PERSONAL CARE – AN OMBUDSMAN PERSPECTIVE

A paper by the Scottish Public Services Ombudsman for The Independent Funding Review of Free Personal Care November 2007

1. Complaints about personal care – particularly arrangements for funding it – are a component of the caseloads of ombudsmen in several jurisdictions. For example:

   - The Health Service Ombudsman for England has since 1994 issued a series of reports on NHS-funded long term care[1] pointing to significant problems and inconsistencies in the way NHS bodies make funding decisions. These reports, along with some significant court judgements (notably Coughlan[2] and Grogan[3]), have led to substantial changes in policy and practice.

   - The Local Government Ombudsmen in England have upheld a number of complaints against councils about support for nursing home charges and meeting care needs[4].

   - In January 2001 the Irish Ombudsman issued a report on nursing home subventions[5] which found that the Department of Health and Children had taken short-cuts, disregarded legal advice, assumed powers which technically it did not have, and resisted a growing weight of evidence and complaints that its subvention scheme was seriously flawed. Subsequently very large sums have been paid out to people wrongly charged in circumstances when nursing home costs should have been met by the State.

2. A workshop on long-term care issues at the British and Irish Ombudsman Association 2007 Annual conference[6] concluded that `The framework for providing long-term care is complex and difficult for all to navigate' which `gave rise to a considerable amount of unfairness and distress'.

---

[1] The most recent is *Retrospective Continuing Care Funding and Redress* issued in March 2007. http://www.ombudsman.org.uk/pdfs/continuing_care_funding_redress_HC386.pdf.

[2] R v North and East Devon Health Authority ex parte Pamela Coughlan [2000] 2 WLR 622. The court found that a local authority can provide nursing services but that this is limited to such services which are provided as ancillary to the accommodation provided by the local authority in fulfilment of a statutory duty. The court also considered the eligibility criteria for NHS funded care and noted that Health department guidance could not alter a legal responsibility under the National Health Service Act 1977. In particular it drew attention to a danger of excessive reliance in the Health department guidance on the need for specialist clinical input. The court concluded that whether it is lawful to transfer care from NHS to local authority responsibility depends generally on whether the nursing services are incidental/ ancillary to the local authority provision and of a nature which the local authority can be expected to provide.

[3] R (on the application of Maureen Grogan) v Bexley NHS Care Trust and Others [2006] EWHC 44. The court ruled that the eligibility criteria for NHS Continuing Care were unlawful as they contained no guidance as to the test or approach to be applied when assessing a person's health needs in determining eligibility.

[4] See for example http://www.lgo.org.uk/news/info.php?refnum=134&startnum=35, http://www.lgo.org.uk/news/info.php?refnum=100&startnum=70, http://www.lgo.org.uk/news/info.php?refnum=75&startnum=90.

[5] http://ombudsman.gov.ie/en/Publications/InvestigationReports/ReportonNursingHomeSubventions/Name,2534,en.htm.

[6] http://www.bioa.org.uk/docs/BIOAConference2007WorkshopReports.pdf.

The position in Scotland

3. Since the Scottish Public Services Ombudsman was established in 2002 we have received complaints against councils about the funding and provision of long-term care and against health boards about the funding (and to a lesser extent, the provision) of NHS continuing care. The numbers of these complaints have been proportionally less than those received by our English equivalents and reveal no clear patterns in terms of issues arising in particular geographical areas. We do not believe any firm conclusions can be drawn from the numbers and geographical spread of complaints coming to us. However there are recurring issues in the complaints which we believe are indicative of problems with the policies and/or their implementation.

4. The complaints against councils have focussed mainly on issues relating to the provision of personal care services and funding for these services. Complaints we receive are to date exclusively from the group of individuals who might be termed 'self-funders'. This is perhaps inevitable as those previously fully-funded were never the intended 'beneficiaries' of this policy. However this group of individuals are also predominantly a group who have had little or no contact with social services over time and who would expect to personally (or through their family) make their own arrangements as a matter of personal autonomy (and also often express a view that they wish to avoid any time or financial costs on the part of the council). Such individuals reflect much of the ethos of the direct payment scheme operated for other aspects of community care services.

5. Complaints about NHS continuing care are almost exclusively about the eligibility criteria and assessment of eligibility for such care. The common theme to such complaints is a concern that the guidance issued by the then Scottish Office (MEL 1996(22))[7] did not reflect the equivalent position in England following the judgement in the Coughlan[8] case and that this has given rise to an approach by Health Boards which considers that any person who is capable of being cared for within a care home environment cannot be eligible for NHS funding. This in turn is based on the view that NHS funding is only available for those who require specialist care and such care is only available within a hospital environment. More details of this are listed below but for the purposes of the Review Group it is important to bear in mind the purpose for which the MEL was written and the function it is in fact currently performing. The MEL set out guidance on how the policy of ensuring that those residents of long-term hospitals and health institutions who were in fact capable of independent living to a greater or lesser extent were enabled to do so. This required a major shift in funding from Health Board to Councils who would become responsible for assessing and providing for the needs of such individuals.

6. An example of such an individual might be an adult with Down's Syndrome who would be able to live an independent life (with assistance as required) outside of an institution. In more recent years the guidance has notably served to highlight a distinction between those whose medical condition is considered an illness which requires hospitalisation and those who are considered able to be looked after elsewhere (notably dementia or

[7] www.sehd.scot.nhs.uk/**mel**s/**1996_22**.pdf
[8] see 2

Alzheimer's patients) even though they only require residential care because of their condition. The Review Group will be aware that this group was (at least in part) the group the Free Personal and Nursing Care policy was designed to assist. Again the complaints we receive are typically on behalf of 'self-funders' as they have most to 'lose' from not receiving NHS fully-funded care and it would seem unlikely that we would ever get a complaint from someone that the funding they were in receipt of came from the wrong source!

Complaints about Council long term care – in particular provision and funding of personal care

7. Cases coming to us indicate a number of problems with the discharge of local authority responsibilities in relation to personal care and variations in practice across Scotland. For example:

8. **Delays in assessment.** In one case (not formally reported) the complainant's aunt (aged 85) was discharged from hospital into a nursing home (at the family's request). A social work assessment of needs was requested prior to discharge but did not happen until five months after discharge so the family had to pay the aunt's costs for five months before social services agreed she was entitled to funding for her personal and nursing care (and indeed all her care) but that they would not back-date such funding or recompense the family for payments already made. The family accepted that some delay was inevitable but felt this was excessive and that they were not prepared to allow their aunt to languish in hospital unnecessarily because the assessment was delayed. We found that there is no time-limit for assessments and this delay was (at the time) in line with delays in other authorities so wasn't maladministration or service failure although the family were disadvantaged by the lack of any time limit for the assessment and there were clear regional variations.

9. **Variations in eligibility criteria.** We have received a number of complaints on charging for food preparation. Two were resolved by the council agreeing they had been in error and (following a decision by the City of Edinburgh Council) reimbursing the charges incorrectly levied. Three were resolved by ex gratia payments. Recently one more complaint (unreported) was closed unresolved when the council advised it was not following the 'Edinburgh' decision as it considered that this was not consistent with the guidance. As definitive interpretation of the guidance would require review by a Court of Law and as this matter is already being considered as part of the work of the CoSLA review group we have concluded that this is not a matter on which we can reach a conclusion.

10. **Delays in provision.** In a reported case[9] a son complained that his father had been assessed as being entitled to payments for his personal care but was told the council did not have sufficient funds to pay. The father was already resident in a nursing home (arranged by his family). The council said his status was monitored but as his needs were properly provided for he was not a priority for funding and would have to wait. The council did

[9] Report published November 2006. Reference 200503650 and 200600724 - http://www.spso.org.uk/reports/report.php?id=307.

eventually start paying (with no further assessment on their part) but would not back-date to the time of the original assessed need being identified and provided. We found that the council had assessed a need and the need was being met. The council were not entitled to 'manage' a 'waiting list' for FPC payments if the service needed was being provided. The Council disputed our findings and sought judicial review of them. Lord Macphail issued his Opinion on the matter on 17 October 2007[10]. He rejected all of the Council's arguments except their argument that the Community Care and Health (Scotland) Act 2002 and the related Regulations only apply where the services in question are provided (*or the provision is arranged)* by the local authority. Lord Macphail therefore found that there was not a statutory duty incumbent on the Council to fund free personal care in the circumstances of this case although he did not consider it would be ultra vires for a council to do so.

11. **Charges made by Care Homes.** In an unreported case we received a complaint from an individual that the council had arranged the placement of a woman in a particular care home which was uniquely (at that time) able to meet her overall needs and assessed her as eligible for personal care payments but not nursing care. The council arranged a contract with the care home for such care but did not mention the possibility of a Route 3 contract for the remaining 'hotel' costs. The care home later decided to increase its charges to all residents to include a charge for nursing care to cover the cost of the nurse employed by them – this charge was applied to all residents whether or not they required nursing care. The council refused to fund the nursing care charge for this lady as she did not require such care. The lady herself was unable to move as even though another home might by then be able to meet her overall needs she was too frail to contemplate such a move. We concluded that there was nothing to stop the care home increasing its costs as it saw fit and that as the Council had no duty to provide nursing care funding in this case there was no action we could take to remedy this situation.

12. **Definition of `ordinary residence'.** We have received complaints concerning disputes over the ordinary residence of a person who moves either between council areas or from England to Scotland and where the two authorities cannot agree on an interpretation of the FPC guidance on the Social Work (Scotland) Act 1968 definition of 'ordinary residence'. There are 2 issues :
    - (case reported September 2007, reference 200601620[11]) whether the person moved at the behest of the council which is then deemed the 'placing authority' or of their own volition - two councils can interpret the facts differently and the service user is left unfunded.
    - the split between NHS and Social Services funding is different in England – the guidance has allowed for an English Local Authority retaining social services responsibility where a service user moves to Scotland but no parallel arrangement exists for the NHS element which ends when a patient physically relocates: Scottish NHS Boards do not have responsibilities concomitant to those of English Primary Care Trusts.

[10] http://www.scotcourts.gov.uk/opinions/2007csoh168.html
[11] http://www.spso.org.uk/reports/report.php?id=612

Other Guidance Issues relating to Community Care

13. **Assessment of Capital.** In calculating whether or not a service user is required to pay for some or all of the services provided to them (or whose provision is arranged) by social services, an assessment of the user's financial assets is made by the council. The assessment is governed by a combination of case law and Executive guidance (commonly known as CRAG). We have received a number of complaints all from relatives of service users in their 70s, 80s and 90s who had previously exercised their right to buy their former council houses (all bought under the old purchase scheme and all exercising their maximum 60% discount after 30 years residence). In essence each case is the same as the service user has passed the home on to a member of their family for no benefit and the Council have now decided to consider the nominal value of the home in the calculation of the individual's assets and therefore considers that they are self-financing. In every case there are no other assets and the elderly person has no actual funds to pay. The timescales vary from 2 to 9 years between the day of transfer to the assessed need for entry into a care home (and consequent financial assessment).

14. Some councils do not take account of transfers made more than 2 years but others go back 5 years (we believe some go back 7 years but don't know this for a fact). There is considerable confusion about what a council can and can't assume and the impact of this. In effect in each case the family tell us that they put up the money for the parent to buy the home with the intention of selling it on for a profit for the family at a later stage. Councils counter this by stating that anyone in their 70s or beyond must know they may have care home costs one day so must principally be getting rid of the home for no value to avoid these costs (this is statistically dubious but reflects some of the opinion in the Court of Sessions judgement in Yule v South Lanarkshire Council (1999)). They also say the home could be passed on in a will – again there are a number of counter arguments to this but all involve making judgements about the reasonableness of the actions.

15. Overall the council arguments presuppose a level of financial and legal sophistication which seems unreasonable. We have also become aware that where capital is assessed there are a number of different formulas adopted by councils in calculating the value to be taken into account – some value the house at actual point of sale and some at point of transfer. Given recent house price increases this can make a substantial difference to the final figure that a service user is deemed to have. In all the cases the service user in fact has only negligible funds available and would ultimately be declared bankrupt if the council enforced the debt – the council relies on the family (who have no legal obligation to pay) stepping in to avoid this. Councils do not appear to have considered the CRAG requirement that the avoidance of care home costs was a 'significant' reason as they believe they are legally entitled by the Yule judgment to assume this was the motive without needing to provide any evidence of this.

Complaints about NHS continuing care – in particular eligibility and funding

16. We have also identified problems in relation to NHS-funded continuing care and see an urgent need for review of the guidance issued by the Scottish Office in 1996 (MEL 1996(22)) which remains in force and unamended. We outlined the problems we see with the MEL in an annex to an investigation report issued in June 2007[12] as follows:

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

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

- The lack of a formalised process for Continuing Care assessment means the public are often unable to obtain clear information about the qualification criteria for NHS funded Continuing Care. There is a lack of clarity about when a patient should be the subject of a multi-disciplinary assessment under the MEL. This assessment generally occurs at the time of a patient's discharge from hospital. Not every patient discharged will require to be assessed under the MEL but there is no clear guidance on how the decision on whether or not to assess is made. Consultants can make discretionary and undocumented decisions that patients are not eligible to be assessed under the MEL and this results in a lack of transparency and inconsistency in the decisions made.

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

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

[12] Reference 200501504 - http://www.spso.org.uk/reports/report.php?id=494.