Parliamentary and Health Service Ombudsman

Continuing Healthcare: an investigation into Hounslow Clinical Commissioning Group

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Executive summary

About NHS Continuing Healthcare

NHS Continuing Healthcare (CHC) is care provided to someone who has complex care needs. The care can be provided in someone's own home, a care home or another place outside of a hospital. The NHS pays for this which covers the full cost of the person's care and residential needs. Local NHS Clinical Commissioning Groups administer it with oversight from NHS England and NHS Improvement.

What happened

Mr R came to us with concerns about how Hounslow Clinical Commissioning Group (CCG) processed the CHC funding and Personal Health Budget (PHB) for his father, Mr Q. He complained that the CCG did not provide the correct level of care to meet Mr Q's assessed needs. He also said it failed to regularly assess and update Mr Q's care plan as his needs changed.

What we found

We found multiple failings in how the CCG administered Mr Q's CHC plan. The CCG:

- did not assess Mr Q's eligibility for CHC frequently enough, resulting in a lot of frustration for Mr R
- did not provide enough funding for the additional staff needed to support the live-in carer
- acknowledged that the live-in carer should have been paid annual uplifts, which they were not
- did not put an appropriate contingency plan in place for Mr Q when the live-in carer was unable to perform his duties.

Putting it right

We recommended that the CCG should:

- acknowledge its failings and the impact these had on Mr R
- apologise to Mr R for the distress caused by its failings
- consider how to address the issue of pay for the live-in carer
- produce a proposal setting out how it will take action to stop similar failings happening in future.

The complaint

Mr R complains about how Hounslow Clinical Commissioning Group processed the Continuing Healthcare (CHC) funding and Personal Health Budget (PHB) for his father, Mr Q. Mr Q was found eligible for CHC in March 2013 and was given a PHB covering live-in care and agency costs. In August 2014, the CCG decided his budget would be paid in two separate ways, which started in February 2015.

Summary of the complaint

Mr R complains that the CCG:

- failed to assess Mr Q's needs regularly
- failed to provide Mr Q with an appropriate level of care between 2013 and 2015 and:
    - even though changes were made to the care plan throughout this period, the CCG did not adhere to these
    - there was a deficit in care provided by the CCG to Mr Q up until he died on 1 April 2021
- did not provide the correct level of care to meet Mr Q's assessed needs when his live-in carer was on annual leave
- did not provide a robust contingency plan to meet Mr Q's needs when the live-in carer was not able to perform his duties, for example, through illness
- withdrew care for Mr Q when he was admitted to Middlesex University Hospital Trust despite clinical recommendation, resulting in a financial loss to Mr R of £4,252.90
- went against the Multidisciplinary Team's recommendations and the independent report it commissioned on 30 July 2015, which both found Mr Q needed 24/7 care
- paid the live-in carer £2,166.67 per month for him to work through the day and night, and did not review or increase this in line with inflation
- made setting up the PHB a difficult and long process, did not provide appropriate help and support, and did not communicate or work collaboratively to put together an appropriate care plan
- failed to provided clarity on the correct use of funds (although a cost form breakdown was provided), which resulted in the CCG accusing Mr R of mismanaging the PHB and surplus funds
- delayed responding to complaints and has not responded to all his concerns.

How this affected Mr R

Mr R says due to inappropriate funding through the PHB he had to top up his father's care costs and provide additional care himself, along with having to pay other associated costs. He says the CCG has not made an adequate offer of reimbursement for these costs, which has left him at a significant financial disadvantage.

Mr R says the CCG's actions have caused psychological distress for him and his family. He says he has not been able to have a family holiday for three years because of the care he has provided to his father. He says he was signed off work for three months due to stress caused by the CCG not providing sufficient care to his father, and he has not been able to take on additional responsibilities required of him at work. Mr R says the CCG's actions have had a significant detrimental effect on his family's physical and mental wellbeing.

What Mr R wants to happen

Mr R wants:

- the CCG to acknowledge that his father's care plans did not meet all his documented needs
- to be reimbursed for costs he has had to pay, including the cost of Mr Q's live-in carer up to the point the PHB started in February 2015
- a review of the live-in carer's salary to bring it in line with inflation and increased living costs, the cost of providing additional care when Mr Q was hospitalised in June 2018 and other costs he has had to pay
- a financial payment to recognise the stress he has suffered, which he says was caused by the CCG's poor handling, maladministration (an organisation doing something wrong or not acting properly) and the time it took to resolve his complaint.

Our decision and recommendations

Summary of our findings

1. The CCG did not assess Mr Q's eligibility for CHC frequently enough. This resulted in a lot of frustration for Mr R, as well as confusion and uncertainty about how he should have been spending the PHB he managed. We uphold this part of the complaint.

2. There is no evidence supporting the number of changes the CCG made to Mr Q's budget over the years. It failed to budget appropriately for Mr Q's needs. This meant his live-in carer worked alone during the nights when two carers were needed. The live-in carer worked, or was expected to work, much more than ten hours per day for many years. The CCG did not provide enough funding for additional staffing to support the live-in carer. Mr R told us the live-in carer threatened to leave because he was expected to work too many hours. This caused Mr R anxiety and uncertainty over who might care for Mr Q. As funding was not allocated from the CCG to cover these hours of care, this work was done either unpaid or paid for by Mr R. We uphold this part of the complaint.

3. The CCG acknowledged that the live-in carer should have been paid annual uplifts, which they were not. We uphold this part of the complaint.

4. The CCG provided limited support to Mr R when explaining his responsibilities for a PHB. This resulted in confusion and frustration over an extended period about how to spend the money in the budget. In March 2018, there was a surplus of around £24,000 in the PHB account. This built up because of the CCG's mistake when setting the 2015 budget, but the CCG did not recognise this. It accused Mr R of mismanaging the PHB and he is rightly aggrieved by this. We uphold this part of the complaint.

5. No appropriate contingency plan was put in place for Mr Q. This resulted in further distress and frustration for Mr R, who was concerned that there could be a sudden and serious deficiency in his father's care at any time. A purported facility to directly access contracted emergency agency provision was not available in practice when tested, raising serious safety concerns. We uphold this part of the complaint.

6. The CCG did not need to provide care while Mr Q was in hospital, because CHC funding and PHBs can only be used outside a hospital setting. But the CCG should have continued paying 80% of the live-in carer's wages (a total of just under £1,200) into the PHB account during Mr Q's hospital admission. We partly uphold this aspect of the complaint.

7. The CCG was right not to pay the £45,659.39 Mr R requested for the live-in carer for care provided during 2013 to 2014. The live-in carer does not have full UK nursing qualifications and is not registered with the Nursing and Midwifery Council (NMC), which is a legal requirement for all nurses working in the UK. For this reason, it is not a failing that they were paid as a carer rather than a nurse. The CCG did pay £6,600 covering a period of care when it had evidence that the carer had a legal right to work in the UK. The CCG agreed that if the time period that the live-in carer was working lawfully in the UK was confirmed, the reimbursement of £6,600 would be an interim payment and it would calculate additional payments. Mr R provided the CCG with the relevant documentation, but we have not seen evidence that the CCG reconsidered its offer or made these payments. We partly uphold this aspect of the complaint.

8. The CCG failed to follow our Principles in its complaint handling. It responded in a timely way on 5 December 2016 to the complaint Mr R submitted on 5 September 2016, but it did not respond to Mr R's initial complaint in 2014. This led to an unnecessarily long complaint process, which caused frustration for Mr R. We uphold this part of the complaint.

9. We found that the CCG arranged adequate care when the live-in carer was on annual leave, because the evidence shows Mr Q's needs can be reasonably addressed by a registered nurse. By arranging care from registered nurses and arranging for them to shadow shifts in advance to learn more about Mr Q, the CCG did what it should have done. We do not uphold this part of the complaint.

Our recommendations

Our Principles for Remedy state that where poor service or maladministration (an organisation doing something wrong or not acting properly) has led to injustice or hardship, the organisation responsible should take steps to put things right.

Within one month of this report, the CCG should write to Mr R (and us) to:

- acknowledge its failings and the impact these had on Mr R
- apologise to Mr R for the distress caused by its failings.

Our Principles say that public organisations should look for continuous improvement and use the lessons learned from complaints to make sure they do not repeat maladministration or poor service.

In line with this, we recommend that within two months of this report the CCG should:

- review all the care plans and budgets for the periods we have considered, taking account of our findings
- produce a proposal on how it will remedy the injustice to Mr R, which should:
    - compare what should have been paid for Mr Q's care with what was paid
    - set out how it will resolve the stalemate between the CCG and Mr R on the extent of the money owed, including compound interest
- consider how to address the issue of pay for the live-in carer, who worked extended hours while only being paid for 10 hours per day, and set out the actions it will take to prevent similar failings happening in future
- send its proposal to us with detailed explanations of its calculations so we can review whether it will satisfactorily remedy the injustice.

The CCG must complete its proposed work to remedy the injustice to Mr R within one month of our report.

By failing to provide enough funding to meet Mr Q's care needs for several years, the CCG has failed to make sure adequate care provision was available to an extremely vulnerable individual. The CCG should:

- refer itself to the local authority safeguarding team to consider whether it should take additional action to make sure others are not put at similar risk of not having their care needs met in future.

Our Principles say that public organisations should put things right and, if possible, return the person affected to the position they would have been in the poor service had not happened. If that is not possible, they should compensate them appropriately.

To decide on a level of financial remedy, we review similar cases where the person has experienced a similar injustice, along with our severity of injustice scale. Following this review, we recommend that the CCG should:

- pay Mr R £4,000 in recognition of the personal injustice of distress, frustration, and uncertainty over several years, caused by the failings we have identified in our report.

Background to the complaint

Mr Q's health conditions

Mr Q was in his nineties when he sadly died in 2021. He could not communicate and relied on carers for all his needs and to maintain his safety. He was diagnosed with Alzheimer's disease in 2002, after which he needed formal care to stay in the home setting.

Mr Q had a stroke in 2002. He had another in 2012, which left him with weakness or paralysis on the right side of his body and swallowing issues. This means he was nil by mouth and relied on a feeding tube directly into the stomach for all nutrition and medication.

Mr Q also had other conditions, including type 2 diabetes, atrial fibrillation (an irregular and often fast heart rate) and recurrent chest infections as he could not swallow, which led to choking. Because of his swallowing issues, he needed frequent suctioning and a percutaneous endoscopic gastronomy tube (PEG tube) through which he received food, fluids and medicines directly into his stomach. He also needed a nebuliser (which was administered several times per day), management of double incontinence, and frequent repositioning.

Mr Q's live-in carer

Mr Q had been living with his family in Dubai until 2012. When he returned to the UK, he brought a live-in carer with him who lived at his address permanently. The live-in carer was employed to provide care and support to Mr Q.

Although Mr R provided the CCG with the written contract of employment he had with the live-in carer, it did not include the number of hours he had to work. There was no Daily Average Agreement formalised between the two parties. This is an agreement about how many hours per day a carer works, rather than how many hours they are present in the home.

Mr Q's Continuing Healthcare funding and Personal Health Budget

In March 2013, the CCG took over care planning for Mr Q as he became eligible for CHC funding. This is NHS funding provided to cover the health and social care needs of people with complex primary health needs. From that point, the CCG commissioned four hours of agency care for Mr Q per day.

In July 2013, Mr Q's needs were reassessed and the CCG increased funding for his care package. He was then given a PHB for his care and support needs. Mr R took responsibility for managing the PHB. With a PHB, people who are entitled to CHC funding can receive this for health and social care as a personal budget they can use to buy the care they need. A PHB is not additional money to CHC funding. It is a way of giving individuals more choice and control over their care, with the agreement of their local CCG.

The amount of money in the individual's PHB is based on their personalised care and support plan (CSP). This plan helps people to identify their health and wellbeing outcomes together with the CCG, and sets out how the budget will be spent to enable them to reach their goals and keep them healthy and safe. A PHB can be paid by a direct payment, notional budget, third-party budget, or a combination of these.

Mr Q was initially given a PHB for both the live-in carer and care agency workers. Mr R managed this as a direct payment. Direct payments are where the PHB holder, or their representative, has the money in a bank account and takes responsibility for purchasing the agreed care and support outlined in the CSP.

In May 2014, the CCG completed an assessment, which recommended that Mr Q receive 24-hour care. In August 2014, the CCG completed a review and decided that the PHB would be paid in two different ways.

A notional budget, managed by the CCG, would pay the agency staff. Under a notional budget, the PHB holder or their representative knows how much money is available for their assessed needs and decides, together with the NHS team, how to spend that money.

A direct payment, managed by Mr R, would pay for the live-in carer and any costs associated with the care. This new way to manage the PHB was approved in August 2014 but did not start until February 2015.

To make sure the CCG had an appropriate CSP and budget in place to meet Mr Q's needs, it commissioned a third party to complete a report on 30 July 2015. This recommended that Mr Q receive 24/7 care, equating to 168 hours per week. It then put in place a new CSP that provided only 97.5 hours of agency care over seven days in addition to the live-in carer.

The PHB budget varied considerably over the years Mr Q received it. The 2015 budget should only have included £500 per week to Mr R for the live-in carer. Additional payments for 'Employed staff' should not have been included in the direct payment. The CCG should have held this amount in a notional budget for agency care. This was corrected in 2016.

Mr R's request for 'backpay'

Mr R asked the CCG for £45,659.39 in 2014. This was for 'backpay' for the live-in carer, whom Mr R believes should have been paid the rate for a nurse. He calculated this by estimating the live-in carer's income at £91.87 per day and multiplying it by 497 days - that is, the period from 6 March 2013 to 15 July 2014.

In February 2015, the CCG paid Mr R £6,600 as partial 'backpay'. The CCG did not agree to any further reimbursements at that stage. In March 2018, following further correspondence, the CCG offered to reimburse Mr R a total of £26,369.73 for:

- incidental supplies: £2,079.84
- salary for the live-in carer from March 2013 to February 2015: £14,063.89
- additional care paid for by Mr R: £10,226.

The CCG's overall calculation differed slightly to what is set out above, because it took off the £6,600 it paid him in February 2015. It also added compound interest. The total it offered him was £21,724.98. Mr R did not accept this offer and instead brought his complaint to us.

In March 2018, there was a surplus of around £24,000 in the PHB account, which the CCG asked Mr R to pay back. There was also a surplus of around £5,500 on a pre-paid credit card. This is a card Mr R held, which the CCG paid into, and was intended to be used to pay for goods and services to meet Mr Q's needs.

How we investigated the complaint

We considered the following information:

- Mr R's complaint information from 2014 to the present day
- correspondence from Mr R and the CCG
- the CCG's complaint file
- the PHB file from the CCG
- care and support plans
- final budget cost forms.

We also got advice from a CHC and PHB clinical adviser who has 41 years of experience as a nurse in all settings, including the acute and primary sector. They have 23 years of extensive experience working in the field of NHS Continuing Healthcare since 1996 (its first inception) to the present day, and of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care Contribution in the care of adults and children.

We use related or relevant law, policy, guidance and standards to inform our thinking. This allows us to consider what should have happened. In this case, we have referred to the following standards:

- NHS England, Guidance on Direct Payments for Healthcare: Understanding the Regulations, 20 March 2014 (Direct Payment guidance)
- Department of Health, National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care (Revised), 2012 (the National Framework)
- Department of Health, Personal Health Budgets Guide, Appendix 4: NHS Oxfordshire Indicative Budgets Setting Model, 2015 (the Oxfordshire Budget Setting Tool)
- Hounslow CCG, Personal Health Budgets: Policy Guidelines and Framework, 2016
- Parliamentary and Health Service Ombudsman, Principles of Good Administration
- Parliamentary and Health Service Ombudsman, Principles of Good Complaint Handling
- Parliamentary and Health Service Ombudsman, Principles for Remedy
- Parliamentary Health Service Ombudsman, Severity of Injustice Scale.

Our findings in detail

Frequency of Continuing Healthcare eligibility and needs assessments

Mr R complains that the CCG failed to regularly assess Mr Q's needs since he became eligible for CHC funding in 2013. Here, we consider the timeliness of the reviews.

Paragraph 181 of the National Framework - 'Purpose and Frequency of Reviews' - states that when an individual has been found eligible for NHS CHC funding, a review should be undertaken within three months of the eligibility decision being made. After this, reviews should be undertaken at least annually. The CCG's policy reflects this and states that 'the frequency and type of reviews will be outlined in the Support Plan and PHB Direct Payment agreement'.

Mr Q was first considered for CHC funding on 13 March 2013 when a Checklist was completed. The Checklist is used to determine if an individual needs an assessment for CHC funding. It does not determine if they are eligible. This triggered the first Decision Support Tool (DST) assessment the next day, which is a full assessment of CHC eligibility. That assessment found Mr Q eligible for CHC funding.

In line with the National Framework and the CCG's local policy, Mr Q's needs should have been assessed within three months of this decision and then at least annually after that. The first assessment was done in July 2013, which is just over three months after he was found eligible. This is in line with the National Framework.

Mr Q's CHC eligibility should have been reviewed annually after that. The CCG says it carried out reviews every year from 2013 to 2020, apart from 2016, but the evidence does not reflect this. We can see that it completed CHC reviews on 24 November 2014, 5 January 2015, 9 September 2016, 14 November 2017, October 2019 and 3 March 2020.

The CCG should have carried out its second review in July 2014. Instead, this took place in November 2014, four months after the annual review was due. This breached the timeframe set out in the National Framework. The third review was only two months after the second, and the next review was 20 months after that - eight months late. The one after that was 14 months later. There was then a period of two years - from November 2017 to October 2019 - where there is no evidence to show that the CCG reviewed Mr Q's eligibility as it should have.

The CCG has not provided any information about why it did not complete timely reviews of Mr Q's eligibility, why it completed the third review four months after the second, or why the 2020 review took place five months after the 2019 review.

Our decision on the frequency of assessment

Overall, the CCG did not assess Mr Q's CHC eligibility in line with paragraph 181 of the National Framework or the CCG's local policy. We consider this to be such a significant shortfall from the applicable standards that it is a failing.

Not regularly reviewing Mr Q's CHC eligibility means the CCG missed the opportunity to review Mr Q's PHB at timely intervals. The CCG's policy sets out that the annual review is an opportunity to review how the PHB is being spent. Failing to carry out these reviews meant there were missed opportunities to review how the PHB was being spent and to make sure it was meeting Mr Q's health needs. From the evidence we have seen, there seems little doubt that this resulted in a lot of frustration for Mr R, as well as confusion and uncertainty about how he should have been spending the PHB. That was an injustice to him.

Mr Q's CHC eligibility was reviewed on 24 November 2014, 5 January 2015 and 9 September 2016, but he was paid an incorrect amount from August 2014 to January 2016. Mr R was paid £1,000.88 per week during this period - the same amount he was receiving before the CCG split the budget. He should have been paid £653 per week during this period - a difference of £347.88 per week. £500 of that should have been allocated as budget for the live-in carer. £153 was for supplies and costs such as tax and National Insurance.

The CCG overpaid him by £10,038.79, and Mr R has since paid this back. The irregularity of the reviews does not appear to be the main cause of the problems that have happened in this case, but it has resulted in a lot of frustration, inconvenience and uncertainty for Mr R. We make a recommendation about putting this right.

Care and support plans

Mr R complains the CCG did not communicate or work collaboratively to put together an appropriate care plan for Mr Q. We considered whether the care plans were adequate and whether they resulted in an appropriate budget for Mr Q's needs.

Section 5 of the Direct Payment guidance explains that the care plan is at the heart of a PHB. It says that, before a direct payment can be made, a care plan must be agreed between the CCG and the person (in this instance, Mr R).

Paragraph 178 of the Direct Payment guidance says it is essential to check at appropriate intervals:

- how the direct payment is being used
- the health condition of the person
- whether the care plan is achieving the agreed outcomes.

This forms part of the duties of the care coordinator who assesses the individual's health or social care needs and, together with the person, develops a care plan to meet them. Paragraph 114 of the guidance says the CCG must name a care coordinator and record this in the care plan.

Instead of providing details of Mr R's care coordinator, the CCG has provided names of individuals who it says were Mr R's direct payment officers. We have not seen any evidence that Mr R was given details of a specific care coordinator throughout the time he received direct payments. This is not in line with paragraph 114 of the Direct Payment guidance and is therefore a failing.

The National Framework says the funding provided by CCGs in NHS CHC packages should be enough to meet the needs identified in the care plan. The Direct Payment guidance reflects this and says the CCG must make sure that the amount of the direct payments paid to, or for, a patient is enough to provide for the full cost of each of the services specified in the care plan.

The CCG has provided limited information about the care and support planning for Mr Q. This is largely due to the limited records it holds. We have seen four CSPs for Mr Q from the period under consideration. These are from 2014, 2015, 2016 and 2019. They are sometimes difficult to follow because of inconsistencies and errors with the dates on the documents. The 2019 CSP is difficult to follow because it was done as a PowerPoint presentation covering topics relating to Mr Q, rather than in the usual format.

2014 care and support plan

A report in 2014 observed that the live-in carer provided 24-hour on call care for Mr Q and was supported by a care agency for 20 hours per week. The report recommended 24-hour care for Mr Q.

Given that Mr Q needed 24-hour care, and many tasks needed two people, we consider that the budget should have included costs for this. It did not. Instead, it included just 20 additional hours of supportive double-up care a week to allow the live-in carer to have a break from clinical duties.

Mr Q needed suctioning at unpredictable frequency throughout the day. The CCG says this was completed by one person, but in 2019 it recognised that this task needed two people. The CCG only provided funding for the live-in carer equivalent to 40 hours per week, plus 20 hours for agency care per week, so there was a potential shortfall of 276 hours support every week. This also meant the live-in carer had to provide care single-handed to meet Mr Q's needs for 148 hours per week. It is not clear why the CSP and resulting budget did not account for two members of staff to be present to perform the duties across every 24-hour period.

2015 care and support plan

The 2015 CSP again set out Mr Q's need for 24-hour care. The CSP indicates that two people needed to be present to undertake many of the care tasks - the additional person to support the live-in carer with clinical care, personal care and transfers. We understand this to mean that two carers should have been present at all times to fulfil these duties. This should have been reflected in the budget that was set but it was not.

Given the care needs outlined in the 2015 care plan, it appears Mr Q needed two carers at all times to safely meet his needs. Despite knowing Mr Q's care needs did not change from day to night, the CCG only provided support for daytime hours.

With only 97.5 hours per week of support from agency carers, the live-in carer worked an additional 70.5 hours per week single-handed. There was further shortfall of 168 hours of double-up care.

In terms of total care hours budgeted for, in 2015 the CCG provided funding for the live-in carer, plus 97.5 hours of daytime support from a care agency. The CCG should have held the agency costs in a notional budget and not paid them as a direct payment. The CCG also allocated funds for an additional 97.5 hours of daytime support through the direct payment, which would fund doubling up the daytime care. This funding was only in place for a few months before it was withdrawn. Since the PHB began, no funding was allocated for additional night-time care on top of the hours worked by the live-in carer, which are not listed in the CSP.

2016 and 2019 care and support plans

The 2016 CSP is similar to the previous two, but the additional hours were removed completely. The 2016 CSP is only a proposed document, which does not appear to have been approved or put in place, so it appears care was provided as per the 2015 CSP until 2019. The 2019 CSP is a very different document and is almost impossible to summarise. As noted earlier, the most recent budget was set at £33,956.00 and did not include any hours of double-up support alongside the live-in carer, nor any additional night-time care outside of the hours the live-in carer should be working.

Our decision on the care support plans and budgets

Overall, there appears to be no evidential basis for the changes to the budgets. Mr Q's condition and needs did not change significantly throughout the period in question. His health did not improve and his care needs did not need less input.

The various assessments and CSPs are consistent in setting out his needs, but the CCG has consistently failed to budget appropriately for those needs. We consider that this falls so far short of what should have happened that it is a failing.

The CCG acknowledges it did not consider Mr Q's night-time needs, and that two carers were needed for 24 hours to meet his needs effectively, in 2014 or in any later reviews. Looking at the impact of this failing, Mr R says the CCG failed to provide Mr Q with an appropriate level of funding. The CCG should have budgeted to make sure two carers were present for 24 hours a day. It did not.

The failure to reflect Mr Q's needs in the budget set to meet those needs meant there was not enough money to pay for his essential care. As a result, Mr R was effectively left with two options: to allow his father to be cared for by one member of staff when two were needed, or to pay for additional staff overnight. Mr R did not have the budget to pay for an additional carer overnight to support the live-in carer, so the live-in carer either worked alone or was supported by Mr R.

In addition, we consider it likely that the £24,000 surplus in the PHB account built up over the short period the 2015 budget was in place. During that period, the CCG was - seemingly in error - putting £1,755 per week into the budget for carers on top of the budget for the live-in carer, but not advising Mr R that this could and should be spent on additional carers.

Live-in carer's budget: 2013 to 2014

Mr R believes the CCG should have paid the live-in carer its rate for a qualified nurse. He believes this should have been set at £91.87 per day. The period claimed between 6 March 2013 and 15 July 2014 is 497 days. £91.87 per day for 497 days equates to £45,659.39.

To reach the figure of £91.87 for the proposed daily rate, Mr R included costs that are not related to the live-in carer's take-home budget. This includes respite care (planned or emergency temporary care provided to caregivers in the form of short-term and time-limited breaks) and annual charges, such as insurance and training costs.

Mr R was responsible for paying him and paying him an appropriate amount. No matter the live-in carer's qualifications and experience, he was employed as a live-in carer and should have been paid accordingly. Mr R paid the live-in carer £550 per week during this period as per the budget provided.

The CCG did budget for the live-in carer's wage during this period. From 6 March 2013 to 15 July 2014, the live-in carer was to be paid £550 per week. This was calculated by budgeting for 1.1 units of care at £500 per week. This works out to £78.36 per day. In 2015, the CCG amended this to 1 unit.

We do not agree with how Mr R calculated the live-in carer's daily rate at £91.87, because the budget for respite and annual charges does not go directly to the live-in carer. These costs should not be included in the amount the CCG pays into the budget towards the live-in carer's pay.

Despite this, on 24 September 2014, the CCG reimbursed Mr R £6,600 for an agreed shortfall. The CCG says the reimbursement for £6,600 was for care commissioned by Mr R between the date of CHC eligibility in 2013 and the start date of the PHB in 2014. The PHB was approved in August 2014 but did not start until February 2015. Funding was then backdated to August 2014.

The CCG wrote to Mr R on 17 June 2015. It said the £6,600 payment was 'to cover the time period where [it] had evidence of a legal work permit for the carer' and 'was calculated as the difference between the NHS commissioned care package and the allocated PHB'. It said it could not make payments for an earlier period without confirmation of the carer's immigration status for that period. The CCG has said if the time period that the live-in carer was working lawfully in the UK was confirmed, the £6,600 would be an interim payment and it would calculate additional payments.

It is unclear how the CCG calculated the £6,600 figure. The CCG said it explained its method of calculating this figure to Mr R in meetings, emails and letters, but we have not seen evidence of this.

Our decision on the 2013 to 2014 budget for the live-in carer

On 19 June 2015, the CCG determined the live-in carer's right to work in the UK. In line with our Principles of Good Administration, which say an organisation should do what it says it will do, the CCG should have recalculated its offer after this date to determine if the repayment of £6,600 was appropriate. We cannot see evidence that it did.

The CCG was right not to reimburse the £45,659.39 Mr R asked for at the time. However, the CCG should recalculate this offer to determine the appropriate amount, taking into consideration when the live-in carer gained the legal right to work in the UK. The CCG should also be clear about how it reached its calculations. It did make further offers for reimbursement but these offers do not reconsider if the £6,600 was enough.

Live-in carer's budget: January 2016 onwards

Mr R complains the budget for the live-in carer has not been increased since he received the Final Budget Form in January 2016. He believes it should take inflation and rising costs into consideration, as well as the number of hours the live-in carer is indicated to work in the care plans. He also believes the rate set for the live-in carer was too low and did not reflect local rates.

The live-in carer's wage

Mr R paid the live-in carer £500 per week, as per the budget, for the entire period under consideration, apart from 6 March 2013 to 15 July 2014 when the CCG budgeted for 1.1 units of live-in care instead of 1.

The CCG confirms it used the Oxfordshire Budget Setting Tool to calculate Mr Q's budget. According to NHS England, £500 is a standardised weekly flat rate for a live-in carer and should cover all the hours of a live-in carer, based on 10 hours per day - 9 hours during the day and 1 hour at night.

Until October 2015, the National Minimum Wage (NMW) was £6.50 per hour (it rose to £6.70 in October 2015). That equates to a wage of £65 for a 10-hour day and £390 for a 6-day week. This was well within the flat rate set. If the live-in carer did only work the expected hours (as per NHS England), it seems the CCG paid enough into the PHB account to allow Mr R to pay him an appropriate wage. The current average wage for a care worker in Mr R's local area is £550 to £615 per week.

The live-in carer's hours

As set out above, Mr R is responsible for paying the NMW to the live-in carer. Because of how the live-in carer came to provide care for Mr Q (outlined in the 'Background to the complaint'), as per the NMW Regulations, it appears he was carrying out unmeasured work. This means the carer did not receive a salary or was paid a set amount to complete a task, regardless of how long it takes, rather than being paid at an hourly rate or according to what they produce. For a care worker, it may be being paid according to the complexity of the client's needs or according to market rates.

Providers who set up their arrangements in this way (in this instance, Mr R) should enter into a Daily Average Agreement with the live-in carer. This agreement specifies that although the worker may be present in the client's home for, for example, a 24-hour period, they will only need to work for a given number of hours per day. This average hours figure is likely to be calculated when the care plan is designed. It would then only be those hours that count when checking the NMW compliance in the live-in care agreement.

As far as we can see, there has never been a Daily Average Agreement between Mr R and the live-in carer. The CCG confirms that Mr R provided a contract of employment with the live-in carer, but this does not outline the number of hours they are expected to work in a 24-hour period. It is almost impossible to know how many hours the live-in carer was expected to work or did work - rather than just being present and available to work - throughout the period.

The CCG should have considered any Daily Average Agreement when setting up the care plan and associated budget. We have not seen any evidence that the CCG ever asked Mr R about this or advised him he needed to set one up. This made our analysis more complicated as there are few primary sources of evidence to show what work was carried out when and by whom.

The live-in carer's night duties

In terms of budgeting, additional rules apply to night workers on top of the rules on maximum weekly working hours and rest breaks. The Government website says night workers must not work more than an average of 8 hours in a 24-hour period. The average is usually calculated over 17 weeks, but it can be over a period of 52 weeks if the worker and employer agree.

As the employer, Mr R was responsible for making sure the live-in carer worked an appropriate number of hours, but it is difficult to see what else he could have done without additional budget or support from the CCG. His goal was to make sure his father's needs were met.

We discussed the duties carried out by a live-in carer with our adviser. They explained that, on top of the daily duties, a live-in carer can get up to a maximum of three times in the night to help the patient. This is known as a 'sleeping night'. If help is needed more than three times in a night, a live-in carer should be paid a 'waking night'. A waking night is defined as an employee staying overnight and working as they would during the day, so there is no chance to sleep. This should have been taken into consideration during the care planning process with Mr R and the CCG.

From the conversations we have had with Mr R, the live-in carer had little opportunity to sleep and rest, apart from on his days off. From the information provided by Mr R for the live-in carer's scheduled and unscheduled duties, and copies of care records, it seems the live-in carer turned Mr Q every two hours and suctioned him approximately 14 times a night.

It appears that Mr Q's care needs changed little, if at all, from day to night. This is supported by the information in the CSPs. The live-in carer should have been paid for a 'waking night' when he was responsible for overnight care. The PHB budgets should have reflected the need for waking night care.

As of 2013 to 2014, and 2015, the CCG set the waking night rate at £10 per hour. In 2016, it set the waking night rate at £15 per hour. It did not allocate a budget for a carer to work waking nights. It should have.

Night-time support

Mr R provided a timesheet to us and the CCG for care provided by additional carers during 2015. This was on top of the care given by the live-in carer and agency care staff during this period. He explains that this was paid for out of his own finances, totalling £10,226.

In its letter of 27 March 2018, the CCG agreed to reimburse Mr R for these costs because it acknowledged there was a gap in domiciliary care being commissioned by the CCG from April to September 2015. Given the CCG's acknowledgement, this gap in funding was a failing.

This resulted in Mr R being £10,226 out of pocket. Mr R has yet to accept this offer, but we consider it appropriate to put this shortfall right. However, this only addresses part of the overall period. Mr Q should have had additional carers for the whole 24 hours, 7 days per week.

Our decision on the budget for the live-in carer from 2016 onwards

The CCG did not provide an adequate budget to fund the level of care Mr Q needed. This falls so far short of the Direct Payment guidance that it is a failing. We have not seen that this affected Mr Q, which is testament to the dedication and care provided by the live-in carer. But we are concerned that the live-in carer has worked, or was expected to work, much more than 10 hours per day. Mr R told us the live-in carer threatened to leave because he was expected to work too many hours. This caused Mr R anxiety and uncertainty over who might have cared for Mr Q. As the required level of care was not budgeted for, this work has effectively been done unpaid or paid for by Mr R. We have made a recommendation to put this right.

The live-in carer's most recent budget

Mr R complains the CCG did not increase the live-in carer's budget in line with inflation and rising costs. The most recent budget the CCG set for the live-in carer was £500 per week. The CCG says it based its calculations on the average cost of a carer performing an eight-hour day. This contradicts the information from the Oxfordshire Budget Setting Tool it used, which calculated the budget based on 10 hours per day. The live-in carer worked a lot more than 10 hours per day.

Our decision on annual pay increases for the live-in carer

In its letter to us dated 30 July 2020, the CCG acknowledged that the live-in carer should have been paid annual uplifts in the hourly rate of care. We accept this is what should have happened, and the budget should have, but did not, include these additional amounts. The CCG added that it has 'amended the rates for the previous financial years 2017/2018, 2018/2019 and 2019/2020 and the differential payment is expected to be made in August 2020'. But it has not done this. We have recommended that it should reimburse this shortfall.

Use of funds in the Personal Health Budget

Mr R complains that the CCG made setting up the PHB a long and difficult process and did not give him appropriate help and support. He says this resulted in the CCG accusing him of mismanaging the PHB and accumulating surplus funds.

The Direct Payment guidance says CCGs should give information, advice and support at every stage of the process, including:

- in discussions about whether to receive direct payments
- in care planning
- in managing and accounting direct payments correctly.

It says it is important to make sure support arrangements are enough to meet the full range of requirements that people receiving direct payments will have.

The guidance gives examples of the sort of support individuals may need. It recommends the CCG specifies the amount of a person's direct payment and how this payment is calculated. It also includes restrictions on how a direct payment may be spent and information on the provision for payroll, training, sickness cover or other employment-related services to help where a person uses direct payments to employ a carer.

The CCG has not provided any evidence of reviews that took place since Mr R received the direct payment on his father's behalf, despite this being part of its policy on monitoring direct payments. Although Mr R confirms financial reviews were carried out, these were sporadic and reported no anomalies. The reviews did not take place as frequently as they should have. This is not in line with the Direct Payment guidance or the CCG's local policy.

Mr R has requested, on several occasions and with support from his advocates, to be given a breakdown of how the budget has been calculated and his responsibilities for what he can spend and on what services. The CCG provided a Final Budget Form but, as far as we can tell, it has not provided a breakdown of how the budget has been calculated. It has only said that it used the Oxfordshire Budget Setting Tool.

We have also requested breakdowns of the budget from the CCG and it provided the same information. We have not seen any evidence of conversations with Mr R about whether the budget is enough. This is an important part of his complaint.

Our decision on the issues relating to the use of funds

From the CCG's internal communication and its correspondence with Mr R, it is clear it has provided limited support to him about what his responsibilities are for a PHB. It also appears that the CCG has failed to monitor his use of funds appropriately. We consider that what it did fell so far short of the requirements that it is a failing in the service provided to Mr R.

This lack of support resulted in confusion about how to spend the money in the budget, and frustration over a long period of time. This was an injustice to Mr R.

In 2018, there was a surplus of around £24,000 in the PHB account. The CCG asked for this money to be paid back because it said Mr R had failed to provide a satisfactory explanation of how these sums built up. It said the money had not been used to secure specified services identified in the care plan and had instead built up in the PHB account.

This was incorrect. The surplus funds were a result of the CCG's mistake. It is understandable that Mr R feels aggrieved by the CCG's accusation that he mismanaged the funds when the fault was the CCG's. This is a further injustice to him. We have made recommendations to put this right.

2015 care support plan

Mr R complains the 2015 CSP is inaccurate because the CCG did not consider that Mr Q needed 24/7 care. Mr R states this went against the Multidisciplinary Team's recommendations and an independent report, which both identified this need. He believes the lack of funding means his father did not receive the hours of care he needed from 2015 until he died.

Mr R is right that the independent report said his father needed 24/7 care and the CSP should have reflected this need. The Direct Payment guidance says the care plan should clearly set out:

- the health needs that the direct payment will address
- the outcomes it intends to achieve
- the services that will be secured by the direct payment to achieve the outcomes.

The direct payments amount should be enough to cover the full cost of the services specified in the care plan.

The 2015 care plan implies that Mr Q needed 2:1 care which equates to 336 hours per week. Care totalling 97.5 hours per day was provided by a nurse to support the live-in carer daily and an additional health care assistant (HCA) on the live-in carer's day off. But this means the live-in carer had to provide care to Mr Q single-handed during the night seven days a week.

Our decision on the 2015 care support plan

We have not seen any indication that Mr Q's needs were different during the night to what they were during the day. It appears that the 2015 care plan does not allow for the required 2:1 care for each 24-hour period. It showed 97.5 hours of care provided by the agency meaning there was a shortfall of 70.5 hours each week, which the live-in carer worked single-handed to meet Mr Q's needs. In total, the shortfall of required care hours each week was 198.5 hours.

The CCG acknowledges that Mr Q needed two carers over a 24-hour period, and that it made a mistake in the calculation of the PHB in terms of carer hours and consequent budgeting to pay for care provision.

We consider that the 2015 CSP does reflect the recommendation for 24-hour care by two carers, but it has only identified Mr Q's care needs for during the day. The problem with this - and with the other CSPs - is that night-time care needs have not been considered, so the budget provided does not allow for this.

We have already taken a view on the impact of this failing and make recommendations on it.

Contingency planning

Mr R complains the CCG did not provide a robust contingency plan to meet Mr Q's needs when the live-in carer was not able to perform his duties, for example, through illness. The CCG told us it had assured Mr R, in December 2013, that contractual arrangements were in place with the domiciliary care provider to provide full support if needed.

The CCG's local policy states that there are several provisions in place to protect customers from potential risks and that a support plan will include contingency planning. It states that support planning will 'assist the customer with any contingency planning, including a backup care provision and ensure that there are sufficient funds in the direct payment account to cover expenses and bills related to the provision of direct payments'.

Mr Q's CSP did not include details for contingency planning. The only reference to this we have seen is in the 2014 Direct Payments Agreement. In this document, the CCG says it 'would need to extend the level of care through [the domiciliary provider at that time] if Private Carer not available'.

The CCG says if the live-in carer was unable to perform their duties, Mr R should have contacted the care agency directly to request cover. The agency would then tell the CCG about the period of cover needed so that it could make arrangements. The domiciliary provider has changed three times over the past four years. The CCG says in each instance the same agreement has been put in place to provide full cover if the live-in carer was not able to fulfil his responsibilities. But the CCG has not provided any evidence of these agreements.

Mr R told us he asked the care agency to provide contingency care, but it refused. We have seen emails from the care agency saying it is not commissioned by the CCG to do this.

Our decision on contingency planning

There was no proper contingency plan in place for Mr Q. This is not in line with the applicable guidance and is a failing.

Mr R says he did not have the budget to source alternative care because he only received a direct payment for the live-in carer's salary. He says he did not have any spare money for additional care because he would still have to pay sick or holiday pay out of the budget he received.

We consider that because contingency funding was not in the care plan it was also not accessible to Mr R. It seems that, if he was to arrange nursing care outside what was listed in the care plan, there was no arrangement in place for him to be reimbursed any costs he may have to pay, leaving him at a financial disadvantage.

Mr R says when he needed to arrange contingency cover, the live-in carer had to extend their hours of working into their rest day, because there was an approximately six-hour delay in providing replacement cover from the agency. He explains that he also had to provide care for his father because there was no one else available. It is unsurprising that this issue has resulted in fear and frustration for Mr R, who is concerned that, at any time, there could be a sudden and serious deficiency in his father's care. We recommend that the CCG takes action to put this situation right.

Care during the live-in carer's annual leave

Mr R complains that the CCG failed to provide the correct level of care to meet Mr Q's assessed needs when the live-in carer was on annual leave. The CCG and Mr R agree it has provided nursing care cover for when Mr Q's live-in carer has been away on extended annual leave. But Mr R says the care provided was not adequate.

The CCG must meet Mr Q's needs if the live-in carer is not available to perform his duties. The Direct Payment guidance says the CCG can provide support from a collective pool of carers. In this instance, the CCG used the care agency who were already familiar with Mr Q.

The CCG arranged shadowing sessions for the nursing agency to make sure the care provision was adequate during the holiday period and sourced registered nurses from the current care agency. Mr R complains that the shadow shifts the CCG commissioned were not enough for the staff to understand his father's needs and left him vulnerable. He says the CCG commissioned 10 hours split over multiple carers, meaning that, because Mr Q requires 24-hour care, the covering staff were not able to cover a 'full shift' to observe his needs.

Our decision on care during the live-in carer's annual leave

We accept that Mr Q had many care needs, some of which were complex. We do not consider that any of those needs, whether individually or collectively, cannot reasonably be addressed by a registered nurse. On arranging for care from registered nurses and arranging for them to shadow shifts in advance to learn more about Mr Q, the CCG did what it should have done.

Clearly, a caregiver who is new to Mr Q would take a little longer to understand his needs and how best to support him. We understand that seeing this shift in the level of familiarity would have been concerning to Mr R, but this does not necessarily mean the care was inadequate.

Mr Q's hospital admission

Mr Q's condition deteriorated and he was admitted to hospital between 15 June and 5 July 2018. Mr R says he had to employ additional staff to meet his father's needs while he was in hospital. He adds that this admission resulted in a financial loss of £4,252.90 because he did not receive funding from the CCG for the additional care his father needed.

There are two parts to this complaint:

- whether the CCG should have paid for staff to care for Mr Q during his admission
- whether the CCG should have continued paying into Mr Q's PHB.

Additional staff during admission

Mr R asked the CCG for funding for a registered nurse to stay with his father and provide 1:1 care while he was in hospital. The CCG told him it does not provide this service and the hospital staff provide all nursing care during admission.

The hospital sent an email dated 18 June 2018 to the CCG asking for additional support. It said the hospital was not staffed sufficiently to meet all of Mr Q's needs. After receiving the email, the CCG reinstated care as per Mr Q's care plan but then withdrew the care the day after without letting Mr R know.

Mr R says he was left with no alternative but to request and finance the nurses working within Mr Q's care package because the hospital did not allocate or assign 1:1 care. We are not able to comment on the hospital's actions because it is not subject to our investigation.

The CCG does not need to agree to a request to provide additional care during a hospital admission. It is not the CCG's responsibility to fill the staff shortages of a hospital to provide care to a patient. It is the hospital's responsibility to make sure a patient's needs are met. If the CCG kept the carers within the PHB and provided care in a hospital setting, it would effectively be paying for the care twice.

Our adviser told us when a PHB holder goes into hospital and wants to use their own carers during their admission, the PHB holder or their representative needs to make an agreement with the hospital for this. This should be done using an Honorary Contract, which outlines insurance cover and what the carers' duties are. There needs to be a clear separation of duties that outlines what the hospital nursing staff should complete and what the private carers should complete.

Personal Health Budget payments during admission

The CCG told us there is no written policy for packages of care to continue when a patient is in hospital. It said these decisions are made on a case-by-case basis. But the CCG's PHB policy says customers who are admitted to a hospital have to pay their carer for up to four weeks after their admission. The amount or retainer will be 80% of their wages and the carer must be available to work during the time the customer is in hospital.

Mr Q's admission lasted less than four weeks. The CCG should have paid 80% of the live-in carer's salary (that is, £400 per week) into the PHB account for the time he was in hospital, but it did not.

Complaint handling: timeliness

Mr R complains the CCG has delayed responding to complaints and did not respond to all the concerns he raised. Our Principles state that organisations should acknowledge complaints and tell the complainant how long they can expect to wait to receive a reply. They add that organisations should regularly inform complainants about progress and the reasons for any delays and provide a point of contact throughout the complaint.

Mr R first raised a formal complaint on 21 October 2014 via an advocacy service. Mr R raised concerns about the PHB not providing sufficient care to his father. There was a complaint resolution meeting on 24 November. The CCG says the complaint was closed after this meeting because it felt it had provided a 'full, frank and detailed discussion regarding the PHB' with Mr R and his advocate which addressed all his concerns. Mr R did not feel that his concerns had been answered and wrote to the CCG on 20 January 2015 outlining the same concerns he raised the previous October.

On 18 May 2015, Mr R's advocate complained that the CCG had not responded to the complaint made in October 2014. The CCG replied on 17 June 2015. It explained that it did not respond to the advocacy service's letter of 21 October 2014 because it emailed a week later withdrawing the complaint. We have seen a copy of the email. It does not say the complaint had been withdrawn, but that consent for the CCG to respond to advocacy service had been withdrawn. The advocacy service advised the CCG to speak with Mr R directly, but it did not.

Our decision on timely complaint handling

The CCG failed to follow our Principles because it did not respond to Mr R's initial complaint in 2014. We acknowledge that it thought the complaint was withdrawn but, given the clear information in the email, we do not consider this to be a valid reason. This is a failing.

Mr R submitted another complaint via Beacon on 5 September 2016. This complaint mirrored the concerns that he submitted in 2014 to which he never received a formal response. The 2016 complaint followed a long appeal where the CCG established and acknowledged that the care package originally provided for Mr Q did not adequately meet his needs.

We established earlier in the report that the CCG paid Mr R £6,600. It does not appear that the CCG made any attempt to liaise with him about any additional reimbursement that he was expecting. The only additional mention of reimbursement by the CCG was in its letter dated 27 March 2018 after Mr R had submitted another complaint.

The CCG sent an acknowledgement on 8 September 2016 noting that it had started an investigation. The CCG also sent a holding letter on 8 November 2016 to say the investigation was still ongoing. It apologised for the delay in providing a full response. It provided a timeframe of two weeks in which it expected to be able to respond in full. We consider that the CCG acted appropriately and in line with our Principles in providing updates for when a response could be expected.

The CCG responded to Mr R's concerns on 5 December 2016. Although the CCG's final response was two weeks later than expected, given the complexity of the issues raised we do not consider the CCG's action in relation to the 2016 complaint to have fallen so far from what should have happened for it to be a failing.

Complaint handling: completeness

Our Principles say organisations should give clear, evidence-based explanations and reasons for their decisions. Mr R says he has never received clear evidence about how the budget was set for his father's care, despite requesting this numerous times. The CCG responded to most of the issues he raised but it failed to provide a clear rationale for how it had set the budget, other than saying it used the Oxfordshire Budget Setting Tool and outlining equivalent local rates.

Our decision on the adequacy of the complaint response

The CCG has not provided transparency in its calculations, either to Mr R or to us. It provided spreadsheets with the final budget but no rationale or evidence to explain how it was calculated or what the figures were based on.

Our Principles say that complaint handling arrangements should be easily accessible to [the CCG's] customers. Not all of Mr R's concerns have been dealt with as a complaint, which means he has had several members of staff from the CCG responding to him.

We have experienced issues with the CCG when staff from the commissioning services have been involved in responding to requests for information. We had to escalate the lack of response on two occasions: 19 December 2019 and 16 July 2020. The delay in responding to our requests appears to be due to commissioning services becoming involved with the complaint and requests for information, instead of the complaints team handling the requests.

Overall, we do not consider that the CCG responded in line with our Principles, which is a failing with its complaint handling. This has led to an unnecessarily long complaint process, which has caused frustration for Mr R.

Summary of the impact we have identified

There were failings in how the CCG handled the PHB and Mr R's complaint. This has resulted in a range of emotional impacts to Mr R, including confusion and frustration.

Over the years, Mr R says the CCG repeatedly failed to recognise or address the physical, emotional and financial burden that has been placed on him and his family. He says they lived in fear and guilt that if they did not find the money or provide additional care themselves to meet Mr Q's needs, he would die.

We have seen evidence that Mr R has had to take time off work, as recommended by his GP, for the stress he was under caring for Mr Q. He has not been able to have a holiday or spend any extended amount of time away from his home environment, for the fear of a scheduling issue with the agency care. He says he has sometimes had to take on the role of a carer to help the live-in carer with his duties when staff have not turned up for their shift.

The CCG's failings resulted in a shortfall of money being paid into the PHB, meaning Mr R was unable to employ a night-time carer to support the live-in carer in caring for Mr Q. This situation continued until Mr Q died.

Mr Q should have received 2:1 care at all times. Instead, he received 2:1 care during the day for some of the week and 1:1 care at night. While there is clear evidence that the live-in carer provided an exceptionally high level of care, he had to do so for unacceptable periods of time and for an unacceptable length of time.

What the CCG has already done to put things right

The CCG was right not to pay Mr R the £45,659.39 he asked for. Instead, it offered him £21,724.98. Exclusive of interest, this included £2,079.84 for supplies, £14,063.89 salary for the live-in carer from March 2013 to February 2015 (this has not been addressed in the report as it is not subject to the complaint) and £10,226 for additional care Mr R had paid for.

The £10,226 reimbursement is straightforward and puts things right for Mr R in terms of reimbursing him for the additional carers he employed from 28 April 2015 to 9 September 2015.

The purpose of the pre-paid card, on which there was a surplus of around £5,500 in March 2018, was for Mr R to buy things like additional supplies needed for Mr Q. It is unclear if and how he used this card but since Mr Q's death the Direct Payments Team at the CCG has closed the PHB account with no outstanding balances.

The Oxfordshire Budget Setting Tool, which the CCG used to calculate the PHB, says a weekly cost may also be included in the indicative budget for supplies (such as gloves and aprons for personal assistants). It does not indicate how much this should be because it would depend on the needs of the individual who receives the PHB. Mr R has claimed £4,045.42 for incidental supplies for the period from March 2013 to February 2015.

The CCG told Mr R it would not normally reimburse supply costs without evidence that they have been paid, but it agreed to fund some supplies that would have been necessary for Mr Q. It acknowledged that Mr R is unlikely to have kept receipts for such items.

The CCG said it was willing to reimburse Mr R £86.66 per month (£20 per week) for incidental supplies from March 2013 to February 2015, which amounts to £2,079.84.

From the budgets we have seen, the CCG allowed £20 per week for using these consumable items. We consider that the CCG's offer, to reimburse Mr R for £20 per week for the period of March 2013 to February 2015, is reasonable. The CCG has not yet paid the agreed £2,079.84 for supplies, due to the ongoing complaints procedure. We make a recommendation about this.

Parliamentary and Health Service Ombudsman

Citygate
Mosley Street
Manchester
M2 3HQ
United Kingdom

Telephone: 0345 015 4033

Textphone: 0300 061 4298

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

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