Parliamentary and Health Service Ombudsman

Retrospective continuing care funding and redress

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Parliamentary
and Health Service
Ombudsman

Retrospective continuing care funding and redress

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Foreword

In February 2003 and December 2004 in my role as Health Service Ombudsman for England, I laid before Parliament two reports about my investigations into complaints about funding for the continuing care of elderly and disabled people. The first of those, NHS funding for long term care (HC 399) made a number of recommendations to strategic health authorities (SHAs) and primary care trusts (PCTs). They included the recommendations that SHAs and PCTs should:

- review the continuing care eligibility criteria used by their predecessor bodies, and the way those criteria had been applied, since 1996, taking into account the Coughlan judgment, guidance issued by the Department of Health and my findings; and

- 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 would 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.

As a consequence of the retrospective review of continuing care cases undertaken by the NHS when following these recommendations, some people have now been granted retrospective NHS funding for continuing care. While I am pleased that some people who had been wrongfully denied funding have now received redress for the maladministration I identified, I have received a number of complaints about the amount of redress paid by primary care trusts.

The complainants have alleged that the redress they received failed to compensate them or their relatives fully for all the financial losses they suffered while having to fund essential long term care.

Primary care trusts have said that, in deciding on the amount of compensation for those who had been wrongly denied funding for their continuing care, they were following Department of Health guidance.

One of the complaints to me was made by Ms T following the refusal of Greenwich Teaching PCT to provide financial redress for the premature sale of her uncle's property. Ms T also complained to me, via her MP, about the role of the Department's guidance in the PCT's decision.

PCTs are within my jurisdiction as Health Service Ombudsman for England and the Department of Health is within my jurisdiction as Parliamentary Ombudsman. Therefore, unusually, I issued a single investigation report in relation to Ms T's complaint. As I consider that the issues raised will be of interest to Members generally, as well as to professionals working in the fields of health and social care, voluntary organisations and advisers, I am laying this report before Parliament under section 10(4) of the Parliamentary Commissioner Act 1967 and section 14(4) of the Health Service Commissioners Act 1993.

Ann Abraham

Parliamentary and Health Service Ombudsman

March 2007

Joint report by the Parliamentary Commissioner for Administration (Parliamentary Ombudsman) and the Health Service Ombudsman for England

Summary

The Parliamentary Ombudsman found that there was maladministration in the Department of Health's decision making and communication of its approach to recompense for wrongly denied continuing care funding. The Department had advised the NHS to pay recompense based on the principle of restitution for only those monies paid out in care fees. Their approach discouraged PCTs from considering full redress, including, for example, redress for claimed financial loss for premature sale of a property or inconvenience and distress that individuals had suffered in making unnecessary difficult decisions about how to fund care. The Health Service Ombudsman concluded that Greenwich Teaching Primary Care Trust had not acted with maladministration and it was not responsible for the consequences of its attempts to implement the Department's unclear and inconsistent guidance to the NHS.

The Department's maladministration resulted in inconsistency in payments. However, for most people this is unlikely to have resulted in significant unremedied injustice.

The Parliamentary Ombudsman recommended that the Department should develop and distribute properly considered national guidance for the NHS on continuing care redress which aims to return individuals to the position they would have been in but for the maladministration which wrongly denied them continuing care funding. The guidance should:

a) include a reminder to the NHS that PCTs can make compensation payments for:

- *financial loss, including interest, which is demonstrably attributable to the wrongful denial of continuing care funding and is aimed at returning the individual to the financial position he or she would have been in but for the maladministration; and,*
- *inconvenience and distress caused by having to make difficult financial decisions at a challenging time which were unnecessary because continuing care should have been funded. Such payments should recognise the degree of inconvenience and*

distress that was suffered by complainants. In some cases this may be a significant sum of money, in others a smaller sum. There will be cases where any such payments will be accounted for by the financial gain from unreclaimed state benefits and/or state pension payments;

b) give clear guidance to the NHS about how to calculate interest payments;

and make it clear that, where inconsistencies in using the Retail Price Index have resulted in significant financial injustice, adequate remedy should be made;

c) include information for PCTs about the responsibilities of local authorities to offer deferred payment agreements from October 2001, so that complaints can be promptly considered by all the relevant bodies;.

d) where, in the light of this guidance on continuing care redress, PCTs identify systemic unremedied injustice, the Department should support them in taking action to remedy the injustice.

The Department accepted the recommendation and agreed to publish such guidance.

Introduction

1. In February 2003 I presented to Parliament my first report on NHS funding for long term care (HC399). This report highlighted my concerns that individuals had suffered injustice as a result of over-restrictive eligibility criteria for continuing care funding. I concluded that weaknesses in the Department's guidance on continuing care had contributed to the local difficulties that I had identified. In response to one of my recommendations the Department asked the NHS to investigate complaints of wrongful denial of continuing care funding and remedy any identified injustice.

2. Since February 2004 my Office has received and considered a number of complaints about the redress paid by Primary Care Trusts (PCTs) as recognition of their maladministration in wrongfully denying NHS funding for the long term care of some elderly and dependent people. The complainants alleged that the financial redress they had received from PCTs did not adequately compensate them for all the financial losses to them or their relatives' estates, nor for the inconvenience and distress they and their relatives had suffered. In the course of my enquiries and investigations, PCTs told me that in compensating those who had been wrongly denied funding for their continuing care, they were following guidance disseminated by the Department.

3. One of these complaints was made by Ms T. Ms T complained about the role of the Department's guidance to the NHS in the refusal by Greenwich Teaching PCT to provide financial redress for the premature sale of her uncle's property. The background to Ms T's complaint is set out in Annex A.

4. In considering Ms T's complaint, I therefore took into account the actions of the Department in deciding on an approach to providing recompense and in issuing guidance on that approach to the NHS. I have assessed the impact of this on Greenwich Teaching PCT as well as the impact on other PCTs across the country. Finally I considered whether the injustice arising from the continuing care funding maladministration I had identified was adequately remedied.

5. The matters raised by Ms T, and others, are within my remit as both Parliamentary Ombudsman and Health Service

Ombudsman for England and there has been consultation within my Office on these points. In reaching a decision in my investigation of the Department as Parliamentary Ombudsman I have taken account of relevant information obtained during my investigation of Ms T's complaint, which includes relevant information emerging from similar complaints about redress for continuing care funding maladministration made to me as Health Service Ombudsman. Similarly, the findings of my investigation of the Department were relevant information for the purposes of my investigation of and decision in Ms T's complaint about Greenwich Teaching PCT, and in other similar complaints made to me as Health Service Ombudsman about the actions of PCTs.

6. During the course of this investigation relevant documents were obtained from a variety of sources and further evidence was taken at interviews. This included a meeting between my investigators and Department officials in February 2005 to discuss the question of redress for maladministration in connection with continuing care funding. I have not included in this report every detail investigated, but I am satisfied that no matter of significance has been overlooked.

The investigation of the Department by the Parliamentary Ombudsman

The basis for the Department's approach on recompense

7. By late April 2003, in response to my first report as Health Service Ombudsman for England on NHS funding of long term care (HC399), the Department had agreed that the NHS should make **recompense** to those wrongly denied continuing care funding. The Department had decided that the basis of this recompense should be **restitution**. In this instance the Department decided that restitution meant reversing the 'false enrichment' of the NHS; that is, that the NHS would pay back the money it had gained by not paying care fees which should have fallen to the NHS's budget.

8. The Department's explanation for their approach of restitution was that the relevant policy team[1] considered it would be:

- what an individual would get if they took court action against the NHS and won;
- consistently applied by the NHS and, therefore, fair and equitable;
- relatively quick and easy to administer;
- in keeping with the need for proper care and use of public funds; and
- in line with Ministers opinions.

9. The Department said that they felt under significant pressure from my Office to rectify the situation quickly and get the retrospective review process under way. In coming to a decision about restitution, precise details of the basis of individual payments had not been discussed with the NHS; at that stage the NHS was simply told that recompense would be due if it was accepted that someone had been wrongly denied continuing care funding.

10. The Department decided that an alternative approach to restitution, such as compensation for financial loss other than fees, would be too time-consuming and potentially too intrusive for complainants. This was because they thought it might involve the NHS in making detailed and complex assessments of individual financial circumstances and they were aware that the NHS was not used to making such assessments. Also, they said they wanted to avoid making judgments about the decisions people had made about how to raise the money to pay for fees. They believed that in most cases there would be no strong causal link between the NHS's denial of continuing care funding and the individual decisions people had made. They considered that the principle of restitution would achieve consistency for all complainants, whereas an alternative system based on those personal decisions and the ability of individuals to prove a causal link would not.

11. The Department's policy team have acknowledged that when they made the decision on restitution they were unaware of HM Treasury Guidance in 'Government Accounting 2000' (GA 2000), which includes the guidance for central government departments on financial redress to remedy the consequences of maladministration. They were, therefore, unaware that GA 2000 includes principles about redress; to aim to return individuals to the financial position they would have been in but for the maladministration on the part of the public body. However, in

1. Continuing Care and Delayed Transfers of Care

response to my investigation, the Department said that, in their opinion, the principle on which their restitution policy was based could be considered to be in line with GA 2000, when considered in hindsight. The Department also told my staff that the GA 2000 section on redress, although applicable to the Department itself, was not applicable to the NHS, which was neither a central government department nor a non departmental public body.

The Department's provision of guidance to the NHS

12. In April 2003 the Department issued advice to Strategic Health Authorities (SHAs) on calculating potential recompense costs: the *'national methodology on estimating continuing care provisions'*. This was the first formal written communication to the NHS with respect to financial calculations for recompense. During my investigation, the Department said that this guidance was intended for NHS finance managers; it advised them how to prepare estimates of the anticipated total cost of recompense. This document also provided advice that the NHS should not adjust recompense payments to take account of an individual's level of benefit income or any social services' means testing, even when these had arisen because of the decision not to award NHS funding for continuing care. The basis for this advice was that: *'The payments are restitutionary claims based on the fact that the NHS body has been unjustly enriched. The NHS pays what it would have paid (i.e. the full costs).'* The Department suggested in this guidance to SHAs that provision be made for payments of interest on recompense at the Bank of England base rate in operation for each relevant financial year, given that the Department's legal advice had indicated that the NHS may be expected to pay interest on continuing care recompense. SHAs were also advised through this document that further guidance on whether and how much interest should be paid on claims was being developed by the Department. The Department have since clarified to my staff that the use of the Bank of England base rate for interest calculations when estimating the anticipated cost of recompense was to ensure that these estimates provided flexibility for calculating individual payments in the future.

13. From then on, the principle of correcting the false enrichment of the NHS was also communicated at regular meetings between the Department and SHA Older People's Service leads and in response to specific queries from the NHS by telephone and email. For example, in May 2004 the Department's Continuing Care Lead emailed a SHA Finance Director in response to a query about restitution, advising *'reimbursement (restitution) is for unjust enrichment ie of the NHS for the cost of care denied. So we pay out for care costs (+ interest) but not anything else'.*

14. No further written guidance on the principles of restitution was issued, nor was there any reference to the existing powers of PCTs to make compensation payments in respect of actual financial loss, inconvenience and distress. When my staff raised this with the Department they maintained that PCTs knew about their existing powers and there had been no need to remind them. However, investigation of the complaints I have received shows that this was initially not clear to all PCTs. Also, PCTs were reluctant to exercise these powers, which they interpreted as being against the Department's guidance. In response to complainants, PCTs indicated that they did not have the power to act in contravention of the Department's guidance.

15. Furthermore, the provision of additional resources for recompense had been calculated on the basis of restitution payments only. During my investigation, the Department explained that at the end of the financial year 2002/2003, £250

million was added to the NHS's national allocation in recognition of the additional financial pressure that would be created by recompense for retrospective continuing care funding. Each PCT was asked to estimate the total costs of recompense in their area, using the Department's guidance issued in April 2003. These estimates were refined during the financial year 2003/2004; resulting in an estimate of approximately £187 million when PCTs' end of year financial accounts were finalised in April 2004. The additional funding was not ring-fenced solely for continuing care funding - this is not unusual for the allocation of funding to the NHS - it was for each PCT to manage its own spend on continuing care recompense within its agreed allocation of funding. The Department made it clear to the NHS that all recompense payments were to be managed within the agreed provision and any additional payments would need to be found from existing PCT budgets.

Final guidance on interest rates

16. In November 2003, the Department issued 'Continuing Care guidance on interest payments' to the NHS. They advised that, subject to local legal advice, the NHS should include interest based on the Retail Price Index (RPI) when paying recompense. This developed their earlier advice of April 2003 to NHS finance managers: *'the NHS may be expected to pay interest on claims. Further advice is being developed.....it may be appropriate for NHS bodies to make provision for interest based on the base rate in operation for each financial year affected.'* The Department have since clarified to my staff that the April 2003 guidance on estimating provisions was not intended to give advice to the NHS about interest for individual payments. In the course of my investigation, the Department provided the formula that they had expected the NHS would use to calculate RPI as a simple rate of interest. The Department clarified that they expected that PCTs should satisfy themselves that their method of calculation had a minimal financial impact on the final value of recompense and that if the impact was significant PCTs might use the more complex formulas to calculate compound interest.

17. The November 2003 guidance on interest rates did not include the Department's rationale for advising the NHS to use the RPI and I have seen no evidence that this was provided in any subsequent communication with SHAs and PCTs. Further, in the complaints put to me, the rationale for, and in some case an explanation of how, the RPI had been applied was not communicated by PCTs to individuals when it was used to uplift restitution payments.

18. In January 2004 a SHA queried the Department's November 2003 guidance on interest payments. They asked whether a higher rate than the RPI might be appropriate and how to respond to complainants on this point. In response, the Department's Continuing Care Lead wrote *'The answer is don't draw attention to it and say Department has issued guidance on interest...The explanation is that recompense means restitution of the actual cost of NHS continuing care that should have been provided...so recompense is of the funds not properly provided, not what the individual might have paid....The recompense therefore covers the cost of services not provided. This is the system being used across the country, and money has been made available to the NHS to support this'* (by email dated 16 January 2004). This response did not explain why the Department decided to advise the use of the RPI, or that this decision should be subject to local legal advice.

19. In the course of my investigation, the Department subsequently provided to my staff two explanations for the use of the RPI. The first reason the Department gave was that the RPI was

widely used by the NHS to measure increases in the cost of care. They said that they had reasoned that the NHS's experience in making such calculations based on a RPI formula would make it the most straightforward method for them to use when calculating interest for continuing care recompense payments. A second reason given by the Department was that they wished to avoid overcompensating individuals because some individuals, when they were wrongly denied continuing care funding, received benefits they would not otherwise have been entitled to. The Department, therefore, contend that the retention of these benefits, combined with the use of the RPI, was equivalent to the use of a higher rate of interest.

Status of the Department's guidance

20. The Department's initial response to my enquiries was that the guidance they gave to the NHS was 'general advice'. They added that 'this was, however, a framework and did not prevent other solutions in exceptional cases. PCTs retained the power to exercise discretion in individual cases'. During my investigation, the Department added that they had been constrained in the amount of formal guidance that they could give the NHS by the principles outlined in 'Shifting the Balance of Power within the NHS' (Department of Health, July 2001).

21. The Department explained that before 'Shifting the Balance of Power', the prevailing culture in the Department and in the NHS created an expectation that the Department would provide prescriptive guidance in all areas of policy. The subsequent devolution of power and decision making to local NHS organisations meant that it was no longer the Department's role to give that same level of direction. The Department considered that they could not be prescriptive in their guidance to the NHS about continuing care recompense. The Department felt that the shift in culture and the redefinition of their relationship with the NHS may have created some uncertainty amongst health service bodies as to the status of their guidance and advice. The Department told my staff that the guidance documents they had provided to the NHS in April and November 2003 were in response to queries they had received from SHAs and PCTs by email and at meetings about how to calculate recompense.

22. The Department reached a national agreement with the Department for Work and Pensions that social security benefits would not be reclaimed from individuals where overpayments had been made. In their April 2003 guidance, the Department told the NHS not to adjust for these payments in estimating total recompense. In November 2003, in response to queries about whether to take benefits into account when making recompense, the Department told SHA Older People's leads at their regular meeting that 'social security benefits should not under any circumstances be deducted from the total amount of compensation'. This was therefore a prescriptive approach in relation to the treatment of social security benefits. The Department went on to clarify at this meeting that interest could be paid to individuals at SHAs' discretion. The document issued by the Department that month stated that it gave 'guidance as to the suggested methodology for the application of interest', adding that PCTs should take their own legal advice about this and payment of interest was discretionary.

Findings of the Parliamentary Ombudsman

23. I will now consider in turn whether maladministration occurred and the impact of any maladministration. When deciding if there was maladministration I considered what was the recognised approach to redress at the time of the Department's decision about recompense. The Department did not have principles of redress for the NHS but, as a central government department, were themselves subject to GA 2000, which includes that: *'the general principle should be to provide redress which is fair and reasonable in the light of all the facts and circumstances of the case. Where the complainant has suffered actual financial loss as a result of the maladministration, or faced costs which would otherwise not have been incurred (and which are reasonable in the circumstances), the general approach should be to restore the complainant to the position he or she would have enjoyed had the maladministration not occurred. Where there is not an actual financial loss or cost, careful judgement will be needed to decide whether financial redress is appropriate and, if so, what constitutes fair and reasonable financial redress. ...Payment for non-financial loss should be exceptional; in all cases, the normal requirements for the proper care and use of public funds apply.'* GA 2000 was revised Treasury Guidance produced subsequent to the Select Committee on the Parliamentary Commissioner for Administration December 1994 report 'Maladministration and Redress'. This report identified the need for a clear principle to inform government consideration of redress and that this should be the principle of aiming to return individuals to the position they would have been in but for the maladministration which occurred. This report also highlighted the need to consider whether further compensation for *'worry, distress or botheration'* is due in the case of justified complaints.

(a) Maladministration in the Department's decision making

24. The issue of recompense for maladministration in continuing care funding decisions was a national problem which, therefore, required a national approach. The Department have said that their policy team felt under pressure to act quickly when deciding on their approach to recompense. I understand this. However, the policy team lacked experience in financial recompense and were aware that the NHS also lacked experience in this area. Unaware of GA 2000 and its underlying principles in relation to redress, the Department adopted an approach that was inconsistent with the prevailing government practice set out in GA 2000. Neither did the Department have sufficient information on the scale of the work involved, the financial resources needed or the types of possible injustice that might have been caused to individuals in addition to the financial loss of the unnecessarily paid fees. The Department's approach to recompense for the NHS's wrongful denial of continuing care funding focused on remedying the impact on the NHS, that is, the NHS's 'false enrichment'. It did not focus on the impact on the individuals who had been denied funding, that is, the injustice they had experienced.

25. The sum of money allocated to the NHS for continuing care recompense was based on the Department's flawed decision to use restitution as the approach to recompense. PCTs had received allocations based on making restitution for the cost of care plus some form of interest only and they were aware that any further costs over their estimate would need to be found from their own budgets. Furthermore, PCTs made estimates of the total future cost of recompense

at a time when there was little understanding of the magnitude of retrospective claims for continuing care. The Department have told me that by April 2004, when there was further information about this likely cost, the Department had allocated more funds to the NHS than they subsequently estimated would be spent. However, in keeping with standard NHS practice, these funds were not ring-fenced for use only on continuing care recompense. I consider that these factors would have discouraged PCTs from considering or making further payments outside of the restitution framework.

26. The Department failed to take into account all relevant factors when formulating their approach of restitution as the basis for recompense. That approach did not meet the prevailing government principles for consideration of redress for maladministration and the Department did not have adequate reason not to meet these. I have concluded that these flaws in the Department's decision making constituted maladministration.

b) Maladministration in the Department's communication with the NHS

27. The decision to pay restitution was poorly communicated to the NHS by the Department and conveyed contradictory messages. The Department failed to explain the rationale behind their restitution policy and their guidance contained insufficient information to enable SHAs and PCTs to make a decision about whether the policy would achieve appropriate redress. The Department failed to remind PCTs of their powers, for example to make compensation payments where the circumstances warranted such payments in recognition of inconvenience and distress. The principles underpinning the decision to pay interest using the RPI were not explained and neither was the reason for the earlier advice given to the NHS that it should include interest at the Bank of England base rate when estimating provisions for continuing care recompense. The guidance was prescriptive about not taking any social security benefits or contributions to the cost of care from social service departments into account when calculating the amount of recompense payable, yet the decision to pay interest remained discretionary.

28. I accept that the process of devolving power and decision making from the Department to NHS organisations introduced by 'Shifting the Balance of Power' influenced the way in which the Department approached their communication of their restitution policy to the NHS. There was a desire not to be prescriptive and to allow the NHS to make discretionary decisions to suit its local arrangements. The Department received queries from the NHS about how to approach continuing care recompense, which culminated in the written guidance I have described in this report. However, I have seen no evidence that the Department effectively monitored queries from the NHS about recompense to inform decisions about whether any clarification was needed on that written guidance. Instead they held the line that the approach should be restitution. Monitoring the appropriateness and effectiveness of their guidance was confined to checking that the restitution approach was legally sound in March 2004.

29. The inconsistency in the Department's approach and a lack of clear guidance to the NHS did not enable health service bodies to take an equitable and consistent approach to recompense. I have concluded that these failures in communication amounted to maladministration.

The impact of the Department's maladministration

Inconsistency in payments

30. The Department's patterns of communication did not support consistency and equity across the NHS in the way in which recompense payments were calculated. Furthermore, although the intention of restitution was to 'pay what the NHS should have paid', the evidence shows that, in practice, the NHS was often reimbursing the **individual** what he or she had paid with some uprating to today's money by means of 'interest' payments using the RPI. In some cases social services means-tested contributions paid direct to the care provider were taken into account when calculating the amount payable.

31. As Health Service Ombudsman I have considered a number of complaints about continuing care recompense where I have identified differences in the way the RPI is applied. In these cases it has been difficult for complainants to identify how interest has been calculated and whether it was accurate, and, therefore, to identify any resulting financial loss. Also, my staff have seen cases where interest at the RPI has been calculated to the date of the individual's death rather than the date the payment of redress was made. As well as differences in the amount of interest paid, PCTs have acted differently and the desired consistency has been lost in the context of other issues where the Department's guidance was relatively clear, such as the non-reclamation of benefits. For example, my staff have seen a case where benefits have been repaid to the Department for Work and Pensions and no interest was paid.

32. There are individuals who complain that, had their relatives' continuing care been correctly funded, they would have received a higher rate of interest on the money used to fund care in a bank or building society savings account or through other financial investment. On the issue of interest payments on financial redress, I consider that normally interest should be paid at the rate applied to County Court judgment debt. However, I also consider that payments made from the public purse should be considered in the round. Therefore, in the example of redress for the wrongful denial of continuing care funding, I would also take account of social security benefits and state pension payments received by care home residents which they would not have been entitled to had their care been correctly funded by the NHS. Many individuals retained benefits and state pension payments, as a result of the incorrect decision about continuing care funding. Having considered some specific cases it appears that, in the round, some individuals have been financially advantaged by the combination of retaining benefits and state pension payments, receiving recompense for the amount of fees paid and, in addition, receiving interest using the RPI. This is when compared to receiving interest at the rate applied to County Court judgment debt and taking account of benefits retained. The background to Ms T's complaint at Annex A illustrates this.

33. Furthermore, in most cases, due to the passage of time, the full records on benefits or state pension payments that were made have been destroyed. Therefore, it is generally not possible to calculate exactly what these overpayments might have been. Given these circumstances, I do not consider that it would be reasonable for PCTs to spend the considerable time and effort required to calculate retained benefits or state pension payments.

34. I would not consider the use of the RPI to be reasonable as a rate of interest unless a clear case was made that it was appropriate. In the circumstances of continuing care retrospective recompense, considering financial recompense individuals have received in the round, including their retained benefits (arising from the national agreement between the Department of Health and the Department for Work and Pensions), I have concluded that this has not resulted in an unremedied injustice for most people.

35. I do consider, however, that differences amongst PCTs in the amount of interest paid together with variations in whether or not benefits have been repaid to the Department for Work and Pensions, provide clear evidence that the consistent approach by the NHS, which the Department aimed for by deciding on restitution, was not achieved.

Unremedied injustice

Additional financial loss

36. Many people have complained to me that they have experienced financial loss in addition to the loss of care home fees and interest. The majority of these complainants claim that this was due to the premature sale of property, although there are other types of complaints. An example is the claimed loss of money on an unnecessary insurance plan for future care fees.

37. The Department have told my staff they did not consider that financial loss due to the premature sale of property would be an issue because it would be unlikely that individuals could demonstrate a causal link between the NHS's failure to fund their care and a decision to sell a property, or take other financial decisions, to enable care home costs to be met.

38. This may be true. I recognise that there are circumstances where the financial loss claimed by individuals cannot simply be attributed to the denial of continuing care funding without considerable speculation. Similarly, it is difficult to establish exactly what their financial position would have been, given the passage of time since the events took place. Many individuals can only speculate as to what they would otherwise have done with property at the time, and are often, understandably, not able to provide any written evidence to support their claim. Furthermore, it is arguable that it would be unreasonable to make the NHS financially liable for the vagaries of the property market.

39. The Department have said that the deferred payment agreement scheme was introduced in October 2001 to prevent the premature sale of property when individuals entered long term care. A deferred payment agreement allows the local authority to place a legal charge on an individual's property instead. Under a deferred payment scheme the individual's full payment of the costs of care is made at the end of the deferred payment period. This allows individuals to keep their homes whilst in a care home for the duration of the deferred payment agreement. However, not everyone is eligible for a deferred payment agreement as an individual's assets are taken into account and some property will have been sold prior to the introduction of the scheme. Annex A gives the example of Ms T, who referred her complaint to the Local Government Ombudsman (LGO) to consider the actions of the London Borough of Greenwich (Greenwich Council) in not offering a deferred payment agreement to her uncle to prevent the sale of his home in 2002. The LGO discontinued his investigation following Greenwich Council's offer to pay £20,000 to Ms T in redress. There may be instances where the financial loss claimed is attributable to the actions, or inaction, of the

local authority, rather than the NHS. There is no evidence to suggest that the implications of the deferred payment scheme on claims for redress following continuing care maladministration were made clear to PCTs - an omission which contributed to a delay in the resolution of Ms T's complaint.

40. Taking into account all these factors I do not consider that payments for claimed financial loss should be made in the absence of clear evidence that the denial of continuing care funding has led to that loss. However, I am clear that there should be appropriate recompense for demonstrable financial loss which can be evidenced by the complainant. Not to do so would result in unremedied injustice.

41. The lack of consistency in the way different PCTs calculated recompense payments means that geographical location was one factor affecting the total amount of financial recompense an individual received. This was unfair to individuals as geographical location is not relevant in the context of redress due for being wrongly denied continuing care funding. I have seen cases where the inconsistency has been so great that, during the course of my investigations, PCTs have made further recompense payments. For example, because social security benefit payments have been deducted or because interest has been applied only to the date of an individual's death, rather than the date of settlement of recompense. When deciding if further payment is due from a PCT as a consequence of their provision of a lower level of recompense to individuals relative to that made by other PCTs, it is important to balance the aim of equity with the aim of not wasting resources on reviews of calculations, especially where some information, such as benefit records, is no longer available. Where the amount of money involved is small, where the amount of money is small relative to the total amount of recompense due or where the amount of money is accounted for by the value of benefits retained by an individual, I would not expect a PCT to make additional payments. However, where a PCT's approach to calculating recompense may have resulted in payments to individuals which are significantly lower than intended by the Department's guidance, I would consider this to be unremedied injustice.

Inconvenience and distress

42. It is clear from the cases I have considered that individuals were forced to make difficult decisions about how to fund care. But for the maladministration which denied continuing care funding, these individuals would not have been making those difficult decisions. Furthermore, these decisions had to be made at an already distressing time when usually elderly relatives were experiencing ill health and traumatic, and often unwelcome, admission to long term care homes was necessary. That people had to make unnecessary difficult financial decisions resulted in inconvenience and distress. I consider that financial redress is appropriate in recognition of this inconvenience and distress. For some people, including Ms T, the amount of financial redress that I would recommend is due is accounted for by the financial gain from unreclaimed benefits. I have set out my findings with respect to the inconvenience and distress that Ms T suffered at Annex A.

Summary of findings of the Parliamentary Ombudsman

43. There was maladministration in the Department's decision making and communication of their approach to recompense for wrongly denied continuing care funding. This resulted in inconsistency in payments and the potential for significant unremedied injustice. The Department's actions did not support the NHS to return individuals to the position they would have been in, but for the maladministration which wrongly denied them continuing care funding.

44. Some individuals received additional benefit payments that they would not have received if they had been provided with continuing care funding. They have not had to return this money and have now also received financial redress equivalent to the continuing care fees payments they made. I have seen examples where the total amount of money provided appears to be equivalent, or exceeds, appropriate levels of financial redress I would expect for a combination of both the inconvenience and distress they experienced and an appropriate level of interest on recompense payments. Therefore, when taken in the round, there is unlikely to be significant unremedied injustice for most people.

Recommendation

45. I have one recommendation: that the Department should develop and distribute properly considered national guidance for the NHS on continuing care redress which aims to return individuals to the position they would have been in but for the maladministration which wrongly denied them continuing care funding. This guidance should:

a) include a reminder to the NHS that PCTs can make compensation payments for:

- financial loss, including interest, which is demonstrably attributable to the wrongful denial of continuing care funding and is aimed at returning the individual to the financial position he or she would have been in but for the maladministration; and,
- inconvenience and distress caused by having to make difficult financial decisions at a challenging time which were unnecessary because continuing care should have been funded. Such payments should recognise the degree of inconvenience and distress that was suffered by complainants. In some cases this may be a significant sum of money, in others a smaller sum. There will be cases where any such payments will be accounted for by the financial gain from unreclaimed state benefits and/or state pension payments;

b) give clear guidance to the NHS about how to calculate interest payments; and make it clear that, where inconsistencies in using the Retail Price Index have resulted in significant financial injustice, adequate remedy should be made;

c) include information for PCTs about the responsibilities of local authorities to offer deferred payment agreements from October 2001, so that complaints can be promptly considered by all the relevant bodies;

d) where, in the light of this guidance on continuing care redress, PCTs identify systemic unremedied injustice, the Department should support them in taking action to remedy the injustice.

Response from the Department of Health

46. In response to a draft of this report the (then Acting) Permanent Secretary said:

'In responding to your 2003 Report, the Department was guided by the need to do what was fair and reasonable in the circumstances. Departmental officials were, in particular, mindful of the impact of continuing care decisions on individuals and their families, as well as the position of the NHS. I am, inevitably, disappointed that you found elements of maladministration in our response; and I am grateful for this opportunity to comment on some of the important issues you have raised.

I note that you identified two factors which contributed to the lack of clarity identified in the Department's communications with SHAs and PCTS: the pressure to start the review as quickly as possible which meant that we developed advice to the NHS in parallel with starting the review process; and the renewed emphasis on devolution to the NHS which influenced the way we communicated it.

The impact of these factors could have been minimised by better monitoring of the review process and better interaction between SHAs, PCTs and the Department. To this end, the Department intends to establish a much closer relationship with the Healthcare Commission, which will enable us to receive updates about cases arising, to monitor trends and to remedy injustice more quickly. It should also be noted that the White Paper, "Our Health, Our Care, Our Say: a new direction for community services" contained a commitment to establish a comprehensive single complaints system across health and social care. The Department published interim guidance on a revised complaints procedure on 1 September 2006, in preparation for the implementation of a consolidated system in 2009.

The approach chosen for recompense was restitution, that is payments were based on the funding the NHS would have provided had it met the cost of the patient's care, together with interest, with allowance for PCTs to make decisions according to individual circumstances. The Retail Price Index was chosen to calculate interest as this is commonly used to calculate the increasing costs of services. Together with retention of benefits, it was equivalent to a higher rate of interest. Overall, over 12,000 cases have been reviewed. I therefore welcome your comment that "there is unlikely to be significant unremedied injustice for most people." I also welcome the comments, made in the letter from your office on 18 January 2006, that you are "not proposing to seek interest payments above RPI because in most cases restitution payment and the unreclaimed benefits will more than cover the cost of the enhanced interest rate".

In response to your recommendation, we will publish guidance reminding PCTs of their obligations and powers regarding redress to clarify issues arising from this report.'

Investigation of Greenwich Teaching PCT by the Health Service Ombudsman

47. PCTs across England have made recompense payments to individuals, or their estates, in circumstances where the NHS had wrongly denied continuing care funding. My Office has received many complaints about the level of recompense paid by PCTs. Some of these complainants, including Ms T, allege that, among other consequences of being wrongly denied continuing care funding, their relatives' homes had to be sold prematurely to meet care home fees. Annex A sets out the circumstances of Ms T's complaint.

Finding of the Health Service Ombudsman

I have found no maladministration in the approach to recompense by Greenwich Teaching PCT

48. The Department did not give clear guidance to the NHS or remind PCTs that they could make compensation payments. When asked for advice, the Department advised quite clearly that nothing more than restitution should be paid. It is therefore difficult to see how Greenwich Teaching PCT, or indeed any PCT, could be expected to exercise their discretion to make compensation payments aimed at returning individuals to the financial position that they would have been in but for maladministration on the part of the NHS. The Department's decision to base the allocation of funds to PCTs on restitution of fees only would also have discouraged PCTs from using other approaches.

49. Therefore, I do not consider that PCTs were responsible for the consequences of their attempts to implement the Department's unclear and inconsistent guidance to the NHS. I have concluded that Greenwich Teaching PCT was not maladministrative in its approach to providing recompense to Ms T. Furthermore, I do not consider that other PCTs acting on the same guidance were likely to have acted maladministratively. However, PCTS should be aware that there may be individuals who have not been provided redress for the injustice they have suffered.

Response from Greenwich Teaching PCT

50. I provided Greenwich Teaching PCT with a draft version of this report. They made no comments on it.

Conclusion

51. I have upheld the complaint against the Department. The Permanent Secretary of the Department has accepted my recommendation to remedy the injustice resulting from the maladministration I have found. The Department will publish national guidance for PCTs on continuing care redress in the near future. I consider this to be welcome and appropriate remedy for the maladministration.

52. I have not upheld the complaint against Greenwich PCT.

Ann Abraham

Parliamentary Ombudsman

Health Service Ombudsman for England

February 2007

Annex

HS-2400 and JW-3141 T

Ms T complained that she would not have needed to sell her uncle, Mr R's, house until after his death had the NHS assessed him correctly as being eligible for NHS continuing care funding.

1. Ms T's uncle was admitted to a nursing home from hospital in July 2002. Before he was discharged, Greenwich Council had advised Ms T that she would need to sell her uncle's property to fund his care costs. Ms T delayed Greenwich Council's financial assessment for several months whilst she pursued an appeal against the decision of Greenwich Teaching Primary Care Trust (the PCT) that her uncle was not eligible for NHS continuing care. Despite several reviews by the PCT and South East London Strategic Health Authority, the PCT declined to fund his care costs. Ms T sold her uncle's home shortly after his transfer to the nursing home.

2. Following a retrospective review in March 2004, the PCT agreed to reimburse the care costs that Ms T's uncle had paid. Ms T claimed that she would have retained her uncle's property until he died in August 2003, and benefited from the resulting increase in value of £20,000. Her uncle had made it clear to her when he was admitted to nursing home care that he did not want his house to be sold and they both found it very distressing to have had to do so. Ms T sought financial redress from the PCT.

3. I agreed to investigate Ms T's complaint against the PCT and the Department in November 2004. In June 2005 Ms T referred her complaint to the Local Government Ombudsman (LGO) to consider the actions of the London Borough of Greenwich (Greenwich Council) in not offering a deferred payment agreement which would have prevented the sale of her uncle's home in 2002. The LGO discontinued his investigation following Greenwich Council's offer to pay £20,000 to Ms T in redress.

4. Whilst the financial loss Ms T claims has been remedied, I consider that it is still the case that Ms T and her uncle experienced the inconvenience and distress of prematurely selling her uncle's home as a result of having to decide how to fund his care.

5. The settlement of £27,651 paid to Ms T by the PCT in March 2004 included a sum of £26,822 for the care home fees that had been paid and £829 'in respect of inflation by reference to the Retail Price Index' (RPI). The PCT did not provide a breakdown of its calculation to Ms T.

6. Based on information provided to my staff by the Department for Work and Pensions, Ms T's uncle retained £4,531 in benefits (attendance allowance and state pension).

An alternative approach to calculating the recompense due to Ms T is based on the principle of applying interest at the County Court judgment debt rate to the care costs paid but taking account of the benefits retained (referred to in paragraph 32).

The cost of care paid by Mr R (£26,822) is multiplied by the time between the start of care and the date the payment was made (20 months) and the interest rate (8%) to give a value of interest of £3,576.

The total sum of care fees plus interest is £30,398. The £4,531 in benefits retained is deducted from this.

I would therefore expect Ms T to have received £25,867.

7. Conclusion

Ms T has been paid £27,651 by the PCT for care costs and interest and retained £4,531 in benefits overpayments; a total sum of £32,182. Therefore, in light of the benefits retained by Ms T's uncle's estate, I consider that further financial redress in recognition of the unnecessary distress and inconvenience caused by having to decide how to fund her uncle's care is not required.

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