention of NHS bodies and asked health authorities to review and, if necessary, revise their criteria to ensure that they were in line with the judgment. They were also asked to reassess patients' eligibility for NHS-funded care where criteria had been revised.

21. However, in a number of the complaints I have seen, any review of the criteria following the judgment seems to have been very limited, and criteria remained unchanged even when it is very hard to see that they were in line with the judgment. I would have expected the Department of Health, when reviewing the performance of health authorities, to have picked this up and taken action itself. But I have seen some evidence to suggest that the Department provided little real encouragement to authorities to review their criteria, and eligibility of patients, actively. My enquiries so far have revealed one letter (in case E.814/00-01) sent out from a regional office of the Department of Health to health authorities following the 1999 guidance, which could justifiably have been read as a mandate to do the bare minimum. The statement in the 1999 guidance, that more guidance would follow later that year, may also have encouraged some authorities to wait before taking significant action.

22. It was nearly two years from the time of the Coughlan judgment before further substantive guidance was issued, and in some health authorities little progress seems to have been made in reviewing their eligibility criteria during that period. There is a significant group of patients whose nursing care cannot be regarded as merely incidental or ancillary to the provision of accommodation which a local authority is under a duty to provide, or of a nature which a social services authority could be expected to provide. It appears to me that some health authorities were reluctant to accept their responsibilities with regard to such patients and were not being pressed by the Department of Health to do so.

23. Since October 2001 the Coughlan judgment has rather less significance as regards eligibility for NHS-funded continuing care (for people who otherwise had to pay the cost of care - including nursing care - in a care home themselves) because care provided by registered nurses is now funded by the NHS. But the impact of the judgment reaches back some way: the judgment elucidated the law as it was, it did not introduce a change in 1999. Even before then it was contrary to the law for health authorities to operate criteria which were out of line with the law, as explained in the judgment. I would not regard their choice of criteria as maladministrative between 1996 and 1999 if the criteria were in line with national guidance. However, I take the view that health authorities still have a responsibility, in the light of the Coughlan judgment, to remedy injustice to patients flowing from any criteria which are now known to have been unlawful. I therefore think it only right for health authorities who have used criteria out of line with the judgment at any point since April 1996 (when it first became mandatory to have written criteria), to attempt to identify any patients who may wrongly have been made to pay for their care in a home and to make appropriate recompense to them or their estates.

24. It is impossible for me to estimate how many people might be affected and the potential total cost of making such payments: but I recognise that significant numbers of people and sums of money are likely to be involved. I also recognise that the responsibilities of the health authorities involved transferred to new

strategic health authorities in October 2002. Furthermore the relevant budget will now be held by primary care trusts, not the new authorities. I can see that none of this will be easy to resolve: but that is not a reason for me to refrain from expecting a remedy for those who have suffered an injustice.

25. Prompted by a letter my predecessor sent to him on completion of the first of these investigations, in August 2002 the Chief Executive of the NHS very helpfully included, in a bulletin sent to Chief Executives of health and social care bodies, a reference my conclusions in that case. It reminded health authorities of the need to consider whether criteria previously applied in their area were similarly at fault and whether patients were wrongly denied NHS-funded care. That was an excellent first step towards resolving the issue, but I can see that further guidance and support will be needed from the Department of Health to ensure that all strategic health authorities take comprehensive and consistent action in this regard. Otherwise I fear I may see further complaints about the way remedial action has been tackled locally.

Recommendations

26. I therefore recommend that strategic health authorities and primary care trusts should:

- **Review the criteria used by their predecessor bodies, and the way those criteria were applied, since 1996. They will need to take into account the Coughlan judgment, guidance issued by the Department of Health and my findings;**

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

27. I also recommend that the Department of Health should:

- **Consider how they can support and monitor the performance of authorities and primary care trusts in this work. That might involve the Department assessing whether, from 1996 to date, criteria being used were in line with the law and guidance. Where they were not, the Department might need to co-ordinate effort to remedy any financial injustice to patients affected;**

- **Consider being more proactive in checking that criteria used in the future follow the guidance.**

The national framework for NHS-funded care

28. While I am in no doubt that the Authorities in the first four completed investigations deserve the criticisms made of them in respect of the criteria they chose to use, it is clear to me that there are more fundamental problems with the system for deciding who does or does not get their care fully funded by the NHS. As the lengthy legal and policy section of this report helps to show, the national policy has been far from simple to understand or apply for some time. A line has to be drawn between people eligible for full NHS funding and those who are not. While, as the Coughlan case illustrates, some possible policy decisions on where to draw that line would be unlawful, various policy decisions are possible within the law. Nothing in this report should be read as commenting on the national policy decision about **where** to draw the line, but I do comment on **how** the line is drawn. As the Royal Commission recognised (see paragraph 6) when referring more widely to state funding, any system must be fair and logical and should be transparent in respect of the entitlement of individuals.

("self-funders") will no longer have to pay for registered nurse care in a nursing home where the NHS assesses such care as needed. The NHS will become responsible for this group from that date.'

The Health Authority policy and criteria

13. In response to HSG 95(8) the Health Authority established a 'Continuing Health Care' Policy (the policy). The criteria under which a patient was entitled to long term in-patient care included when he/she has:

'such complex clinical needs that s/he requires at least weekly assessment and/or review by a consultant. Has been assessed for rehabilitation and found to have no further capacity from such programmes.

OR

'daily care incorporating continual intensive care skilled health care supervision and/or intervention on a 24 hour basis. Has been assessed for rehabilitation and found to have no further capacity from such programmes.'

14. The Health Authority also published a patient leaflet entitled 'Your Entitlement to Continuing [NHS-funded] Care' which listed the criteria which would entitle patients to NHS-funded continuing care as:

'When their health needs are so complex and difficult that they:

- need skilled health care staff to look after them around the clock;

- need a weekly review of their condition by an NHS consultant;

- are unlikely to get better or benefit from rehabilitation therapy.

'when they could die at any moment and it would not be right to transfer them from hospital…'

Sequence of events

15. I set out below the principal events and correspondence relevant to the matters investigated.

30 May 2001 - Mrs R was admitted to hospital following a severe stroke.

19 June - The hospital stated that Mrs R was ready to be discharged to a nursing home. A nursing assessment was completed for Social Services, which showed that their criteria for nursing home placement were met. The nursing records state:

'Mrs R … currently requires 24 hour care and attention under the supervision of a registered nurse … nursing home care is indicated … Does not require NHS Continuing Health Care.'

13 July - The Health Authority's criteria for NHS continuing care were considered, following a request from the family for NHS-funded care. A multi-disciplinary assessment of Mrs R was carried out by a Clinical Nurse Specialist, Consultant Geriatrician, Tissue Viability Nurse and a Physiotherapist. They concluded that Mrs R was not eligible for continuing care funding stating that:

'Mrs R's clinical needs are not so complex that she requires at least weekly assessment and or review by a Consultant.

'Daily care can be provided under the supervision of a Registered Nurse with supporting visits from the Tissue Viability Nurse.'

On 13 July a meeting took place between Mrs R's family and the multi-disciplinary team that had assessed Mrs R. Mrs R's condition was discussed. In relation to NHS-funded continuing care an explanation was given as to why the criteria were not met and the copy of the criteria and printed eligibility form was given to the family.

17 July - Mrs S wrote to the Health Authority to ask for a review of the assessment.

'I request a review of the assessment made on 19 June … My mother's present condition is very serious as following the severe stroke she suffered on 30 May, she is paralysed on her left side and is unable to feed unaided. She cannot walk or sit upright and is totally reliant upon others for her health and well-being. The burns she sustained at the time of the stroke … are not healing after seven weeks of hospital treatment … Her left arm and hand are also very swollen at present. She has also suffered considerable memory loss as a result of the stroke, resulting in problems of family recognition.'

14 August - A different Consultant Geriatrician carried out a further assessment of Mrs R's eligibility for in-patient continuing care. In his letter to the hospital Commissioning Manager, the Consultant Geriatrician wrote:

'… [Mrs R] is now ten weeks after a severe stroke which left her immobile, needing hoisting for

- where the complexity or intensity of their medical, nursing care or other clinical care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multi-disciplinary team;

- who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff;

- have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.'

HSC 1999/180 - Ex parte Coughlan: Follow-up Action

8. In August 1999, in response to a Court of Appeal judgment in a case brought by Miss P Coughlan (the Coughlan judgment), the Department of Health issued further guidance on continuing health care in the circular HSC 1999/180. It included in its summary of the judgment:

'The NHS does not have sole responsibility for nursing care. Nursing care for a chronically sick person may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's needs. ... Whether it was unlawful [to transfer responsibility for the patient's general nursing care to the local authority] depends, generally, on whether the nursing services are merely (i) incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category…'

9. The Department's guidance included in its description of the judgment:

'(d) Local Authorities may purchase nursing services … only where the services are:

(i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide ...; and

(ii) of a nature which it can be expected than an authority whose primary responsibility is to provide social services can be expected to provide.

(e) Where a person's primary need is a health need, then this is an NHS responsibility ...'

HSC 2001/015 - Continuing Care: NHS and Local Councils' Responsibilities

10. In June 2001, the Department of Health produced new guidance, HSC 2001/015, the purposes of which included consolidating guidance on continuing NHS health care in light of the Coughlan judgment. This cancelled all of the previous guidance I have cited including HSG (95)8, and HSC 1999/180. Health authorities, in conjunction with primary care trusts (PCTs) and local councils were asked to ensure that continuing health care policies complied with the guidance by 1 October 2001 and by 1 March 2002, they should have agreed joint eligibility criteria, setting out their respective responsibilities for meeting continuing health and social care needs. (Note: In May 2002, in their guidance Fair Access to Care Services, the Department of Health said that continuing care criteria needed to be agreed at Strategic Health Authority level by 1 October 2002.)

11. Annex C of the guidance, 'Key issues to consider when establishing continuing care eligibility criteria', listed the matters which health authorities in discussion with local councils should consider when establishing their eligibility criteria for continuing NHS health care. These included:

'• The nature or complexity or intensity or unpredictability of health care needs (and any combination of these needs) requires regular supervision by a member of the NHS multi-disciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

• A need for care or supervision from a registered nurse and/or a GP is not sufficient reason to receive continuing NHS health care.

• The location of care should not be the sole determinant of eligibility. Continuing NHS health care may be provided in a NHS hospital, a nursing home, hospice or the individual's own home.'

The guidance did not explain exactly how these factors should affect eligibility.

HSC 2001/17 - Guidance on Free Nursing Care in Nursing Homes

12. In September 2001, in circular HSC 2001/17, the Department of Health issued guidance on free nursing care in nursing homes stating:

'… from 1 October 2001, those people paying fees for nursing home care in full from their own resources

29. From what I have seen, the national policy and guidance that has been in place over recent years does not pass that test. Those who complain to me find the system far from fair or logical and often cannot understand why they or a relative are not entitled to NHS funding. At times entitlement seems to have depended in part variously on ill-defined distinctions between:

- Specialist and general health care;

- Health care and social care;

- Care by registered nurses and care by others.

As the Coughlan judgment points out, basing eligibility on the need for specialist care does not cater for the situation where the demands for nursing care are continuous and intense. It can also be unclear what constitutes specialist care: for instance, does that include input from mental health nurses?

30. The distinction between health and social care (and that between care by registered nurses or by others) is a blurred one which has also shifted over time. Nurses have been trained to take on tasks which years ago would only have been carried out by doctors; and auxiliary nurses, care assistants and carers increasingly perform tasks which, in the past, would have been carried out by registered nurses. Long term carers can learn to handle tasks which would, even now, usually be carried out by nurses or other clinical staff. Some patients needing long term care need help with a wide range of basic activities: to the average patient or carer, the distinction professionals might make between health and social needs is largely irrelevant.

31. I do not underestimate the difficulty of setting fair, comprehensive and easily comprehensible criteria. The criteria have to be applied to people of all ages, with a wide range of physical, psychological and other difficulties. There are no obvious, simple, objective criteria that can be used. But that is all the more reason for the Department to take a strong lead in the matter: developing a very clear, well-defined national framework. One might have hoped that the comments made in the Coughlan case would have prompted the Department to tackle this issue. However efforts since then seem to have focused mainly on policy about free nursing care. Authorities were left to take their own legal advice about their obligations to provide continuing NHS health care in the light of the Coughlan judgment. I have seen some of the advice provided, which was, perhaps inevitably, quite defensive in nature. The long awaited further guidance in June 2001 (see paragraph 11 and Annex) gives no clearer definition than previously of when continuing NHS health care should be provided: if anything it is weaker, since it simply lists factors authorities should 'bear in mind' and details to which they should 'pay attention' without saying how they should be taken into account. I have criticised some Authorities for having criteria which were out of line with previous guidance: except in extreme cases I fear I would find it even harder now to judge whether criteria were out of line with current guidance. Such an opaque system cannot be fair.

Recommendation

32. The Department of Health should review the national guidance on eligibility for continuing NHS health care, making it much clearer in new guidance the situations when the NHS must provide funding and those where it is left to the discretion of NHS bodies locally. This guidance may need to include detailed definitions of terms used and case examples of patterns of need likely to mean NHS funding should be provided.

Assessing against criteria

33. Given the freedom to decide their own eligibility criteria within the loose national framework, health authorities have adopted a range of approaches, both to the criteria themselves and to procedures and guidance underlying them. Looking at most of the sets of criteria we have seen, it is fairly easy to identify a group of people who would definitely not be eligible for funding, and a very small group of people who definitely would be eligible (many of whom would not be well enough to leave hospital). But there is a large number of people in the group in between. Now and in the past, a line has to be drawn through that group, and this is done using generally quite subjective and broadly drafted criteria. Yet which side of the line a patient's needs are judged to fall can make an enormous financial difference to the patient and their family.

34. Some authorities have attempted to address this problem by producing detailed guidance and procedures on the assessment of patients and the application of their criteria. Some use specific assessment 'tools'. Where the guidance and procedures are well-drafted and properly promulgated and understood by all those doing assessments, that can at least assure some degree of consistency in the application of the criteria within the authority's area. But unless they are published alongside the criteria themselves, patients and carers can be left inadequately informed as to how decisions about eligibility are actually being made.

35. Other health authorities have little or no practical guidance about the application of the criteria, and it is left to clinical staff in the community or hospitals to interpret them as best they can when assessing patients. This will almost inevitably lead to inconsistency.

36. The Department of Health does not appear to have provided any significant help to NHS bodies on methods and tools for assessing against eligibility criteria for continuing NHS health care. Although the Department is in the process of introducing a 'single assessment process' for older people, the associated guidance does not suggest whether or how this could provide a basis for, or contribute to, the assessment of eligibility for continuing NHS.

Recommendation

37. The Department of Health should consider how to link assessment of eligibility for continuing NHS health care into the single assessment process and whether it should provide further support to the development of reliable assessment methods.

Conclusion and recommendations

38. The findings in the cases reported today and the themes emerging from those still under investigation lead me to conclude that:

- The Department of Health's guidance and support to date has not provided the secure foundation needed to enable a fair and transparent system of eligibility for funding for long term care to be operated across the country;
- What guidance there is has been mis-interpreted and mis-applied by some health authorities when developing and reviewing their own eligibility criteria;
- Further problems have arisen in the application of local criteria to individuals;
- The effect has been to cause injustice and hardship to some people.

39. I therefore **recommend** that strategic health authorities and primary care trusts should:

- Review the criteria used by their predecessor bodies, and the way those criteria were applied, since 1996. They will need to take into account the Coughlan judgment, guidance issued by the Department of Health and my findings;
- Make efforts to remedy any consequent financial injustice to patients, where the criteria, or the way they were applied, were not clearly appropriate or fair. This will include attempting to identify any patients in their area who may wrongly have been made to pay for their care in a home and making appropriate recompense to them or their estates.

Annex E

Case No. E.1626/01-02

Refusal to provide continuing care funding

Complaint against:

Birmingham Health Authority

Complaint as put by Mrs S

1. The account of the complaint provided by Mrs S was that on 30 May 2001, her 90 year old mother, Mrs R, was admitted to hospital following a severe stroke, which had left her immobile, incontinent, and confused. As it was unlikely that Mrs R's condition would change, Mrs S thought that her mother should be transferred to a nursing home close to her family. On 19 June hospital staff assessed Mrs R against Birmingham Health Authority's criteria for eligibility for NHS funding for such care and decided that she did not qualify.

2. On 17 July, Mrs S wrote to the Health Authority challenging that decision. She complained that she had not been consulted or involved in the initial assessment process. On 22 August, the Health Authority's Commissioning Manager advised Mrs S that a second assessment of Mrs R had been completed and that she did not meet the criteria for NHS Continuing Care. On 11 September Mrs S wrote to the Health Authority to request a review of the decision to fund her mother's care. However, on 5 October the Health Authority advised Mrs S that the decision not to fund care was appropriate and that it had been decided that a review panel was unnecessary. On 10 December Mrs R was transferred to a nursing home. The Health Authority agreed to fund the nursing element of her care. Mrs R died six days later. Mrs S remains dissatisfied.

3. The matters investigated were that:

(a) The Health Authority's criteria for eligibility for continuing in-patient care were unreasonable; and

(b) The review process was not properly applied.

Investigation

4. The statement of complaint for the investigation was issued on 11 March 2002. On 1 April 2002 the Health Authority became part of the Birmingham and The Black Country Health Authority (the new Health Authority). Comments were received from the new Health Authority and relevant papers, including Mrs R's clinical records, were examined. I have not put into this report every detail investigated; but I am satisfied that nothing of significance has been overlooked.

Background

5. The statutory framework for the provision of health services is outlined in paragraph 6; paragraphs 7 - 12 summarise relevant Department of Health guidance on Continuing Care and paragraph 26 outline the review process. Relevant health authority policies and criteria are summarised in paragraphs 13-14 and 27. Following Mrs S' request that her mother should receive NHS-funded care in a nursing home closer to her family, Mrs R was assessed against the Health Authority's criteria for continuing in-patient care. At that time, the relevant national guidance was HSG (95)8 and HSC 1999/180; however in June 2001 new guidance was issued, HSC 2001/015, which superceded the previous guidance.

Complaint (a): the Health Authority's criteria for eligibility for continuing in-patient care were unreasonable

Statutory framework

6. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that it is the Secretary of State's duty to provide services 'to such extent as he considers necessary to meet all reasonable requirements ...,' including 'such facilities for ... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service; ...'

National guidance on Continuing Care HSG (95)8 - NHS Responsibilities for Meeting Continuing Health Care Needs

7. In 1995 the Department of Health published HSG (95)8. This national guidance stated that with effect from April 1996, health authorities were required to have clear eligibility criteria in place for continuing NHS health care. Health authorities had to set priorities for continuing health care within the resources available to them. Annex A of the guidance 'Conditions for Local Policies and Eligibility criteria for Continuing Health Care', listed a number of conditions that health authorities had to cover in their local arrangements and included the following:

'E Continuing in-patient care

'... The NHS is responsible for arranging and funding continuing inpatient care, on a short or long term basis, for people:

Group 2: People whose needs are such that they can live in a nursing home but require a degree of continuing health care beyond that which is routinely offered in a registered nursing home

These are people who are discharged from hospital to a nursing home or admitted to a nursing home from the community, whose needs are such that they require an intensive and complex personal care package beyond the customary level of care offered by the home. They will be eligible for NHS funding of the extra nursing care they require over and above the general nursing care included in the standard nursing home price. They represent the kind of people whose placement in a nursing home is supported by the Section 28A Grant, which is a sum of money passed by the Authority to Social Services for this purpose.

Patient needs	**NHS-funding**
1. Patients with multiple and complex nursing and medical problems, i.e. three or more of the following:* · Immobility requiring two or more skilled persons to transfer and/or skilled use of a hoist; · Double incontinence; · Severe pressure sores exposing muscle, tendon or bone or deep tissues; · Leg ulcer covering 50% or more of the lower leg; · Continuous subcutaneous infusions; continuous oxygen therapy; feeding by gastrostomy; frequent changes of tracheotomy tube; · Insulin-dependent diabetes and regular blood glucose monitoring; · Brittle Parkinson's disease requiring prompt intervention and frequent medication; · Convulsions requiring prompt intervention but without the threat of deterioration of the patient's general condition.	These patients will be eligible for NHS funding of the health care costs, that is within the range for that client group and is over and above the general nursing care. This arrangement will be subject to a full assessment of needs by health and social service staff and agreement between the agencies that the extra cost charged by the nursing home is justified. Patients are also eligible for NHS funding of items of medical and nursing equipment, which can only be provided through a hospital. Patients remain eligible for NHS-funded GP and specialist health care services while in a in a nursing home.
2. Patients with dementia whose confusion and challenging behaviour cannot be managed in the community and requires care in a specialised nursing home.	As above.
3. Regular therapeutic support where deemed essential by a consultant to be delivered by professionally qualified staff.	As above.

* (These are not intended to be used as absolutes, more as a general guide to the degree of dependency. The overall clinical picture is equally important).

40. I also **recommend** that the Department of Health should:

- Consider how they can support and monitor the performance of authorities and primary care trusts in this work. That might involve the Department assessing whether, from 1996 to date, criteria being used were in line with the law and guidance. Where they were not, the Department might need to co-ordinate effort to remedy any financial injustice to patients affected;

- Review the national guidance on eligibility for continuing NHS health care, making it much clearer in new guidance the situations when the NHS **must** provide funding and those where it is left to the discretion of NHS bodies locally. This guidance may need to include detailed definitions of terms used and case examples of patterns of need likely to mean NHS funding should be provided;

- Consider being more proactive in checking that criteria used in the future follow that guidance;

- Consider how to link assessment of eligibility for continuing NHS health care into the single assessment process and whether the Department should provide further support to the development of reliable assessment methods.

Annex A

Extracts from HSC 2001/015, LAC (2001)18

Continuing Care: NHS and Local Councils' responsiblities, 28 June 2001

'....**Continuing NHS Health care**

18. There are a number of key issues to bear in mind when arranging or reviewing continuing NHS health care:

- the setting of the care should not be the sole or main determinant of eligibility. Continuing NHS health care does not have to be provided in an NHS hospital and could be provided in a nursing home, hospice or the individual's own home;

- the timescale of the care can vary between the remainder of an individual's life and episodes of care;

- the local eligibility criteria for continuing NHS health care are based on the nature or complexity or intensity or unpredictability of health care needs (see Annex C for further details on eligibility criteria for continuing NHS health care);

- patients who require palliative care and whose prognosis is that they are likely to die in the near future should be able to choose to remain in NHS-funded accommodation (including in a nursing home), or to return home with the appropriate support. Patients may also require episodes of palliative care to deal with complex situations (including respite palliative care). The number of episodes required will be unpredictable and applications of time limits for this care are not appropriate;

- the impact on social security benefits for people receiving continuing NHS healthcare will vary according to the location of that care:

if an individual is placed, under the NHS Act 1977, as an in-patient in a hospital or similar institution (which may include a nursing home) where food and accommodation costs are met by the NHS, certain social security benefits are downrated after six weeks and again after 52 weeks (see Schedule 7 of the Income Support (General) Regulations 1987 [S.I. 1987/1967]); where people are receiving continuing NHS health care in their own home, the NHS meets the full cost of their health care needs. Social security benefits (which may include disability benefits) available to support the individual's other costs are not downrated....

'Annex C - key issues to consider when establishing continuing NHS health care eligibility criteria

All Health Authorities, in discussion with local councils, should pay attention to the details below when establishing their eligibility criteria for continuing NHS health care.

1. The eligibility criteria or application of rigorous time limits for the availability of services by a health authority should not require a local council to provide services beyond those they can provide under section 21 of the National Assistance Act (see point 20 of the guidance for the definition of nursing care used in the Coughlan judgment).

2. The nature or complexity or intensity or unpredictability of the individual's health care needs (and any combination of these needs) requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

3. The individual's needs require the routine use of specialist health care equipment under supervision of NHS staff.

4. The individual has a rapidly deteriorating or unstable medical, physical or mental health condition and requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

5. The individual is in the final stages of a terminal illness and is likely to die in the near future.

6. A need for care or supervision from a registered nurse and/or a GP is not, by itself, sufficient reason to receive continuing NHS health care.

7. The location of care should not be the sole or main determinant of eligibility. Continuing NHS health care may be provided in an NHS hospital, a nursing home, hospice or the individual's own home.

Guidance on free nursing care will include more details on determining registered nurse input to services in a nursing home, where the care package does not meet continuing NHS health care eligibility criteria.'

1998. However it appears from what it did at the time (paragraph 21) and its comments in paragraph 23, that the Authority has misunderstood the crucial point: it was not about whether Mrs Z should still have been in the nursing home but whether her eligibility for funding there had changed. If, as appears to be the case, its review was simply of the appropriateness of the placement, then it was inadequate. It might have been that the home remained the appropriate placement but that Mrs Z's needs had increased to the point where, even using the Authority's defective criteria, she fell into Group 1 and was entitled to funding. I have not seen evidence that that possibility was considered. I uphold the complaint.

Conclusion

42. I have set out my findings in paragraphs 32-41. I have upheld the complaints for the reasons given above. The new Authority has asked me to convey to Mr Z - as I do through this report - its apologies for those shortcomings and has agreed to act on my recommendation in paragraph 40.

Appendix to E.814/00-01

Group 1: People whose needs make them eligible for continuing heath care as an in-patient

These are people who would normally need to live in a hospital setting, a specialised nursing home or hospice because the specialised nature of continuing health care they require could not be provided in any other setting.

Patient needs	Site of care	NHS-funding
1. Patients who require constant attention of a qualified nurse and constant availability of on-site specialist medical expertise 24 hours a day.	Hospital (NHS or independent) Hospice Specialised nursing home	100%
2. Patients who require highly complex or specialist equipment to maintain life (which could not be provided outside hospital) and staff trained to maintain the equipment and provide emergency care in the event of equipment failure.	Hospital (NHS or independent) Specialised nursing home	100%
3. Patients with a high degree of dependence on nursing care, who also have a condition which fluctuates unpredictably and which without frequent and prompt intervention by an on-site specialist team might lead to death, deterioration or severe distress. Examples of such conditions include brittle diabetes; frequent, prolonged convulsions; terminal illness with severe problems of symptom control.	Hospital (NHS or independent) Hospice Specialised nursing home	100%
4. Patients in coma or in a persistent vegetative state.	Hospital (NHS or independent) Specialised nursing home	100%
5. Patients admitted compulsorily under the terms of the Act; or patients who would meet the requirements of the act for compulsory admission but are willing to be admitted voluntarily.	Hospital (NHS or independent)	100%

provision of accommodation, or of a nature which a local authority could be expected to provide. Yet under the Authority's criteria, the NHS would only fund the **additional** healthcare costs, above those for general nursing care in a nursing home. The Local Authority would be expected to fund all the other nursing costs: that seems to me to be out of line with the Coughlan judgment. I criticise the Authority for not amending its criteria, and for not reconsidering the eligibility of patients adequately in the light of the judgment. As the judgment did not change the law, only clarify it, that reconsideration needed to be retrospective as well as prospective. However I have taken note of the letter sent to the Authority by the Regional Office of the Department of Health (paragraph 7) immediately after the 1999 guidance. That does seem to me to have been likely to encourage authorities to believe that it would be acceptable to make minimal, if any, changes to their policies, and I mitigate my criticism of the Authority accordingly.

37. Mr Z has suggested that the NHS had an obligation to fund Mrs Z's nursing home care because, he suggests, she would have required such care but for the falls that she suffered in hospital. This investigation has not looked into whether Mrs Z's falls should have been prevented. That is not a matter between Mr Z and the Authority but between him and the Trust, and I would not have expected the Authority to take that allegation into account in deciding on Mrs Z's eligibility but to leave him to resolve that with the Trust.

38. Mr Z also complains about lack of timely information either about the financial implications of the discharge to a nursing home or about the continuing care review procedure. The question of advice on financial implications is largely one for social services, though Trust staff might be expected to provide some basic information. I note that the LGO investigation found that Mr Z was made aware of the financial implications of his mother's move to a care home and the possibility of a legal charge for residential accommodation. I see no reason to disagree with this finding. However I have seen no evidence that the Authority informed Mr Z about the review procedure until after Mrs Z left hospital, even though it was aware of his dissatisfaction with the plans for his mother's care at least some time before her discharge from the hospital. Although I recognise that the Authority may not have been told of her discharge from hospital, I can see that it was very unhelpful that Mr Z was told about the procedure by the Authority when (under the guidance at that time) it was too late to ask for a review as Mrs Z had already left hospital.

39. In conclusion, I do not see any force in some of Mr Z's arguments including those relating to the Mental Health Act, but I do have other significant concerns about how the Authority set its eligibility criteria and applied them to Mrs Z, particularly in the light of the Coughlan judgment. That calls into question whether in fact Mrs Z should have been deemed eligible for NHS funding. It is certainly very possible (but not entirely certain) that, if appropriate criteria had been applied, Mrs Z would have qualified for fully funded care at some point. I uphold the complaint.

40. I turn now to the question of remedial action. The organisation of the NHS has changed since these events. Berkshire Health Authority no longer exists. Responsibility for setting eligibility criteria now lies with a new Thames Valley Health Authority (the new Authority), and the relevant budget for funding such care will be held by a Primary Care Trust (the PCT). While I recognise that the new Authority played no part in these events, I must regard it as responsible for taking remedial action. I **recommend** that as a matter of urgency the new Authority should review the eligibility criteria across its area from April 1996 to date to ensure that they were (and are) in line with the Coughlan judgment and other relevant guidance. It should then promulgate any revised criteria, with any necessary detailed guidance and training on implementation, to relevant trusts in its area. The new Authority, in consultation with the PCT, should then arrange for Mrs Z's eligibility to be reconsidered against the amended criteria, using information available about her condition and needs while in the nursing home. It should write to explain to Mr Z and to me the reasons for its new decision: if it is that she should have been deemed eligible for care for all or part of the time she was in the nursing home it should pay to her estate a sum sufficient to ensure that it is no worse off than it would have been if the NHS had funded her nursing home care for the appropriate period. The new Authority should also devise a scheme to identify any patients who may have been wrongly refused NHS funding for in-patient continuing care in its area, and liaise with other NHS bodies to ensure that appropriate recompense is made.

Findings (ii)

41. Were funding arrangements reviewed after Mrs Z's fall and re-admission to hospital in late 1998? It appears that her mobility was significantly reduced following her hip fracture. The Authority would not itself assess Mrs Z's clinical condition and needs, but rely on the Trust and Social Services to do that. It would need to make sure that her eligibility for NHS funding was reconsidered in the light of that. The Authority says that it did ask the Trust to reassess Mrs Z in November

Annex B

Case No. E.208/99-00

Funding for a patient's care in a nursing home

Complaint against:

The former Dorset Health Authority (the Authority) and Dorset HealthCare NHS Trust (the Trust)

Complaint as put by Mr X

1. The account of the complaint provided by Mr X was that his father, (Mr X senior), suffered from Alzheimer's Disease. In December 1997 his father was admitted to a nursing home in Hampshire (the Nursing Home), initially for respite care. In February 1998 a team which included Trust staff decided that Mr X senior did not meet the Authority's eligibility criteria for the provision of NHS-funded in-patient continuing health care. He remained at the Nursing Home until its closure in February 2000, with his care being funded by means-tested Social Services benefits and his own resources. From 2 February 2000 until his death in February 2001, he resided at another nursing home in Devon, where his care continued to be funded in the same way. In January 1998 Mr X suggested to the Authority that the NHS should be responsible for funding his father's long-term nursing care. The Authority explained that if a person were sufficiently ill to require NHS care, then that would be provided within a local hospital; its policy was to fund nursing home placements only if there was no suitable hospital or other in-patient facility available. The outcome of Mr X senior's assessment meant that responsibility for funding his care rested with the local authority. Mr X was dissatisfied with the Trust's final reply. On 22 April 1998 he made a request for an independent review (IR), principally on the basis that the Authority's criteria for funding long-term in-patient continuing health care were more restrictive than allowed for in national guidance. After a further attempt at local resolution he made a second request for an IR. The Authority closed its file in April 1999 because Mr X had not clarified his outstanding concerns. Mr X remained dissatisfied.

2. The complaints investigated were that:

(a) the Authority's eligibility criteria for funding long term NHS in-patient continuing health care were unreasonably restrictive and did not reflect the principles laid down in the relevant NHS guidance; and

(b) the Trust failed properly to assess Mr X senior's eligibility for NHS-funded continuing in-patient care.

Investigation

3. The statement of complaint for the investigation was issued on 8 November 2000. Comments were obtained from the Trust and the Authority and relevant documents, including clinical records, were examined. I have not included in this report every detail investigated; but I am satisfied that no matter of significance has been overlooked.

National guidance

Eligibility criteria - health care needs

4. In 1995 the Department of Health issued guidance HSG(95)8 on NHS responsibilities for meeting continuing health care needs. The guidance detailed a national framework of conditions for all health authorities (HAs) to meet, by April 1996, in drawing up local policies and eligibility criteria for continuing health care and in deciding the appropriate balance of services to meet local needs. The guidance stipulated that the NHS had responsibility for arranging and funding continuing in-patient care, on a short or long-term basis, for people:

'…. where the complexity or intensity of their medical, nursing care or other care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team….

'…. who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff.

'….who have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.'

The in-patient care might be in a hospital or in a nursing home.

5. In further guidance, EL(96)8, in February 1996 the Department of Health said:

'…. It will be important that eligibility criteria do not operate over restrictively and match the conditions laid out in the national guidance. Monitoring [of authorities' criteria] raised a number of points where eligibility criteria could be applied in a way which was not in line with national guidance:

.... • *an over reliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing in-patient care.* There will be a limited number of cases, in particular involving patients not under the care of a consultant with specialist responsibility for continuing care, where the complexity or intensity of their nursing or other clinical needs may mean that they should be eligible for continuing in-patient care even though they no longer require frequent specialist medical supervision. This issue was identified by the Health Service Commissioner in his report on the Leeds case and eligibility criteria should not be applied in a way to rigidly exclude such cases.'

6. In August 1999 the Department of Health issued further guidance on continuing health care in a circular HSC 1999/180. This was in response to a Court of Appeal judgment in the case R v. North and East Devon Health Authority ex parte Coughlan (the Coughlan case). That judgment summarised its conclusions as follows:

'(a) The NHS does not have sole responsibility for nursing care. Nursing care for a chronically sick person may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's needs…. Whether it was unlawful [to transfer responsibility for the patient's general nursing care to the local authority] depends, generally, on whether the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category....

The Department's guidance included in its description of the judgment:

'(b) The NHS may have regard to its resources in deciding on service provision.

'(c) …. HSG(95)8 …. is lawful, although could be clearer.

'(d) Local authorities may purchase nursing services under section 21 of the National Assistance Act 1948 only where the services are:

(i) merely incidental to the provision of the accommodation which a local authority is under a duty to provide to persons to whom section 21 refers; and

(ii) of a nature which it can be expected than an authority whose primary responsibility is to provide social services can be expected to provide.

'(e) Where a person's primary need is a health need, then this is an NHS responsibility.

'(f) Eligibility criteria drawn up by Health Authorities need to identify at least two categories of persons who, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a Health Authority. Secondly, there are those whose nursing services in general can be regarded as the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.'

Authorities were advised to satisfy themselves that their continuing and community care policies and eligibility criteria were in line with the judgment and existing guidance, taking further legal advice where necessary. Where they revised their criteria they should consider what action they needed to take to re-assess service users against the revised criteria.

7. A Royal Commission on Long Term Care had reported in March 1999. That had recommended that housing and living costs for those in long term care should be paid for by individuals according to their means, but that the cost of necessary personal care should be met by the state. In England the government decided to adopt a rather different approach: from October 2001 the NHS has funded care in nursing homes provided by registered nurses (for those who would otherwise have to pay): but not all personal care provided by other staff.

Responsible authority

8. In 1993 the Department of Health issued guidance on establishing district of residence: the health authority where the person was usually resident was responsible for funding care. The guidance explained that where a placement by Social Services was temporary, then the health authority of usual residence remained responsible for health care funding. If a permanent placement in a home was funded totally by a health authority outside their area, then they remained responsible for funding: otherwise the health authority in which the home was situated became responsible.

v) The funding arrangements were not reviewed when her needs changed after her fall at the home, and re-admission to hospital.

33. This investigation is not about the actions of the Trust or Social Services: but about the Authority. However I will deal in turn with whether each of these points indicates that the Authority acted unreasonably in refusing to fund Mrs Z's continuing care. First I shall deal with the point about compulsory admission. Mr Z is correct that had his mother been admitted compulsorily she would have been entitled to NHS funding under the Authority's policy - but that would have been only while she continued to require compulsory detention. The Appeal Court decision on the Bournewood case meant that for a period, at around the point when Mrs Z was admitted to hospital in May 1998, the law was understood to mean that patients, who lacked capacity to consent to in-patient psychiatric treatment, could not receive it informally and the possibility of compulsory admission would need to be considered. However by the time Mrs Z moved to the nursing home in August 1998 the House of Lords had overturned the Appeal Court ruling. The Ombudsman's Psychiatric Adviser points out that the whole tenor of the Mental Health Act is to encourage voluntary, rather than compulsory admission, where possible. I see no reason to believe that, even if Mr Z had attempted to make an application for compulsory admission under the Act, during the period his mother was in the home, the necessary medical recommendations would have been obtained, or that the Authority should have treated Mrs Z as if she was or had been under compulsory detention.

34. Mr Z has also argued that because, in his view, his mother should have been admitted compulsorily under Section 3 of the Act initially, her subsequent care in the nursing home amounted to after-care under Section 117 of the Mental Health Act and should therefore have been NHS-funded. However, even if Mrs Z had been admitted compulsorily in April/May 1998, that would not have meant that all her subsequent care had to be NHS-funded, but only that which could properly be regarded as after-care and only for as long as after-care was needed. Furthermore I have noted the findings of the LGO about the actions of the ASW in April (paragraph 15). Even though the Court of Appeal judgment in the Bournewood case would have made it more likely that someone such as Mrs Z was admitted compulsorily while it was regarded as providing legal precedent, the fact that it was later overturned means that the law **never** prevented informal admission in the circumstances concerned. I cannot see then that the Authority can be criticised for not accepting that Mrs Z should have been compulsorily admitted to hospital under Section 3 and that her nursing home care amounted to after-care.

35. I turn now to the Authority's criteria and the implications of the Coughlan judgment. That was given in July 1999 i.e. after Mrs Z had first been assessed and admitted to the nursing home in August 1998. I cannot therefore expect the Authority to have taken account of it when Mrs Z was first assessed. I can however expect it to have taken account of previous Department of Health guidance, especially HSG 95(8) - paragraph 4. I was concerned that whilst the first two of the Authority's criteria for full NHS funding (i.e. for Group 1) state that the possible site of care includes a specialised nursing home, they are defined in such a way as to mean that care could only be provided in hospital i.e. patients must require constant availability of on-site specialist medical expertise 24 hours a day or highly complex or specialist equipment to maintain life (which could not be provided outside hospital). The third criterion does seem to leave some scope for patients who do not require hospital care, depending on how the term 'specialist' is interpreted. However even in its comments to this Office, the Authority seems to suggest that the fact that Mrs Z did not require on-site medical provision is particularly significant in suggesting that she did not qualify for full NHS funding: however, some patients who do not require that level of care could still be eligible under HSG 95(8). It therefore seems to me that the criteria and the way they were applied were not consistent with national guidance.

36. Following the Coughlan judgment authorities were asked to satisfy themselves that their criteria were in line with the judgment and, where they were revised, to consider what action was needed to reassess patients against the new criteria. Here was an opportunity for the Authority to review its criteria. Although the Authority told me that the legal advice it received was that the Coughlan judgment did not have a bearing on Mrs Z's case: when I saw the advice itself, it was not as clear cut as that. Furthermore I find it impossible to see that the Authority's criteria, which were not changed in the light of the Coughlan judgment, are compatible with it. Patients such as Mrs Z judged to be in Group 2, had been assessed by the Authority as having 'multiple and complex nursing and medical problems' and were described as requiring 'an intensive and complex personal care package beyond the customary level of care offered by [a nursing home].' I cannot see how the total amount of nursing care such a patient would need would be likely to be merely incidental or ancillary to the

The oral evidence of the Authority's Continuing Care Manager

27. **The Authority's Continuing Care Manager** told the Ombudsman's Investigating Officer that the leaflet describing the Authority's continuing care review procedure had been widely available on all hospital wards where it was likely to be needed. The admission to the second Hospital in late 1998 was for a purely orthopaedic condition and did not have any effect on Mrs Z's mental health needs.

Investigation by the LGO concerning information given to Mr Z about the financial implications of Mrs Z's admission to a care home

28. The LGO found that Mr Z had a meeting with the Social Services Care Manager on 22 May 1998 and he was given a copy of the publication 'Care Services and Homes' (Berkshire - 1996/7) and a copy of the Department of Health booklet 'Moving Into a Care Home - Things You Need to Know'. The LGO was satisfied that the publications provided sufficient information and concluded that there was 'ample evidence that Mr [Z] was made aware of the financial implications and the possibility of a legal charge for residential accommodation....'.

Advice of the Ombudsman's Adviser on psychiatry

29. The Ombudsman's Psychiatric Adviser commented that the whole tenor of the Mental Health Act is to encourage voluntary, as distinct from compulsory, admission. Until medical recommendations have been made no one can apply for compulsory admission because any application must be founded on signed medical recommendations in the correct form. In Mrs Z's case no recommendations were made and therefore the question of advising the nearest relative of the right to make an application did not arise. If doctors decide against making a recommendation neither the ASW nor the nearest relative can compel them to do so. In terms of clinical practice he was satisfied that the doctors acted correctly.

Advice of the Ombudsman's Adviser on mental health nursing

30. The Ombudsman's Adviser on mental health nursing matters commented that when Mrs Z was admitted to the Hospital on 23 May 1998, she was admitted as an 'informal' patient. Mrs Z met the criteria for Group 2 because she was immobile, suffered with dementia and displayed challenging behaviour that required nursing/residential accommodation and she needed therapeutic support from appropriately qualified staff. Mrs Z did not require 24 hour patient care in a hospital environment. In the view of the adviser, Mrs Z fell into Group 2 of the Authority's criteria.

31. Turning to the question of why the Authority did not require or arrange for another formal assessment of Mrs Z's needs before discharge from the second Hospital. She was admitted to that hospital in November 1998 because she required surgery on her hip. Mrs Z was immobile and her mental state was stable. The advisor said that there was no reason for her not to return to her placement in the nursing home.

Findings (i)

32. Mr Z has put forward a number of arguments to support his contention that the Authority should have funded his mother's nursing home care in its entirety. His main arguments are:

i) That Mrs Z's condition at the time of the initial assessment, and at all times after, was such that she should have been admitted compulsorily under the Mental Health Act to the Hospital, in which case she would have been entitled, as of right, to have had her after-care fully funded (paragraph 17). The rights of the nearest relative should have been explained to Mr Z and a failure to do so denied him the opportunity to apply for Mrs Z to be admitted under Section 3 of the Act, which, if successful would have resulted in 100% NHS funding. That the manner of Mrs Z's admission to the Hospital, and the fact that she was in a locked ward, amounted to compulsory detention and negated the proposition that she was an informal patient; consequently she was entitled to 100% NHS funding.

ii) Her needs were such that she qualified for 100% NHS funding; and various Court judgments - particularly the Coughlan judgment - support his case.

iii) That the NHS had an obligation to fund Mrs Z's nursing home care because, were it not for the falls she sustained in the Hospital, she would not have needed to go to the nursing home.

iv) That essential information about the financial consequences of Mrs Z's admission to the nursing home were not provided to Mr Z before Mrs Z's discharge from the Hospital. Also he was not made aware of the continuing care review procedure until after Mrs Z had been discharged from hospital when it was too late for him to request a review.

9. However in 1998 a guidance note HSC 1998/171 was issued to NHS bodies on allocation of funds to HAs and Primary Care Groups (PCGs) in 1999-2000. This said that HAs would 'continue to be primarily responsible for all those resident in their boundaries' and linked their responsibilities to patients registered with GPs which were part of PCGs for which HAs were responsible. In 1999 Primary Care Trusts (PCTs) were being established and regulations (The PCTs (Functions) (England) Regulations 2000) determined that a PCT was responsible for funding care for patients of GPs within the PCT's remit. Those regulations came into force in April 2000.

10. A replacement for the 1993 guidance on district of residence (paragraph 8) was issued in draft form in October 2002.

Local guidance

11. In April 1996, the Authority published its original policy and eligibility criteria for the provision of continuing health care. A revised version, under which Mr X senior was first assessed, was published in April 1997. It included:

'**Health Authority Responsibility**
2.2 The Health Authority sees as its responsibility the provision of continuing in-patient or residential care for people who:-

- need regular specialist medical or nursing supervision or treatment; or
- have complex medical, nursing or other clinical needs; or
- are likely to die in the very near future and for whom discharge from hospital would be inappropriate.

'2.3 The Health Authority is committed to arranging and funding continuing in-patient or residential care for people who have such needs. Explicit eligibility criteria are contained in each of the care group sections which follow….

'**Nursing Homes**
2.19 People in nursing homes are funded either privately or through the local authority…. Exceptionally the placement might be funded by the NHS where no suitable hospital or other in-patient facility exists…. The Health Authority will not fund nursing home placements other than in the exceptional circumstances described above....

'**Older People Suffering From Mental Illness or Dementia**
5.1 The Health Authority will continue to fund continuing care for people who meet the eligibility criteria set out below. The policy and criteria outlined below apply to older people suffering from dementia and those with severe functional mental illness….

'**In-patient Continuing Care**
5.2 People will be provided with NHS continuing in-patient care if, following clinical assessment, one or more of the following apply:

a) The person's behaviour is extremely restless and in any other residential setting they would be at risk.
b) The person's behaviour is highly aggressive, either physically or verbally, to such an extent that it requires specialised multi-disciplinary team management, including behavioural strategies, in a controlled environment.
c) The person's behaviour is highly uninhibited and could not be managed in any other residential setting.
d) The person has difficult behaviour coupled with heavy physical dependency requiring active regular supervision (weekly or more frequently) by a consultant.
e) The person requires secure care under Home Office Regulations.
f) After acute treatment or palliative care in hospital or hospice, the person is likely to die in the very near future and discharge from [NHS] care would be inappropriate.

'5.3 In Dorset such provision will usually be made in a local NHS facility, either a small residential unit or as part of a community hospital. Clinical management will in all cases be by a consultant psychiatrist.'

Annex four to the policy lists the services then purchased to meet needs in the area. It indicates that the Authority funded 131 continuing care beds for older people suffering from mental illness or dementia.

Mr X's concerns

12. In a letter to this Office on 13 June 2000, Mr X summarised his complaints as being:

'The Dorset Health Authority misled me, through protracted correspondence and prevarication to conclude that they were responsible for meeting my father's continuing health care needs. It was only after many months of delay that their convenor…. refused to grant me an independent review on the grounds that the [Authority] were not, in fact, the responsible authority.

'I contend therefore that either [the Authority] were deliberately obstructive with the intention of

frustrating my legitimate complaint, or .... they were grossly incompetent if they really were unaware of the geographical and administrative boundaries of their own jurisdiction....

'....My original complaint was that my father was entitled to fully funded continuing health care as he was suffering from a disease and that the eligibility criteria against which he was assessed were unlawful in that they did not accord with published guidelines....

'The (later) judgment .... and the subsequent Appeal Court ruling .... in Coughlan, vindicates my contention that my father always was, and remains, entitled to receive fully funded NHS nursing care ....'

13. A letter dated 18 October 2000 from Mr X to the Ombudsman included:

'....my father is in the final stages of Alzheimer's Disease.... He.... requires 24-hour nursing care. The law says.... he is entitled to receive that care free of charge from the NHS….

'[The Authority's refusal to fund his care] is unlawful because in July 1999 the Court of Appeal decided that Miss Pamela Coughlan was entitled to have all her care costs met by the NHS. In their judgment their Lordships concluded that a local authority may purchase "nursing services merely incidental or ancillary to the provision of (the) accommodation…". Their Lordships added "Miss Coughlan needed services of a wholly different category". Clearly Miss Coughlan's care was not considered "merely incidental or ancillary" to her need for accommodation and she was therefore entitled to receive NHS-funded care.

'In fact it is the law that if the primary reason for being in a nursing home is to meet a health, not a "social" need, then all care must be free....

'A comparative analysis between the care supplied to Miss Coughlan and to [Mr X]…. shows conclusively that there is no fundamental difference whatsoever between the nursing services supplied to [Mr X] and those supplied to Miss Coughlan….

'The Appeal Court did not create new law, but simply clarified the existing law. My father is therefore entitled to receive full retrospective care funding from the date he first entered [the] Nursing Home in December 1997. His daily nursing records show that his needs are basically unchanged and illness was, and is, his sole reason for being in a nursing home. In other words, had he not developed Alzheimer's Disease he would have remained in his own home....'

Correspondence and key events

14. I set out below a summary of the key correspondence and events.

1997

Mr X senior lived with his wife in Dorset. He suffered from Alzheimer's Disease. From July 1997 he received periods of assessment and respite care by the Trust in Wimborne, under the care of a consultant in the psychiatry of old age (the consultant).

1 December 1997

Mr X senior was discharged home after a period of respite care. Subsequently Mr X expressed concern to NHS staff about his mother's ability to continue caring for his father, saying he felt that long term care was needed.

19 December 1997

Mr X senior was admitted to the Nursing Home initially for a four week placement of respite care, organised by Dorset Social Services.

1998

13 January 1998

Mr X wrote to Social Services saying that there was no question of his father being able to return home at the end of the planned period of care on 16 January. He said he felt that his father's long term care was the responsibility of the NHS not Social Services. He said he had been in touch (where Mr X senior received respite care in Wimborne) about the situation. Mr X senior remained in the nursing home as a long term resident.

26 January 1998

After speaking to Mr X on the telephone, the Authority's contracts manager wrote to the Trust about the arrangements for Mr X senior.

27 January 1998

Mr X wrote to the contracts manager expressing the view that as Mr X senior was suffering from an illness, the Authority - rather than Social Services - had a statutory duty to fund his long-term nursing care. Three days later he sent the contracts manager invoices for his father's care at the nursing home, and requested that they be settled by the Authority on behalf of the NHS.

6 February 1998

The contracts manager replied reiterating what he had said in the previous telephone call. He said that Social Services departments were responsible for funding care in nursing homes. If someone was sufficiently ill to require NHS care, then that would be

'[Mr Z] subsequently advised the Authority that [Mrs Z] had been discharged from the [second] Hospital back to [the nursing home]. Following [Mrs Z's] return to [the nursing home], [Mr Z] engaged in considerable correspondence with the Authority regarding who should bear responsibility for paying for [Mrs Z's] care. The Authority continued to maintain that [Mrs Z] did not qualify for 100% care, and this has remained the Authority's position throughout this case.

'In correspondence entered into in July/August 1999, [Mr Z] raised the issue of the [Coughlan judgment]…. [The Authority] sought several legal opinions about the judgment, but was advised that [it] did not have a bearing on [Mr Z's] mother's case. [Mr Z] was advised of this opinion in several letters from the Authority.

'On [16 January 2000], the Authority received a formal request from [Mr Z] for an [IR] of his complaint that the Authority would not fund 100% of [Mrs Z's] care.

'After taking professional advice and consulting with an Independent Lay Panel Chairperson, the Authority's Convener advised [Mr Z] that a Panel would not be convened. The Convener and the Chairperson were satisfied that the Authority had made its decision regarding funding in accordance with the Continuing Healthcare Criteria. [Mr Z] was advised that if he was unhappy with the convener's decision he could approach the Health Service Ombudsman.

'On [25 November 2000], [Mr Z] contacted the Authority again, to advise that he had approached the Ombudsman. [Mr Z] also requested a reassessment of his mother's needs, as her condition was deteriorating very rapidly. The Authority advised [Mr Z] that [Mrs Z's] needs would be reviewed by…. Social Services, and that the Authority would respond to any reassessment. Unfortunately, Mrs Z sadly passed away on [26 November 2000].'

23. The Authority also commented as follows:

'The Authority does not feel that this complaint is justified, and does not feel that it has acted unreasonably in refusing to fund 100% of [Mrs Z's] continuing care.

'….In relation to [Mrs Z's] admission to an orthopaedic ward at the [second] Hospital in November 1998, the Authority is satisfied that it was appropriate for [Mrs Z] to return to [the nursing home]. [Mrs Z's] admission to the [second] Hospital was as a result of a fall at [the nursing home], and was not related to the deterioration in her mental health. During her stay at the [second] Hospital, the Authority contacted the hospital to confirm that assessments were taking place. The Authority was anxious to ensure that any discharge took account of [Mrs Z's] condition. The Authority was assured that the discharge back to [the nursing home] was the most suitable and appropriate destination. Therefore, the Authority feels that it was not necessary to arrange reassessment of [Mrs Z's] needs following her second hospital admission in 1998, as that admission concerned her physical rather than her mental well-being. It was felt that return to [the nursing home] was in [Mrs Z's] best interests and was the proper course of action under the circumstances.'

The Authority Director's oral evidence

24. **The Director** told the Ombudsman's Investigating Officer the decision that Mrs Z qualified for only part funding by the Authority stemmed from the Consultant's clinical assessment of her condition. The Consultant was firmly of the view that Mrs Z's condition had not necessitated formal admission under the Act. She had no previous history of mental illness and her problems were largely age related. On the basis of the Consultant's assessment Mrs Z seemed to fall clearly into the category of patients with senile dementia whose confusion and challenging behaviour could not be managed in the community and who needed nursing care in a specialised nursing home at a level over and above that which a general nursing home might provide. It was in recognition of that extra element of nursing care that the Authority contributed towards the costs of Mrs Z's care.

25. The Director acknowledged that **if** Mrs Z had been admitted under Section 3 of the Act she would have been entitled to have her nursing home care fully funded.

26. Mrs Z's needs would have been kept under constant review and a formal reassessment could have been instigated at any time by Social Services staff, her GP or the nursing home. In addition to that she would have been subject to routine annual reassessments. The primary function of any reassessment was to ascertain whether there was a need to amend the care she was receiving. Secondary to that there was the issue of funding. In any case where the care was changed, those responsible would notify the Authority if it was considered that the funding arrangements might no longer be appropriate. Mrs Z's care needs had been reassessed while she was in the second Hospital. There had been no significant change in her mental condition at that time.

not going,' three times. She would not have gone if he had not forced her out of her chair and taken her to the ambulance. The ambulance crew had noted Mrs Z's reluctance in their records (Note: The Ambulance Service records stated '[Mrs Z] refusing to travel and is very confused'). He understood that a person could not lawfully be admitted as an informal patient without that person's consent. In support of that view he referred to the Court of Appeal judgment of December 1997 (paragraph 16).

20. At no time while Mrs Z was a patient in the Hospital had anyone provided written information about her future care or about the financial implications of her having to go into a nursing home. Neither was he given any information about the Authority's review procedure for decisions about funding. There had been mention of a 'funding package' but nothing had been said about Mrs Z having to pay anything towards that. At the date of Mrs Z's discharge to the nursing home Mr Z still expected all her care to be funded by the authorities concerned.

21. After his mother was admitted to the second Hospital Mr Z asked repeatedly for her needs and funding to be reassessed but to the best of his knowledge that was never done. (Note: The Authority provided evidence that it did request a reassessment of Mrs Z while she was in the second Hospital between 4 November and 18 November 1998, and that it was told that she was able to return to the nursing home.) He considered that his mother's circumstances were identical in all material respects to Miss Coughlan's (paragraph 6).

The Authority's response to the Statement of Complaint

22. In its formal response to the complaint to the Ombudsman the Authority wrote:

'[Mrs Z] was admitted to [the] Hospital on [23 May 1998]. [Mrs Z] was diagnosed as suffering from Moderate Vascular Dementia. It was planned that [Mrs Z] would enter [a residential home for the elderly mentally ill (EMI)] (the residential home) on [17 July 1998]. However, following a fall at [the] Hospital, [Mrs Z] was re-assessed and it was determined that her physical condition was such that she required care in a Nursing Home with EMI facilities.

'Arrangements were subsequently made for [Mrs Z] to be placed in [the nursing home], which is a registered EMI Nursing Home, once a bed became available. An application for Joint Funded Placement was made on behalf of [Mrs Z] on [21 July 1998]. It was agreed that.... Social Services would pay £366 per week and [the Authority] £84 per week. As [Mrs Z] had a property to sell, [the] Borough Council would require a contribution from her towards the costs of her care.

'[Mr Z] has contended that [Mrs Z] should have qualified for 100% Authority funding and that.... Social Services should not have had to bear any responsibility for the cost of her care. The Authority have engaged in considerable correspondence since August 1998 with [Mr Z], in order to explain why it is considered that [Mrs Z] only qualified for a joint funded placement, and not a fully NHS-funded placement.

'On [24 August] [Mrs Z] was allocated a place at [the nursing home] and arrangements were made by [the] Borough Council to place a charge on [Mrs Z's] property, until her property could be sold.

'[Mr Z] has argued that it was out of medical necessity, following a number of falls at [the] Hospital, that [Mrs Z] had to enter [the nursing home], rather than [the residential EMI home] where he had intended to place [Mrs Z] following her discharge from [the] Hospital. It has been [Mr Z's] belief that his mother should have been assessed under Group 1 of the.... Authority's published criteria [see paragraphs 15 to 18 above].... He has also stated that he felt that [Mrs Z] required on-site medical expertise 24 hours a day.

'However, the Authority has explained on several occasions to [Mr Z], that his mother was assessed as meeting the criteria for Group 2 of the Authority's Continuing Care Needs and as such her funding was to be shared by the Authority and [the] Borough Council. This arrangement was agreed by the Joint Funded Panel, which met on [21 August 1998].

'In November 1998, [Mrs Z] suffered a serious fall at [the nursing home], and [Mr Z] once again attested that his mother should qualify for 100% funding of her care.

'At this stage the Authority sought legal advice, and further advice from the Authority's medical adviser. It was explained to [Mr Z] that the assessment of his mother's requirements was made by [the Consultant].... who was aware of the criteria for continuing care, which was why an application for joint funding was made. It was also pointed out to [Mr Z], that the medical care provided to [Mrs Z] was not 24 hour care. Rather it was care appropriately provided through Primary Care, by [general practitioners] on a visiting basis only.

provided in a hospital. Social Services had confirmed the assessment previously made by the consultant that Mr X senior did not require admission to an NHS in-patient facility for his continuing care. Responsibility for funding of the care therefore rested with the local authority. He returned Mr X's invoices. He also sent Mr X a copy of the Authority's eligibility criteria for continuing in-patient care.

9 February 1998

Mr X rejected the contracts manager's contention that the Authority was not responsible for funding Mr X senior's care, on the basis that his father appeared to meet some of the Authority's criteria for continuing in-patient care.

10 February 1998

The consultant and a community psychiatric nurse (CPN) reassessed Mr X senior at the nursing home and said that he did not meet the Authority's criteria for NHS-funded continuing care.

11 February 1998

The contracts manager informed Mr X that the consultant's most recent assessment of Mr X senior had been that NHS care was not appropriate. He said again that the Authority expected any Dorset resident who met the criteria for continuing care to be admitted as an in-patient to an NHS facility, and that the Authority would not expect to meet the costs of a nursing home placement, as those were funded by Social Services.

23 February 1998

Mr X wrote to the Authority's chief executive, expressing dissatisfaction with the contracts manager's decision that Mr X senior's care was ultimately the responsibility of Social Services. He reiterated his view that as his father was clinically ill, his nursing care and treatment was the responsibility of the NHS and should be provided free of charge.

27 February 1998

The Authority's chief executive explained to Mr X that:

- It was the Authority's policy to fund placements in nursing homes only if there were no suitable hospital or other in-patient facility, because there were sufficient beds in the Authority's area to meet the needs of all those patients requiring NHS continuing in-patient care;

- Mr X senior was placed in a nursing home after the consultant assessed him as not requiring NHS in-patient care;

- If Mr X senior's health needs changed in the future and, following admission to hospital, he was reassessed as meeting the criteria for in-patient care, the Authority would expect him to remain in hospital;

- The NHS Community Care Act 1990 gave local authority and Social Services departments responsibility for funding nursing home placements, taking into account the financial means of the individual.

5 March 1998

Mr X replied contending that the Authority's policy was in breach of their own published criteria and NHS guidelines. He pointed out that authorities could pay for nursing home places.

22 April 1998

After exchanging further correspondence with the Authority's chief executive Mr X wrote to the Authority's convener (the convener), requesting an IR and explaining his chief concerns:

1. The Authority's criteria for continuing in-patient care were not applied correctly in his father's case. He had not seen a report of his father's initial assessment by the consultant and did not, therefore, know how it had been carried out or on what basis his father was assessed as not meeting the criteria;

2. The Authority's criteria were more restrictive than allowed for in the NHS national guidance. He said that neither of the first two bulletted points of 2.2 in the Authority's criteria (paragraph 11) made it clear that supervision required was for weekly or more regular interventions and that supervision covered specialist equipment as well as treatments: nor did that section reflect the national guidance about people with rapidly degenerating conditions. On sections 5.1 to 5.4, he pointed out that limiting the reference to supervision to that by consultants was more restrictive than the national guidance and referred to EL(96)8 (paragraph 5). He expressed concern about references in paragraph 5.2 to the person being at risk 'in any other residential setting'. That seemed to imply that people could only meet the criteria if admitted to an NHS facility. He said that if, as that and the contracts manager's letter suggested, the Authority's intention was to **never** fund placements in nursing homes then that was out of line with the Authority's policy and with national guidance.

22 May 1998
The Authority's assistant patient services manager replied to Mr X that the first of the above concerns should be put to the Trust's chief executive, as the consultant who assessed Mr X senior was employed by the Trust. She advised Mr X to pursue his broader concerns with the Trust and Southampton and South West Hampshire Health Authority, because Mr X senior had become a Hampshire resident once his placement in the Nursing Home became permanent and he registered with a Hampshire GP. The assistant added that the Authority could consider Mr X's request for an IR of his concern that their criteria for continuing in-patient care were more restrictive than allowed for in national guidance.

1 July 1998
Mr X senior was discharged from the Trust's Old Age Psychiatry Service, as he no longer needed psychiatric input.

Further correspondence with Mr X ensued.

1 September 1998
The convener informed Mr X of his proposal to consider his request for an IR on the basis of Mr X's concern that the Authority's eligibility criteria for continuing in-patient care were more restrictive than allowed for in national guidance. He sought Mr X's confirmation that he was happy with that proposal and requested evidence that his father consented to him pursuing the complaint. (He did not receive a reply from Mr X.)

9 October 1998
The convener informed Mr X that, as matters stood, he could not proceed further with his request for an IR, as Mr X had failed to provide either agreement as to which matters fell within the Authority's remit or evidence that his father supported the complaint.

11 October 1998
Mr X informed the convener that he had replied to the convener's letter of 1 September, but he had addressed the letter incorrectly. He confirmed that he wished to proceed with his complaint against the Authority, he consented to contact with the Trust and said that he had power of attorney to act for his father.

20 October 1998
The assistant patient services manager informed Mr X that a copy of his original letter of complaint (dated 22 April) had been sent to the Trust's chief executive, and that the convener was considering Mr X's request for an IR.

25 October 1998
Mr X wrote to the Trust's chief executive, saying that his complaint was not primarily that the Trust had incorrectly applied the Authority's eligibility criteria for the provision of continuing health care, but that the criteria were unsound and fundamentally flawed.

26 October 1998
The Authority sought confirmation from the South and West Regional Office of the NHS Executive (Regional Office) that its current policy and eligibility criteria for continuing in-patient care were in accordance with national guidance.

9 November 1998
Regional Office told the Authority that in early 1996, it had assessed the Authority's original policy and eligibility criteria and found it to conform to the national guidance (to which I have referred in paragraph 4). Having examined the revised version, Regional Office staff had concluded that it did not unduly restrict access to services.

20 November 1998
The Trust's chief executive explained to Mr X that a multi-disciplinary team, led by the consultant, assessed Mr X senior at the nursing home on 10 February 1998 and decided that he did not meet the criteria for NHS funding for care for older people suffering from mental illness or dementia. He also listed the criteria which would normally result in an individual being provided with NHS continuing in-patient care. He explained that in-patient care would have been arranged for Mr X senior if the team had felt that any of those criteria applied to him. However, the team felt that Mr X senior no longer needed specialist psychiatric input and his psychiatric medication had been stopped.

2 December 1998
Having taken clinical advice, the convener advised Mr X of his decision not to grant an IR at that stage. He referred the complaint for further local resolution so the Authority could give a fuller explanation of the background relating to continuing care arrangements.

1999

17 February 1999
The Authority's chief executive provided Mr X with a fuller explanation of the background to the NHS and Community Care Act of 1990 in relation to continuing care arrangements.

23 February 1999
Mr X wrote to the convener, copying the letter to the chief executives of the Authority and the Trust. He

'….I can confirm that at no time has the Health Authority refused to allow a reassessment to be carried out, the timing of assessments is carried out by those professional, clinical and operational staff closest to the care of the client involved. The Health Authority will respond to any reassessment when carried out.'

26 November - Mrs Z died.

Legislation on Compulsory Admission under the Mental Health Act

13. The Act provides that applications under Section 2 (admission for assessment) and Section 3 (admission for treatment) may be made by either an ASW or a patient's nearest relative. In either case the application must be founded on written recommendations by two registered medical practitioners.

14. Section 118 of the Act made it a function of the Secretary of State to prepare a code of practice (the Code) for the guidance of medical practitioners and others responsible for the admission and treatment of patients under the Act. The Code states that compulsory admission powers should only be used in the last resort. Section 3 of the Act should only be used if treatment cannot be provided unless the patient is detained. Treatment or care should be provided in the least controlled and segregated facilities compatible with the patient's own health or safety, or the safety of other people. In judging whether compulsory admission is appropriate, account should be taken of other forms of care or treatment, including, where relevant, consideration of whether the patient would be willing to accept medical treatment in hospital informally.

15. An ASW has responsibility for co-ordinating the process of assessment. The ASW must attempt to identify the patient's nearest relative and ascertain his or her views. Where possible the ASW should inform the nearest relative of the reasons for considering an application for admission for treatment under the Act and of the effects of making such an application. Although the ASW is usually the right person to make an application, the ASW should advise the nearest relative of his or her right to make the application. The ASW must discuss with the patient's nearest relative the reasons for a decision not to make an application for admission to hospital, if requested to consider such an admission by that relative. (Note: The LGO concluded that there was no maladministration by the ASW in this case in regard to Mr Z's complaint about her actions in April and May 1998).

16. Mrs Z was admitted to the Hospital after the Court of Appeal decision in R v. Bournewood NHS Trust ex parte L (2 December 1997), but before the House of Lords decision on that case on 25 June 1998. The Court of Appeal's view had been that patients who lacked capacity to consent to hospital admission could not receive treatment for mental disorder informally even though they had not expressed dissent. The House of Lords overturned that judgment. As the current version of the code makes clear, if at the time of admission the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. If a patient lacks capacity at the time of an assessment or review, it is particularly important that both clinical and social care requirements are considered. Account must be taken of the patient's ascertainable wishes and also of the views of immediate relatives on what would be in the patient's best interests.

17. Section 117 of the Act requires health authorities and social services authorities to provide after-care services for any person normally resident in their area who is detained under Section 3, until such time as the authorities are satisfied that the person concerned is no longer in need of such services. In February 2000 the Department of Health issued guidance HSC 2000/003 on Section 117 aftercare following a High Court judgment in R v. Richmond LBC ex parte Watson, 28 July 1999. That said that authorities might not charge for residential accommodation provided as a part of after-care service under Section 117.

Mr Z's evidence

18. **Mr Z** told the Investigating Officer that he had been much relieved when Mrs Z was being admitted to the Hospital, but he had not then realised that if she had been admitted compulsorily, instead of informally, she would have qualified to have her continuing care fully funded by the NHS as part of a programme of after-care for a patient entitled to that care in accordance with Section 117 of the Act. He believed that the Consultant had been willing to recommend compulsory admission but had been persuaded not to do so in order to safeguard the Authority and Social Services from any financial liability for her continuing care. No one had told him that, as Mrs Z's nearest relative, the Act gave him the right to make an application for admission.

19. Mr Z considered that he had been left no alternative but to force his mother to enter hospital. No alternative care had been offered. Mrs Z had been very resistant to leaving her house and had said, 'I'm

of Mrs Z's admission to the Hospital with the NHS Trust responsible. He added, however, that the Authority preferred that patients be admitted voluntarily where possible, so as not unnecessarily to deprive them of their liberty.

13 August - The Director told Mr Z that the Authority had received legal advice on the Coughlan judgment and did not consider that it had a bearing on the funding of Mrs Z's care.

25 August - Mr Z asked the Director to explain why the judgment was not considered relevant in his mother's case.

26 August - The Authority received a letter from its solicitors with several pages of notes by the solicitors on the Authority's criteria document in the light of the Coughlan judgment. Those include a comment that one section of the document does 'not seem to be entirely in line with Coughlan' and in another that the paragraph is 'contrary…. to the decision in Coughlan'. It raises various questions about the criteria and arrangements for patients considered to be in Group 2 (as Mrs Z was).

25 November - After obtaining further legal advice on Mrs Z's circumstances the Director wrote to Mr Z reaffirming and '….bringing to a conclusion the debate about….' the Authority's position that his mother was correctly assessed as meeting the Authority's criteria for Group 2 of its policy in respect of continuing health care needs at the time of Mrs Z's admission to the nursing home. The Authority had obtained specific legal advice on Mrs Z's case in October 1999. That ended:

'You mention that [Mrs Z] meets Group 2…. of the [Authority's] criteria. It refers to patients whose confusion and challenging behaviour cannot be managed in the community and requires care in a specialised nursing home. This wording seems at odds with [Mrs Z's] position - and I am not sure I follow the distinction between specialised and specialist….

'[Mrs Z] is clearly very dependent in terms of the daily activities of life, but I imagine that if she would be classified as 100% NHS many others would be as well. She is clearly far less dependent on specialised health input than Miss Coughlan. I imagine her need for nursing attention is not "continuous and intense" (to use the court's phrase) and that her general requirement is for normal nursing home provision.

'[Mrs Z's] case is an interesting one to bear in mind when considering the [Coughlan judgment]. Presumably someone in her condition may reach a stage of such continuous need as to entitle her to 100% NHS-funded treatment. If so, do the criteria make this happen?'

7 December - Mr Z wrote again to the Director, stating that in his opinion the Coughlan judgment was relevant as his mother's need for accommodation and support was primarily to enable her health needs to be met. The judgment required that care, accommodation and support should all be provided free in those circumstances. Mr Z argued that there was no obligation on his part as next of kin to move her from the Hospital and that as she would be receiving free NHS round the clock nursing care in hospital, Social Services should not be involved in Mrs Z's care.

22 December - The Director told Mr Z how he could pursue his complaint by asking for an IR under the NHS complaints procedure.

16 January 2000 - Mr Z sent a full and detailed statement of his complaint to the Authority's Complaints Manager. He alleged that the Authority, in concert with Social Services, made a calculated attempt to evade payment for long term care which it was under a duty to provide. In May the Borough Council wrote to Mr Z to say that, having liaised with the Authority, they had been informed that the Authority had reviewed Mrs Z's case and concluded that she continued not to meet the criteria for 100% funding.

22 June - After seeking professional advice and consulting a Lay Chair the Convener wrote to Mr Z saying that he had decided not to convene an IR panel. He considered that the Authority had clearly demonstrated compliance with its policy for continuing care and that establishing a panel would not resolve the complaint.

25 July - Mr Z complained to the Ombudsman.

25 October - Mr Z wrote to the Authority's Chief Executive saying that Mrs Z was unlikely to live beyond Christmas 2000 and asking him to arrange a further appraisal of his mother's needs, which he regarded as purely palliative and thereby rendering her eligible for full funding.

21 November - The Chief Executive confirmed that a review of Mrs Z's needs would be carried out. The letter stated:

referred to the initial judgment in the Coughlan case. He said that that clearly and categorically placed responsibility for **all nursing care** upon the responsible health authority. He also expressed his intention to seek professional advice concerning the legality of the continued means-tested funding of his father's care by Dorset Social Services.

6 March 1999
Mr X made another request to the Authority for an IR. By that time he summarised his complaint as, 'In refusing to fund my father's continuing health care needs [the Authority] are in breach of their legal obligations under current NHS statute'. He referred again to the initial judgment in the Coughlan case.

15 March 1999
The Authority's convener asked Mr X to clarify his outstanding concerns in the light of the chief executive's detailed reply to Mr X of 17 February. He said that a further request for IR could only be considered in relation to the original complaint.

22 April 1999
Having heard nothing further from Mr X, the Authority closed its file.

27 April 1999
Mr X complained to the Ombudsman about the actions of the Authority, the Authority's convener and the Trust.

17 May 1999
One of the Ombudsman's staff asked Mr X to provide further information. Mr X did not reply to that letter until 14 February 2000.

2000

6 January 2000
The owners of the nursing home informed Mr X of its imminent closure. They said that they would liaise with Mr X, the Authority and Social Services to ensure that Mr X senior was found a suitable home with the minimum amount of disruption.

7 January 2000
Mr X asked the Authority's chief executive if Mr X senior could be reassessed against the NHS continuing care criteria. That letter included:

'In view of the ruling by the Court of Appeal in the Coughlan case, it appears that Alzheimer's patients in particular are entitled to receive NHS care free of charge as there is a primary need for constant health care, thus the whole of that care must, according to Government guidance, be borne by the NHS.

'I would therefore be grateful if you would take the necessary action to ensure that my father receives the level of care to which he is entitled…. funded by the NHS in accordance with current law.'

18 January 2000
The chief executive of The New Forest Primary Care Group wrote to Southampton and South West Hampshire Health Authority's commissioning manager. That letter included:

'I have asked [Mr X senior's GP] if he would liaise with District Nursing and Dorset Social Services so that a joint assessment [of Mr X senior] can be carried out as soon as possible.

'My understanding is that although Dorset Social Services retain responsibility for [Mr X senior's] social care needs, the Southampton and South West Hampshire Health Authority and New Forest Primary Care Group have responsibility for meeting health needs if they are in line with the continuing care criteria....'

2 February 2000
Mr X senior moved to a nursing home in Devon.

14 February 2000
Mr X wrote to the Ombudsman with further information and explained his outstanding concerns.

February 2001
Mr X senior died.

Complaint (a) The Authority's eligibility criteria are unreasonably restrictive and do not reflect the principles laid down in the relevant NHS guidance

The Authority's comments

15. A letter dated 29 November 2000 from the Authority's chief executive to the Ombudsman included:

'…. I…. would wish to emphasise at an early stage that, while [Mr X senior] was resident in Dorset when he entered respite care in…. [the] Nursing Home, on 14 January 1998 he registered with [a GP] in Hampshire, as the placement had become permanent. From 1 April 1999, as part of the changed arrangements for establishing Primary Care Groups, he became the responsibility of…. Southampton and South West Hampshire Health Authority. Our files indicate that [Mr X] did not contact [the Authority] about his father's care until 22 January 1998 when he

spoke to [the contracts manager]. It appears that he was in contact with Dorset Social Services prior to that date….

'I consider that [the Authority's] eligibility criteria for funding long-term NHS in-patient continuing health care are not unreasonably restrictive and reflect the principles laid down in the relevant NHS guidance. Extensive consultation took place before drawing up the policy, as explained in my letter of 17 February 1999 to [Mr X], and has taken place since. As a result of [Mr X's] concerns [the Authority] contacted [Regional Office] for their view on the policy and criteria and received confirmation that it conformed to national guidance and did not unduly restrict access to services. The letter from [Regional Office's director of policy], dated 9 November 1998 confirms this….

'….As the convener requested, [Mr X] was sent a further letter by me explaining the background to the NHS and Community Care Act 1990 in relation to continuing care arrangements. This is my letter of 17 February 1999.

'By this time the judgment in the case of R v. North and East Devon Health Authority, ex parte Coughlan, had been published and [Mr X] wrote to [the Authority] (and others) to inform us that he was taking legal advice as a result of that judgment. He also made a further request for an [IR]….

'As a result of the Coughlan judgment and the contents of [HSC(99)180] [the Authority] asked its legal advisers…. to examine the April 1997 Policy and Eligibility Criteria for the Provision of Continuing Health Care and received confirmation in a letter dated 3 November 1999 that it was in accord with the spirit of the Coughlan judgment.

'Based on the recommendation made by [the Authority's legal advisers] the Authority has, since November 1999, applied the eligibility criteria in accordance with the Court of Appeal judgment as distinct from the precise wording of the policy document….'

16. The chief executive of the new Dorset and Somerset Health Authority (who had been the chief executive of the Authority until its abolition at the end of March 2002) provided further comments in October 2002. In those he said that:

'It was only in November 1999 that the former Dorset Health Authority was advised that there might be a difficulty arising from the interpretation of the policy and eligibility criteria in the light of [the Coughlan judgment]. In a letter of advice [from its solicitors] the former Dorset Health Authority was advised not to implement any amendments until further guidance from the Department of Health was issued. Further legal advice received in February 2000 confirmed that any difficulties might lie in the interpretation of the policy rather than the precise wording of the policy itself….

'The above legal advice was received some time after the assessment of the eligibility of [Mr X senior] for continuing care was undertaken but it was taken into account when the revised policy and eligibility criteria were produced in 2001.'

Those comments also included:

'The former Dorset Health Authority undertook an in-depth review of its policy and eligibility criteria for continuing health care and published a revised document in December 2001. This review took into consideration the judgment of the Court of Appeal *ex parte* Coughlan and the ensuing guidance from the Department of Health published in June 2001…. The updated criteria were examined and modified by the legal advisors to the former Dorset Health Authority before the final version was agreed.

'The review in 2001 acknowledged that the original criteria could give rise to an interpretation that was restrictive. The former Dorset Health Authority satisfied itself that the updated criteria agreed in 2001 could not be applied in such a restrictive way.'

17. The legal advice received by the Authority in November 1999 included:

'….There is a danger in eligibility criteria defining "specialist" in extremely narrow terms. "Specialist" should not be assessed by looking at the level of qualification required for a particular task. Rather, it is necessary to look at the intensity, quantity, continuity and range of the nursing services required….

'….Although the judgment is not retrospective, it is one which is deemed to clarify the law and therefore to say what the law has always been. It follows that if anyone has paid for nursing care that ought to have been provided on the NHS then they may be entitled to reclaim the monies spent….

'**Recommendations**

'….Even though I have identified parts of the policy document that might be suitable for amendment, I do not recommend any immediate steps are taken to

27 September - Mr Z drew the Locality Commissioner's attention to Section 117 of the Act, which he said placed a duty on health authorities and social services authorities to provide after-care services for patients who have been detained in hospital under the Act. He said that Mrs Z had entered hospital under the same circumstances as if she had been compulsorily detained. He enclosed an invoice received from Social Services for Mrs Z's accommodation in the nursing home.

7 October - The Authority said that following Mrs Z's discharge from the Consultant's care, it was now for Mr Z to settle the invoice from Social Services for his contribution to Mrs Z's care in the nursing home.

8 November - Mr Z told the Locality Commissioner that his mother had been admitted to the second Hospital as a result of a fall she had had at the nursing home. As he did not expect her to be able to walk again he considered that the case for full funding by the Authority was even stronger.

11 November - The Authority's legal advisers indicated their agreement with the line being taken by the Authority in respect of Mrs Z.

18 November - The Locality Commissioner told Mr Z that a full reassessment of his mother's needs would be carried out before she was discharged from the second Hospital. She reasserted the view that Mrs Z's needs on discharge from the Hospital were not such as to qualify her for full NHS funding. Mrs Z did not need 24-hour on-site medical cover. The Authority's public health adviser considered primary care services of the kind provided by her GP to be sufficient. Neither had Mrs Z needed palliative care of the kind envisaged in the Authority's Group 1 criteria, which applied to patients with very intensive needs during the final stages of life.

21 November - Mr Z told the Authority that after having hip surgery his mother had returned to the nursing home but had lost all mobility.

22 November - Mr Z wrote to the Locality Commissioner reiterating the view that, as the Consultant considered Mrs Z ill enough to be admitted compulsorily to hospital, the Authority's own policy placed it under an obligation to classify her as Group 1, thereby entitling her to full NHS funding. He also contended that as Mrs Z's 'nearest relative' those responsible for her admission were under a statutory duty to inform him, before Mrs Z was admitted to the Hospital, that he had the legal right to require that she be admitted compulsorily. He considered that the failure so to advise him may have been deliberate.

8 December - Mr Z wrote once more to the Locality Commissioner asking that his mother's needs be reassessed. He told her that he was suggesting to Social Services that Mrs Z might return to her own home if all the care she needed could be provided in that setting. If at any time in the future the situation became untenable he might apply for Mrs Z to be compulsorily admitted under the Mental Health Act, which would have the effect of forcing the Authority to pay for any after-care.

14 December - Mr Z sent a further statement to the Locality Commissioner in which he wrote that he had received a letter from the Consultant stating that Mrs Z had had a chronic mental disorder when he visited her on 30 April 1998. Mr Z repeated his contention that Mrs Z had qualified for compulsory admission to Hospital and that the full costs of her care and treatment in the nursing home should be funded by the Authority.

4 February 1999 - The Locality Commissioner wrote to Mr Z saying that a colleague of hers had contacted the second Hospital while Mrs Z was a patient there and had been told that her needs had been reassessed and the decision made that she should be discharged back to the nursing home. Any decisions about compulsory admission under the Mental Health Act would be 'under the direction and discretion of the mental health team'. The Authority's Group 1 criteria applied only to patients whose detention under the Mental Health Act continued in a nursing home or other long term setting. The mental health team had not indicated any need for Mrs Z to be so detained.

7 March - Mr Z replied that at no time before Mrs Z was moved to the nursing home in August 1998 had anyone told him or any other member of his family how Mrs Z's care and treatment in the home would be paid for.

12, 19 and 25 July - Mr Z wrote further letters to the Authority. He referred in some to the Coughlan judgment (paragraph 6), which he said supported his case. He complained that there had been a failure to inform him, as Mrs Z's nearest relative, of his right to apply for her to be admitted compulsorily. As a result, on 23 May 1998, he had been obliged 'to forcibly move [Mrs Z] from her home and thence to enter an ambulance which had been ordered'. Her admission to the Hospital had therefore been involuntary.

5 August - The Authority's Director of Strategy and Development (the Director) acknowledged Mr Z's letters and said that he was obtaining legal advice about the effect of the Coughlan judgment. He advised Mr Z to pursue his concerns about the manner

23 May - Mrs Z was admitted to the Hospital (where she stayed until she was discharged on 24 August), diagnosed with vascular dementia. (Note: Mr Z said that he had to physically coerce her to leave her home and enter the ambulance.)

5 July - Mrs Z suffered a fall at the Hospital.

8 July - Mr Z complained to the General Manager of the Hospital (which at that time was managed by another trust) about the fall that Mrs Z had had.

21 July - An application was made for Mrs Z to be given a joint funded placement in a nursing home for elderly mentally infirm (EMI) people. The application included a detailed nursing assessment. She was said to need 'all help with daily living, except feeding'. Compulsory admission, under Section 3 of the Act, was said to have been considered but not implemented. Mrs Z was described as resistant to help and needing supervision if she was to take the medication she needed.

24 July - Mr Z told the Authority's Complaints Manager that as a result of the fall his mother was no longer fit enough to be transferred to a residential home, as previously planned.

17 August - Mr Z wrote to the Chief Executive of the Trust saying that he was unhappy with the reply to his complaint. In the course of that letter Mr Z stated that he had visited the nursing home on 17 July to discuss his mother's placement there. A member of Social Services staff had been in contact with the Authority and funding had been approved, but a place at the nursing home was not presently available. The letter continued 'It is my understanding that the Authority is responsible for such funding as is necessary.... However, it appears that [the Borough Council] will be funding the major portion of the care my mother will receive in [the nursing home]. It is my considered opinion that it is [the Authority] which should be paying in total.... since she now needs constant supervision to prevent injury to herself, I see no reason why.... Social Services should take responsibility for her care when, in fact, this present situation is caused directly by her stay in an NHS facility.'

Mr Z copied his letter to the Authority's Locality Commissioner, saying that as the circumstances had changed and Mrs Z now needed nursing home care he expected the NHS to pay for it.

21 August - Joint funding was approved for Mrs Z to go to the nursing home: £366 from Social Services and £84 from the Authority.

24 August - Mrs Z moved to the nursing home.

28 August - The Locality Commissioner sent Mr Z a copy of the Authority's policy (see paragraph 9) and wrote:

'You will see from [the policy] that the responsibilities for health funding are determined by an assessment process which looks at the health needs of an individual. In this sense it is the presenting condition which determines needs and responsibility not the means by which these arose. Your correspondence with [the Trust] will no doubt continue to consider causation. For this reason I am unable to support your view that the Health Authority is responsible for meeting the full [nursing home] costs. I believe the Health Authority have responded in an identical way as they would to any individual patient who presented with this mixture of need. Specialist nursing home care fits clearly into the Group 2 criteria, which are for joint funding arrangements.

'If you have concerns with how we have applied the criteria in your mother's case, you may find it helpful to follow the Review Process. I enclose a leaflet which explains how this works. I should stress however, that the Review Process is only open to you while your mother remains an in-patient....'

The leaflet that was enclosed described the procedure for reviewing decisions on eligibility for NHS continuing in-patient care (paragraph 5).

10 September - Mr Z wrote back to the Locality Commissioner pointing out that the information about the review procedure arrived too late for him to pursue an appeal as his mother had already been transferred to the nursing home by the time he received the leaflet. He also commented that prior to receiving the Locality Commissioner's letter he had been given no written information whatever with regard to his mother's care, its funding, or other related matters. Having read the Authority's policy he was more convinced than ever that Mrs Z's care should be fully funded by the Authority and he enclosed a detailed statement of his reasons. In essence, Mr Z contended that at an assessment on 30 April 1998 the Consultant had been willing to admit Mrs Z to hospital compulsorily under the Mental Health Act; that Mrs Z's present condition was such that she needed one to one attention throughout the day; that as her physical and mental condition would not improve she was terminally ill; and that she needed palliative care. He maintained that on each of those grounds the Authority's policy stipulated that Mrs Z's nursing home care should be 100% NHS funded.

implement those recommendations. This is particularly so given that further guidance is expected to be issued by the Department of Health in the near future....

'I also recommend that a "risk management" exercise is undertaken. The Health Authority may wish to identify cases in which NHS funding has been refused because a particular patient was not regarded as requiring "specialist" nursing care. It would be prudent to identify all cases where patients are regarded as receiving "general" nursing services but those services are of an "intensity, quantity, continuity and range" that might be considered beyond the responsibility of a Local Authority. This exercise will identify those cases for which the Health Authority might have future responsibility and cases for which there is potential "retrospective" financial responsibility.

'Apart from planned amendments to the document, the Health Authority should consider the manner in which the eligibility criteria is applied at the present time. The Health Authority should ensure that its policy is applied in accordance with the Court of Appeal judgment as distinct from the precise wording of the document. This is important....'

The further legal advice received by the Authority in February 2000 included:

'The Opinion from Counsel also identifies a problem with paragraph 2.19. As currently drafted paragraph 2.19 states that the Health Authority will only be prepared to fund where no suitable hospital or other in-patient facility exists. This is the point I mentioned in my earlier letter of advice. I do not think that this requirement cannot [sic] be sustained in the light of the Court of Appeal's Judgment in Coughlan.

'Counsel's opinion is that the requirement for active regular supervision by a consultant - as a pre-condition for continuing in-patient care - cannot be sustained. This is not a point that I covered in my previous letter of advice. However, I think that Counsel's opinion is probably right....

'I remain of the view that specific risks to the Health Authority in the short term lie in the manner in which the eligibility criteria are applied as distinct from the precise wording of the criteria.'

Findings (a)

18. Mr X has been arguing since January 1998 that the NHS should pay the full cost of his father's nursing home care. During the period since then he has put forward various reasons why he believes that to be so, mainly that the Authority's eligibility criteria were over-restrictive. Before I consider the arguments about that I need first to resolve the question, which otherwise causes confusion in this case, of **which** HA (if any) might have been responsible for Mr X senior's care at what point.

19. In 1998 responsibility for NHS funding rested with the HA where the patient was usually resident (paragraph 8). Mr X senior lived in Dorset and first moved to the nursing home in Hampshire only for respite care. It was at that point that his son requested NHS funding for Mr X senior's long term care: and since his permanent home at that point was still in Dorset, it was quite correct that he was then assessed under the Authority's criteria with a view to them funding his care. If he was, properly, not eligible for NHS funding by that Authority at that point then, once he became permanently resident at the home in Hampshire, the HA there (not that in Dorset) became responsible for any NHS care he needed. Mr X could have asked for his father to be assessed under the Hampshire criteria in 1998. On the other hand if Mr X should in fact have been judged eligible for funding by the Authority for his long term care in January/February 1998, under the terms of the 1993 District of Residence guidance (paragraph 8) then they would have retained that responsibility (while he still met their eligibility criteria) even though the home was in the area of Southampton and South West Hampshire Health Authority. The subsequent guidance on funding of HAs, PCGs and PCTs suggests that that situation changed in April 1999, when the Southampton and South West Hampshire Health Authority would have become the responsible body for any funding.

20. So the key issue in this case is whether Mr X senior should have been considered eligible for funding by the Authority from early 1998 to March 1999. His son argues that he should have been. He says that the Authority's criteria were unnecessarily restrictive, and that his father was entitled to funding for his care because he needed the care as a result of a disease. He has quoted from the judgment by the Appeal Court in the Coughlan case in support of his view.

21. I found that the Authority was responsible, in February 1998, for determining whether Mr X senior's condition meant that he fulfilled the criteria for NHS funding for his care. I shall deal first with the Authority's criteria in relation to the national guidance in 1998 (i.e. before the Coughlan decision). Mr X explained his chief concerns about that to the Authority's convener on 22 April 1998 (paragraph 14). He questioned first section 2.2 of the document setting out the Authority's policy on funding continuing

health care. However that section did not attempt to define fully the Authority's criteria, as section 2.3 made clear but, it seems to me, was a summary. I do not therefore think it unreasonable that it does not cover all the points in the national guidance. I think Mr X's concerns about sections 5.1 to 5.4 are more valid. While I recognise that the Regional Office apparently accepted that the criteria were not over-restrictive, it seems to me that the criteria, 5.3 in particular, do imply that **only** those patients requiring clinical management by a consultant will be eligible: whereas EL(96)8 emphasises that that should not be the case. I am also uneasy at the way the criteria appear to link eligibility to needing care in an NHS unit. One would expect any HA to have a number of people entitled to NHS continuing care, and some HAs might have enough provision in NHS facilities to meet all those needs whereas others might not. So a reluctance to fund care outside the NHS does not necessarily indicate a failure to make sufficient provision: though if all the long term care was provided in large institutional hospital settings it would raise questions about the quality of life offered to such patients. However the crucial issue in this case is how the Authority's criteria were likely to be applied in practice. Whereas the criteria do indicate (at 2.19) the possibility of exceptions being made, given the general wording that was likely to be missed by those trying to interpret the policy. Indeed that seems to have happened in Mr X's case: the contracts manager's early correspondence with Mr X seemed to take the line that, because Mr X senior could be cared for in a nursing home rather than in an NHS facility, that necessarily meant he did not qualify for funding. So I do conclude that, in practice, the criteria were rather too restrictive in comparison to the relevant NHS guidance at the time. I am not at this stage expressing any view as to whether that led to any practical injustice to Mr X senior, i.e. whether or not that meant he did not receive NHS-funded care to which he was entitled. I shall return to that point.

22. Before that however I shall deal with Mr X's other initial argument (not linked to the national guidance), that his father was necessarily entitled to NHS funding for his care because it was precipitated by his illness. I am not aware of any legislation which says that whenever any type of care is needed because of an illness, that should be provided by the NHS. It is well established in law that the NHS does not have to provide even all **health** care which a person might need, and the guidance following the Coughlan judgment picked up that point saying that the NHS may have regard to its resources when deciding on resource provision. That guidance also made it clear that the judgment did not call into question that local authorities may make provision for nursing care, as well as more general personal care. So I do not see that the fact that Mr X senior needed care because of a disease meant that **all** that care necessarily had to be provided by the NHS.

23. That brings me to Mr X's final argument that his father's fundamental entitlement to NHS funding for his care was established by the Coughlan judgment. He quotes the part of the judgment which says that it is generally unlawful for authorities to transfer responsibility for nursing care to local authorities unless the care is incidental or ancillary to the local authority services. He says that the nursing services his father received (in 2000) were very similar to Miss Coughlan's. While Mr X does not appear to have had a direct response from the Authority on this point, despite his letter of 7 January 2000, they told me that they had received legal advice that their criteria were 'in accord with the spirit' of the Coughlan judgment and that since November 1999 they had applied the eligibility criteria in accordance with the judgment rather than the precise wording of the policy document.

24. I have to say that I find that unconvincing. I have explained earlier why I concluded that, in practice, Dorset's criteria were rather more restrictive than envisaged by HSG(95)8. But in the light of the Coughlan judgment, and the subsequent guidance, they were far too restrictive. Many patients who required significant amounts of nursing care, which could not be regarded as merely incidental or ancillary to the provision of accommodation by a local authority, would not satisfy the Dorset criteria. The fact that since November 1999 they felt the need to apply the criteria in a different way, and not in accord with the precise wording of their policy document, suggests that they were aware of a discrepancy. The legal advice which they received (paragraph 17) identified various concerns with the policy but did not recommend immediate changes to it, partly because further guidance was expected from the Department of Health. I can see that that expectation might have influenced HAs to take less immediate action than they might otherwise have done. However I cannot see how the Authority could expect the criteria to be applied in a way consistent with the judgment without changing them and/or guidance accompanying them: especially when clinical assessments under the criteria might be done by various different staff, often those employed by local NHS trusts rather than the Authority itself. Nor can I see that that approach provides adequate transparency for the public about the eligibility criteria.

The Authority's policy in respect of the funding of continuing health care needs

9. The Authority's policy was contained in a booklet entitled 'NHS Responsibility For Meeting Continuing Healthcare Needs in Berkshire'. It included the following statements of principle:

'Everyone who requires the primary and specialist health care services should be eligible to receive those services funded by the NHS. They should be eligible to receive them wherever they live, whether it is at home, in a residential or nursing home, in a hospital or any other setting.'

and

'Anyone who requires continuing and regular medical treatment, nursing care or rehabilitation therapy at a level of intensity or degree of specialisation which cannot be sustained at home or in a residential or nursing home setting (even when access to the primary and specialist health care services is available), should be eligible for continuing NHS care in an appropriate setting.'

and

'Some patients discharged to a nursing home will need an intensive and complex personal care package which is beyond the customary level of care offered by the home. Such patients may also be eligible for NHS funding of those aspects of health care which are beyond the general nursing care routinely expected in a registered nursing home.'

10. The policy specified broad groups of people and the degree to which each group qualified for NHS funding. **Group 1** comprised 'people who would normally need to live in a hospital setting, a specialised nursing home or hospice because the specialised nature of continuing health care they require could not be provided in any other setting.' All persons categorised as belonging to Group 1 qualified for 100% NHS funding. **Group 2** comprised 'people who are discharged from hospital to a nursing home or admitted to a nursing home from the community, whose needs are such that they require an intensive and complex personal care package beyond the customary level of care offered by the home.' People in Group 2 did **not** qualify for 100% funding, they qualified for NHS funding of the extra nursing care required over and above the general nursing care included in the standard nursing home price. In the case of patients who were terminally ill and needed specialist palliative care, responsibility for placement and funding rested entirely with the Authority. The level of NHS funding was to be determined after a full assessment of needs by health and social services staff and agreement between the Authority and the relevant social services authority that the extra cost charged by the nursing home was justified.

11. The policy gave examples of the types of need that might qualify a person for inclusion in each of the groups. (The Authority's policy for Group 1 and Group 2 is in the appendix.) Under Group 2 the examples given included people with multiple and complex nursing and medical problems; people needing regular therapeutic support deemed essential by a consultant and of a kind which could only be delivered by a professionally qualified person; and patients with dementia whose confusion and challenging behaviour cannot be managed in the community and who require care in a specialised nursing home.

Chronology of key events and evidence

12. I now summarise the key correspondence between Mr Z, the Authority and others involved:

27 November 1997 - Mrs Z visited by a consultant in old age psychiatry (the Consultant). The diagnosis was that Mrs Z might be suffering from moderate chronic organic brain syndrome.

1 December - The Consultant wrote to Mrs Z's GP concluding that he would consider '….admission to the…. [the Hospital] informally or formally, should the situation get into crisis. In the longer term she is likely to require long term residential care, in view of the progressive nature of her illness'.

30 April 1998 - An Approved Social Worker (ASW), a Care Manager, and the Consultant visited Mrs Z at her home following an incident when she was found wandering outside.

6 May - The Consultant wrote to the GP about the visit to Mrs Z's home on 30 April. The Consultant described his assessment of Mrs Z at that visit. Concluding his letter, the Consultant wrote:

'....The question of formal admission to [the] Hospital on Section 3 [of the Mental Health Act 1983 - (the Act)] was considered, but on balance, it was agreed by us to waive formal admission presently, if [Mrs Z] can be persuaded to accept more intensive domiciliary care and perhaps day care. It was left to [the] ASW.... and [a social services care manager] to negotiate such arrangements with [Mrs Z] and her sister. I would consider admission to [the Hospital], formally if need be, if the situation reaches crisis point....'

'The review procedure is intended as an additional safeguard for patients assessed as ready for discharge from NHS in-patient care who require ongoing continuing support from health and/or social services and who consider that the Authority's criteria for NHS continuing in-patient care (whether in a hospital or in some other setting such as a nursing home) have not been correctly applied in their case.

'The review procedure applies to all patients who have been receiving NHS in-patient care, whether in a hospital, or arranged and funded by the NHS in a hospice, nursing home or elsewhere, and to all client groups covered in local eligibility criteria.'

6. In August 1999 the Department of Health issued further guidance on continuing health care in a circular HSC 1999/180. This was in response to a Court of Appeal judgment in the case R v. North and East Devon Health Authority ex parte Coughlan (the Coughlan judgment). That judgment summarised its conclusions as follows:

'(a) The NHS does not have sole responsibility for nursing care. Nursing care for a chronically sick person may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's needs…. Whether it was unlawful [to transfer responsibility for the patient's general nursing care to the local authority] depends, generally, on whether the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category.'

The Department's guidance included in its description of the judgment:

'(b) The NHS may have regard to its resources in deciding on service provision.

'(c) HSG (95)8 is lawful, although could be clearer.

'(d) Local authorities may purchase nursing services under section 21 of the National Assistance Act 1948 only where the services are:

> (i) merely incidental to the provision of the accommodation which a local authority is under a duty to provide to persons to whom section 21 refers; and
>
> (ii) of a nature which it can be expected than an authority whose primary responsibility is to provide social services can be expected to provide.

'(e) Where a person's primary need is a health need, then this is an NHS responsibility.

'(f) Eligibility criteria drawn up by Health Authorities need to identify at least two categories of persons who, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a Health Authority. Secondly, there are those whose nursing services in general can be regarded as the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.'

Authorities were advised to satisfy themselves that their continuing and community care policies and eligibility criteria were in line with the judgment and existing guidance, taking further legal advice where necessary. Where they revised their criteria they should consider what action they needed to take to re-assess service users against the revised criteria.

7. On 7 September 1999 a Regional Office of the NHS Executive (the Regional Office) sent to all health authorities in their region (including Berkshire Health Authority) a letter about the Coughlan judgment. It included:

'The judgment…. does not comment on all aspects of continuing care policy - just those elements which impact on nursing care in nursing homes. There is no need to reconsider other aspects of local policies. There is a review of policy and guidance on continuing care which is due to report towards the end of this year, so it would be premature for [Authorities] to carry out a major review of local policy at this point. Health Authorities may wish to bear this in mind when considering their approach.'

Authorities were asked to report to the Regional Office on what action they had taken in response to HSC 1999/180.

8. No further national guidance on continuing care eligibility criteria was issued until June 2001 (i.e. after Mrs Z had died).

25. I note the legal adviser's suggestion that the Authority should conduct a 'risk management' exercise to identify cases where, in the light of aspects of the Coughlan judgment, the Authority might have a 'retrospective financial responsibility'. I have not seen any evidence to suggest that the eligibility of patients (and Mr X senior in particular) was properly reviewed following the judgment. Although, by the time of the judgment, events had moved on since it seems that responsibility for any appropriate funding for his care had passed to Southampton and South West Hampshire in April 1999, the Authority should have checked that the initial judgment about his eligibility (back in 1998) was reasonable in the light of the judgment and subsequent guidance. I uphold the complaint.

26. I turn now to the question of remedial action. In 2001 the Authority finally did review its policy and eligibility criteria and adopted a new version in December of that year. The organisation of the NHS has also changed since these events. The Authority no longer exists. Responsibility for setting eligibility criteria now lies with a new Dorset and Somerset Health Authority (the new Authority), and the relevant budget for funding such care will be held by a PCT. While I recognise that the new Authority played no part in these events, I must regard them as responsible for taking remedial action. I **recommend** that the new Authority should, with its associated PCT and local authority colleagues, review the eligibility criteria for funding continuing care that have been in operation since April 1996 to ensure that they were (and are) in line with the Coughlan judgment and other relevant guidance. I further **recommend** that the new Authority should, with colleague organisations, then determine whether there were any patients (including Mr X senior) who were wrongly refused funding for continuing care, and make the necessary arrangements for reimbursing the costs they incurred unnecessarily. While Mr X has compared his father's needs in 2000 with those of Miss Coughlan, as I have explained earlier, it seems that the Authority were not responsible for providing his father's health care by then. Furthermore Mr X senior suffered a degenerative condition, so he was more likely to be eligible for funding as time went by. The appropriate way forward seemed to me to be for his eligibility in 1998-9 to be reconsidered in the light of available information about his condition then, once appropriate criteria for that period had been developed.

Complaint (b) The Trust failed properly to assess Mr X senior's eligibility for NHS-funded continuing in-patient care

27. In correspondence to the Trust in October 1998 Mr X referred to his complaints about them being as follows:

'….I have not been provided with a copy of [my father's] original health care assessment. I have received a copy of a letter (12.3.98) from [my father's consultant], addressed to [the Authority's contracts manager], simply stating that [my father] "does not meet the criteria for continuing care"….

'Neither the precise way in which my father fails to "meet the criteria" nor the tests (if any) which were carried out in order to arrive at this conclusion are specified in this letter. I can thus only conclude that my father "fails to meet the criteria" simply because [the consultant] says so. Clearly this is unacceptable and open to challenge.

'In the absence of a detailed clinical report a definitive correlation between the Health Authority's published criteria and my father's condition cannot be made….'

Trust's comments

28. A letter dated 28 November 2000 from the Trust's chief executive to the Ombudsman included:

'[Mr X] initially contacted [the Authority's chief executive] in early 1998 and [the Authority's chief executive] subsequently passed [Mr X's] complaint to me in October 1998 to respond to the issues regarding the health assessment of his father.

'I replied to [Mr X] in November 1998 advising that following the assessment of his father the clinical opinion was that he did not meet the criteria set by [the Authority]. In March 1999 [Mr X] kindly sent me a copy of a letter he had sent to [the Authority] and I acknowledged this the day after receipt….

'[HSC(99)180] was brought to the attention of all Consultants and General Managers within the Trust. However the Trust complies with implementing the criteria set by [the Authority] for continuing care eligibility and I understand that [the Authority] sought legal advice about this. I believe they were advised there was no need to change the criteria they had set….

'In response to the issue under investigation by your office…. 'the Trust failed to properly assess [Mr X senior's] eligibility for NHS-funded in-patient care' I would like to make the following points.

'In my letter to [Mr X] dated 20 November 1998…. I have given the background for the assessment and the reasons why Trust staff felt [Mr X senior] did not meet [the Authority's] eligibility criteria for continuing care. I also offered the opportunity for [Mr X] to access his father's notes if he wished to see the original health care assessment.

'….These criteria are included in the "Policy and eligibility criteria for the provision of continuing health care" produced by [the Authority] in April 1997….

'[The consultant] and his team, who carried out the review, were of the opinion that [Mr X senior] did not meet [the] criteria for in-patient continuing care and as [Mr X senior's] needs were being met by the…. Nursing Home he was discharged on 1 July 1998 from the Trust's elderly mental health service.

'Having had the opportunity of reviewing the complaint again; and following further discussion with [the consultant] and [the Trust's manager for elderly mental health], I cannot disagree with [the consultant's] clinical opinion and the decision taken at the time appears appropriate, given [the Authority's] eligibility criteria.'

Documentary evidence

29. The Authority's contracts manager wrote to a senior manager at the Trust on 26 January 1998. That letter included:

'[Mr X] telephoned me on 22 January to discuss the situation and I explained to him that continuing care in a nursing home was the financial responsibility of the Local Authority. If a patient was considered sufficiently unwell to meet our criteria for continuing care then we would expect that an admission would be made to a local hospital.

'We also discussed the assessment which had been carried out by [the consultant] and I explained that [the consultant] did not consider that an admission to hospital was appropriate, thereby confirming that [Mr X senior] was a Local Authority responsibility….

'I would be grateful if you could let me know when [Mr X senior] was last assessed and whether or not you feel that a reassessment could reasonably be requested by his son.'

30. The Trust were asked to provide the Ombudsman with relevant documentation from Mr X senior's medical records relating to assessments carried out by Trust staff in relation to the Authority's eligibility criteria. The papers they provided did not include any detailed assessment against each of the Authority's criteria. Most detail about the assessment was provided in a letter from Mr X senior's consultant to his GP on 12 February 1998. That said:

'I reviewed [Mr X senior] today with [a community psychiatric nurse] CPN…. We had the opportunity of meeting two trained nurses who knew [Mr X senior] well….

'After an initial period when [Mr X senior] was similar to his presentation [at the Trust's own unit] namely agitated, pre-occupied with one of his former jobs (in a slaughter house), restless and sleeping poorly, there has been a change after three weeks. He appeared to be more confused and disoriented but there was an improvement in his behaviour. He is now much more tolerant of other people, more accepting of personal care so much that the female staff can manage him. He no longer wanders, he is not irritable and there is much less pre-occupation with slaughtering animals. He can be quite friendly with other residents. He needs a good deal of assistance with his personal care. He has not tried to abscond.

'[Mr X senior] himself responded in a friendly manner to our interview. I don't think he really remembered me but was able to say that he liked staying where he appeared to be disoriented [sic]. He thought the staff were good. There was a marked change in his demeanour from when I remember him before. He was quite happy to sit in the chair and there was no sign of the agitation previously. He talked of killing just once.

'He is tolerating the medication without any problems and does not appear sedated.

'Whilst the cognitive aspects of his dementia may have deteriorated lightly there have been marked changes in other respects for the better. He does not meet the Health Authority's continuing care criteria and indeed has settled very well in [the] Nursing home. The staff are happy he stays….'

31. The consultant wrote to the Authority on 12 March 1998:

'I am writing to update you on the situation regarding [Mr X senior]. I formally reviewed him on 10th February 1998 with the CPN…. who has been

Annex D

Case No. E.814/00-01

Refusal to provide continuing care funding

Complaint against:

The former Berkshire Health Authority (the Authority)

Complaint as put by Mr Z

1. The account of the complaint provided by Mr Z was that on 23 May 1998 his 90 year old mother, Mrs Z, was admitted to a hospital in Wallingford (the Hospital), suffering with vascular dementia. On 17 August Mr Z wrote to the Authority saying that should his mother be discharged to a residential home the Authority should fund her continuing care. On 24 August Mrs Z was discharged to a nursing home (the nursing home). On 28 August the Authority's Locality Commissioner wrote to Mr Z saying that the Authority was not responsible for the full costs of his mother's continuing care needs. She told Mr Z that if he remained dissatisfied it was open to him to pursue his concerns through a 'Review Process', details of which were enclosed with her letter. On 10 September Mr Z wrote to the Authority stating that his mother's care should be funded totally by the NHS. In November Mrs Z was admitted to another hospital (the second Hospital) where she underwent hip surgery. Following a further exchange of correspondence the Authority wrote to Mr Z, on 18 November, saying that his mother did not satisfy the Authority's criteria for 100% funding. On 16 January 2000 Mr Z wrote to the Authority requesting an independent review (IR) of his complaints. On 22 June the Authority's convener wrote to Mr Z refusing that request. Mrs Z died on 26 November 2000.

2. The matters investigated were that:

(i) The Authority acted unreasonably in refusing to fund Mrs Z's continuing care; and

(ii) The Authority failed to arrange for Mrs Z's needs to be re-assessed following her second hospital admission, in November 1998.

Investigation

3. The statement of complaint for the investigation was issued on 7 December 2000. The Authority's comments were obtained and relevant documents were examined. The Ombudsman's Investigating Officer took evidence from Mr Z and a number of the Authority staff. He also made enquiries of the Department of Health and consulted with the Office of the Local Government Ombudsman (LGO), about a related complaint against a Borough Council (the Borough Council) made by Mr Z which that office investigated. I have also noted documents relating to a separate complaint by Mr Z against another trust. Professional advice was provided by the Ombudsman's Advisers on psychiatry and mental health, whose views are given in paragraphs 29 to 31 of this report. The Authority's policy for Continuing Care Group 1 (that provided with 100% NHS funding) and Group 2 is at the appendix.

Relevant Legislation and Code of Conduct

National Guidance

4. In 1995 the Department of Health issued guidance HSG (95)8 on NHS responsibilities for meeting continuing health care needs. The guidance detailed a national framework of conditions for all health authorities to meet, by April 1996, in drawing up local policies and eligibility criteria for continuing health care and in deciding the appropriate balance of services to meet local needs. The guidance stipulated that the NHS had responsibility for arranging and funding continuing in-patient care, on a short or long term basis, for people:

'….where the complexity or intensity of their medical, nursing care or other care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team….

'….who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff….

'who have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.'

The in-patient care might be in a hospital or in a nursing home.

5. In 1995 the Department of Health also issued guidance HSG (95)39 to health authorities, NHS trusts and other bodies. The circular included guidance on arrangements for reviewing decisions on eligibility for NHS continuing in-patient care. Relevant extracts from that guidance are set out below:

Appendix to E.420/00-01

Mrs N - Assessment of Care Needs

Mobility
Prior to admission, Mrs N was previously mobile in the house. She had poor sitting balance and was nursed mainly in bed, however she was able to sit in the chair for about three hours each day supported by pillows at her side. A goluo-lifting hoist was used to transfer her from bed to chair, as she was unable to weight bear.

Continence
Mrs N was incontinent of urine and had a urethra catheter in place. She was unable to make her needs known and required assistance with her bowels every three to four days.

Skin
A small grade 2-3 break was noted on Mrs N's left buttock and she required her position to be changed every two or three hours.

Personal hygiene
Mrs N required assistance with all care. Although she could move her hand and left arm, she was unable to participate in washing. Mrs N needed help with oral care as she was taking nil by mouth.

Communication
Mrs N was unable to speak at all and would smile in response to someone smiling at her. She had difficulties with her hearing and required the use of a hearing aid in her right ear.

Dietary needs
Mrs N was unable to swallow and required a PEG feeding regime. It was noted that she tolerated the feeding regime well and that the PEG site presented no problems during her stay.

Social interaction
Generally, Mrs N was very pleasant and often smiling. She was unable to communicate verbally and did not appear to have any insight or recognise people around her.

providing regular follow-up. He does not meet the criteria for continuing care and appears well settled in the nursing home. He himself wishes to remain there and the staff reported that they were quite happy he should do so.'

Findings (b)

32. Mr X complained that the Trust failed properly to assess Mr X senior's eligibility for continuing in-patient care. He complains that the Trust had been unable to provide him with any detailed clinical assessment showing why his father did not meet the criteria. Following correspondence from the Authority to the Trust, Mr X senior's consultant psychiatrist visited him in February 1998 and assessed him. The most detailed record of that assessment seems to be in his letter to Mr X senior's GP. Like Mr X, I would really have expected to see a record of a more formal assessment against each of the criteria. However, I do not think it is appropriate to criticise the Trust because that was lacking in this case. The Authority's contracts manager's letter to the Trust (paragraph 29) would reasonably lead them to believe that the crucial factor in deciding on eligibility for NHS-funded care was whether or not Mr X senior required hospital admission. The consultant felt that he did not (and I have seen no evidence which would cause me to question that). I can understand therefore why the consultant did not go on to record a more detailed assessment in terms of the Authority's published criteria. I **recommend** that in future assessments of eligibility for NHS continuing care by the Trust should include recording why the patient is considered to meet, or not to meet, each of the criteria. However, I do not see that the Trust deserve criticism in this case. I do not uphold the complaint against them.

Conclusions

33. I have set out my findings in paragraphs 18-26 and 32. The Trust has agreed to implement my recommendation in paragraph 32. The new Authority has agreed to implement my recommendations in paragraph 26. They say they are prepared to consider reimbursement to Mr X on receipt of the necessary details of expenditure incurred. They have asked me to convey through my report - as I do - their apologies to Mr X for the shortcomings I have identified.

Annex C

Case No. E.420/00-01

Inappropriate application of policy for the funding of continuing care and failure to properly assess a woman's eligibility for NHS-funded continuing in-patient care

Complaint against:

The former Wigan and Bolton Health Authority (the Health Authority) and Bolton Hospitals NHS Trust (the Trust)

Complaint as put by Father N:

1. The account of the complaint provided by Father N was that his mother, Mrs N, had suffered several strokes, as a result of which she had no speech or comprehension and was unable to swallow, requiring feeding by PEG tube (a tube which allows feeding directly into the stomach). Mrs N was being treated as an in-patient in the Trust's stroke unit and was discharged to a nursing home in Kent on 24 May 2000, so as to be near her son. She was assessed by Trust staff before her discharge as being ineligible for funding of continuing in-patient care. Father N raised concerns with Trust staff about their assessment but was not advised how to make a formal complaint about that. Mrs N's nursing home care in Kent was privately funded. Father N considered that the Health Authority's decision not to fund his mother's continuing care was inequitable, as an assessment by the health authority in whose area she was then living (the second health authority) said that, if they were responsible for her care, she would have been eligible for continuing care funding. Father N complained to the Health Authority, who remained responsible for Mrs N's care, on 23 May 2000, and requested a review of his mother's assessment, which was refused on 2 June. He requested a further review on 31 July, and was again refused on 28 August. Father N remained dissatisfied. (Sadly, Mrs N died on 1 September 2001, during the course of the investigation of the complaint).

2. The matters investigated were that:

(a) The Health Authority's policy for the funding of continuing care was not applied appropriately in Mrs N's case; and

(b) The Trust failed to assess properly Mrs N's eligibility for NHS-funded continuing in-patient care.

Investigation

3. The statement of complaint for the investigation was issued on 26 April 2001. Comments were obtained from the Health Authority and the Trust; and relevant documents, including clinical records, were examined. My investigating officer took evidence from Father N, and from Trust and Health Authority staff. Evidence was also obtained from the second health authority. Two of my professional advisers, a hospital consultant and a senior nurse, provided advice on the clinical issues. Their advice is incorporated into this report at paragraph 28. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

Background

4. The statutory framework for the provision of health services is outlined in paragraph 5; paragraphs 6-10 summarise relevant national guidance; and relevant health authority policies and criteria are summarised in paragraphs 11-12. Over the years Health Service Ombudsmen have considered a number of complaints about continuing care. In January 1994 the then Ombudsman made a special report (HC 197) on a complaint about the failure by Leeds Health Authority to provide long-term NHS care for a brain-damaged patient. Leeds Health Authority's policy was to make no provision for continuing in-patient care at NHS expense either in hospital or in private nursing homes. My predecessor found that that was unreasonable and constituted a failure in the service provided by the health authority.

Statutory framework

5. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that it is the Secretary of State's duty to provide services 'to such extent as he considers necessary to meet all reasonable requirements….', including 'such facilities for.... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;....'. The National Health Service and Community Care Act 1990 (the 1990 Act), the relevant parts of which were implemented in April

(b) The Trust failed to assess properly Mrs N's eligibility for NHS-funded continuing in-patient care

34. I do not hold the Trust responsible for the actions of the Health Authority in determining the criteria. Although they would have been sent the guidance following the Coughlan case for information, and might helpfully have questioned what action the Health Authority had taken in response, I hold the Trust responsible only for their assessment against the criteria they were given. In her letter to the Trust of 2 June 2000 (paragraph 16), the Assistant Director criticised the Trust's documentation and conduct of the multi-disciplinary review. It is clear that the assessment provided by the second Consultant (paragraph 16, 27 July) was much more detailed. The Trust's Chief Executive (paragraph 20) and the Chairman (paragraph 25) were under the impression that the assessment checklist indicated who had attended a multi-disciplinary review meeting. The Consultant Physician (paragraph 21) has said that that was not the case. Even if the relevant disciplines had all been involved in the assessment, that does not mean that all Mrs N's needs were assessed. For example, there was a misunderstanding at the time between the Trust and the Health Authority about the significance of PEG feeding. The Assistant Director (paragraph 27) said that each case should be dealt with on its merits, and the decision based on the level of dependency of the individual patient. She wrote to Trusts in February 2001 emphasising the need for a holistic view to be taken on each individual case, although that was too late in Mrs N's case.

35. My professional advisers have advised that the Trust staff carried out an appropriate assessment of Mrs N's needs, based on the policy and guidelines provided to them **at that time** by the Health Authority. I accept that advice. I **recommend** that the Trust should remind staff responsible for carrying out such assessments to record the basis of their decisions clearly in the medical records; and to clarify who is party to the decision whether a patient is eligible for funding. (The Trust subsequently advised me that they were currently piloting a scheme for producing collaborative documentation, which will provide details of each patient episode, including diagnosis, treatment, medications and continuing care assessments.) I uphold this complaint only to the extent that Trust staff should have sought appropriate advice if they were unsure about how to interpret the guidance provided by the Health Authority.

Conclusions

36. I have set out my findings in paragraphs 29-35. I have concluded that the Health Authority wrongly failed to provide care for Mrs N. I turn now to the question of remedial action. The organisation of the NHS has changed since these events. Wigan and Bolton Health Authority no longer exists. Responsibility for setting eligibility criteria now lies with a new Greater Manchester Health Authority (the new Authority), though the relevant budget for funding such care will be held by the Bolton PCT. While I recognise that the new Authority played no part in these events, I must regard them as responsible for taking remedial action. I **recommend** that the new Authority, in consultation with Bolton PCT, should ensure that Mrs N's estate is left no worse off than it would have been had the NHS-funded her nursing home care. The new Authority and the Trust have agreed to implement this recommendation and have asked me to convey to Father N - as I do through my report - their apologies for the shortcomings I have identified. They will contact Father N directly to let him know what is being done to put matters right.

37. I also **recommend** that the new Authority should, with its associated PCT and local authority colleagues, review the eligibility criteria for funding continuing care that have been in operation since April 1996 to ensure that they were (and are) in line with the Coughlan judgment and other relevant guidance. The new Authority has agreed to implement this recommendation and I welcome action taken in recent weeks on this matter.

38. I further **recommend** that the new Authority should, with its associated PCT and local authority colleagues, determine whether there were any other patients who were wrongly refused funding for continuing care, identify them and make the necessary arrangements for reimbursing the costs they incurred. The new Authority has agreed, in principle, to implement this recommendation. I welcome action taken in recent weeks to establish the feasibility of so doing. I have asked the Health Authority to report back to me by 1 October on this matter.

39. I recognise that the conclusions I reached in this case may have the same implications for many other health authorities and trusts as they do for the new Authority and these PCTs. I have, therefore, written to the NHS Chief Executive and Permanent Secretary inviting him to draw this case and my recommendations to the attention of NHS organisations; and to determine how best they might be supported in undertaking this important and urgent work.

Professional advisers' opinion

28. The Ombudsman's professional advisers (the first and second assessor) reviewed Mrs N's medical records and were satisfied that Trust staff had carried out an appropriate assessment of Mrs N's needs according to the policy and guidelines provided to them at that time by the Health Authority. Although it appeared that not all the multi-disciplinary team had been present when the Consultant Physician had completed the tick box assessment form for Mrs N, the advisers said that this was normal practice in many hospitals. In the advisers' view, patients with a PEG tube require routinely the use of specialist health care equipment and monitoring by a trained nurse.

Findings

(a) The Health Authority's policy for the funding of continuing care was not applied appropriately

29. Father N saw the fact that the Health Authority would not fund his mother's care, when the second health authority said they would have done, as evidence of injustice. I can understand why he took that view. However, NHS policy does allow for different eligibility criteria in different parts of the country; and the law does not allow me to question the merits of a discretionary decision properly taken. It was for the Health Authority to decide, within the law and national guidelines, what level of services they provided for the residents in their area, although they had to be prepared to justify the balance and level of the services they proposed to arrange and fund. So the fact that different judgments were made about Mrs N's eligibility by two different health authorities does not necessarily mean that either was acting maladministratively or failing to provide a service which it was its function to provide.

30. The Health Authority's criteria reflected the national criteria in most respects. However, the emphasis in the Health Authority's criteria was on the need for care to be provided under the direction of a consultant and normally in a hospital setting. It is apparent from the Consultant Physician's evidence that in practice the need for consultant input was used as the sole criterion when he was involved in assessing patients. That is not surprising, given the wording of the Health Authority's policy and the lack of detailed guidance on its interpretation. However, it is disappointing that more account had not been taken of the reminder on this point in EL(96)8 (paragraph 9).

31. Of even more concern is the lack of any evidence that, in developing and applying their policy, the Health Authority had adequately taken into account the implications of the Coughlan judgment and the new national guidance in 1999 which followed it. They had had ample opportunity to do so before Mrs N was assessed in 2000, but do not seem to have taken any positive action in that direction until February 2001, when the Assistant Director wrote to trusts on the subject. Even then, the Health Authority do not seem to have reviewed the policy thoroughly or to have reconsidered Mrs N's case in the light of the judgment. I criticise them for that. (Note: Further guidance on continuing care was issued in 2001 and guidance on the single assessment process was issued in 2002 (paragraph 13). NHS bodies should be following that guidance.)

32. The NHS guidance on dealing with applications for review of decisions about continuing care gives health authorities the right not to convene a panel, if the patient falls well outside the eligibility criteria. It also provides a checklist of issues to be considered before referring a case to a panel. It is not the role of review panel members to consider the eligibility criteria themselves, only their application. In this case, the Chairman (paragraph 25) did not make any notes of his first review of Father N's request for a panel. That was remiss of him. The second time he reviewed the case he voiced his opinion that Mrs N fell well outside the eligibility criteria. I find that conclusion surprising in the light of the information about Mrs N's disability that was documented in her medical records, and as he was by then aware of Father N's concern that the second health authority had a different view. It would have been wiser in all the circumstances to put the matter before a review panel, where independent clinical advice could be obtained.

33. It is clear from the information I have seen about Mrs N's condition that she was extremely dependent and required a high level of physical care: like Miss Coughlan, she was almost completely immobile; and she was doubly incontinent. I have seen no evidence that she had breathing difficulties as Miss Coughlan had; but she required PEG feeding, which Miss Coughlan did not. She was unable to communicate verbally. I cannot see that any authority could reasonably conclude that her need for nursing care was merely incidental or ancillary to the provision of accommodation or of a nature one could expect Social Services to provide (paragraph 15). It seems clear to me that she, like Miss Coughlan, needed services of a wholly different kind. If the Health Authority had had a reasonable policy, and applied it appropriately, they would have provided NHS care for Mrs N. They failed to provide a service which it was their function to provide. I uphold the complaint.

1993, significantly increased the responsibilities of local authorities so as to include provision of accommodation for people who need it by reason of illness. Section 47 of the 1990 Act requires local authorities to carry out an assessment of a patient's needs before deciding whether or to what extent they were required to provide services to meet those needs.

National guidance

6. In 1995 the Department of Health issued guidance HSG(95)8 on NHS responsibilities for meeting continuing health care needs. The guidance detailed a national framework of conditions for all health authorities to meet, by April 1996, in drawing up local policies and eligibility criteria for continuing health care and in deciding the appropriate balance of services to meet local needs. The guidance says that 'health authorities…. will need to set priorities for continuing health care within the total resources available to them. While the balance, type and precise level of services may vary between different parts of the country in the light of local circumstances and needs, there are a number of key conditions which all health authorities…. must be able to cover in their local arrangements. These are set out in Annex A….'. Annex A includes the following passages:

'E Continuing in-patient care
All health authorities…. 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 arranged and funded by the NHS in hospital or in a nursing home…. The NHS is responsible for arranging and funding continuing in-patient care, on a short or long term basis, for people:

- where the complexity or intensity of their medical, nursing care or other clinical care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team;

- who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff;

- have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision....'

'G Access to specialist or intensive medical and nursing support for people placed in nursing homes, residential homes or in the community
Some people who will be appropriately placed by social services in nursing homes, as their permanent home, may still require some regular access to specialist medical, nursing or other community health services. This will also apply to people who have arranged and are funding their own care. This may include occasional continuing specialist medical advice or treatment, specialist palliative care, specialist nursing care…. It should also include specialist medical or nursing equipment (for instance specialist feeding equipment) not available on prescription and normally only available through hospitals….'

7. Also in 1995, detailed guidance was issued on how health authorities and trusts should deal with applications for review of decisions about continuing care - HSG(95)39 'Arrangements for Reviewing Decisions on Eligibility for NHS Continuing In-patient Care'. The scope of the procedure was described as being to check that proper procedures had been followed, and to ensure that the health authority's eligibility criteria had been properly and consistently followed. It included, as an appendix, a checklist of issues to be considered before referring a case to a panel. It also included:

'4. The review procedure is intended as an additional safeguard for patients assessed as ready for discharge from NHS in-patient care who require ongoing continuing support from health and/or social services, and who consider that the health authority's eligibility criteria for NHS continuing in-patient care (whether in a hospital or in some other setting such as a nursing home) have not been correctly applied in their case….

'19. The health authority does have the right to decide in any individual case not to convene a panel. It is expected that such decisions will be confined to those cases where the patient falls well outside the eligibility criteria, or where the case is very clearly not appropriate for the panel to consider…. Before taking a decision the authority should seek the advice of the chairman of the panel. In all cases where a decision not to convene a panel is made, the health authority should give the patient, his or her family or carer a full written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.'

8. In respect of NHS trusts, the guidance indicated the need for them to:

> '• review arrangements for discharge of patients with continuing health or social care needs….
>
> '• review procedures for supplying appropriate information to patients and their families and any carers….
>
> '• ensure appropriate front line staff are fully conversant with the review procedure as outlined in this guidance, and with eligibility criteria.'

9. In further guidance, EL(96)8, in February 1996 the Department of Health said:

'….It will be important that eligibility criteria do not operate over restrictively and match the conditions laid out in the national guidance. Monitoring [of authorities' criteria] raised a number of points where eligibility criteria could be applied in a way which was not in line with national guidance:….

> • *an over reliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing in-patient care.* There will be a limited number of cases, in particular involving patients not under the care of a consultant with specialist responsibility for continuing care, where the complexity or intensity of their nursing or other clinical needs may mean that they should be eligible for continuing in-patient care even though they no longer require frequent specialist medical supervision. This issue was identified by the Health Service Commissioner in his report on the Leeds case and eligibility criteria should not be applied in a way to rigidly exclude such cases.'

10. In August 1999 the Department of Health issued further guidance on continuing health care in a circular HSC 1999/180. This was in response to a Court of Appeal judgment in the case R v. North and East Devon Health Authority ex parte Coughlan (the Coughlan case). Miss Coughlan was described in the judgment as tetraplegic, doubly incontinent, requiring regular catheterisation, and with difficulty in breathing. The judgment summarised its conclusions as follows:

'(a) The NHS does not have sole responsibility for nursing care. Nursing care for a chronically sick person may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's needs…. Whether it was unlawful [to transfer responsibility for the patient's general nursing care to the local authority] depends, generally, on whether the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category….'

11. The Department's guidance included in its description of the judgment:

'(b) The NHS may have regard to its resources in deciding on service provision.

'(c) ….HSG(95)8…. is lawful, although could be clearer.

'(d) Local authorities may purchase nursing services under section 21 of the National Assistance Act 1948 only where the services are:

> (i) merely incidental to the provision of the accommodation which a local authority is under a duty to provide to persons to whom section 21 refers; and
>
> (ii) of a nature which it can be expected than an authority whose primary responsibility is to provide social services can be expected to provide.

'(e) Where a person's primary need is a health need, then this is an NHS responsibility.

'(f) Eligibility criteria drawn up by Health Authorities need to identify at least two categories of persons who, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a Health Authority. Secondly, there are those whose nursing services in general can be regarded as the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.'

12. Authorities were advised to satisfy themselves that their continuing and community care policies and eligibility criteria were in line with the

that. He had sympathy for Father N's concerns, and was concerned about how many other Wigan and Bolton patients might also be disadvantaged in a similar fashion. He was unable to recall when or why PEG feeding had been excluded as criteria for NHS continued care funding in Wigan and Bolton. He said there was no detailed guidance available on how to interpret 'specialist nursing needs', or 'specialist equipment'. Therefore, clinicians tended to make a decision on the basis of whether or not regular consultant input was required by a patient. He had asked the Trust authorities to review the application of the eligibility criteria, but was not aware that anything was being done about that.

23. The **Director** said she was not aware of the Consultant Physician writing to her or to any other hospital manager about his concerns about interpretation of the continuing care eligibility criteria. In any case, such matters were not for the Trust to decide but would require negotiation with the Health Authority. In respect of the use of PEG feeding tubes the Director said her recollection was that the use of such devices fell outside the eligibility criteria, based on a precedent set in another case some years prior to Mrs N's case. She could not recall the details of that but there had been consultation with the Health Authority and it would have been the Assistant Director who provided advice on that. The Director said that the Trust had a responsibility to ensure they applied the criteria consistently within the Trust; but that the Health Authority was responsible for ensuring consistency of application across all trusts in their area.

Health Authority evidence

24. At the start of the investigation the **Chief Executive** provided a written response to the complaint which included:

'On commenting on the statement of complaint, although this is a complex matter, I consider that the Authority's policy for the funding of NHS continuing care was not applied inappropriately. A multi-disciplinary team assessment was made in [Mrs N's] case and the decision reached was that she did not require NHS continuing care. A placement in a nursing home was felt most appropriate. I should also like to clarify that the Health Authority's eligibility criteria relates to the need for a service and not the amount of funding. This means that the Trust would assess the need for NHS continuing care and not the funding of a nursing home place.'

25. The Chairman told the investigator that he had no record of his first review of Mrs N's case, but would have reviewed the case against the NHS guidance, including the checklist, and the Health Authority criteria for continuing care. He had seen Mrs N's medical records and reviewed those in detail. He was aware she had a PEG feeding tube. He was not medically qualified, but could interpret the notes sufficiently well to make an assessment. He did not normally seek clinical advice when deciding whether to convene a panel and did not consider it necessary to do so in this case. Such advice would be provided if a panel was set up. He had decided that the procedures had been followed appropriately. The form completed by the Trust showed that a multi-agency meeting had been held and who had attended that. It also confirmed that the staff were unanimous in deciding that Mrs N did not meet the criteria for NHS continuing care; and he had to accept their professional opinion on that. On that basis, he decided that Mrs N fell well outside the eligibility criteria, and was not a marginal case and, therefore, a continuing care review panel was not required.

26. When he was asked to review the case again in August 2000, the Chairman was aware that Father N had been told that his mother would qualify for funding in Kent, although he did not recall having seen written evidence of that. The notes he made at the time showed that he wondered whether it might be relevant to compare the Health Authority's criteria with those of the second health authority. He decided that was not appropriate, as he was merely required to check that the procedures had been properly applied, and that an assessment had been correctly carried out against the Health Authority criteria. The Chairman had since reviewed the papers again, and still felt that his initial decision had been appropriate and that Mrs N's case had been dealt with appropriately.

27. The **Assistant Director** said that she was the Health Authority's nominated officer responsible for continuing care. There had been no policy decision on whether the use of PEG tubes should make a patient eligible for continuing care. Each case was dealt with on its merits, and the decision should be based on the level of dependency of the individual patient. For example, some patients, especially those with dementia, were less able to cope with PEG tubes and might have a tendency to pull them out if not constantly supervised by nurses. Such patients would be more likely to be eligible for NHS funding. The Assistant Director said that letters had been sent to all trusts, in February 2001, emphasising that a holistic view should be taken on each individual case. Trust staff were also provided with training and support about the eligibility criteria.

placed in a nursing home. This was based on the fact that she did not require constant supervision of the consultant and her nursing needs did not require specialist nursing/clinical intervention and could be provided by staff in a nursing home setting.

'[Mrs N's] daily living needs were assessed by the multidisciplinary team and were documented by [the] Social Worker in the Social Service Assessment Sheet, [copy provided].

'From the feedback provided at the MDT and entries made in the medical notes, it was evident that [Mrs N] had made very little or no improvement throughout her stay on the ward. This fact is further supported by the entry made in the nursing records on 3rd May where it states that [Mrs N] was not very responsive to therapy.

'A discussion between [the lead Consultant - Stroke (the lead Consultant)] and [Father N] took place where he asked her about the possibility of moving his mother to a stroke unit in [a hospital in Kent]. It is noted that [the lead Consultant] suggested it would not be in his mother's best interest to transfer to another stroke unit in view of her limited potential for future rehabilitation.

'As [Father N] was returning home the following day [the lead Consultant] suggested it would be more appropriate to look at nursing homes in the Kent area as this would be more suited to her needs, he agreed to do this. On the 8th May [Father N] contacted the ward to inform them he had found a placement to suit his parents. The records on this date show that [Father N] agreed to discuss the placement with his parents' Social Workers….

'It is clear that from the entries in the nursing notes dated 10th May up to her discharge and from the Social Worker's information document that [Father N] wished to secure funding for his mother's continuing care.

'The nursing staff explained that funding for NHS continuing care was not allocated by the nursing team and suggested that [Father N] discuss the issue of funding with the Social Worker. The nursing staff made every effort to assist [Father N] and liaise with the Social Worker leaving a message on her answer phone on 10th May 2000. [The Social Worker] contacted the ward later that day and it is noted that she informed the staff that although she was [Mr N's] Social Worker, funding had been discussed with [Father N] for his parents and that they were self-funding. Please see the written entries in the case information sheet within the Bolton Social Services assessment document to support this statement, [note: a copy was provided].

'I understand that [Father N] thought that his mother should be funded because he had been informed that [the second health authority] funded patients for nursing home care who have had dense strokes and [are] on a PEG feeding regime. The explanation given to [Father N] from Social Services is summarised by [Mrs N's social worker]….

'In summary, it is clear that [Mrs N] had complex care needs. However those care needs did not meet the Wigan & Bolton Health Authority Eligibility Criteria for Continuing Care. [Mrs N] was initially under the care of [the Consultant Physician], however, she was transferred to the care of [the lead Consultant] on her transfer to the stroke ward. [The Consultant Physician] provided cover for [the lead Consultant's] leave (which was at the time of [Mrs N's] assessment against the eligibility for continuing care criteria) continuity of care was therefore maintained. It is important to note that [the lead Consultant] was also in agreement that [Mrs N] did not fulfil the eligibility criteria for continuing care. The clinical team made every effort to meet the needs of [Mrs N] and her son.'

21. The **Consultant Physician** confirmed that an entry dated 17 May 2000 in the medical records was his record of the multi-disciplinary team meeting. It was his normal practice to record such meetings in the medical notes. The notes showed that he was aware at that time that the second health authority would have funded Mrs N's care. The notes also showed that the Physiotherapist and the Occupational Therapist were present at the meeting. There would also have been a nurse present; but the Consultant Physician thought the Social Worker had not been available that day. Although the Trust's formal response and the checklist indicated that the Social Worker and others were present, the Consultant Physician explained that his understanding was that the tick boxes on the form were to show who was involved in the patient's care and overall assessment, not just who was present on the day of the multi-disciplinary meeting.

22. The Consultant Physician said that, since the receipt of Father N's complaint, he had given considerable thought to the interpretation of the Health Authority's eligibility criteria. Until Father N had told him that the second health authority would fund NHS continuing care for his mother he was not aware that different areas applied the eligibility criteria differently. He was very concerned about

judgment and existing guidance, taking further legal advice where necessary. If they revised their criteria they should consider what action they needed to take to reassess service users against the revised criteria.

13. In June 2001 the Department of Health issued guidance in a circular HSC 2001/015, on the new arrangements for continuing health care embodied in the Health and Social Care Act 2001. This required health authorities to comply with the guidance by October 2001 and, working in conjunction with Primary Care Trusts (PCTs), agree joint eligibility criteria and set out their respective responsibilities for meeting continuing health and social care needs by 1 March 2002. A further circular - HSC 2002/001, was issued in January 2002 (after the events complained about) which provided guidance on the implementation of the single assessment process for older people, as part of the National Service Framework for Older People.

Health Authority policy and criteria

14. The Health Authority's 'Policy for Meeting Continuing Health Care Needs', (the policy) revised in July 1997, defined continuing in-patient care as: '….health care which is provided on a long-term basis or on a short-term basis under the direction of a consultant'. The policy said that such care would, in most cases, be provided in a hospital setting, but '….may in a small number of cases be provided within a nursing home environment where the equivalent level of specialist health care will be given'. The policy listed four groups of people who were eligible for continuing in-patient care, including:

'a) Patients for whom the complexity or intensity of their medical, nursing care or other clinical care…. requires the regular…. supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team.

'b) Patients who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff.

'c) Patients who have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.'

15. On 15 February 2001 (after Mrs N's case had been reviewed) the Health Authority's Assistant Director of Service Strategy (the Assistant Director) wrote to staff in various trusts, including the Trust's Director of Service Development (the Director). The letter set out a broader framework for establishing that consideration of continuing care was fully addressed. It included detailed advice on the type of criteria to be applied in respect of the patient's physical and mental condition. The letter referred to the Coughlan case (paragraph 10) and included:

'In summary, the Court of Appeal stated that a Health Authority is obliged to provide health care services unless (a) they can legitimately be regarded as incidental to or ancillary to accommodation services; or (b) they are of a nature which one can expect Social Services to provide. The overriding test is whether the need is primarily a health care need.'

Sequence of events

16. I set out now, in greater detail, the sequence of events in which the Trust and the Health Authority were involved with Mrs N's care, and her son's subsequent complaint about the funding of her care:

4 April 2000 - Mrs N collapsed at home, and was taken by ambulance to a hospital, which is managed by the Trust. She was assessed later that evening as having suffered a dense, right-sided stroke, and was admitted to a ward.

Mrs N remained in hospital until she was well enough to have a PEG feeding tube inserted (a naso-gastric tube was used in the interim). The PEG insertion appears to have taken place some time between **27 April** and **3 May**.

14 May - A Social Services assessment was carried out which concluded that Mrs N needed 24 hour supervised care in a nursing home.

17 May - A checklist for eligibility for NHS continuing care was completed by the Consultant Physician, which recorded that Mrs N did not meet any of the eligibility criteria.

23 May - Father N wrote to the Health Authority requesting a review of the multi-disciplinary assessment.

2 June - The Assistant Director wrote to Father N telling him that the chairman of the review panel (the Chairman) had decided that the decision not to fund Mrs N's continuing care was appropriate. On the same day the Assistant Director wrote to the Trust, with copies to Father N and Social Services, drawing their attention to aspects of the case which it was considered could have been handled with greater sensitivity. The letter included:

'There appears to have been collusion by staff in processing [Mrs N's] discharge to Kent in line with [Father N's] wishes. It might have been better if, at an earlier stage, a clearly defined multi disciplinary meeting had been called with consideration given to future care, including NHS in-patient care. The outcome of such a meeting including completion of the check list could have been recorded before moving on to the next stage of discharge.'

12 June - Mrs N was discharged to a nursing home in Kent.

28 June - Father N complained to the Chief Executive of the Health Authority about the decision by Trust staff that his mother was not eligible for funding for continuing care, on the basis that she would have been funded by the second health authority.

26 July - The Health Authority Deputy Chief Executive replied. He clarified the earlier letter of 2 June. He told Father N that the Chairman had decided not to convene a continuing care review panel because he had decided that the correct procedures had been followed: they had confirmed that Mrs N did not require continuing NHS in-patient care.

27 July - Mrs N was assessed by a consultant physician in Kent (the second Consultant), who wrote a letter to Mrs N's new GP which included the following:

'… on arrival from [the hospital] with a PEG tube in situ she had sacral pressure sores and an ankle pressure sore which has healed with the good care provided. She is currently being nursed on a pressure-relieving mattress and with a Waterlow score of 20 [indicating a high propensity for pressure sores] this should continue.

'The lady is doubly incontinent and need hoisting to transfer. She has contractures on her right side, which was affected by the hemiplegia [paralysis of one side of the body]. Tone on the left side was remarkably normal and I am not convinced that the previous diagnosis of Parkinsonism [a progressive disease affecting the brain] actually was not pseudo-Parkinsonism due to multiple cerebral infarct pathology [strokes]. She is being fed by a PEG tube and this will need to continue. All the pressure areas were intact. She is deaf…. She is also partially sighted. She is dysphasic [unable to communicate in speech and/or writing] and could not meaningfully communicate with me. It is doubtful that a hearing aid will actually improve communication in practice. There is no potential for rehabilitation and no point in further physiotherapy or other assessment.

'She will need to have review by our dietician and in approximately four months time will need replacement of the PEG tube, which should be arranged through our endoscopy unit.… With regard to her level of orientation it is important that she does recognise her son who visits most days. Also during our examination she was able to cover herself with bedclothes moving her left arm.

'Apart from this lady's current need for enteral feeding which will continue in the long term, her care needs can be met by general nursing care. However, on local criteria PEG feeding is interpreted by myself and the review process as qualifying her for NHS continuing care….'

31 July - Father N wrote to the Deputy Chief Executive, rejecting the Health Authority response on the grounds that it was unjust, and seeking a further review.

9 August - The Health Authority asked the Chairman to reconsider the request for a continuing care review panel.

29 August - The Chief Executive wrote to Father N confirming that the Chairman had reviewed the case again, but still declined to set up a continuing care review panel. The Chief Executive's letter said that a comparison of the Health Authority criteria with those of the second health authority showed little difference. The Chairman had given his opinion that Mrs N fell well outside the eligibility criteria and was not a marginal case

Father N's evidence

17. In his letter of complaint to the Health Authority dated 23 May 2000, **Father N** wrote:

'….Asking [the Consultant Physician] on what printed criteria he based his decision to reject her eligibility for Continuing In-patient Nursing Care, he replied that it was based on his opinion that she no longer required the care of a Consultant. When I replied that the criteria were wider and included the four areas of eligibility outlined on page 14 of [the Health Authority's] "Policy for Meeting Continuing Health Care Needs" April 1997, revised July 1997, he did not seem to be aware even of these broad areas, which include more than the need for a Consultant….

'I conclude that there has been a total lack of transparency vis a vis staff, patients, main carers and relatives on the part of [the Trust] and [the Health Authority] with regard to the criteria for Continuing Care, for which the NHS is responsible. I have only been made aware of this by the excellent practice of [the second health authority], who are implementing the criteria for Continuing Care and spending the funds set aside for this purpose….'

18. In putting his complaint to me, Father N wrote:

'We must pay for care in Bolton. In Kent, my mother's condition would make her eligible for continuing care…. [The Health Authority] have confined themselves to the issue of whether the correct discharge procedure has been carried out. My complaint centres on the injustice of not providing a service that another Health Authority does provide. This is making a mockery of the principle of a National Health Service.'

19. In a later letter he also wrote: 'I wish also to repeat that the heart of my complaint is the fact of varying criteria for continuing care between health authorities, operating within a National Health Service, which of necessity should give equal service across the country. I should also want to maintain that the criteria for continuing care in the Wigan and Bolton Health Authority are not applied in the same way as in Kent….'.

Trust evidence

20. At the start of the investigation the Trust's **Chief Executive** provided a written response to the complaint. I set out below most of that letter:

'In response to your request for our comments relating to the Trust's assessment for eligibility for NHS continuing care, I feel a brief summary of [Mrs N's] care may be helpful.

'[Mrs N] was admitted to [a hospital which is managed by the Trust] on 5th April 2000 after collapsing at home. Prior to her admission [Mrs N] had been well and was the main carer for her husband who suffered from Parkinson's disease. The medical assessment at this time indicated that [Mrs N] had suffered a dense stroke with marked right-sided weakness and that she was aphasic [suffering a disorder of the language function] and therefore unable to communicate. She was incontinent of urine and was catheterised. The plan was to transfer [Mrs N] to the ward for further monitoring of her condition. A request was sent to the stroke team for assessment and a CT brain scan [computerised scan of the brain] ordered.

'[Mrs N] was assessed for admission to the stroke ward on 12th April and was transferred to the ward later that day. This ward is dedicated to the rehabilitation of stroke patients and the team consists of medical and nursing staff, physiotherapists, occupational therapists and language therapists. Other professionals such as dieticians, and social workers provide input to the planned care for patients on this ward.

'[Mrs N's] needs [were] assessed by the team and are summarised in Appendix I [attached as an annex to this report]. It is our practice to begin patient discharge planning soon after admission to allow the required time for the ongoing assessment of the patient and to ensure that all relevant parties are involved in discussions surrounding patient care needs.

'On reviewing [Mrs N's] records and through discussions with staff, there is clear documented evidence that multidisciplinary and multiagency communication took place throughout her admission.

'Weekly multidisciplinary team meetings (MDT) take place on the unit in order to review patients' ongoing care and to discuss future care arrangements. These are working meetings where a number of patients are discussed. It is not our usual practice to invite carers to these meetings. [Father N] was in regular contact with the ward and the staff thought that discharge communications were good and he was kept well informed of his mother's progress. We recognise that it may have been helpful to include [Father N] in these decision making processes.

'In [Mrs N's] case consideration was given to her husband's ongoing needs and those of her son [Father N], who was anxious that his parents should be moved to Margate to live near him.

'These MDTs are well established on the wards and are attended by all disciplines involved in the patient's care and are summarised in the nursing communication records.

'At the meeting held on the 17th May the following staff were present [the Consultant Physician, a Staff Nurse, a Physiotherapist, an Occupational Therapist, a Social Worker, and a Speech Therapist]…. The team discussed [Mrs N's] eligibility for NHS continuing care in line with Wigan and Bolton Health Authority policy and eligibility criteria. The checklist form was completed by [the Consultant Physician] in collaboration with the other team members [copy provided].

'It was agreed by all disciplines that [Mrs N] did not require continuing in-patient care and would be best