Local Government OMBUDSMAN

Parliamentary and Health Service Ombudsman

A report by the Health Service Ombudsman and the Local Government Ombudsman about the provision of section 117 aftercare

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of the Health Service Commissioners Act 1993

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Foreword

We are laying before Parliament, under section 14(4) of the *Health Service Commissioners Act 1993* (as amended), this report on a joint investigation into a complaint made to us as Health Service Ombudsman for England and Local Government Ombudsman for England.

The complaint is about Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) and Wiltshire Council (the Council). The complaint was made by Miss M about the standard of mental health care provided to her late mother, Mrs M, and particularly about the necessity for Mrs M to fund her own placement in a residential care home.

Our reason for laying this report before Parliament is to allow our joint investigation report to be in the public domain.

Dame Julie Mellor, DBE
Health Service Ombudsman
for England

Dr Jane Martin
Local Government Ombudsman
for England

October 2012

Summary

The complaint

Mrs M had suffered from depressive illness since the 1950s. Over the years, this had meant that she had sometimes needed to be admitted to a mental hospital during acute periods of her illness. In 1989, due to a severe recurrence of her illness, Mrs M was compulsorily detained in hospital under section 3 of the *Mental Health Act 1983*. She was discharged home again that year and continued to live at home, cared for by her husband, and supported locally by mental health services under the supervision of a consultant psychiatrist. Following her husband's death in 1998 Mrs M lived alone; in the period from 1997 to 2003 she went into hospital on five occasions as a voluntary patient for periods of between several weeks and several months. Since 1999, it had been noted that there had been a deterioration in her physical health: she began to experience falls, her gait had changed, and she became incontinent and needed considerable help with daily activities. No definite cause for this deterioration was ever found but, by 2004, she was not coping well at home and she went into a residential care home (the Care Home) where she remained for the rest of her life. She died in October 2009. Throughout her time as a resident of the Care Home, Mrs M had funded her own care.

Our investigation

We investigated complaints by Miss M (Mrs M's daughter) that it was wrong that Mrs M had been expected to fund her own care in the Care Home – that this should have been provided under section 117 of the *Mental Health Act 1983* (which makes provision for patients who have been compulsorily detained under the Act to receive free aftercare). Miss M complained that the explanation she had been given about her mother's ineligibility for section 117 funding, by the Trust, was unreasonable; and that the Trust's assertion that the admission had been for physical needs, rather than for mental health needs, was an attempt to avoid responsibility for funding the placement. Miss M also complained that her mother's subsequent discharge from the Community Mental Health Team (CMHT) in 2005 was inappropriate, and that the provision of care and treatment by the Trust from the admission to the Care Home to her mother's death was inadequate. She complained too that the transfer of responsibility for her mother's care to the Council's Adult Social Care team (ASC team) in 2008 had been inappropriate; and finally that the assessment of her mother's needs following that transfer did not adequately take into account her mother's needs or her own views, her mother's medical history, nor the opinions of medically qualified professionals. To sum up, Miss M said that her mother's complex needs were not met, that she was placed in the Care Home and then forgotten, and that she then failed to receive the treatment she needed.

Our findings

We found that the delivery of aftercare services for Mrs M under section 117 of the *Mental Health Act*, and her discharge from that provision, were not properly considered in accordance with relevant legislation and guidance; and the later explanations given about this by the Trust and by the Council were inadequate and contradictory. We found too that the procedure followed in discharging Mrs M from the CMHT in 2005 was not in accordance with relevant guidance. However, we did not consider that these failures were the cause of significant injustice to Mrs M or Miss M. We did not find that Mrs M failed to receive the medical or social care services that she needed from the Trust or the Council. There was no fault in the arrangements for

the admission to the Care Home, in the care provided by the Trust and the Council after the admission, nor in relation to the transfer of care to the Council's ASC team and the later assessment of her needs. Most significantly, we did not find that the period of residential care in the Care Home should definitely have been funded by the Council under the provisions of section 117.

We concluded that there was no doubt that Mrs M had severe and enduring mental health problems following her discharge from compulsory detention in hospital in 1989, and we noted that the severity of these acute episodes had resulted in informal admissions to hospital between 1987 and 2003. However, we also noted that there was considerable evidence, from professional and clinical staff involved with Mrs M, that her physical deterioration and inability to cope at home alone, dating from the end of that period, could not definitely be attributed to the underlying depressive illness that had been so severe in previous years. It was acknowledged by staff that Mrs M's physical and mental health problems were interrelated, but there was evidence that her later symptoms could be attributed to a more general deterioration that was possibly linked to symptoms of dementia.

Conclusion

We found evidence of some failures on the part of the Trust and the Council; but in the absence of any consequent injustice that we could identify, we did not uphold any of Miss M's complaints.

Introduction

1. This is the report on our joint investigation into Miss M's complaint made on behalf of her late mother, Mrs M, about Avon and Wiltshire Mental Health Partnership NHS Trust (the Trust) and Wiltshire Council (the Council). This report contains our findings and conclusions with regard to Miss M's areas of concern.

The complaint

2. Miss M complains that the Trust and the Council failed to properly assess and provide for the health and social needs of her mother, Mrs M, from 2004 until her death in October 2009. In particular:

    - The Trust's explanation that her mother was not covered by section 117 of the *Mental Health Act 1983* (the Act) was unreasonable, in that her mother was entitled to receive aftercare services under the provisions of section 117 (from now referred to as aftercare services) following her compulsory detention in 1989 under section 3 of the Act; that her mother's care at the Care Home[1] should have formed part of aftercare services; and that the Trust's assertion that her mother was not entitled to such aftercare was incorrect and had no evidential basis.

    - The Trust's assertion that her mother's admission to the Care Home was for her physical needs (rather than for her mental health needs) is an attempt to avoid the responsibility of the NHS to fund her mother's care at the Care Home.

    - Her mother's discharge from the Community Mental Health Team (CMHT) in July 2005 was wholly inappropriate, given her mother's long-term mental health needs, the inadequate assessment of her needs, and the failure to involve her mother's family in the process or inform them of the discharge.

    - The provision of care and treatment by the Trust between October 2004 and October 2009 was inadequate and offered little or no support for her mother's mental health needs.

    - The transfer of responsibility for her mother's care to the Council's Adult Social Care (ASC) team in December 2008 was inappropriate.

    - The assessment of her mother's needs following the transfer of responsibility for her care to the Council did not adequately address her mother's health and care needs nor her emotional needs and well-being; and did not take into account her own views, the opinions of the medically qualified professionals involved in her mother's care, nor her mother's medical history.

3. Miss M says that neither the Trust nor the Council met her mother's complex needs; that her mother was placed in the Care Home and then '*forgotten*'; that her mother received no further treatment, rehabilitation or reviews; and that the Trust's and the Council's actions contributed to the rapid deterioration in her mother's physical and mental health. She further complains that by the time she realised that her mother had been discharged from the CMHT, Mrs M had had no mental health support for three

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[1]The Care Home provides residential care and is registered under the categories of old age and dementia. It is not a nursing home.

years. Miss M says that when her mother's care was transferred to the Council in December 2008, she was effectively blocked from accessing mental health services at the Trust despite her need for ongoing support.

Summary of our decision

4. Having considered all the available evidence related to Miss M's complaint, including her recollections and views, and taking account of the legal and clinical advice we have received, we have reached the following decisions.

5. We have found evidence of maladministration by the Trust and the Council in that:

   - the delivery of aftercare services for Mrs M under section 117 of the Act, and discharge from that provision, was not properly considered in accordance with relevant legislation and guidance;
   - the explanation later given to Miss M about this was inadequate and contradictory; and
   - the procedure that was followed in Mrs M's discharge from the CMHT in 2005 was not in accordance with relevant guidance.

6. However, we do not consider that these failures were the cause of significant injustice to Mrs M or Miss M. We see no reason to conclude that failure by the Trust or the Council contributed to Mrs M's decline in health, or that she failed to receive medical or social care services for which a need was identified. Although Mrs M had been detained under section 3 of the Act in 1989, we do not conclude that the provision of residential care in 2004 should have been funded under section 117 of the Act.

7. We do not find fault in the arrangements for Mrs M's admission to the Care Home, the care provided after Mrs M's admission, and the transfer of her care to the Council's ASC team or the assessment of needs by the Council. Therefore we do not uphold Miss M's complaints.

The Ombudsmen's remit and powers

The Health Service Ombudsman's remit

8. By virtue of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she 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.

9. In doing so the Health Service Ombudsman considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the organisation, a failure by the organisation to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the organisation. If she finds that service failure or maladministration 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.

The Local Government Ombudsman's remit

10. Under the *Local Government Act 1974*, part III, the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from maladministration by local authorities (councils) and certain other public organisations. She may investigate complaints about most council matters, including the provision of social care.

11. If the Local Government Ombudsman finds that maladministration has resulted in an unremedied injustice, she too will uphold the complaint and may recommend redress to remedy any injustice she has found.

Powers to investigate and report jointly

12. *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations, and produce joint reports in respect of complaints that fell within the remit of both Ombudsmen.

13. In this case, the Ombudsmen agreed to work together because the health and social care issues were so closely linked. A co-ordinated response, consisting of a joint investigation leading to the production of a joint conclusion and proposed remedy in one report, seemed the most appropriate way forward.

The basis for our determination of the complaint

Introduction

14. In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we begin by comparing what actually happened with what should have happened.

15. So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application

and those which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those organisations and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

16. The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

17. Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the organisation or individual complained about constitutes a departure from the applicable standard. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

18. The overall standard that we have applied to this investigation is set out below.

The general standard

19. The Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy are broad statements of what the Ombudsmen consider public organisations should do to deliver good administration and customer service, and how to respond when things go wrong.

20. The same six key Principles apply to each of the three documents. These six Principles are:

    - Getting it right
    - Being customer focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right, and
    - Seeking continuous improvement.

21. One of the Principles of Good Administration particularly relevant to this complaint is:

    - *'Getting it right'* – amongst other things, this means that all public organisations must comply with the law and have regard for the rights of those concerned. They should act according to their statutory powers and duties and any other rules governing the service they provide. They should follow their own policy and procedural guidance, whether published or internal. Public organisations must act in accordance with recognised quality standards, established good practice, or both – for example, about clinical care.

The specific standards

Legislation and statutory codes of practice

Mental Health Act 1983

22. The Act sets out the law in relation to the assessment, care and treatment of people with a mental health disorder. Section 3 provides for compulsory admission to hospital for treatment. If a person is detained under this section and is subsequently discharged from hospital, they are entitled, under the provisions of

section 117, to receive *'after-care services'* (which are not defined in the Act).

23. Section 117 requires local health authorities and local social services authorities (in this instance the Trust and the Council) to provide aftercare services, in co-operation with voluntary agencies, for persons discharged following detention under section 3. Aftercare services must be provided until such time as the local health and social services authorities are satisfied that the person concerned is no longer in need of these services.

Mental Health Act 1983: Code of Practice

24. In 1990 the Department of Health first published the *Mental Health Act 1983: Code of Practice* (the Code of Practice) for practitioners working within the framework of the Act. Subsequent editions were published in 1993, 1999 and 2008. Section 26 of the Code of Practice (1990 version) sets out guidance on the issue of aftercare services. It states that the purpose of aftercare is to enable a patient to return to their home or accommodation, other than a nursing home, and to minimise the chances of them needing any future inpatient hospital care.

25. The Code of Practice states that health and social services authorities should agree procedures for establishing *'proper aftercare arrangements'*. It also stipulates that when a decision has been made to discharge a patient from hospital, the responsible medical officer must ensure that a discussion takes place to organise the management of the patient's continuing health and social care needs. This discussion will usually take place in *'multi-professional clinical meetings'* held in psychiatric hospitals and units. The Code of Practice stipulates that this discussion should involve the patient's responsible medical officer, a nurse involved in caring for the patient in hospital, a social worker specialising in mental health work, the GP, a community psychiatric nurse, the patient, and any nominated representative. Issues for consideration should include:

    - the patient's wishes and needs;
    - the views of any relevant relative, friend or supporter of the patient;
    - establishing a care plan which is based on *'proper assessment and clearly identified needs'*, including day care arrangements, appropriate accommodation, outpatient treatment, counselling and personal support, assistance in welfare rights, and managing finances; and
    - the appointment of a key worker.

26. The multi-professional discussion should establish an agreed outline of the patient's needs and assets, taking into account their social and cultural background, and agree a timescale for implementation of the various aspects of the care plan. The care plan should identify all key people with specific responsibilities with regard to the patient.

27. The Code of Practice also stipulates that proper records should be kept of all those patients for whom section 117 could apply, and of those for whom arrangements have been made. It states that care plans, when agreed, should be recorded in writing, and the care plan should be regularly reviewed. The key worker (also known as the care co-ordinator) is responsible for arranging reviews of the plan until it is agreed that the plan is no longer necessary. The senior officer in the key

worker's agency responsible for section 117 arrangements should ensure that all aspects of the procedures are followed in the care, assessment, review and discharge of patients who are entitled to receive aftercare services under the provisions of section 117.

National Health Service and Community Care Act 1990

28. The *National Health Service and Community Care Act 1990* sets out the duties of local social services authorities in respect of assessment of needs, and gives them overall responsibility for community care services. This includes services arranged or provided under section 117 of the *Mental Health Act 1983*.

29. Section 47(1) of the *National Health Service and Community Care Act 1990* states:

> *'... where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority –*
>
> *(a) shall carry out an assessment of his needs for those services; and*
>
> *(b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.'*

The Care Programme Approach

30. The delivery of all mental health services was framed within the *Care Programme Approach* (the Care Programme Approach), introduced by the Department of Health in 1991 as the principal strategy for the provision of mental health services within the community. It continues to occupy a position of prime importance in mental health care.

31. The main elements of the Care Programme Approach were systematic arrangements for assessing health and social needs of people accepted into specialist mental health services. They included: a multi-agency care plan; the appointment of a key worker to monitor and co-ordinate care (the care co-ordinator); and regular review of the care plan.

32. In 1999 the Department of Health published a policy booklet, *Effective Care co-ordination in mental health services: modernising the care programme approach* (the Care Programme Approach guidance). It set out the role of the care co-ordinator as having the responsibility for co-ordinating care, keeping in touch with the service user, ensuring that the care plan is delivered and reviewed as required, and that other members of the care team are advised about changes in the circumstances of the service user. The Care Programme Approach guidance stated that systems should be in place to ensure that '*the co-ordination of care and treatment is effective*'.

33. At the time of the events complained about, the Care Programme Approach was delivered according to either the standard or the enhanced level. According to the Care Programme Approach guidance, patients on the standard level of the Care Programme Approach might include individuals who require support from one agency; were *'more able to self-manage their mental health problems';* and who *'pose little danger to themselves or others'*. Patients on the enhanced level of the Care Programme Approach might include individuals with a severe mental illness who have multiple care needs (for example,

housing or employment); were likely to require *'more frequent or intensive interventions, perhaps with medication management*'; were more likely to have mental health needs co-existing with other problems; and were more likely to be a risk to themselves or others. In practice, patients on the enhanced level of the Care Programme Approach required a greater level of support from more than one professional or agency, and more frequent review (for example, care plans reviewed on a six-monthly basis, as opposed to the yearly basis for patients on the standard level of the Care Programme Approach).

34. Risk assessment is an essential and ongoing part of the Care Programme Approach process. The Care Programme Approach guidance stated that people on the enhanced Care Programme Approach would have an appropriate multi-agency care plan to meet their needs, which would include detailed contingency and crisis plans. It also stated that they would have a care co-ordinator allocated with clear responsibilities and tasks, as agreed by the care team. The guidance stated that the care co-ordinator was responsible for keeping in close contact with the service user and for updating the basic care plan and crisis plan. In respect of the care plan, the guidance stated that:

    'An individual service user's care plan must be based on a thorough assessment of their health and social care needs. This assessment will involve the user and the carer, where appropriate, as central participants in the process.'

35. The Care Programme Approach guidance also referred to the needs of patients' families. It stated that:

    'the process of the [Care Programme Approach] *is clearly intended to deliver care to meet the individual needs of service users. However, those needs often relate not just to their own lives, but also to the lives of their wider family. The* [Care Programme Approach] *should take account of this.'*

Mental Health Policy Implementation Guide: Community Mental Health Teams

36. In 2002 the Department of Health published the *Mental Health Policy Implementation Guide: Community Mental Health Teams* (the Implementation Guide), which sets out the functions that CMHTs need to perform. It states that CMHTs provide services to two key groups of people. Most patients treated by the CMHT have time-limited disorders and are referred back to their GPs after a period of weeks or months. However, a substantial minority of patients remain with the CMHT for ongoing treatment, care and monitoring for periods of several years. This includes patients who require ongoing specialist care for: '[s]*evere and persistent mental disorders associated with significant disability'* such as schizophrenia and bipolar disorder, or disorders where the level of support required exceeds that which a primary care[2] team could offer.

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[2] Primary care is a term used to describe community-based health services. It covers services provided by GPs, community or practice nurses, community therapists (occupational therapists and physiotherapists), and dentists.

37. The Implementation Guide emphasised the importance of good communication and liaison amongst healthcare professionals, including primary care providers. It highlighted the importance of good note-keeping, and also stated that: *'families and carers should be involved in the* [Care Programme Approach] *as much as possible'*. The Implementation Guide also recommended regular team meetings including the consultant psychiatrist, where actions were agreed and changes in treatment for individual clients discussed with the whole team. The guide stressed the importance of managing physical health problems and stipulated that they should be identified and discussed with the GP. In terms of arrangements for discharge and transfer from CMHT care, it stated that:

- *'Patients should be discharged back to primary care promptly when they are recovered ...*
- *'Discharge letters need to be comprehensive and indicate current treatment and procedures for re-referral...*
- *'For patients with complicated care needs discussion at the liaison meeting is indicated before discharge.'*

National Service Framework for Older People

38. In March 2001 the Department of Health published the *National Service Framework for Older People*, which established eight national standards for the health and well-being of all older people whether they live at home, in residential care, or are being cared for in hospital.

39. Standard two relates to *'Person-centred care'*, and aimed to ensure that older people were *'treated as individuals and* [that] *they receive appropriate and timely packages of care which meet their needs'*. It referred to the *'single assessment process'* that involves a detailed assessment of a patient's health and social needs in the round, including physical and mental health needs. It also stated that all older people should receive an assessment that is matched to their *'individual circumstances'*. It stipulated that the single assessment process should consider the user's perspective; their clinical background; disease prevention; personal care and physical well-being; their senses; mental health (cognition – thought processes, including dementia and depression); relationships; safety and immediate environment; and resources. It recognised that assessment may identify the need for more specialist assessments – for example, when there is a specialist medical need such as cognitive impairment.

Fair access to care services – guidance on eligibility criteria for adult social care

40. In January 2003 the Department of Health published *Fair access to care services – guidance on eligibility criteria for adult social care* (the Eligibility guidance). It provided councils with social services' responsibilities with a framework for determining eligibility for adult social care, and set out how they should carry out assessments and reviews, and support individuals through these processes. The guidance stated that the decision on whether adults seeking social care support are eligible for help should be made: *'following an assessment of an individual's* ***presenting needs****'*. It goes on

to stipulate that the: *'scale and depth of the assessment should be proportionate to the individual's presenting needs and circumstances'*.

41. Section 4 of the Eligibility guidance stated that reviews should be undertaken at regular intervals to ensure that the care provided to individuals is still required and is achieving the agreed outcomes. These reviews should include a reassessment of an individual's needs.

Health Service and Local Authority circulars

42. In 1989 the Department of Health issued a health service circular, HC(89)5 *Discharge from Hospital*. This stated that no patient may be discharged from a hospital until the doctors concerned have agreed, and management is satisfied, that everything reasonably practicable has been done to organise the care that the patient will need in the community. This includes making arrangements for any necessary follow-up treatment and support in the home or the place they are being discharged to. The patient or their relatives must be fully informed about medication, symptoms to watch for, and how to seek help if required. One member of staff looking after the patient should be given responsibility for checking that the necessary action has been taken before a patient leaves the hospital. There should be a checklist of the action taken and this should form part of the patient's medical records.

43. In 1989 the Department of Health also issued a local authority circular (LAC(89)7) that drew the attention of local authorities to HC(89)5 and requested that they review their existing procedures to ensure that patients do not leave hospital without adequate arrangements being made for their support in the community.

44. In February 2000 the Department of Health issued a joint health service and local authority circular *After-care under the Mental Health Act 1983*: *section 117 after-care services*. This set out changes in procedures relating to aftercare services following certain court judgments. It stipulated that aftercare services could not be charged for, and that policies for section 117 aftercare should set out clearly the criteria for deciding which services fall under section 117 and which authorities should finance them. The section 117 aftercare plan should indicate which services are provided as part of the plan. The circular stressed that section 117 aftercare does not have to continue indefinitely and the responsible health and social services authorities should decide in each case when aftercare services provided under section 117 should end, taking account of the patient's needs at the time. It stipulated that the patient, their carers and other agencies should *'always be consulted'*.

Advice and guidance on the funding of aftercare under section 117 of the Mental Health Act 1983

45. In July 2003 the Local Government Ombudsmen published a special report entitled *Advice and guidance on the funding of aftercare under section 117 of the Mental Health Act 1983* (the Local Government Ombudsmen's report). The report set out the law on this issue and the Local Government Ombudsmen's consideration of complaints received about aftercare. The Ombudsmen referred to a judgment on 28 July 1999 in which the High Court decided that charges may not be made for aftercare, including accommodation, provided under section 117. The judgment also stated:

'Aftercare provision does not have to continue indefinitely. It must continue until such time as the health authority and local authority are satisfied that the individual is no longer in need of such services ...

'There may be cases where, in due course, there will be no need for aftercare services for the person's mental condition, but he or she will still need social service provision for other needs, for example, physical disability. Such cases will have to be examined individually on their facts.'

46. The Local Government Ombudsmen's report also referred to a circular sent to local authorities in February 2002, following the July 1999 judgment. This stated that social services authorities who were still charging for aftercare services under section 117 should immediately cease to do so. It stated that the decision that an individual no longer needs aftercare should be made while taking account of *'the patient's needs at that time'*. The authority responsible for providing particular services should take the lead in deciding when aftercare services are no longer required. It stated that: '[t]*he patient, his/her carer, and other agencies should always be consulted'*.

47. In considering a complaint about Leicestershire County Council, the Local Government Ombudsmen referred to the attempts to place a date on when aftercare (which in this case included accommodation at a care home) had ceased. Leicestershire County Council said that, where a consultant had discharged someone from their care and that person did not require, or was no longer in receipt of, specialist mental health services, then they could be deemed to have been discharged from their entitlement to aftercare under section 117 at the point when the specialist services were withdrawn. However, the Ombudsmen referred to the Government's advice that consultation with the patient and their relatives must be part of the decision-making process for aftercare, and that this must take place before a joint decision can be made by health and social services that aftercare is no longer required. In this case, consultation was not possible because the patient had since died. The Ombudsmen concluded that such a decision could not be made retrospectively and therefore the patient had been entitled to receive aftercare under section 117 until she died.

48. The Local Government Ombudsmen highlighted the efforts of Wiltshire Council in identifying all those who should have been receiving aftercare. The Council had reviewed case files from the relevant mental health teams and contacted care providers. However, the Ombudsmen noted that the Council had found that there was no instant way of identifying all those entitled to restitution. Where the Council had found cases where decisions had been made to discharge section 117 without the proper process being followed, they took the view that section 117 should continue to apply until a proper discharge was completed.

49. The Local Government Ombudsmen said, with regard to retrospective decisions that aftercare is no longer necessary:

'We see very little scope under the [Code of Practice] *for a retrospective judgment to be made ... that a patient's status as a recipient of section 117 aftercare can have changed ... For all those reasons a retrospective assessment may be found to be maladministration, subject always to the particular facts of each case.'*

50. The Local Government Ombudsmen issued advice on the issue of aftercare, including:

- *'that, in general,* [social services authorities] *should not carry out retrospective assessments purporting to remove a person from section 117 aftercare as from an earlier date ...*
- *'that, where previous assessments to end section 117 aftercare were not properly made, then restitution will generally be appropriate until a proper assessment is devised ...*
- *'that people who have paid for section 117 aftercare are entitled to financial restitution with interest.'*

The investigation

Introduction

51. During this investigation our staff contacted Miss M on a number of occasions to confirm our understanding of the nature of her concerns. Our staff have examined Mrs M's medical records, and information from the Trust and the Council about their attempts to resolve the complaint at local level. In addition, our staff interviewed Trust and Council staff who were involved in Mrs M's care or in the handling of Miss M's complaint. Our staff also met Miss M on 13 June 2011.

52. We obtained specialist advice from two clinical advisers: a Consultant Psychiatrist (the Medical Adviser), and a Mental Health Nurse (the Nurse Adviser). The clinical advisers are specialists in their field and, in their role as advisers, they are completely independent of any NHS organisation.

53. We have not included all the information found during the course of the investigation, but we are satisfied that we have not omitted anything of significance to the complaint and our findings.

Key events

54. Mrs M had a history of affective bipolar disorder dating back to 1955, and had had a number of admissions to psychiatric hospitals. In 1989, after being admitted voluntarily to a psychiatric hospital, she was detained under section 3 of the Act. On discharge from hospital in June 1989 she was discharged from the section 3 order, and arrangements were made for her to attend occupational therapy sessions at the hospital (which she did for some months before deciding she did not wish to attend any longer), along with regular appointments with a consultant psychiatrist, and attendance at a clinic to monitor lithium levels. She saw the consultant regularly until 1996. The records which the CMHT have been able to locate make no reference to any decisions about provision under section 117 of the Act, and there is no evidence of any assessment, review or social work involvement at that time.

55. In a letter dated 29 February 1996 to Mrs M's GP, the consultant psychiatrist said Mrs M:

> *'appeared to be very well, asymptomatic and her medication* [was] *unchanged. ... At present I am seeing her at 3 monthly intervals and although she has been well for many years she seems to appreciate the contact she has from time to time.'*

56. Mrs M was admitted voluntarily to a psychiatric hospital in 1997 for over four weeks. Her husband was admitted to hospital in July 1998 and Mrs M went into hospital again on the day that he died. She remained there for four-and-a-half months and was readmitted a month later for a further three months. She was admitted to hospital again in 2001 for nine weeks, and again in 2003 for over two weeks. Mrs M lived alone following her husband's death.

57. In 1999 Mrs M had been referred to a consultant neurosurgeon because of a marked deterioration in her physical health. She had a tendency to falling, her gait had changed, she had become incontinent of urine, and needed considerable help with day-to-day activities. Mrs M was admitted to a general hospital for treatment of hydrocephalus, and was fitted with a shunt that resulted in an improvement in her mobility. She was referred to a neurosurgeon in 2002 because her mobility had deteriorated, but no evidence was found that the shunt was malfunctioning or that this had caused her physical decline. At the time of her admission to the psychiatric hospital in 2003, no significant problems with her physical health were recorded.

58. From 2001 the CMHT operated under a partnership agreement between the NHS and the Council to provide an integrated health and social care team. Social workers were seconded to the CMHT. Social workers and health workers within the CMHT delivered services on behalf of both the Council and the Trust. Mrs M was supported by a community psychiatric nurse following her discharge from hospital in July 2000. The community psychiatric nurse commented in her care plan review of 6 October 2003 that Mrs M's *'mental health needs remain and are of enduring nature and will need ongoing CMHT input'*. CMHT support was ongoing up to and including her admission to the Care Home.

Admission to the Care Home in October 2004

59. In April 2004 a consultant psychiatrist noted that Mrs M was free from depression, but he noted that she: *'continues to be rather Parkinsonian and although has no tremor has a shuffling gait and marked bradykinesia* [3] *and mask- like faces'*. The community psychiatric nurse who had been supporting Mrs M since the 1990s recorded that her problems differed from previous occasions, and that her decline had a physical and age-related origin. Mrs M was then 79 years old.

60. From June 2004 Mrs M was prescribed medication for Parkinsonian symptoms and was seen regularly by the community psychiatric nurse and the consultant psychiatrist. In August 2004 she was seen at home by the consultant psychiatrist, who undertook to review her antidepressant medication because she *'remains in her low mood'*. In September 2004 the consultant psychiatrist asked the GP to review Mrs M's physical state because he was: *'quite disturbed by the deterioration in her gait'* and by her increasingly frequent falls.

61. On 4 October 2004 the community psychiatric nurse recorded that Mrs M's physical and mental health needs were so interconnected that it was impossible to assess which was the primary need. She arranged a package of care for Mrs M at home with the Social Services Home Assessment Team (HAT) and her bed was moved downstairs; but this was not

[3] Bradykinesia: slow movement. Bradykinesia is often associated with an impaired ability to adjust the body's position. Bradykinesia can be a symptom of nervous system disorders, particularly Parkinson's disease, or a side effect of medications

sufficient and Mrs M was unable to remain at home. On 7 October the community psychiatric nurse noted that Mrs M was overwhelmed and wanted to go into a care home for respite.

62. The community psychiatric nurse arranged a placement for Mrs M at the Care Home (a residential care home, not a nursing home), and she moved there on 8 October 2004. In a fax to the Care Home, the community psychiatric nurse requested *'a respite, rehabilitation admission'*. She said that Mrs M had a long-standing depressive illness and had been known to the mental health team for many years, that she had been unwell physically and mentally since March 2004, and that her antidepressant medication was being reviewed. She noted that Mrs M required: *'care to give her "asylum" in the true sense of the word. Peace from trying to orchestrate her life'*, and that the plan was for her to return home.

63. The community psychiatric nurse noted that she had advised Miss M to investigate finances, but no request was made for consideration of the funding of the placement at the Care Home, and Mrs M paid the full fees from her own resources.

64. Miss M says that she was told that her mother was being placed at the Care Home because there were no psychiatric hospital beds available for her mother at that time. (The community psychiatric nurse told our staff that this was not the case and that she had arranged the placement at Mrs M's request because she needed help in looking after herself.) The CMHT files do not contain any reference to the consideration of a hospital admission.

65. Following her move to the Care Home, the consultant psychiatrist and the community psychiatric nurse visited Mrs M and recorded that she appeared to be improving mentally but that her mobility had worsened. The community psychiatric nurse requested the GP to make a referral to a consultant physician to determine if anything could be done to enable Mrs M to return home. The consultant psychiatrist reviewed Mrs M in the Care Home on 12 October and asked the GP to let him have: *'any report that yourself or the HAT team have regarding her physical health'*.

66. On 5 November 2004 the community psychiatric nurse carried out a care plan review based on her recent contact with Mrs M, the consultant psychiatrist, and Miss M. The Care Programme Approach review document (dated 6 December 2004) stated that Mrs M was on the enhanced level of the Care Programme Approach and that the placement at the care home was *'a consequence of increased mental and physical health needs'*. The community psychiatric nurse noted that Mrs M had complex mental and physical needs, and was so handicapped by the latter that, at present, it was unsafe for her to return to her own home. The care plan stated that Mrs M's mental health had improved following a change in her medication, but that she would continue to be assessed, and the cause of her physical health and mobility problem was being investigated.

67. In January 2005 a consultant physician at Salisbury District Hospital concluded that there was no apparent neurological cause for her falls, and noted that Mrs M's depression was clinically significant, that she was withdrawn, and that she lacked confidence.

68. Miss M believes that the community psychiatric nurse *'abandoned'* her mother at the Care Home. The community psychiatric nurse has said that Mrs M was being appropriately looked after at the Care Home with 24-hour cover, so that it was not necessary for her to visit so often.

The discharge from the CMHT in July 2005

69. Mrs M's case was transferred in February 2005 from the community psychiatric nurse to a CMHT social worker, who became her care co-ordinator.

70. Mrs M was reviewed in April 2005 by the consultant psychiatrist, who concluded that from a psychiatric point of view she was remarkably well, but noted that her mobility was a major issue. He requested that she continue to receive her antidepressant medication from her GP, but did not arrange to see her again. He noted that the social worker should remain involved in her care for a few months but that she could be discharged from the CMHT if she were to remain at the Care Home.

71. Also in April 2005 Mrs M was reviewed by the consultant physician who considered that her problems were more mental health related than physical, and that she might have *'psychomotor retardation secondary to depression'*. She requested a psychiatric review and an assessment for Parkinson's disease.

72. The social worker visited the Care Home on 9 May 2005 but the contemporaneous notes indicate that she did not speak to Mrs M, who was engaged in an activity session at the time. She noted concerns raised by staff about Mrs M's difficulties in day-to-day living, and concluded that her needs were being met at the Care Home. She requested a reassessment of Mrs M's mental health to determine whether this was the cause of her recent symptoms and deterioration.

73. A locum consultant psychiatrist reviewed Mrs M on 7 June 2005, and concluded that she was not currently depressed and that her affective illness was not the cause of her mobility problems.

74. The social worker visited again on 18 July 2005, but again did not speak to Mrs M, who was engaged in an activity session. Following discussion with staff, the social worker noted that Mrs M was a permanent resident and was settling well. She concluded that Mrs M's needs were being met at the Care Home and that there was no longer a role for the CMHT. The social worker completed the paperwork to discharge Mrs M from the CMHT in July 2005. The care plan she completed said that Mrs M was on the standard level of the Care Programme Approach, that Mrs M would continue to be offered appointments with a consultant psychiatrist so that her mental health could be assessed, and that the Care Home staff knew that although she was being discharged from the CMHT, a re-referral could be made.

75. The social worker has told our staff that she would not have made the decision to discharge Mrs M from the CMHT by herself. She would have discussed the case with the consultant psychiatrist (who was part of the CMHT), and it would have been discussed at a weekly team meeting before the decision to discharge was made. There is no record of such discussions. The social worker said that she attempted to contact Miss M to discuss the proposed discharge, but again there is no record of this.

2005 to 2008

76. Following an assessment by a consultant physician in August 2005, it was confirmed that Mrs M did not have Parkinson's disease. He noted that she had *'the akinetic rigidity syndrome (Gegenhalten)*[4] *associated with advanced Alzheimer's disease'*. He said that there was little that drug treatment could do to help, but asked that physiotherapists visit to maximise her mobility.

77. The records from the Care Home indicate that Mrs M's depression was managed with medication prescribed by her GP. There were references to her mood being low for short periods of time, but generally she was well. There is no record of any concern being expressed about her mental health by Mrs M, her family, the staff at the Care Home, or the healthcare professionals who came into contact with her during this time.

78. A care manager from the Care Home wrote a letter on 17 October 2006 stating that Mrs M had declined both physically and mentally in the previous six months. She noted that physically Mrs M was unable to carry out simple tasks and that her mobility was poor, requiring help from two carers at all times because she was unable to walk on her own. She also noted that she was unable to hold long conversations with anyone, and found it difficult to concentrate and understand what was said to her. She also wrote that *'she suffers from severe depression which she has medication for'*.

79. In January 2008 Mrs M was assessed by the occupational therapy and physiotherapy team at the Trust. They confirmed that Mrs M had restricted movement at her elbow joints. They noted that she had poor cognitive function and that she was unable to engage in activities of daily living, requiring assistance from staff to prompt all activities. Mrs M was given a home exercise programme.

80. There is no recorded contact with the CMHT between 2005 and February 2008 when, at Miss M's request, a consultant psychiatrist from the CMHT assessed Mrs M's capacity in connection with an application to the Court of Protection. The consultant psychiatrist stated that Mrs M had had chronic anxiety and depressive disorder since 1955, and established dementia since 2005. He noted that Mrs M was no longer able to understand complex information about her financial affairs, that she was aware that she was no longer able to do this, and that Miss M currently managed her affairs.

The transfer to social services in 2008

81. In March 2008 Miss M complained to the CMHT about increased fees at the Care Home. A senior practitioner at the CMHT arranged a meeting with Miss M, Mrs M, her care manager at the Care Home, and a duty community psychiatric nurse from the CMHT. The community psychiatric nurse's assessment indicated that Mrs M did not have high mental health needs but that she had a high level of general nursing needs. She concluded that Mrs M had a high level of needs that could be managed in an ordinary residential care home, but that she might require nursing care if her mobility continued to deteriorate. She also concluded that Mrs M did not meet the criteria for a full continuing healthcare assessment (for full NHS funding).

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[4] Gegenhalten syndrome is a motor disorder with symptoms such as slowness, rigidity, impaired balance and gait.

82. Miss M refused to pay the increased fees at the Care Home and Mrs M was served with a notice of eviction. Miss M contacted the senior practitioner to request assistance in finding a new home for her mother because she wanted her mother to live nearer to her. The senior practitioner arranged for Mrs M to remain at the Care Home and for the Council to fund the additional fees until a satisfactory resolution could be found.

83. By letter dated 26 June 2008, Miss M complained formally to the Trust that her mother's needs were not being met, and about the lack of consultation and information she received about the Care Home and the fee structure. She said her mother's mental and physical health deteriorated significantly after her admission to the Care Home; and she complained about the decision to discharge her mother from the CMHT (which Miss M had not been informed about), given her long-term mental health problems and needs. She said that in line with section 117 of the Act, her mother was entitled to receive aftercare services until the point of discharge from mental health services. She said that following her compulsory detention in 1989, her mother was regularly assessed and reviewed and was not discharged until 2005 (albeit inappropriately) while she was in the Care Home.

84. The Trust responded on 1 August 2008 that they did not accept the basis of the complaints made. The Trust said that following Mrs M's discharge from hospital, she would have received aftercare under the provisions of section 117 until it was no longer needed, and they were liaising with the Council to establish when aftercare ended.

85. In an email dated 28 August 2008, the community service manager at the Trust who was investigating Miss M's complaint said:

    'I am sticking my neck out on this one as we do not have the paperwork to back up that discharge. 3.3 of the s117 policy clearly states that discharge should be joint decisions and should be discussed in detail at the ICPA [Integrated Care Programme Approach] *review meeting, which it was not. I am trying to keep this as simple as possible as there is too much evidence from our own procedure to hang us.'*

86. On 2 September 2008 the Trust wrote that Mrs M was discharged from her entitlement to receive aftercare services on 8 December 1995, when she was discharged to her own GP on the grounds that she did not require continuing follow up by the CMHT. On 20 October the Trust provided a copy of the psychiatrist's letter of 29 February 1996 (paragraph 55).

87. The Trust said that aftercare services are triggered on discharge from a compulsory detention under the Act, and are aimed to ensure safe discharge and prevent readmission to hospital; the need for aftercare must come from an assessed need arising from the person's mental health disorder. The Trust acknowledged that Mrs M was entitled to aftercare services when she was discharged from the hospital on 12 June 1989; and said that she received services such as outpatient appointments, monitoring medication, and access to a community psychiatric nurse and occupational therapy, and that these constituted aftercare services for the purposes of section 117. The Trust acknowledged that people can remain eligible to receive aftercare services in line with section 117 for some time after

discharge, but said it does not follow that in the event that their condition deteriorates, any service needed in the future will automatically be aftercare under the provisions of section 117. The Trust said that the decision to move Mrs M to residential accommodation did not arise as a result of her mental health disorder, and it was also not aimed at preventing admission to hospital for treatment of this mental health disorder. They said that the provision of residential accommodation was not part of aftercare services within the meaning of section 117, and therefore did not qualify for funding.

88. During a local resolution meeting on 27 November 2008 Miss M said that, contrary to the Trust's assertions, the 1996 letter was not a letter of discharge and that her mother had not been formally discharged from aftercare services until 2005. The Trust provided notes of the resolution meeting that Miss M says were not an accurate nor comprehensive record of the meeting.

89. Miss M made several complaints about the care given to her mother at the Care Home. The senior practitioner agreed to arrange a meeting between her, the manager and Miss M to try to resolve these concerns. It took some time to agree a date but it was eventually arranged for December 2008. However, the meeting did not go ahead because it was decided that Mrs M's needs could be managed more appropriately by the Council's ASC team (paragraph 2) than by the CMHT, and the case was referred to the ASC team in December 2008. The senior practitioner has explained that it was not considered appropriate to proceed with the meeting because the ASC team were now responsible for managing the case. Miss M says that the referral of the case to the ASC team deprived her of an opportunity to pursue her concerns: about her mother's discharge from the CMHT; that her mother's mental health needs were not being met; about the home's high fees and the inadequate care provided for her mother at the Care Home; and that the transfer to the ASC team was inappropriate because of her ongoing complaint to the Trust.

The assessment of Mrs M's needs by the ASC team in 2009

90. A social worker was appointed care manager for Mrs M on 6 January 2009. She visited the Care Home on 13 January to carry out an assessment of Mrs M's needs. Miss M was unable to attend but the social worker met Mrs M and the workers supporting her. Her notes record that Mrs M was mostly happy at the Care Home and considered it to be her home; and that although she would have liked to live closer to her daughter, she hated moving and would therefore prefer to remain at the Care Home. The social worker noted that Mrs M's general health was good and she was generally content. She noted Mrs M's history of mental illness, which she had been told had been stable for approximately four years. She did not identify any significant issues in Mrs M's placement, and concluded that it was appropriate for her needs. The manager of the Care Home, who was present, agreed that Mrs M's needs were fully met, but said the issues in respect of the fee increases needed to be resolved.

91. On 21 January 2009 Miss M complained about the assessment by the social worker. She said that it was based on inadequate information and that there was no assessment of her mother's ability to walk or care for herself. She insisted that no further assessments be conducted unless she and her mother's advocate were present. The Council responded on 30 January 2009 to explain the background to the referral to the ASC team and the purpose of the assessment carried out. The Council said that the transfer was in Mrs M's best interests because her physical needs outweighed her mental health needs, that the assessment was appropriate and in line with good practice, and that as they were now aware of Mrs M's advocate, they would ensure that she was involved in any visits. The Council concluded that there had been some misunderstandings, and that to ensure clear communication they would in future communicate with Miss M in writing.

92. Miss M remained dissatisfied with the Council's response and wrote again on 13 February 2009. She complained that the transfer of her mother's care arose from the local resolution meeting, and that there had been no assessment of her mother's health needs, which was unacceptable, given that her mental health needs were in dispute. She complained that the assessment was not independent and had failed to consider properly her mother's physical capabilities. In response, the Council said that the assessment carried out was not intended to include a full assessment of her mother's mental health, and maintained that the assessment was appropriate; but offered to arrange another assessment by a different social worker. Miss M did not respond to this offer and a reassessment was not undertaken.

93. Miss M informed the Council that her mother's savings had fallen below the threshold level. The Council undertook a financial assessment in March 2009, following which it assumed responsibility for payment of Mrs M's fees at the Care Home.

94. Miss M had first raised the possibility of her mother moving to another care home in June 2008. At that time the senior practitioner at the CMHT had offered to assist in arranging the move to a care home close to London. Miss M complains that although the Council's social worker said that she would help in finding accommodation for Mrs M nearer to Miss M's home (in London), no assistance was provided. She says that when she asked for assistance the Council said it could not find a placement outside Wiltshire.

95. Councils are required to review care plans at six-monthly intervals. The social worker wrote to Miss M on 13 July 2009 to invite her to a review meeting. Miss M responded in a letter dated 31 July that she was unable to attend on the proposed date. She did not ask for the review to be postponed. The file notes record that the social worker discussed this response with her manager, who advised her to proceed with the review that was already overdue. The review proceeded as planned on 4 August.

96. The social worker said that she contacted Mrs M's advocate (whom she knew from work on other cases) by telephone to invite her to the review meeting. The advocate was unable to attend. The review, completed on 4 August, concluded that Mrs M was suitably placed at the Care Home.

97. Miss M said that the advocate told her that she had not been invited to the review meeting. In response to our enquiries, the advocate reviewed her records and found no note that she had been invited. However, she said it was possible that she had been invited but did not record it. She said that, generally, social workers could be relied on to invite her to such reviews. The advocate said that even if she had attended the review, she did not think the outcome would have been any different. She said that she last saw Mrs M on 2 July 2009 and closed her case on 10 September.

98. Mrs M was admitted to hospital in September 2009 and sadly died there on 12 October.

Miss M's comments during our investigation

99. Miss M said that during previous relapses of depressive illness, when her mother reached the point that she was no longer able to self-care, admission to hospital was inevitable. She said that she was told by the psychiatric nurse that her mother had been placed at the Care Home because there were no hospital beds available. She also said that after her admission to the care home in October 2004, her mother's physical and mental deterioration was considerable. She has told us that she believed that when her mother's psychiatrist left the Trust, proper treatment was withdrawn and there was inadequate monitoring of her mental health needs.

100. Miss M said that she was not consulted in any way about her mother's discharge from the CMHT in 2005, and did not become aware of it until 2008. She believed that her mother should have been referred back to the CMHT in 2006 when she became severely depressed, and that her mother's need for regular mental health assessments was not recognised in the assessment carried out in March 2008.

101. Miss M said that she was not happy with the care provided at the Care Home and wanted to move her mother. She had expected to discuss this at the meeting with the senior practitioner from the CMHT, which was cancelled; the Council told her that it was not in their remit to find a home outside Wiltshire and refused to help her. With no assistance, the prospect of moving her mother was daunting and she gave up the idea.

102. Miss M said that when her mother had moved to the Care Home, the community psychiatric nurse asked whether Miss M would be prepared to fund it, and because she thought it was only a temporary measure she agreed.

The Trust's response to the complaint

103. In responding to enquiries during this investigation, the Trust said that they could not provide any evidence of a multidisciplinary meeting to confirm that Mrs M had no longer been eligible for free aftercare services. They provided a copy of her discharge from compulsory detention under section 3 of the Act (12 June 1989); and a letter of 3 July 1989 which, they said, identified no provision for aftercare services, but which did state that follow-up would be provided through outpatients and community occupational therapy support. Therefore, they considered that the discharge from section 117 aftercare services occurred on 12 June 1989. The Trust said that there was no indication that this decision was inappropriate, given Mrs M's clinical presentation.

104. The Trust maintain their view that the decision to discharge Mrs M from the CMHT in 2005 was appropriate, because she no longer required specialist provision from the CMHT because she resided at the Care Home.

The Council's response to the complaint

105. The Council provided no formal response to our proposal to undertake this investigation.

106. The Council's social worker explained that when she assessed Mrs M's needs in January 2009, she was considering whether her care needs were met by her current placement: it was an *'overview'* assessment, not an in-depth study. If she had considered that there was a need for further medical assessment (which had not been identified by the staff at the Care Home or the GP), she would have ensured that the referral was made. However, she saw nothing to suggest that Mrs M's medical and physical needs were not being met. It seemed clear to her that the case was appropriately placed with the ASC team.

107. The social worker said that she would have provided assistance in finding a new placement for Mrs M if requested, but was aware that although Mrs M would have liked to live nearer to her daughter, she did not really want to move from the Care Home. It was clear she had the mental capacity to make that decision.

Clinical advice

The nursing advice

Discharge from section 117

108. The Nurse Adviser confirmed that Mrs M was entitled to receive aftercare services under section 117 of the Act. She said that in keeping with the Code of Practice (which was first published in 1990, after Mrs M's discharge), any discharge decision would usually only be made following a multidisciplinary review meeting. The Nurse Adviser found no evidence of any such meeting, or that the Trust or the Council ever appropriately agreed that Mrs M no longer required aftercare services.

Basis of admission to care home

109. The Nurse Adviser said that before admission to the Care Home, Mrs M should, in line with the Care Programme Approach and the Care Programme Approach guidance, have had a robust assessment to formulate her needs. She said that as Mrs M was on the enhanced level of the Care Programme Approach, there should have been ongoing assessment of her health and social care before the admission to the Care Home. The Nurse Adviser referred to the ongoing monitoring of Mrs M's mental health, but she found no evidence of any assessment of her physical needs before admission. Therefore, she concluded that there was no specific evidence that Mrs M was admitted to the Care Home primarily for her physical needs. The Nurse Adviser noted that Mrs M had been closely monitored by the community psychiatric nurse and the second consultant psychiatrist in the period immediately before her admission to the Care Home,

and commented that the decision to admit her seemed reasonable.

Discharge from CMHT

110. The Nurse Adviser said that, in line with the Care Programme Approach, Mrs M should not have been discharged from the CMHT without appropriate assessment of her health and social needs. As part of this, there should have been a medical review to assess whether she was medically fit for discharge. The Nurse Adviser said that there was no evidence of any such assessment and the clinical records suggested that the decision to discharge Mrs M was made in isolation by the social worker, who was acting as her care co-ordinator. She noted that, contrary to the requirements of the Care Programme Approach, there was no robust assessment of Mrs M's health and social care needs and no multidisciplinary review meeting involving her family. The Nurse Adviser said that the social worker's assessment of Mrs M was based on conversations with the proprietor of the Care Home, and that the social worker did not even speak to Mrs M.

The medical advice

Discharge from section 117

111. The Medical Adviser said that there should be a *'clear paper trail'* for patients entitled to receive aftercare services in line with section 117. This should have included documentary evidence confirming the agreement that a patient no longer needed aftercare services, and the reasons for that. He concluded that there is no evidence that the Trust or the Council appropriately decided that Mrs M no longer needed aftercare services under the provisions of section 117 in 1989, in 1996, or at all. He said that despite this, the Trust did not *'neglect'* Mrs M's mental health need for aftercare, and they provided *'appropriate clinical treatment and care for her in the community until at least 2005'*. He said that Mrs M's symptoms and the risk to herself and others varied at times, but her *'underlying condition persisted'*. He concluded that at no point between 1989 and 2005 could it be said that she *'no longer had a significant and serious mental disorder'*. However, the Medical Adviser found no evidence that Mrs M experienced any *'adverse clinical consequences'* as a result of any failure to meet section 117 obligations.

Basis of admission to the Care Home

112. Mrs M was under the Care Programme Approach in the period leading to her admission to the Care Home. The Medical Adviser said that the Care Programme Approach was designed to ensure that people with enduring mental illness are robustly assessed and reviewed with transparency of process, and with the involvement of patients, their family, carers, and professionals. He said that there should be detailed documentation of assessments, reviews, and care plans. The decision to enter the Care Home should have been discussed with Mrs M and her family, and there should have been an assessment to ensure that the proposed placement was appropriate. The Medical Adviser found no evidence to demonstrate that Mrs M had been appropriately assessed in line with the requirements of the Care Programme Approach.

113. The Medical Adviser noted that Mrs M was *'seriously depressed ...* [and] *her physical condition was very poor'* at the time of her admission. He said that the severity of her mental illness may have meant that Mrs M was unable to make a decision about her care and in these circumstances,

the health professionals should have made a decision based on their assessment of her *'best interests'*. The Medical Adviser noted that the clinical records showed that Mrs M wanted to avoid admission to hospital.

114. The Medical Adviser said that Mrs M's clinical condition was closely monitored by the Trust in the time immediately before her admission to the Care Home. He said that Mrs M was facing a clinical emergency and immediate action was required. The placement enabled an assessment to be undertaken while Mrs M received appropriate observation and care, which would not have been possible had she remained in her home. The Medical Adviser said that she could have been admitted to hospital for assessment, but that this was not recommended by the medical staff nor desired by Mrs M. He said that the decision to admit Mrs M to the Care Home was in line with established good practice at the time.

115. The Medical Adviser said that it was not evident that Mrs M's mental condition had had no bearing on her need for care home admission. He said that if Mrs M's needs were seen as primarily physical, she would have been admitted to hospital or transferred to the specialist care of physicians in the care of the elderly. He noted that her condition fluctuated and there were phases in which physical incapacity was present. He said that this supported the view that Mrs M's physical and mental needs were intertwined.

116. The Medical Adviser said that there is sufficient evidence in the clinical records to confirm that one of the stated purposes of Mrs M's admission to the Care Home was to prevent hospital admission. He said that, if one were to take the view that the services provided by the Trust from June 1989 until October 2004 were part of section 117 aftercare, then Mrs M's admission to the Care Home might be interpreted as forming part of that aftercare.

Discharge from the CMHT

117. The Medical Adviser said that in line with the Care Programme Approach, Mrs M and her daughter should have been consulted on the discharge from the CMHT, which represented a *'significant change in care provision'*. He said that there was no evidence that the assessment of Mrs M prior to discharge was in accordance with the Care Programme Approach. He noted that there was no record of discussion nor consultation with the third consultant psychiatrist about the discharge. There was no evidence that Mrs M or her daughter were consulted about the discharge.

118. Furthermore, the limited clinical records meant that it was not possible to say with certainty whether Mrs M was clinically fit for discharge from the CMHT. The Medical Adviser noted that the CMHT had confidence in the care provided at the Care Home, and in the skills of the senior staff there, to detect and ask for assistance with any significant change or deterioration in Mrs M's mental health. However, although he could not conclude that the decision to discharge Mrs M from the CMHT was appropriate, the Medical Adviser found no evidence of any adverse consequences as a result of this decision.

Care and treatment

119. The Medical Adviser commented that he could identify no failings in the care and treatment given to Mrs M by the CMHT.

Our findings

120. We have considered all the available evidence about Miss M's complaint and taken account of clinical advice which, we note, is finely balanced. We have reached the following conclusions.

Section 117 funding

121. In 1989 Mrs M was detained under section 3 of the Act and as such was eligible for free aftercare, with funding of service provision under section 117. When responding to Miss M's complaint, the Trust did not provide consistent explanations about Mrs M's discharge from section 117 provision. They initially said that discharge was in 1996 when the consultant psychiatrist had referred Mrs M to her GP. But after further research of Mrs M's medical records, they said that it had taken place in 1989, at the time of her discharge from the section 3 detention. At neither time had the Council and the Trust followed any specific procedures for discharge from section 117 funding, and the Trust have recognised that they did not have the documentation to back up the discharge. We note that the Code of Practice (paragraph 24) that contains specific guidance about this was not published until 1990 – after Mrs M's discharge. Nevertheless, in our view, the failure by the Trust to consider Mrs M's eligibility for section 117 funding at any contemporaneous stage was maladministrative. We now consider whether this maladministration by the Trust was the cause of an injustice to Mrs M.

122. The Code of Practice, with its specific guidance on arrangements for funding of, and discharge from, section 117 provision, was issued in 1990. When Mrs M had been discharged from the section 3 detention in June 1989, she had not been included on any register of patients or service users being funded under section 117, or for whom section 117 would apply (as later advised in the Code of Practice). The services which Mrs M received on her discharge from the section 3 detention – occupational therapy, follow-up appointments with her consultant psychiatrist, and clinic attendances – were arranged in the usual way through the NHS, and no provision was made for any other specific services for which funding under section 117 of the Act was required. ('*After-care*' under section 117 is not defined in legislation or other guidance, but it is primarily aimed at preventing the need for further admissions to hospital or nursing care.) In any event, for 15 years after the 1989 discharge from section 3, Mrs M did not pay for any service provision for which section 117 might have been relevant. When the Council reviewed their records in 2002, Mrs M was not identified as a service user for whom procedures relating to the discharge from section 117 had to be reconsidered.

123. We have noted that the special report issued by the Local Government Ombudsmen in 2003 advised that, in general, social services authorities should not carry out retrospective assessments purporting to remove a person from section 117 aftercare as from an earlier date. However, it seems to us that Mrs M's case can clearly be distinguished from the cases considered in the special report, where the service users had all been detained under section 3 during the 1990s, and had all been placed in residential care relatively soon after discharge from section 3. Also, the starting point in all these cases had been an acceptance that section 117 aftercare was being provided – which is not the case here.

124. Our Medical Adviser has suggested that if one were to accept that section 117 was in fact being provided upon discharge in 1989, it might be possible to assume a continuous link from that date until the admission to the Care Home in 2004. However, we have seen that in the period following Mrs M's discharge from the section 3 detention in 1989, it seems that there had been nothing to prompt the Trust or the Council to review her need for section 117 provision. She continued to suffer from mental illness (as she had done for many years), but had periods when her condition was relatively stable and she did not require provision of additional or specific services for which section 117 would have applied. It does not seem to us that entitlement to free services should continue perpetually, regardless of intervening events and changing personal circumstances. We do not see any firm basis for concluding that such an eligibility continued up to the point of admission to the Care Home. In the particular circumstances of Mrs M's case, we do not consider that the lack of a specific discharge from section 117 obliges the Council to accept her as having been eligible for section 117 funding in 2004, many years after the section 3 detention was discharged. The evidence about the underlying nature of Mrs M's need to be admitted to residential care seems mixed. The key point is that we cannot say with any degree of certainty that the admission to the Care Home can be linked directly to aftercare needs that might have been present in 1989. We cannot, therefore, conclude that the failure to consider Mrs M's eligibility for section 117 definitely led to an injustice to her or her family.

The admission to the Care Home

125. We see no grounds to criticise the arrangement made for Mrs M's placement at the Care Home. It was apparently an appropriate response to her needs at the time and was initially intended as a respite measure. Miss M maintains that she was told that it was only arranged because there were no hospital beds available. However, the community psychiatric nurse says that this was not the case; and there is no other evidence to support Miss M's recollection. The records do not indicate that a hospital placement was considered appropriate at that time.

126. It is not disputed that Mrs M continued to suffer symptoms of mental illness before and after her admission to the Care Home. The possibility of a link between her physical deterioration and her mental health was recognised and investigated after her admission to the Care Home, as noted in referrals to consultant physicians and consultant psychiatrists for assessment of the cause of the physical deterioration. Because of her increased physical disability, Mrs M continued to require residential care and support, which was provided in the Care Home.

127. Although we recognise that, inevitably, Mrs M's deterioration over time can be seen as the result of combining mental and physical ill health, we do not consider that the circumstances of Mrs M's placement at the Care Home warrant a recommendation that the very significant costs involved should be funded under section 117 of the Act. We do not conclude that there is clear evidence that this should be the case.

The discharge from the CMHT

128. It is clear that Mrs M's discharge from the CMHT did not accord with the prescribed procedures or guidance. The only written records relate to action taken by a social worker. There is no record of consideration in a multidisciplinary meeting of the proposal to discharge her, and no record of the involvement of the consultant psychiatrist or Mrs M and her family in the decision. In our view, this was maladministration.

129. However, we do not consider that this was the cause of an injustice to Mrs M or her family, because we see no reason to conclude that service provision for Mrs M would have been different had the discharge followed appropriate procedures. Mrs M was receiving full-time support for her daily living needs from the staff at the Care Home. Her mental health fluctuated, but she continued to be treated with medication. The evidence indicates that Mrs M was clinically fit for discharge from the CMHT and that it was reasonable to conclude that she did not require continuing specialist input from the CMHT at that time. The care plan noted that staff at the Care Home were aware that a re-referral could be made to the CMHT, should the need arise.

Provision of care by the Trust between 2004 and 2009

130. Mrs M's physical needs were supported by the Care Home; and her health needs, including her mental health needs, were then the responsibility of her GP. The Trust's occupational and physiotherapy service were involved in January 2008, and recommended a programme of physical exercise. Until 2008 no concerns were raised about the suitability of Mrs M's placement at the Care Home, and staff there felt able to meet her needs.

131. Miss M feels very strongly that her mother's mental and physical needs should have been addressed more proactively by the Trust during the time her mother was resident at the Care Home. She has stated that, if it had been, her physical deterioration would not have progressed in the way it did. However, in our view, the available evidence does not support her contention that there was fault by the Trust or by the Council in the provision of care during this period.

Transfer of responsibility for care to the Council's ASC team

132. The CMHT had closed Mrs M's case in 2005. In 2008 they responded to an approach from Miss M and assessed whether Mrs M would be eligible for NHS continuing healthcare funding. They also dealt with the complaint that Miss M subsequently made, but Mrs M's case was not re-opened by the CMHT because they did not consider that there was a need for specialist input from mental health services.

133. It became clear in late 2008 that Mrs M did require support, because of the threat to her placement in the Care Home following an eviction notice after a fee increase had not been paid. At that stage Mrs M's principal need was not for mental health support, but for support to ensure that she had somewhere appropriate to live. We consider, therefore, that it was reasonable for the case to be passed to the ASC team and for a social worker to be allocated to undertake an assessment of need. We see no evidence of fault by the Council or by the Trust here.

134. Miss M complains that the transfer to the ASC team deprived her of assistance from the CMHT's senior practitioner, led to the cancellation of the meeting at which this would be discussed, and prevented her from pursuing her complaint about the Trust. It is true that the senior practitioner did not continue her involvement after the case was opened by the ASC team, and that this was the reason for the cancellation of the planned meeting. However, this seems to us a reasonable consequence of the decision that the ASC team was the appropriate body to address Mrs M's needs at that time. The transfer to the ASC team did not prevent Miss M from pursuing her complaint about the Trust.

The assessment following transfer to the ASC team

135. *The National Service Framework for Older People* (paragraph 39) makes it clear that in assessing the need for services, local authorities should follow a person-centred approach; and that the scale and depth of the assessment should be proportionate to the individual's presenting needs and circumstances. It stipulates that the single assessment process should consider the user's perspective; their clinical background; disease prevention; personal care and physical well-being; their senses; mental health; relationships; safety and immediate environment; and resources. It recognises that assessment may identify the need for more specialist assessments.

136. The social worker who undertook the assessment of Mrs M's needs in January 2009 followed the usual procedures and concluded that her placement at the Care Home was appropriate. The record of the assessment indicates that the social worker took account of Mrs M's health needs and her history of mental illness. She considered that the assessment was proportionate to Mrs M's presenting needs, and saw no reason to seek specialist advice.

137. Miss M was concerned that the assessment had not included an in-depth assessment of her mother's mental health and the causes of her physical decline. The ASC team considered Miss M's concerns but did not agree that the assessment had failed to address relevant issues. In response to Miss M's complaint about this, the ASC team offered to arrange for a new assessment by a different social worker, but Miss M did not pursue this offer.

138. We see no reason to criticise the approach followed by the ASC team. The evidence indicates that the ASC team took account of Mrs M's presenting needs and other relevant information, and reached a view after following procedures that accorded with the relevant guidance.

139. We see no grounds to criticise the ASC team's decision to proceed with the planned review arranged for August 2009, after considering Miss M's response to the invitation to the review. The evidence is not conclusive about whether Mrs M's advocate was invited as she should have been. But in any event, we see no reason to believe that the outcome of the review would have been any different if the advocate had attended – which is the view of the advocate herself.

Miss M's response to the draft report

140. Before preparing the final version of this report, we sent Miss M a draft for her comments. Miss M raised a number of issues in response to the draft report which have been addressed in a separate covering letter to her. She disagrees fundamentally with our conclusions but, although we have made some minor changes to our report as a result of her response, our findings have not changed.

141. Amongst the main issues she raised were that there was strong evidence that her mother was suffering from a relapse of her severe depressive illness at the time of her admission to the Care Home, and that the complex physical and mental health problems she presented with in October 2004 were identical to those presented at earlier admissions to psychiatric hospital between 2001 and 2003. In paragraphs 126 and 127, we acknowledge that Mrs M continued to suffer symptoms of mental illness before and after her admission to the Care Home. We have, however, concluded that because of her increased physical disability, Mrs M required full-time support for her daily living needs, which was provided at the Care Home. The circumstances of her placement there do not seem to us to warrant a definite recommendation that the Care Home costs should now be funded retrospectively under section 117 of the Act.

142. Miss M has also reiterated her belief that her mother's admission to the Care Home took place because there were no hospital beds available. As we have explained in paragraph 125, the records do not indicate that a hospital placement was considered appropriate at that time. She also said that at no other time when her mother suffered a relapse of her mental illness was she '*abandoned*' as she was, and asks why the CMHT abruptly withdrew treatment following her mother's admission to the Care Home. While we have made it clear in paragraph 128 that the process of Mrs M's discharge from CMHT did not accord with the prescribed procedures and guidance, we remain of the view, as set out in paragraph 129, that we do not consider that that caused an injustice to Mrs M or her family, because she received full-time support for her daily living needs in the Care Home.

143. Miss M has also suggested that our decision in her case, about liability for section 117 aftercare payments, is not in line with previous cases considered by the Local Government Ombudsman. We have explained to her that we do not consider that her own complaint is exactly similar, in relevant aspects, to previous complaints that we have considered; nor that we are contradicting previous guidance or conclusions reached by the Ombudsmen here.

Summary

144. Miss M understandably feels that her mother's lifelong mental illness could and should have been addressed more actively towards the end of her life, and that this might have reduced her physical incapacity. However, the evidence we have seen does not support a conclusion that the Trust and the Council failed to assess and provide for her mother's health and social needs properly from 2004 until her death in October 2009. Therefore, we do not uphold Miss M's complaints.

Final remarks

145. In this report we have set out our investigation, findings and conclusions with regard to the care Mrs M received from the Trust and the Council. We can assure all the parties to the complaint that we have investigated the complaint impartially and that our conclusions have been drawn from careful consideration of detailed evidence and the advice of our professional advisers.

Dame Julie Mellor, DBE
Health Service Ombudsman for England

Dr Jane Martin
Local Government Ombudsman for England

October 2012

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