Local Government
OMBUDSMAN

Parliamentary and Health Service Ombudsman

Report by the Health Service Ombudsman for England and the Local Government Ombudsman on a joint investigation into a complaint made by Mr D

Complaint about: Plymouth Council (the Council)
NHS Plymouth Primary Care Trust (the PCT)

Complaint made by: [X] Solicitors on behalf of Mr D

Health Service Commissioners Act 1993
and Local Government Act 1974

May 2014

Contents

Introduction

1. This is the final report on the investigation into Mr D's complaint about the PCT[1] and the Council. The report contains our findings, conclusions and recommendations with regard to Mr D's complaint.

The complaint

2. Mr D has schizophrenia[2] and Asperger's syndrome.[3] In August 2004 he was discharged from detention under the *Mental Health Act 1983*. From that time he has received a package of 24-hour care to help him lead an independent life in accordance with the provisions of section 117 of the *Mental Health Act*. This care was jointly funded by the Council and the PCT under a partnership agreement (the Plymouth Mental Health Partnership – the Partnership). Until 2009 a care package was provided by an independent care company (the Care Company). Mr D complained (through his solicitor) that the Partnership did not monitor the Care Company effectively in respect of the standard of care and accommodation they provided. He also complained about the PCT's response to his complaints about the Care Company.

3. Mr D said he had to pay a top up to the amount of rent paid to the Care Company, who provided his accommodation from 2004 to 2009. He had no record of what he paid because the Care Company looked after his bank accounts. However, he said he overpaid the sum of £7,500 in rent. Mr D wanted a detailed explanation of how and why the Partnership did not monitor the standard of care provided by the Care Company, and why they did not identify and rectify problems earlier. He sought reimbursement of monies owed to him.

---

1 On 31 March 2013 the PCT was abolished in accordance with the NHS reforms. From 1 April 2013 responsibility for provision of the services complained about transferred to Northern, Eastern and Western Devon Clinical Commissioning Group (the CCG).

2 Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms including: hallucinations (hearing or seeing things that do not exist); delusions (unusual beliefs not based on reality, which often contradict the evidence); muddled thoughts based on the hallucinations or delusions; and changes in behaviour.

3 Asperger's syndrome is a form of autism. Autism, or autistic spectrum disorder (ASD), is a lifelong developmental disability that affects how a person makes sense of the world, processes information and relates to other people. People with the condition have difficulties in three main areas: social communication; social interaction; and social imagination. Its impact can vary widely and some people who have it can live relatively independently, while others have high dependency needs requiring a lifetime of specialist care.

4. The specific matters we investigated were:

    - Mr D's complaint that the Partnership failed to monitor adequately his section 117 aftercare services between 2004 and 2009 while those services were provided by the Care Company. This included monitoring the standards of care and accommodation and the management of his financial affairs. Mr D said that failings by the Partnership meant that his money was misused and he had a poor standard of care and accommodation.

    - Mr D said his concerns about these matters were not adequately addressed by the Partnership and he was left with unsatisfactory and incomplete answers to his complaint.

The decision

5. We find that the monitoring of Mr D's aftercare by the Partnership fell so far below what it should have been that this was service failure. This led to injustice for Mr D. We have also found that the way the Partnership handled Mr D's complaint was so poor that this was maladministration. This led to injustice for Mr D and his family. We therefore uphold the complaint about the Partnership.

Role of the Ombudsmen

6. The Health Service Ombudsman carries out independent investigations into complaints made by, or on behalf of, people who claim to have suffered injustice or hardship because of poor treatment or service provided by the NHS. The Local Government Ombudsman has a similar remit in respect of services provided by councils. Our investigations include consideration of the way in which complaints about services have been handled during earlier stages of the process, and what decisions and actions were taken in the light of the law and of good practice in existence at the time of the actions.

7. Both Ombudsmen look at all the circumstances surrounding a complaint and try to resolve it in a way that is fair. Where we uphold a complaint, we look to the public organisations involved to provide an appropriate and proportionate remedy for the injustice or hardship suffered by complainants.

The Ombudsmen's remit, jurisdiction and powers

General remit of the Health Service Ombudsman

8. The *Health Service Commissioners Act 1993* gives us powers to investigate complaints about the NHS in England. We may investigate complaints about NHS organisations such as trusts, family health service providers such as GPs, and independent persons (individuals or organisations) providing a service on behalf of the NHS. By law, we can require any person to give us information or documents relevant to our investigation.

9. When considering a complaint we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.

10. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether what went wrong was serious enough to be maladministration or service failure.

11. We then consider whether that maladministration or service failure has led to an injustice or hardship that has not been put right. If we find an injustice that has not been put right, we may recommend action. Our recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. We might also recommend the organisation take action to stop the same mistakes happening again.

General remit of the Local Government Ombudsman

12. Under the *Local Government Act 1974*, the Local Government Ombudsman investigates complaints of injustice arising from maladministration and/or service failure by local authorities (councils) and certain other public organisations.

13. The Local Government Ombudsman may carry out an investigation in any manner that is appropriate and may make such enquiries and obtain such information from such persons as she thinks fit.

14. If the Local Government Ombudsman finds that maladministration and/or service failure has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, she may recommend redress to remedy any injustice she has found.

Powers to investigate and report jointly

15. *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* gives the Health Service Ombudsman and the Local Government Ombudsman powers to share information, carry out joint investigations and produce joint reports.

16. In this case, we agreed to work together because the Council and the PCT were jointly responsible for Mr D's aftercare arrangements.

How we decided whether to uphold this complaint

17. We set out in an annex to this report the standards that applied at the time of the events complained about (Annex A).

The investigation

18. We have looked at all the relevant evidence for this case, including Mr D's medical records, and papers provided by the Council and the PCT. We sought comments from the PCT and the Council. Mr D and his solicitor, the Council and the CCG have had the opportunity to comment on a draft of this report.

19. We took advice from one of our clinical advisers – Dr X MB ChB (Hons), MMedSci, MRCPsych, a consultant psychiatrist (the Adviser). Our clinical advisers are experts in their field. In their role as advisers they are completely independent of the NHS.

20. We have not included in this report everything we looked at during the investigation, but we have included everything important to the complaint and to our findings.

Background to the complaint

21. We have set out in an annex to this report a more detailed chronology of the relevant events and documentation related to Mr D's care and the history of his complaint (Annex B). What follows is only a brief summary of the key events.

22. Following Mr D's discharge from detention under the *Mental Health Act* in August 2004, the PCT and the Council (under their partnership agreement) commissioned and funded the Care Company to provide aftercare for him, in accordance with section 117 of the *Mental Health Act*. The Care Company were Mr D's appointees[4] and had responsibility for his financial affairs. He was placed on the enhanced Care Programme Approach (CPA) (Annex A, paragraph 6), which was to be overseen by a care co-ordinator.[5]

23. In November 2007, August 2008 and May 2009, Mr D's family complained to the PCT and the Council about the standard of care and accommodation that the Care Company were providing and about alleged financial irregularities, including that Mr D had been paying a shortfall in his housing benefit and should not have been because his aftercare was provided under section 117 of the *Mental Health Act*. The PCT looked into matters but no formal written responses were sent. In the meantime, in October 2009 the Care Company gave notice of withdrawal from the contract to provide care for Mr D and a new provider was found (the second provider). In February 2010 the PCT agreed to reimburse money that Mr D claimed he had paid on his rent if evidence of those payments was provided. In July the PCT met Mr D and his family and informed them that they considered the original complaint about the standard of care had been concluded in October 2009 when the Care Company withdrew care provision. In October the PCT confirmed this formally. They apologised that it had taken so long to resolve the complaint.

Complaint to us

24. Mr D's solicitor complained to us on Mr D's behalf in February 2011. She said his complaints included the following:

- Mr D was given notice to quit his tenancy; the owner of the property was an employee of the Care Company and one of his carers.
- There was a problem with the bath at the third property where Mr D had lived (property three) and the landlord had the water supply cut off.
- There were then problems with the shower and the landlord did not arrange to repair this, which meant that Mr D had no access to a bath or shower at home for about six months.

---

4 Appointeeship is a term used by the Department for Work and Pensions (DWP). This means that someone else, an appointee, can manage the state benefits of an individual if they are unable to do so either because of mental incapacity or severe physical disability. An appointee can be either an individual (friend or relative) or an organisation (for example, a company, health authority, solicitor, or local authority).

5 A care co-ordinator is a named individual (usually a nurse, social worker or occupational therapist) appointed to co-ordinate the assessment of a person's care needs and the care planning process. The social worker who wrote the CPA and social and housing needs care plans when Mr D left hospital in September 2004 was his first care co-ordinator. A new care co-ordinator was identified in 2005. The next was allocated in 2007, and there were two further changes of care co-ordinators in that year. In 2009, two care co-ordinators were appointed successively.

- Mr D was locked in his home with carers at night and although waking night cover was funded, the carers would go to sleep and leave him awake.
- Mr D was compelled to spend weekends with his parents to get respite from the poor standard of accommodation and the unacceptable situation with the carers.
- Meetings were held between Mr D, his family, the PCT and the Care Company but the concerns raised were not addressed. Instead the PCT suggested reviewing the care plan and reassessing Mr D's needs.
- The Care Company were inappropriately made appointees for Mr D's benefits.
- Mr D paid deposits for private rented accommodation and should not have done. He also paid shortfalls in rent when another tenant he was sharing with moved out, and should not have done.
- The Care Company did not apply for discretionary housing benefit[6] during this time.
- Cash held in the house was not properly accounted for.
- Mr D paid for activities that should have been provided as part of the section 117 aftercare arrangements because they were to meet an assessed need.
- The PCT did not address these concerns.
- There has been no account of the investigation that took place and what action, if any, the PCT took against the Care Company or what they have done to prevent recurrence.
- The PCT said they would reimburse money paid by Mr D if evidence was submitted but obtaining this evidence from the Care Company has been difficult and the PCT would not help to obtain this.

6 Discretionary housing payments come from a fund held by a local council that can be paid in the short term to individuals in financial hardship to help them cover their rent where housing benefit is not enough, or to help them start a tenancy.

The Council's response to us

25. The Council wrote to us on 15 August 2012. They explained that there was no formal contract between the Council and the PCT but under the partnership agreement[7] they provide various services such as assertive outreach, community mental health teams and home treatment teams. The Council explained how the funding for Mr D's care was organised:

> '*Following determination of eligible needs the apportionment of funding between health and social care was agreed using a health and social care matrix assessment tool that was used during this period to identify the financial contribution that the PCT and the Council would make to the cost of the care package. The agreement to proceed with the placement was approved by a panel that included representation from the PCT and the Council. In this case, the funding apportionment reached was initially 30% PCT and 70% Council. In October 2007* … [this] *changed* [to] *15.45% PCT* [and] *84.65%* [sic] *the Council.*'

26. They said it was not clear from their records that anybody other than Mr D was managing his finances in a formal way but his father (Mr D senior) and the Care Company provided support for budgeting. In response to a complaint that the Care Company took money from Mr D's account to pay for his placement, they said they had no evidence to suggest this and they did not know how it could have happened. They pointed out that:

> '*Documentation clearly states that* [Mr D's] *care was funded by s117 and his financial contribution towards this was zero. The Council were the contracting authority and paid* [the Care Company] *directly for care provided and received reimbursement from the PCT for their contribution.*'

27. The Council said that monitoring Mr D's care was the PCT's responsibility because they provided care co-ordination for him under the CPA. In a further letter to us dated 25 October 2012, they said:

> '*the identification of Mr D's need for accommodation was not a need that related to his s117 aftercare. The element of support he received from* [the Care Company] *in relation to his accommodation needs was to identify accommodation for him to rent, not to directly provide him with the accommodation itself, which he paid for through his welfare benefits … .*'

7 Section 31 of the *Health Act 1999* imposed a duty on NHS organisations to develop partnerships with local authorities for commissioning and developing integrated services, for example, for older people or people with mental health problems (paragraph 2).

The Care Company's response to our investigation

28. On 18 October 2012 the Care Company wrote to the Council in response to enquiries we had made to the Council while deciding whether to investigate Mr D's complaint. The Care Company supplied records of Mr D's benefits, records of income and expenditure, records of financial transactions between him and the Care Company, and tenancy details.[8] They said there were some records missing.[9] Their letter included:

> '*The landlord of* [property three] *was at the time an employee of* [the Care Company]. [Our] *understanding … is that prior to being a support worker for* [the Care Company] *he was employed as a Primary Guide for* [the Care Company]. *Primary Guides provided supported accommodation (as both landlord and support provider) as a service that had been commissioned by the local authority. A requirement of this service was that Primary Guides underwent extensive and rigorous checks to ensure suitability. At the time of moving to* [property three Mr D] *had been notified that he would be losing his tenancy at* [property two] *and was at risk of becoming homeless. There is no evidence in* [our] *files regarding any discussions that took place with regard to this placement, however we are not aware that any objections were raised at this time.*'

The PCT's comments to us

29. While we were deciding whether to investigate Mr D's complaint, we made enquiries to the PCT. In a letter dated 14 April 2011 they told us:

> '*… the original complaint was made by* [Mr D's] *stepfather in 2007 and was relating to care being provided at that time. At the time … the PCT did not investigate complaints raised about a commissioned service and therefore* [the Care Company] *were asked to respond …. Through ongoing meetings and correspondence with family members and* [Mr D's] *solicitor other matters have arisen which were not part of the original complaint. …*'

---

8 Tenancy agreements for the following accommodations were provided: property one from 16 August 2004, rent £580 per month for two people. It states in the agreement '*It is a condition that rent payments under this agreement will be paid by* [the Care Company] …'; property two from 2 May 2006, no detail of rental cost (the Care Company were guarantors); property three from 6 November 2006, rent £550 per month (rent payments to be made by the Care Company as appointees on behalf of the tenant); property four from 9 March 2009, rent £67.95 per week.

9 The missing documentation included personal finance (personal expenditure) records dating from 30 August 2006 to 23 January 2007 and from 9 March 2009 to 29 April 2009; house finances (housekeeping costs) from 7 September 2004 to 5 October 2004, 9 November 2004 to 16 November 2004, 7 September 2006 to 3 January 2007, 20 March 2009 to 11 May 2009 and 17 June 2009 to 30 September 2009.

30. In November 2011 Plymouth Community Healthcare (the organisation that had become the lead agency for Mr D's care in October 2011) wrote to us:

> '*The case has been thoroughly reviewed during meetings between NHS Plymouth, providers, legal representatives and the family during the past 4 years. … The concerns relating to financial issues were as a consequence of ongoing meetings … neither of which was part of the complaint made in 2007 and* [have] *therefore not been dealt with through the complaints procedure*.'

They confirmed that:

> '*… the way in which the care provision was monitored as a commissioned service was not to a suitable standard. However, this relates to care provided in 2007. Improvements have been made to how commissioned services are monitored since that time and work remains ongoing in liaison with social care colleagues. … NHS Plymouth has agreed to consider repayment of monies paid on receipt of evidence of these outgoings … .*'

The Council's response to our further enquiries

31. During our investigation we asked the Council to:

- confirm the total amounts of what Mr D paid, what his housing benefit was, and why there was a difference;
- supply a copy of the original section 117 aftercare plan from 2004; and
- provide evidence to corroborate their statement in the letter of 25 October 2012 that the identification of Mr D's need for accommodation was not a need that related to his section 117 aftercare.

32. In a letter dated 6 September 2013 the Council's customer relations manager said:

> *'I can confirm that the Council does not hold a record of the total amount of money that* [Mr D senior] *paid in rent on behalf of* [Mr D]. *We do not keep such records as these relate to the contractual arrangements entered into between landlord and tenant. All tenancy agreements stipulate the requirements of both parties.* [The Care Company] *have provided all paperwork they have relating to this case which does not provide the information you need. As* [Mr D senior] *paid* [his son's] *rent on his behalf I would suggest that he may be able to supply bank statements detailing the amount paid.*[10]
>
> *'I note from your letter that* [Mr D] *states he overpaid his rent "by about £7,500 due to a shortfall in housing benefit". We are aware that the complaint lodged with the NHS by* [Mr D's solicitor] *culminated in a meeting* [between] [Mr D]*, his solicitor and representatives of the PCT. At this meeting an agreement was made by the NHS that if evidence could be provided of an overpayment in rent they would reimburse* [Mr D]. *However, to date no evidence has been provided by the family or the solicitor of this amount. As neither the NHS nor the Council has been provided with this information I would like to request a breakdown of* [how] *this figure has been calculated, together with evidence of payment.*
>
> *'I have discussed* [the point about the identification of Mr D's need for accommodation not being a need that related to his section 117 aftercare] *with … the responsible manager and he has informed me:*
>
> *"this statement was derived from discussion with the social worker who was involved with the aftercare planning at the time, who fortunately is still with the department. The separation of the 'aftercare' from the 'payment of rent' was not explicitly spelt out in any of the care plans or recorded in the notes as far as I am aware. The statement is therefore a reflection of what I 'believe to have been the case' based on my discussion with the social worker, the guiding principles of the code of practice and the fact that a tenancy agreement was entered into by* [Mr D] *and not the council."*
>
> *'… Despite thorough searches neither the NHS nor the Council are able to locate a document specifically titled "aftercare plan". However as previously stated and supplied to you the CPA care plan and the Council's support plan would have been considered to be the relevant documents in this case.'*

10 We note that Mr D and his family have not claimed this.

Clinical advice

33. We have attached the advice on which we have relied at Annex C.

Findings

34. In reaching our findings on Mr D's complaints we have taken account of the Health Service Ombudsman's Principle of Good Administration – '*Getting it right*' – which includes that public organisations must comply with the law and follow their own policy and procedural guidance; and act in accordance with recognised quality standards, established good practice or both, for example about clinical care (Annex A).

Monitoring Mr D's aftercare

35. The first matter we have considered is the way the Partnership monitored Mr D's section 117 aftercare services between 2004 and 2009. This is the complaint put to us by Mr D's solicitor (paragraph 4). We have not considered each of the detailed complaints that they put to us in February 2011 (paragraph 24) but we have looked at the underpinning issue: the actions taken by the PCT and the Council to monitor the services Mr D received in relation to finance, housing and assessment and review of his aftercare.

36. Section 117 of the *Mental Health Act* states a duty for health authorities and local social services departments jointly to provide aftercare services for a person discharged from detention under the *Mental Health Act* for as long as the person needs them. Mr D was discharged from detention under section 3 of the *Mental Health Act* in August 2004. Therefore, in order to 'get it right', the Partnership should have provided aftercare services for Mr D in accordance with the *Mental Health Act*, their reference guide and their local guidance on section 117 aftercare (Annex A). We have also taken account of the clinical advice received on established good practice in reaching our findings (Annex C).

37. The national and local guidance states that the needs of the person detained (including their immediate mental and physical health care, as well as accommodation and other social care needs) should be assessed while they are in hospital, and an aftercare plan should be recorded. While Mr D was still in the psychiatric unit, a social worker started to prepare for his discharge. In September 2004, he completed a CPA care plan, as Mr D was placed on the CPA programme (Annex A, paragraph 6, Annex B, 3 September 2004). He also completed a social care assessment. These documents set out the expectations of the care to be provided for Mr D, such as that he was to have a 24-hour care package provided by the Care Company. However, we could find no separate section 117 aftercare plan that showed all Mr D's identified aftercare needs on discharge from hospital and how they would be met. This was a failure to follow the applicable guidance.

38. The national and local guidance also states that the aftercare plan should be reviewed every six months. We found only three section 117 reviews (dated 19 November 2007, 16 January 2008 and 14 August 2009) for Mr D for the entire five-year period from 2004 to 2009. The reviews in November 2007 and January 2008 appear to have been prompted by complaints made by Mr D's family. Our Adviser said the reviews were both '*perfunctory*'. The review in August 2009 also appears to have been carried out in response to the complaint in May that year about Mr D's finances, because when discussing the complaint it became apparent that there had been no section 117 review since January 2008 (Annex B, 5 June 2009). Our Adviser said the section 117 review in August 2009 was more of a complete reassessment due to the lack of an original aftercare plan and the lack of regular reviews of the arrangements in place for Mr D's aftercare.

39. Plymouth Community Healthcare (the lead agency for Mr D's care in 2011) told us they accepted there had been poor monitoring in 2007 but that improvements were made thereafter (paragraph 30). However, it is clear that the problems with monitoring continued into 2009: there were only two section 117 reviews in that time. Again, this was a significant failure to follow the applicable guidance over a considerable period of time.

40. We find it very concerning that there was almost a complete lack of section 117 reviews, given that: the purpose of such aftercare is to prevent deterioration of a person's mental health and support their reintegration into the community; that it was known back in 2007 that there were concerns about the care being provided by the Care Company; and that the commissioners of Mr D's care package were accountable for the money they spent in this respect. We conclude that, as there was no separate aftercare plan for Mr D, and no regular or adequate monitoring of Mr D's section 117 aftercare from 2004 to 2009, this was so far below the applicable standards that it amounts to service failure by the Partnership.

Injustice to Mr D

41. The consequences of this service failure were significant. Mr D said that as a result of the failure to monitor his aftercare, he had a poor standard of care and accommodation, he had to pay a shortfall in the rent for his accommodation, and his personal money was misused.

42. The Council told us that accommodation was not part of Mr D's aftercare plan, and the Care Company's role in this respect was only to find somewhere suitable for him to rent. If that was the case, it ought to have been recorded in the aftercare plan (had there been one) and we could not find this specified in any of the other discharge documentation written at the time. On the contrary, we believe that the documentation from May to September 2004 indicates that accommodation **was** a consideration in Mr D's aftercare planning, for the following reasons:

- The memo of 25 May 2004 is about funding for a **residential** placement for Mr D. It was understood that '*all and any aftercare arrangements*' could not be charged to him. The memo stated that the entire package would cost £1,785 per week but this was a '*worst case scenario*' if there was nobody to share the accommodation costs (Annex B).

- An earlier memo of 18 May 2004 showed that the £1,785 figure **included** rental of property (Annex B).

- The CPA care plan dated 3 September 2004 stated that Mr D required a '*therapeutic living environment*' and the social and housing services care plan of the same date stated that the aim was to move Mr D to '*supported community living*' and that by the time of the next review he would be settled in '*his new home @* [property one] *under the care & supervision of* [the Care Company]' (Annex B).

- The '*Individual Service User Contract*' of 7 December 2004 for the purchase of residential services (separate from the contract for the purchase of day services) showed that the care being purchased was a 24-hour supported living package provided by the Care Company, costing £1,785 per week and that Mr D's contribution towards this care package was nil (Annex B).

43. It is our view, therefore, that the original intention was for Mr D to have accommodation and its cost included as part of his aftercare. In other words, it was an identified need. The confusion over how this need should be met was in consequence of the Partnership's failure to specify this need clearly in a separate section 117 aftercare plan at the time of discharge.

44. The PCT agreed to reimburse Mr D for the money he had paid to cover the housing benefit shortfall, subject to proof. We believe there is sufficient supplementary documentary evidence to support Mr D's claim that he was (wrongly) expected to cover the shortfall, that such payments must have been made, and so proof of payment was not the issue. We base this on the following evidence:

    - The Care Company's staff accepted the account of the complaint as put: that Mr D covered the shortfall in housing benefit at property one and that he paid double rent for a period of time (Annex B, 8 June and 6 July 2009).

    - The Care Company explained how this happened at a meeting with mental health staff (Annex B, 6 July 2009).

    - The Care Company supplied documentation showing the rent paid and the housing benefit awarded (Annex B, 6 July 2010).

    - Nobody at the PCT or the Council appears to have analysed this data to confirm what it shows.

    - Mr D's solicitor analysed the data and said it showed that the total housing benefit shortfall covered by Mr D was £8,074.21 (Annex B, 5 and 6 July 2010).

- The fact that the PCT agreed to reimburse Mr D (subject to proof) indicates that they recognised he should not have covered the shortfall in the first place (Annex B, 8 February 2010).

45. We conclude that Mr D should not have been charged for his accommodation at all and that he was erroneously charged the shortfall in his housing benefit. These charges were in consequence of the failure to have a clear aftercare plan in place and the failure to monitor the aftercare arrangements.

46. The system put in place for Mr D's household finances was the use of tins into which money was voluntarily paid, or taken out, as required. The figures were recorded in ledgers but some of the data is missing (footnotes 8 and 19). Irrespective of that, the system was open to abuse, although we cannot say whether such abuse occurred. The Care Company acknowledged that Mr D had somehow opened two personal bank accounts and that he had incurred an overdraft on one of them (Annex B, 8 June and 6 July 2009). This should not have happened if they were properly helping him to budget effectively. The Care Company acknowledged that this was unacceptable (Annex B, 6 July 2009).

47. There were serious problems with the standard of accommodation Mr D had at property three, where he lived for over two years. It was acknowledged that there were no bathing facilities for six months and there were tensions with the landlord, who was also Mr D's carer (Annex B, 8 June and 6 July 2009). Again, the Care Company acknowledged that this was unacceptable (Annex B, 6 July 2009). It was certainly not the '*therapeutic environment*' envisaged for Mr D's aftercare.

48. Mr D's family also raised concerns about the adequacy of the therapeutic and developmental input provided for him. These were important aspects of his section 117 aftercare and the problems with them were not identified soon enough due to the lack of reviews. (We note that these concerns were not directly addressed by the PCT in their response to Mr D's family's complaints – see our separate findings on the PCT's complaint handling.)

49. It was not possible to assess Mr D's needs accurately or to check how or whether his needs were being adequately met without a clear aftercare plan and regular monitoring. Mr D is a vulnerable person who should have received the support and services he needed from the Partnership. Instead, he was placed in unsuitable accommodation for a prolonged period; he was wrongly charged for his accommodation; he was put at risk of financial exploitation; and his finances were managed inappropriately by the Care Company. This poor standard of aftercare was in consequence of the Partnership's service failure.

The PCT's handling of Mr D's complaint

50. The second matter we have considered is how the PCT and the Council dealt with Mr D's complaints about his aftercare. Mr D complains that his concerns were not adequately addressed and that he has had unsatisfactory and incomplete answers. In order to 'get it right', the PCT and the Council should have acted in line with our Principles of Good Complaint Handling: '*Being customer focused*' – which includes that public organisations should deal with complaints promptly, avoiding unnecessary delay, and keep the complainant regularly informed about progress and the reasons for any delay; and '*Being open and accountable*' – which includes that public organisations should give clear, evidence-based explanations, and when things have gone wrong they should explain fully and say what they will do to put matters right as quickly as possible (Annex A).

51. Mr D's family made complaints on his behalf to the PCT and the Council in 2007, 2008 and 2009 about the standard of care provision by the Care Company, his accommodation and his finances. There was no specific contract for the Partnership between the PCT and the Council, but the Council appear to have accepted that the PCT would investigate the complaints on their behalf because the PCT were managing Mr D's care (Annex B, 6 August 2008). The Council were, nevertheless, responsible for the joint resolution of the complaint.

52. The chronology at Annex B (and other papers we have seen) show that much work was done by the PCT's complaints manager to try to address the complaints as they arose. A review of the commissioned care was arranged in October 2007, and a case conference was arranged to look at whether the best care was being provided for Mr D in February 2008.There is evidence that PCT staff considered how to protect Mr D from incurring any other financial debt when that issue arose (Annex B, 13 May 2009). These were appropriate responses to the concerns raised but there was a significant lack of progress resulting from these activities and few updates were given to Mr D and his family. This was not customer-focused. The activities and discussions also did not seem to lead anywhere. At the many staff meetings or discussions held in 2009 (15 January, 17 February, 5 and 16 June, 6 July and 14 August), the problems raised were frequently discussed and acknowledged and it was noted several times that there was a lack of aftercare reviews and that the care co-ordinators were not doing their jobs. Discussions and meetings also revealed a lack of knowledge about what Mr D's care needs were and what his care plan should have included (for example, on 12 December 2008, 15 January, 5 and 25 June, 21 July and 14 August 2009, and April 2010). The problems were recognised but not resolved.

53. In May 2009 the PCT asked the Care Company for a specific response. They investigated and sent a statement to Mr D senior on 8 June 2009. This set out their position on some of the matters raised. An assistant clinical manager from the PCT who became involved with the investigation gained detailed information at a meeting with the Care Company's staff on 6 July 2009. This explained how the housing benefit shortfall had occurred, and set out what the tenancy/accommodation and finance problems were. The Care Company acknowledged these problems and recognised that some of the situations that occurred were unacceptable. Some of this information was explained to Mr D and his family at a meeting on 7 September 2009.

54. It was reasonable for the PCT to ask the Care Company to investigate matters that concerned them directly, but the PCT – as the commissioners of Mr D's aftercare with the Council - should have synthesised the information that came out of the various discussions; taken the responsibility for resolving those problems; and informed Mr D and his family in writing of the actions they were taking to prevent recurrence, in line with '*Being open and accountable*'. The meeting on 7 September 2009 was ostensibly to update Mr D and his family about the investigation, but inexplicably at that time the PCT decided to carry out further investigations. The PCT reiterated this commitment in a letter dated 2 October 2009. At a staff meeting on 8 February 2010 the PCT recognised that the new care package from the second provider was working well and the only thing outstanding was the reimbursement issue. At a final meeting in July 2010 the PCT declared that the original complaints about the standard of care were concluded in October 2009 when the Care Company withdrew from their contract. They said nothing about the promised further investigation. They sent Mr D a formal written response on 18 October 2010 in which they stated that local resolution was complete.

55. Although the new care package signalled a good outcome, the PCT should still have provided detailed answers to the complaints made. However, their letter did not do so. It did not address at all the concerns about the adequacy of Mr D's therapeutic and developmental input and it stated that the finance issues were a separate matter, not a complaint. As such, several aspects of Mr D's complaints have never been fully addressed. In line with '*Being open and accountable*' the Council should have been copied into the final response and they should have told Mr D whether they accepted the PCT's findings. There is no evidence that this happened.

56. As we said at the outset, there is evidence that appropriate actions were taken in response to Mr D's complaints and some detailed investigative work revealed answers and explanations for some of the things that went wrong in Mr D's care. However, given the protracted time and lack of progress when considering the complaints; the lack of updates; the lack of substantive explanations despite information having been gathered; the failure to address some issues; and the failure to acknowledge responsibility for all the things that went wrong in Mr D's aftercare, we consider that the PCT's complaint handling on behalf of the Partnership was not in accordance with the Principles of Good Complaint Handling. We conclude that it was so far below the applicable standards that it amounted to maladministration.

Injustice to Mr D

57. The injustice to Mr D is that the response to his complaints did not lead to adequate or prompt improvements in the standard of services he was receiving.

Conclusions

58. Having studied the available evidence and taken account of the clinical advice provided by the Adviser, we find that the monitoring of Mr D's aftercare by the PCT and the Council fell so far below what it should have been that this was service failure. We have also found that the way the PCT handled Mr D's complaint was so poor that this was maladministration. This service failure and maladministration led to injustice for Mr D. We therefore uphold Mr D's complaint about the PCT and the Council.

Recommendations

59. In making our recommendations, we have taken account of the Health Service Ombudsman's Principles for Remedy and in particular:

- '*Being customer focused*' – which includes quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship.
- '*Seeking continuous improvement*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation).

60. We recommend that, within a month of the date of the final report on this investigation, the PCT and the Council should:

    a. write jointly to Mr D to acknowledge the service failure (paragraph 40) and maladministration (paragraph 56) we have identified and apologise for the injustices (paragraphs 43 to 49 and 57) he suffered in consequence; and

    b. each provide financial redress to Mr D, not only for the distress and inconvenience he suffered due to poor living conditions and prolonged periods of inadequate aftercare (paragraphs 43 to 49), but also as a remedy in respect of money he should not have had to pay. While we accept that there is no absolute proof to verify the sums that Mr D claims he paid towards rent and non-refundable deposits, we note (Annex B, 5 and 6 July 2010) that his solicitor made a serious attempt, using data provided by the Care Company that the Partnership commissioned, to calculate the extent of the potential financial shortfall Mr D suffered. On the balance of probability we find the solicitor's calculations to be credible and we note that neither the PCT nor the Council have been able to undermine those calculations, since the data sources they would need to do that (systematic and properly kept records) are not available because of inherent failings in the monitoring of the service that they commissioned. Taken as a whole therefore, we believe that the PCT and the Council should provide a total financial remedy to Mr D of £12,000 split equally between both organisations.

A copy of the letter of apology and evidence of payment to Mr D should be sent to us.

61. In order to ensure that appropriate lessons are learnt from this complaint, we recommend that, within three months of the date of the final report, the PCT and the Council should tell us:

    - what they have already done to ensure they have learnt the lessons from the failings identified (paragraphs 40 and 56) by this upheld complaint; and

    - what steps they plan to take, including timescales, to avoid a recurrence of these failings in future.

62. The PCT and the Council should send a copy of the action plan to Mr D; [X] Solicitors; both Ombudsmen; and NHS England (Devon, Cornwall and Isles of Scilly local area team). They should ensure that NHS England are updated regularly on progress against the action plan. As noted in footnote 1 of this report, on 1 April 2013 the CCG became responsible for the provision of services previously provided by the PCT. We look to them to take forward the actions to implement the recommendations made to the former PCT.

Comments by the CCG and the Council at the draft report stage

63. On first seeing a draft of this report, the CCG wrote to us on 12 February 2014. They said that they and the Council acknowledged the service failure and maladministration identified in paragraphs 40 and 56 of the report and they accepted our recommendation to apologise to Mr D and to draw up action plans. However, they did not agree to reimburse Mr D for money paid for his rent (which was a separate recommendation in the draft report on our investigation) without proof of payment. They did not accept that providing accommodation was part of Mr D's section 117 aftercare plan, although they accepted that this should have been clearer in his records. They said the PCT had originally agreed to reimburse Mr D only for rent paid to cover the shortfall created at property one when the second tenant left. They understood that Mr D senior had paid this shortfall. They said their legal advice was to make no payment until they had received evidence that Mr D had paid it himself. They said they were aware that payments had been made, but not who had paid them. They said that Mr D's benefits included a figure to cover his rent.

64. We asked the Council and the CCG for evidence to support their contention that accommodation was not part of Mr D's aftercare plan. On 24 March 2014 the Council supplied documentation we had already seen during our investigation. The Council said that Mr D's accommodation was not in itself '*aftercare*' and it was a principle '*well established in case law*' that '*all individuals require accommodation irrespective of whether they have needs arising from mental disorder*'. We informed the CCG and the Council that we had carefully considered all their comments but this did not lead us to alter our findings and recommendations. However, after further negotiation, the CCG and the Council agreed to our recommendations for overall redress.

Final remarks

65. In this report we have set out our investigation, findings, conclusions and decision with regard to Mr D's complaint.

Dame Julie Mellor DBE
Parliamentary and Health Service Ombudsman

Dr Jane Martin
Local Government Ombudsman

May 2014

Annex A: The relevant standards in this case

1. The Health Service Ombudsman's Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[11] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

2. The Principle of Good Administration particularly relevant to this complaint is:

    - *'Getting it right'* – which includes that public organisations must comply with the law and follow their own policy and procedural guidance; and act in accordance with recognised quality standards, established good practice or both, for example about clinical care.

3. The Principles of Good Complaint Handling relevant to this complaint are:

    - *'Being customer focused'* – which includes that public organisations should deal with complaints promptly, avoiding unnecessary delay, and keep the complainant regularly informed about progress and the reasons for any delay.

    - *'Being open and accountable'* – which includes that public organisations should give clear, evidence-based explanations, and when things have gone wrong they should explain fully and say what they will do to put matters right as quickly as possible.

Mental Health Act 1983

4. Section 3 of the *Mental Health Act 1983* allows a patient to be compulsorily detained in hospital for treatment where two registered doctors agree that it is necessary. Section 117 of the *Mental Health Act 1983* states that where a patient has been so detained and leaves hospital, it is the duty of the health authority and the social services authority to provide aftercare services until such time as the authorities are satisfied that the person concerned is no longer in need of such services. It is a requirement that the person subject to section 117 of the *Mental Health Act 1983* should have a jointly agreed individual aftercare plan.[12]

11 The detail about our Principles can be found at: www.ombudsman.org.uk.

12 In 1999 the High Court held that charges should not be made for aftercare services, including accommodation provided under section 117. In 2000 the Department of Health issued advice (LAC (2000)3) to councils and health authorities confirming that aftercare services should not be charged for and requiring that health authorities and social services authorities should issue jointly agreed local policies on providing section 117 aftercare.

5. There is guidance related to the *Mental Health Act – Mental Health Act Code of Practice* published in 2008. Although this post-dates Mr D's discharge from hospital, it is relevant for the subsequent reviews of his aftercare. Chapter 27 covers the duty to provide aftercare for patients under section 117. It includes:

'*27.4 Services provided under section 117 can include services provided directly by PCTs or LSSAs* [local social services authorities] *as well as services they commission from other providers.*

'*27.5 After-care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills, or learning new skills, in order to cope with life outside hospital. …*

'*27.8 … the planning of after-care needs to start as soon as the patient is admitted to hospital. …*

'*27.11 … it is important that all patients who are entitled to after-care under section 117 are identified and that records are kept of what after-care is provided to them under that section.*

'*27.12 In order to ensure that the after-care plan reflects the needs of each patient, it is important to consider who needs to be involved, in addition to patients themselves. This may include:*

- *the patient's responsible clinician;*
- *nurses and other professionals involved in caring for the patient in hospital;*
- *a clinical psychologist, community mental health nurse and other members of the community team;*
- *the patient's GP and primary care team;*
- *subject to the patient's views, any carer who will be involved in looking after them outside hospital, the patient's nearest relative or other family members …*

'*27.13 A thorough assessment is likely to involve consideration of:*

- *continuing mental healthcare, whether in the community or on an out-patient basis;*
- *the psychological needs of the patient and, where appropriate, of their family and carers;*
- *physical healthcare;*
- *daytime activities or employment;*
- *appropriate accommodation;*
- *identified risks and safety issues;*

- *any specific needs arising from, for example, co-existing physical disability, sensory impairment, learning disability or autistic spectrum disorder;*
- *any specific needs arising from drug, alcohol or substance misuse (if relevant);*
- *any parenting or caring needs;*
- *social, cultural or spiritual needs;*
- *counselling and personal support;*
- *assistance in welfare rights and managing finances …*

'*27.17 The after-care plan should be recorded in writing. Once the plan is agreed, it is essential that any changes are discussed with the patient as well as others involved with the patient before being implemented.*

'*27.18 The after-care plan should be regularly reviewed. It will be the responsibility of the care co-ordinator (or other officer responsible for its review) to arrange reviews of the plan until it is agreed that it is no longer necessary.*'

Care Programme Approach

6. The Care Programme Approach (CPA) is a specific way of assessing, planning and reviewing a person's mental health care needs. Individuals should be involved in the assessment of their own needs and in the development of the plan to meet those needs. The person should be informed about their different choices for care and support available to them. There should be a formal written care plan that outlines any risks and includes details of what should happen in an emergency or crisis. A CPA care co-ordinator (usually a nurse, social worker or occupational therapist) should be appointed to co-ordinate the assessment and planning process. The care co-ordinator should make sure that the care plan is reviewed regularly. A formal review should be made at least once a year. This should consider whether CPA support is still needed.

Local guidance

7. The Plymouth Mental Health Partnership have a joint operational policy guidance for section 117 aftercare. The policy dated July 2002 was the one in use at the time of Mr D's initial move from an acute psychiatric unit (the psychiatric unit) to section 117 care in the community. Under the heading '*Planning for aftercare*' it states:

'*The RMO* [responsible medical officer[13]] *will convene a multi-agency review/section 117 meeting to plan the aftercare and a designated care co-ordinator will be identified. … The current CPA care plan replaces any other paperwork. The care plan must reflect the identified needs of the patient and must specify how these needs will be met, who will be responsible for action, and a review date. …*

'*Providing all of the following points are dealt with in the 117 meeting, there should be no reason to have separate CPA and discharge meetings.*

'*The aim of the meeting is to draw up an after-care plan, based on the most recent multi-disciplinary assessment of the patient's needs. Those concerned must consider the following issues:*

'*… a care plan based on proper assessment and clearly identified needs* [similar to the list in the *Mental Health Act Code of Practice* – Annex A, paragraph 5].

'*When the care plan is agreed, the team should ensure that a care co-ordinator is identified to monitor the care plan. … Joint funding arrangements for the after-care plan must be agreed before the after-care plan is put in place.*

'*Duties of the care co-ordinator*

'*… The care co-ordinator is responsible for reviewing all patients subject to section 117 aftercare at the minimum of 6 monthly. This is done at CPA reviews with all involved personnel, including* [*the responsible medical officer*]*, social care staff, and relevant agencies involved in the aftercare.*

'*Identification and report of deficiencies for aftercare provision*

'*Any deficiencies should be reported to local managers initially and a service development need form should be submitted to the Mental Health Act office … .*'

13 Since 2008 this role is now termed 'responsible clinician'.

Annex B: Chronology of events

2004

18 May – While Mr D was still in hospital his then social worker completed a needs assessment and cost calculation for a care package for him once he was discharged in accordance with section 117 of the *Mental Health Act*. The figure for this was £1,785 inclusive of staff hours to supervise him day and night and rental of property.

25 May – The social worker wrote a memorandum to Council and PCT colleagues headed '*Funding for residential placement for* [Mr D] …'. This states:

> '*It is currently planned that, upon discharge from the* [psychiatric] *Unit, the above young man will be cared for within a dedicated residential placement created by* [the Care Company]*, to meet his very specific needs. …*
>
> *'Letters from* [the Care Company] *outlining their projected care package are enclosed for your information and you will note the cost of this package is currently estimated at £1785 per week.*
>
> *'This is a "worst case" scenario based on there being no other suitable patient available to share residence with* [Mr D]. …
>
> '*… The client's individual DSS benefits.* [Mr D] *is currently subject to section 3* Mental Health Act 1983 *and will therefore be discharged under section 117 Discharge Protocol. As such, the costs of any and all aftercare arrangements cannot be charged to the client and therefore* [Mr D's] *DSS benefits cannot be taken into consideration.*'

3 September – The social worker drew up a social and housing services care plan for Mr D. The stated aim of this was to '*Move* [Mr D] *from long stay hospital detention in the* [psychiatric] *Unit to supported community living*'. This was to be achieved by moving him '*from ward detention to the care of* [the Care Company] *in a dedicated community care project with 24 hr supervision as part of a specific, post "discharge", supported living package …*'. By the time of the next review, it was expected that:

> '[Mr D] *should have moved to his new home @* [property one] *under the care & supervision of* [the Care Company] *staff working to a specific interventive care package. It is hoped that* [Mr D] *will have settled well into his new living arrangements and that progress will have been made with regard to addressing* [Mr D's] *Asperger presentation.*'

A CPA care plan was also drawn up showing that Mr D was on the 'enhanced' programme. One of the specified aims of the care plan was '*to provide* [Mr D] *with an appropriate, ongoing, therapeutic living environment*'.[14]

14 There does not appear to have been a separate section 117 aftercare plan drawn up at this time.

7 December – An '*Individual Service User Contract for the Purchase of Residential/Nursing care services*' form issued by the Council's department for social and housing services was completed for Mr D's care package. It showed that the care being purchased was a 24-hour supported living package provided by the Care Company costing £1,785 per week and that Mr D's contribution towards this care package was zero.[15]

2007

27 October – The partner of Mr D's mother wrote to Mr D's social workers to complain that the Care Company staff were essentially '*baby-sitting*' him rather than doing anything to stimulate or help develop him. This letter was forwarded to the PCT.

16 November – The PCT considered that Mr D did not have the mental capacity to consent to their releasing information about him to his mother's partner, and that authorisation from a healthcare professional was required. The PCT wrote to inform Mr D of this. In view of the concerns raised, the PCT decided to review the Care Company's care provision as they were commissioning it.

19 November – There was a section 117 review meeting.[16] The record of the meeting stated under '*Areas to be covered*':

> '*1. Social circumstances – housing: … The accommodation is rented, and it is stated on his CPA review that he was happy with* [the Care Company]. … *Finances:* [Mr D] *has been in receipt of Disability Living Allowance since 2004. After essential bills are paid out of* [Mr D's] *money, he has a monthly allowance of £102 approx'*. It was concluded that the current arrangements should continue.

2008

16 January – There was a section 117 review meeting. It was concluded that the current treatment and care was '*very beneficial*' to Mr D and should continue.

18 February – The PCT wrote to the acute mental health service suggesting a case conference and further assessment to see if the best care was being provided for Mr D. No progress was made on this until PCT staff chased this up in June.

5 August – Mr D senior complained to the Council about the provision of care by the Care Company and the standard of accommodation. He complained that there were frequent changes of address, which was unsettling for his son; the landlord at one time had been a carer employed by the Care Company who had harassed Mr D; and there was no access to a bath or shower at that property for nearly six months due to the need for repairs.

---

15 Note: there is a separate contract dated 6 September 2004 for 'the Purchase of Day Opportunities and/or Domiciliary Care Services'.

16 There are no records of any section 117 aftercare review meetings before this time.

6 August – Internal emails between the Council and PCT confirmed that the PCT were managing Mr D's care and that the Council's responsibility was discharged through the partnership agreement.

15 August – The PCT's complaints manager emailed colleagues to confirm that a case conference would be arranged to discuss how to deal with Mr D senior's complaints.

24 September – Mr D's solicitor wrote to the PCT in support of the complaint about his care provision. She supplied more detail about the accommodation problems. She said that earlier complaints had not been addressed.

14 October – A social worker who had become Mr D's care co-ordinator informed the PCT of the date for the case conference to discuss Mr D's care. There were then problems getting people to attend the meeting.

12 December – The meeting to consider Mr D's case was held. It was recognised that accommodation and tenancy issues were outstanding and that there was a need for a mental capacity assessment for Mr D. There were ongoing issues with the adequacy of provision of care by the Care Company and about what Mr D's clinical needs were. It was agreed that Mr D's care would be overseen by his care co-ordinator.

2009

15 January – The PCT and the Council held a joint follow-up meeting. Agreed actions included assessing Mr D's current care and accommodation needs; a summary of the care provided by the Care Company; the costs of the care package; to check on whether there had been a capacity assessment for Mr D; to establish whether a section 117 aftercare meeting had yet occurred.

February – Mr D's solicitor requested for a copy of his records relating to his placement and the provision of his care package from the Care Company.

17 February – The PCT checked the progress made on the action plan drawn up in January. They acknowledged that Mr D's care co-ordinator had been absent for some time and a new care co-ordinator was asked to review his case.

21 April – Mr D's solicitor wrote to the PCT about the outstanding complaints. She said Mr D was now in new accommodation but the problems with the Care Company had not been addressed.

23 April – The PCT's complaints manager emailed colleagues to try to arrange a follow-up meeting to discuss the complaints. She said '*This is now an urgent situation and a meeting is a priority*'.

5 May – Mr D senior wrote to the social worker. His letter included:

> '*There is also a new issue of an internal debt to* [the Care Company] *caused by them agreeing to his renting a property at £550 pcm from one of their employees and now saying he owes the difference between his Housing Benefit and that rent. They made no attempt to apply for discretionary monies from Housing Benefit on his behalf; ran a debt on his account, under their appointeeship; and now want him to pay back this "internal" debt.*'

13 May – At a staff meeting an action point was recorded that:

> '*Clarity* [is] *needed on the finance issues from* [the Care Company] *and* [to] *advise* [Mr D] *to stop paying any further monies to* [the Care Company]. … *If* [The Care Company] *have a problem with* [Mr D] *not paying then ask them to contact* [the adult social care team leader].'

22 May – The consultant psychiatrist in charge of Mr D's mental health care wrote to the PCT's assistant director of commissioning saying:

> '… [the Care Company] *have informed* [Mr D] *that he is £1,600 in personal debt, and this is in addition to a £1,000 overdraft, that may be the result of* [the Care Company] *staff accessing* [Mr D's] *personal account via a debit card. It seems that* [Mr D] *is getting a range of housing benefits to fund his placement, despite my understanding that he was funded under 117. The £1,600 deficit was due to a higher rate of rent than* [Mr D is] *provided for.*'

5 June – At a CPA review it was noted that there had been no aftercare documentation since 2007 and no aftercare plan; and that the last section 117 review was in February 2008.[17] The action plan included: care co-ordinator to be a social worker; the care package from the Care Company and provision of section 117 aftercare to be clarified; confirmation of the percentages of payment for rent and for care; and the financial issues to be investigated.

8 June – In response to the complaints raised, the Care Company wrote to Mr D senior enclosing a statement from the current service manager. The statement included:

> '[Mr D] *has been supported by* [the Care Company] *for several years. He currently is supported in his own house for 102 hours per week with sleep-in support every night.* [Mr D] *has some mental health difficulties which require constant monitoring.*
>
> '*I became aware of a number of issues last year. These were:*
>
> 1. [Mr D] *had, allegedly, caused damage to his flat (causing water damage in the bathroom). This resulted in his landlord serving an eviction notice.* [Mr D senior] *said that* [Mr D] *was not being 'managed' properly or the damage would not have occurred. The change of Service Manager … had seen a marked improvement in the general running of the service and this was agreed by* [Mr D senior].
> 2. *It came to light last winter that* [Mr D] *had, somehow, run up a sizeable overdraft, amounting to about £1000.* [Mr D senior] *was, understandably, very concerned about how* [Mr D] *had been able to do this when he has 24 hour support. We have not been able to establish, despite concerted efforts, who, if anyone, had assisted* [Mr D] *to do this.*

17 The records show that the section 117 aftercare review was in January 2008, not February.

3. *On applying to become* [Mr D's] *appointee* [Mr D senior] *was made aware of a considerable debt owed by* [Mr D] *to* [the Care Company]. *This appears to be mostly rent shortfalls paid to* [the Care Company].

4. *I have tried to work positively with* [Mr D senior] *and have met him several times. I have always responded quickly to his concerns and, on several occasions, believed we had made progress and sorted things out to his satisfaction.'*

The service manager went on to list some difficulties that the Care Company staff said they were having in providing care for Mr D. These included differences of opinion between staff and Mr D's family about what care should be provided and some staff had decided that they preferred not to work with Mr D.

16 June – The PCT met Mr D and his family. Mr D raised concerns about the rent he was being charged by the Care Company. A new care co-ordinator reviewed Mr D's clinical records and found the care plans and assessments were out of date.

24 June – Mr D's solicitor wrote to the PCT's complaints manager chasing progress on the response to the complaint.

25 June – An assistant clinical manager at the PCT wrote to Mr D's solicitor saying that a multidisciplinary meeting would be helpful to discuss what should be provided as part of the section 117 aftercare.

6 July – Mr D's social worker and the assistant clinical manager had a meeting with the Care Company's staff to discuss the problems that had been complained about. The notes of the meeting included the following:

> '*The original* [care package] *agreement was that* [Mr D] *would be living with another individual in a shared house and* [the Care Company] *would be commissioned to provide a 24 hr service to both individuals. However the second individual did not move in leaving* [Mr D] *… solely responsible for the rent of a property for two people. His housing benefit did not cover the full amount of the rent.*
>
> '*A subsequent move to* [property three was] *unsatisfactory* [as Mr D] *was living in property … owned by* [an employee of the Care Company] *… who was directly involved in the delivery of* [Mr D's] *care package and he resided next door …*
>
> '[The Care Company's area manager] *… accepts that the arrangement was not an acceptable one.*
>
> '*… at this property,* [Mr D] *unfortunately flooded the bathroom. … the insurance covered the … damage …* [but] *the landlord is now debating with* [Mr D senior] *the cost of additional repairs that he feels are … more than "wear and tear"* [for example cigarette burns on the bedroom carpet]. *Neither* [the area manager nor the service manager] *knew whether a deposit or bond had been paid prior to* [Mr D] *moving in.*
>
> '[The Care Company] *package involved them becoming appointees for* [Mr D's] *finances from their initial involvement back in 2004. The process at this time was to voluntarily sign this role over to such organisations if agreed. This process has now changed.*

'[The Care Company] *retain this role to date however* [Mr D senior] *has begun a process of seeking to take this over.*

'*… A joint account was then set up … in the name of* [Mr D] *and* [the Care Company]. *All benefits are paid into this account … From this account standing orders are set up to pay rent and other such bills.* [Mr D] *does not have direct and unsupervised access to this account; he does not hold a card for example.*

'[Mr D] *then has two other "personal" accounts. Whatever was left from the joint account after paying bills is supposed to then be transferred into one of his personal accounts. (*[The service manager] *did not know where the second personal account had come from). A minimum figure of £35 is transferred each week. There was never any more than that due to the shortfall in housing benefit and rent. Subsequently a debt began to accrue.*

'*It was on his personal account that an overdraft was agreed and spent, in theory with the knowledge and support of* [the Care Company] *staff.* [The service manager and the area manager] *both commented that this was not acceptable and that* [the Care Company] *staff should not have supported this.*

'*… there is a tin kept at the house. This has £35 added each week for activities, cinema trips etc.*

'*there is another tin that has £50 per week added for the purchase of food and electricity.*

'[The service manager] *stated that the tins are accessed by* [Mr D] *and* [the Care Company] *staff when needed. Financial sheets are then completed to record monies being added or removed from the tins with receipts added.* [The service manager] *is confident that these financial sheets could be provided if required.*[18]

'[The area manager] *stated that* [the Care Company] *make a voluntary contribution to the food tin. As* [the Care Company] *provide 24 hr cover, this contribution would cover their costs for food they might consume. Neither* [the service manager] *nor* [the area manager] *could be specific about the contribution however stated that it was £60 to £80 per month. … the financial sheets could provide clarity of how much was paid and when … there doesn't appear to be a regular schedule for paying into this or a set amount.*

'*… There does not appear to have been any robust review under section 117*

'… [The service manager said] *that …* [the Care Company] *provide a package predominantly between Monday and Friday. He also reports that this has been a particularly difficult issue as …* [the Care Company] *provide staff and then find that* [Mr D] *has gone to stay at his parents. Then staff member does not remain at* [Mr D's] *address without him being there, they are redeployed or they go home on full pay and then return when* [Mr D] *does. …*

---

18 Note: the Ombudsmen's investigators have seen these documents.

'*… staff involved in delivering the care are now requesting that they do not work with* [Mr D] *… they reported that* [Mr D senior] *would allegedly make derogatory comments about* [the Care Company] *in their presence …*

'[The area manager and the service manager] *wished to make it clear that they both found face to face contact with* [Mr D] *and his family to be productive and pleasant however they feel there is often an unhelpful and "aggressive" tone. …*

'… [The area manager] *suggested that* [the Care Company] *cease to provide a package for* [Mr D].'

The assistant clinical manager who wrote the notes recorded his intention to arrange a section 117 review as a priority.

21 July – In the daily record sheet from Mr D's clinical records, the assistant clinical manager wrote the details of a conversation he had with the team leader from social care who questioned whether Mr D had the mental capacity to have entered into legal agreements when signing his tenancy agreements.

24 July – The assistant clinical manager met the PCT's complaints manager and the PCT's solicitors. It was agreed that the original tenancy agreement from 2004 should be traced, together with the '*property set up from discharge from hospital. This would indicate whether* [Mr D] *signed an agreement indicating he would be liable to cover the full amount of the rent if the* [second tenant] *left*'.

10 August – Mr D's social worker and the assistant clinical manager visited Mr D at home. One of the listed purposes of the visit was to '*explore* [Mr D's] *capacity with regards to … signing the tenancy agreement for* [property four]' (his most recent property). They made the judgment that Mr D had capacity in relation to his ability to sign the tenancy agreement.

12 August – A member of staff from the psychiatric unit (where Mr D had been detained under section 3 of the *Mental Health Act 1983*) responded to enquiries made by the assistant clinical manager. He confirmed that he did not know if Mr D had signed the original tenancy agreement.

14 August – A section 117 review meeting was held. The current arrangements were to continue. It was noted that Mr D's housing benefit now covered his rent costs and that he was living in a stable environment. After the meeting the assistant clinical manager informed the PCT's complaints manager that the relationship between Mr D, his parents and the Care Company appeared '*unsalvageable*'. He recorded that there was a lack of regular section 117 reviews and input from health and social care staff since 2004. He noted that there was to be another meeting in September to address the questions about the original accommodation arrangements and financial issues. The assistant clinical manager said '*My feeling is that we may well be significantly closer to drawing a close to the complaint that has been outstanding now for 2 years or more if this meeting goes ahead*'.

7 September – A meeting was held between PCT staff, Mr D, his family, his solicitor, social services and the mental health services. It was confirmed that the Care Company were giving notice of withdrawal from the contract from October. It was recorded that Mr D had paid double rent in 2004 when the second resident left; housing benefit had not covered all the costs; additional housing benefit funds were not applied for on Mr D's behalf; housing benefit was now noted to be above the rent payable. The issue was raised of whether Mr D should have paid rent when he was subject to section 117 aftercare. It was agreed that these matters would be investigated. There was a need for a full assessment of Mr D's current situation.

2 October – The PCT wrote to Mr D's parents confirming that they would investigate the tenancy and financial issues with their legal advisers. They said that an interim independent care provider (the second provider) had been commissioned to provide Mr D's care during the week and that his parents could support him at weekends. This would continue until they had undertaken an updated assessment of Mr D's needs.

From October to December Mr D's solicitor chased a response from the PCT several times. The PCT informed them that investigations were ongoing. They were considering another meeting with Mr D and his family to discuss the outcome of the investigations.

2010

19 January – The PCT's complaints manager informed Mr D's solicitor that there would be a meeting on 8 February between the commissioners of his care and mental health service staff. She promised a further update after the meeting.

8 February – The meeting of the commissioners and mental health service staff took place. The PCT agreed to reimburse the rent payments, subject to evidence of payments made being supplied. They noted that the arrangements with the second provider were working well and there had been no complaints from Mr D or his family about them. Afterwards, the PCT's complaints manager updated Mr D's solicitor and requested evidence to support the reimbursement claim.

22 February – The PCT completed a full assessment of Mr D's situation. It was concluded that he still required a 24-hour support package to enable him to live independently and safely in his own home.

In March Mr D's solicitor asked the PCT about progress with their response and informed the PCT that there were difficulties obtaining financial records from the Care Company. In April internal emails and memos show that there was ongoing consideration of the reimbursement matter and what section 117 aftercare for Mr D should include. In May the PCT proposed a meeting with Mr D and his family on 6 July. Mr D's solicitor requested responses to her previous letters.

9 June – PCT staff met their legal advisers to discuss how to respond to the issues raised by Mr D's family and solicitor.

5 July – Mr D's solicitor wrote to the PCT providing more detail about the discrepancies between the housing benefit and rent charges in the documentation from the Care Company.[19] She itemised the shortfalls as follows:

> '*The joint tenant who lived at* [property one] *with my client* [Mr D] *from the start of the tenancy on 16th August 2004 left on 20th October 2004. My client's housing benefit increased to £82.50 per week at that point as he was treated as fully liable for the full rent of £580 per month. There was therefore a shortfall.*
>
> '[The Care Company documentation] *shows no record of the charges for rent from August 2004 until November 2004 and only appears to indicate that* [Mr D] *was charged his share of the rent (£290) for the months November 2004 to April 2005 when he was the sole resident tenant however it would appear likely that my client was made to pay, by* [the Care Company]*, the whole rent for the property amounting to £580 per calendar month out of his funds between October 2004 and April 2005.*
>
> '*My client then moved to* [property two] *on 10th May 2006 but* [the Care Company] *did not notify housing benefit until August 2006. This created an underpayment of ongoing Housing Benefit at the new address and a smaller overpayment in respect of* [property one] *due to the late notification of a change of address by* [the Care Company] *in May 2006. This … resulted in £91.49 overpayment of Housing Benefit in respect of* [property one] *for the period 10th May 2006 to 22nd May 2006 and then a shortfall of £31.09 per week entitlement between 20th May 2006 and 21st August 2006 (15 weeks + £466.35 loss to my client) as a direct result of the late notification.*
>
> '*There is no record of any application for a Discretionary Housing Payment in respect of meeting shortfalls in rent. …*
>
> '*The total shortfall between rent charged and the benefit claimed is £7493 without taking into account the rent payable when my client was the sole tenant at* [property one]*. This also does not include the deposits which were taken for each of the tenancies some of which were not returned.*
>
> '*This also does not take into account that despite having a 24/7 care package no leisure activities, no education pursuits and no basic skills training was funded through the package. Also no holiday provision was made within the care package … .*'

19 Note: this is the same financial data given to us by the Care Company via the Council – see footnotes 7 and 8.

6 July – The PCT met Mr D, his family and his solicitor. The PCT said they considered that the original complaint about the standard of care had been concluded in October 2009 when the Care Company withdrew care provision. They agreed to put this in writing to Mr D and his family. The minutes included that:

> '*LC* [director of professional practice at the PCT] *emphasized that at the meeting in September 09 it was agreed that NHS Plymouth would reimburse any monies inappropriately paid by* [Mr D] *on receipt of appropriate evidence to substantiate the sums claimed. It was reiterated that as a public organisation NHS Plymouth would require a full audit trail of any sums it reimburses, and therefore until such time as it was provided with appropriate evidence, the position remains unaltered.*'

Following the meeting, Mr D's solicitor wrote to the PCT having further analysed the printouts of financial data provided by the Care Company. She calculated that the total shortfall of housing benefit amounted to £8,074.21. She also stated that the data showed that Mr D had paid a sum totalling £2,165, which was for deposits on properties and advance rent payments. In August she notified the PCT that it was difficult to get financial information from the Care Company to substantiate Mr D's claim.

18 October – The PCT wrote to Mr D senior outlining the actions they had taken (as listed above) to address the original complaint about the standard of care received from the Care Company. They said that if the Care Company had not terminated the contract, they would have done so themselves, but they had to ensure a suitable alternative care provider was in place first. They said the care arrangement with the new provider was working well. They accepted that it had taken a long time to resolve the complaint and apologised for the anxiety this caused. They considered it important to separate the complaint about the standard of care by the Care Company from the concerns Mr D and his family had about financial issues, which were ongoing. They advised Mr D and his family to contact them if there were any outstanding matters, or to contact us if they remained dissatisfied at the end of the complaints process.

21 December – The PCT's solicitors wrote to Mr D's solicitor confirming that the original complaint about the Care Company was concluded in October 2009 and that the PCT would not enter into protracted correspondence about that matter.

Annex C: Clinical advice

What should have happened?

1. Our Adviser studied the Partnership's section 117 aftercare policy documents dated July 2002, July 2007 and Feb 2012. He said:

> '*In keeping with Trust policy and national expectation* [Mr D] *should have had an aftercare plan developed. Trust policy dictates that this should have taken place alongside a review of his care plan under the Care Programme Approach. This meeting should have involved the patient, professionals, carers and family and others as consistent with the* Mental Health Act Code of Practice *paragraph 27.12 … . An aftercare plan should have been agreed based around* [Mr D]*'s identified needs.*
>
> '*There should then have been reviews of the aftercare plan at least every six months based around* [Mr D]*'s identified care needs with the aftercare plan being continued, developed or changed in response to these. Such reviews should have included the people still involved in his care (similar to those invited to the original meeting) allowing them to raise any concerns at that stage.'*

2. The Adviser noted that the Partnership's policies state that the role of the care co-ordinator is to monitor the aftercare plan. He said all the policies suggest that such review should occur every six months but that the policies from 2007 and 2012 also mention the need for an additional review three months after discharge from hospital. He said:

> '*All versions of the document link the review of s117 aftercare plans to care plan reviews under the Care Programme Approach. This is consistent with normal practice as there is usually considerable overlap between the two processes. However the fact that a s117 review has taken place alongside a CPA review needs to be separately documented. This is reflected in paragraph 5.4 of the 2007 review of the policy though not the earlier version.'*

What did happen?

3. The Adviser could find no evidence of the original aftercare plan for Mr D. He noted that there appear to have been care plan reviews under the CPA but documentation seemed '*relatively brief*' and there was nothing to suggest that a section 117 aftercare review was routinely undertaken as part of these reviews. He said he could not see '*scrupulous adherence to the s117 monitoring process*' as he would expect.

4. There was a section 117 aftercare review meeting in November 2007. The Adviser said:

> '*This review seems to cover some issues one would expect to see in a s117 aftercare plan, including current psychiatric circumstances and aspects of the care package. The attendees include relevant parties. It was undertaken the same day as a CPA review for which there is more detailed information and yet the record of the s117 review remains perfunctory. For example, the reason for the review is given as "117 meeting – re: capacity" yet no capacity assessment or the decision to which capacity was felt relevant is mentioned. There is no clear list of* [Mr D]*'s assessed needs. Furthermore, there is inadequate mention of who would monitor the aftercare package, the intended outcomes from the interventions suggested, and who was responsible for their implementation or any timescales.*'

5. There was a further section 117 aftercare review meeting in January 2008. The Adviser said the personnel who attended were suitable. He said the review seemed to cover issues he would expect to see covered: psychiatric circumstances; aspects of the care package; contingency planning; and current treatment. He noted that the quality of accommodation was not discussed in detail. He concluded: '… *the review may formally have counted as a s117 review but it was also perfunctory*'.

6. There was a further section 117 review on 14 August 2009. The Adviser said:

> '*Due to the infrequent and brief records of s117 aftercare review meetings before this time, this was less a review and more a case of professionals meeting with the patient, his family, his advocate and representatives of the team supporting him in the community to discuss his social circumstances, current interventions, his finances and family concerns regarding how care was being delivered.*'

7. Mr D was allocated a new care co-ordinator in 2009. The Adviser commented that this person then had to:

> '*start remedial work to address the years of neglect, essentially undertaking an assessment of need from scratch and reassessing various aspects of* [Mr D]*'s function. It is clear that during this period a lot of concerns arose regarding the care being provided by the independent sector provider funded as part of the original aftercare plan. Had these reviews taken place, these concerns should have been identified far earlier.*'

Conclusion

8. The Adviser concluded:

> '*In summary,* [Mr D]*'s care co-ordinators did not conduct adequate or frequent enough aftercare plan reviews between 2004 and August 2009. This meant that in 2009 the new care co-ordinators had to undertake much remedial work to address numerous concerns that had arisen in the interim, reassess* [Mr D]*'s needs and effectively devise a new aftercare plan from scratch.*'

9. The Adviser commented on the impact of this for Mr D and his family. He said:

> '*The failure to monitor the aftercare plan meant that concerns regarding the behaviour of those funded by the PCT to provide* [Mr D] *with a significant amount of care were only tackled very belatedly. This required a rapid reorganisation of his care plan.*'