Local Government
OMBUDSMAN

Parliamentary and Health Service Ombudsman

Report

in confidence

on a joint investigation into complaint no 11004229 against Kirklees Metropolitan Borough Council and South West Yorkshire Partnership NHS Foundation Trust

20 November 2013

Investigation into complaint no 11004229

against Kirklees Metropolitan Borough Council and South West Yorkshire Partnership NHS Foundation Trust

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The Local Government Act 1974, section 30(3) generally requires me to report without naming or identifying the complainant or other individuals. The names used in this report are therefore not the real names.

Key to names used

Dr X	the complainant
Mr and Mrs X	his parents
Mr AX	his brother

The social worker
The social worker's manager/Community Mental Health Team manager (CMHT)
The group manager for older people's services
The Community Psychiatric Nurse CPN)
The investigating officer
Dr Z

Report summary

Subject

The complaint relates to the assessment and care arranged by the Trust and Council for Dr X's parents, who suffered from dementia. When Mr X suffered an injury after Mrs X struck him, the Trust and Council failed to raise a safeguarding alert. Mr X returned home for some months with an inadequate package of care. The Trust failed to reassess his prescription for Aricept in line with NICE guidance. When Mr X later went into respite care, without properly consulting Dr X the Trust and Council applied for a Deprivation of Liberty Order to prevent Mr X's return home, although Dr X had arranged a package of care. The Trust sent a copy of a report about Mr and Mrs X's future care direct to Mrs X, which caused her much distress.

Finding

There was maladministration on the part of the Council and the Trust which caused injustice to Dr X and to Mr and Mrs X.

Recommended remedy

The Council and Trust should apologise to Dr X for failing to have due regard to his concerns about his parents. They should review the way in which they involve relatives in assessing and planning for the care of family members with dementia. They should review their joint arrangements for responding to complaints. The Trust should review the way it reassesses prescriptions for Aricept in line with NICE guidance. The Council and Trust should make a payment of £1000 to Mr and Mrs X in acknowledgement of the distress caused to them. The Trust should make an additional payment of £250 to Mrs X in recognition of the distress caused to her by the receipt of the report about her future care. The Council and Trust should make a payment of £500 to Dr X to acknowledge the distress and frustration caused to him by a failure to consult with him properly about his parents' care. They should also consider a further payment to him for any financial loss he can evidence was caused by the failure to consult with him properly about the arrangements for his father's care. The Council and Trust have agreed these remedies.

Introduction

1. Dr X's complaints span the remits of the Health Service Ombudsman and the Local Government Ombudsman. Dr X agreed to a joint investigation by the Health Service Ombudsman and the Local Government Ombudsman. This report sets out our findings, conclusions and recommendations with regard to those aspects of Dr X's complaints which we agreed to investigate. We wrote to Dr X in June 2012 explaining our decision not to investigate other aspects of his complaint.

The overarching complaints

2. Dr X complains that the Council and the Trust failed to act appropriately in respect of the care of his parents, Mr and Mrs X. He says that after his parents moved closer to him in 2008 for more support, at his request the Council arranged a care package for personal care for Mr X who was suffering from dementia. In March 2009 Mr X was admitted to hospital with acute glaucoma (increased pressure within the eye) possibly caused by Mrs X, who was also beginning to suffer with dementia, striking him in the face. He says Mr X was discharged home with a hastily-arranged social care package.

3. Dr X says that no-one from the community mental health team (CMHT) took into account his concerns about his mother's failing mental health: despite the information about her memory problems available from Mrs X's previous CMHT, Mrs X's new CMHT said that she was suffering from stress caused by looking after Mr X. However, in September 2009 Mrs X was admitted to hospital with a urinary tract infection and after suffering an allergic reaction to the antibiotics prescribed to treat her. Mr X was admitted on a respite basis to a care home while Mrs X was in hospital. Dr X says when he requested Mrs X's discharge he was telephoned by Dr Z, a consultant in psycho-geriatric medicine, advising him against taking Mrs X home. Dr X began to make arrangements for his father's discharge from the care home where he said standards were deteriorating.

4. Dr X says he informed the CMHT that he had appointed a nurse to act as private carer for his father when he came out of the care home. He says that when he first told the team this there was no indication that his arrangements were unsatisfactory; however, he says that he was telephoned a week later - a few days before his father's intended discharge — and was asked if he would revise his decision to take his father home. He says he was told that there had been a meeting of professionals who had decided that the care he was planning for his father was inadequate, because he had not arranged 24 hour care, and a Deprivation of Liberty Safeguarding (DOLS) order was being requested to ensure his father remained in the care home. Dr X says he understood it was Dr Z who had deliberately excluded him from the meeting.

5. Dr X says that no-one from the CMHT was willing to explain to his mother, who was expecting her husband to be discharged home, that Mr X would have to stay in the care home. He complains that as a result of the DOLS order, he was unable to maintain the services of the carer he had employed. He says that in order to secure his father's discharge home, he had to arrange care through an agency which could provide 24 hour care. He considered that the carer who attended was young and inexperienced and did not understand that Mrs X needed to be involved in Mr X's care. He says within 48 hours the arrangement broke down because the carer tried to impose her authority on Mrs X who then assaulted her.

6. Dr X says that the consequence of the failure of the Council and the Trust to act properly was that he spent time and energy setting up a care package for his father which then had to be abandoned. He says that his mother was extremely distressed by the realization that she could not care for her husband at home. He himself felt belittled by his exclusion from the relevant meetings and says he was misrepresented in the Deprivation of Liberty application.

Dr X's complaint about the Council

7. Dr X complains in particular about:

    - the assessments of Mr X's dementia and the failure to implement the safeguarding process;
    - the way in which the decision was taken to authorise a Deprivation of Liberty order on Mr X in the care home, despite Dr X's arrangements for his care at home;
    - the failure to include Dr X in the meeting when the intention to request a Deprivation of Liberty order was discussed; and
    - the way the Council handled his complaints.

Dr X's complaint about the Trust

8. Dr X complains in particular about:

    - the failure to carry out a medical assessment of Mr X (which Dr X had requested) for his continued treatment with Aricept (a drug intended to slow down the progress of dementia);
    - the discharge of Mr X from hospital without raising a safeguarding alert despite evidence that Mrs X had injured him;
    - the way Dr Z sought to exclude Dr X from the meeting where a Deprivation of Liberty order for Mr X would be discussed;

- the way the Trust handled his complaints.

The Ombudsmen's remit, jurisdiction and powers, and the basis for our determination of the complaint

9. We have set out in Annex A our respective remits and relevant powers. Annex B provides a detailed explanation of how we determine complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration. This explanation includes full details of the general and specific standards that we apply. Annex C sets out the specific guidance and legislation relevant to the matters under investigation in this case.

Investigation

10. Our investigator has met Dr X to discuss his concerns. We also examined relevant evidence including the Council's and Trust's records and case notes for Mr and Mrs X, and interviewed Council officers and Trust staff who were involved in the events about which Dr X complains. It has not been possible to interview Dr Z who is absent on long-term sick leave. We have also obtained clinical advice about some aspects of Dr X's complaint from a consultant psychiatrist who specializes in the management of common disorders in clinical psychiatry in older people, including dementia. The clinical adviser, Dr Ola Junaid, FRPsych, is a specialist in her field and in her role as our adviser is completely independent of any NHS body. We also considered whether the Trust and the Council demonstrated the Ombudsman's Principle of '*Getting it right*' (Annex B).

11. In this report we have not referred to all of the information examined in the course of the investigation but we are satisfied that nothing significant to the complaint or our finding has been omitted.

What Happened

Background information

12. Mr X was 80 years old at the time of these events and was suffering from advanced Alzheimer's disease, a common form of dementia for which there is no cure. He was being cared for by Mrs X, his wife. Mrs X had also started to suffer from memory problems and episodes of delusional behaviour. Mr and Mrs X moved house from another area to be nearer to their children (Dr X, and his brother Mr AX) for support. (Dr X and Mr AX acknowledge that they have a difficult relationship with each other but they both provide support for their parents.) In March 2009 Dr X asked the Council to arrange help for his parents. A social worker visited Mr and Mrs X at home to complete a community care assessment (Dr X and his wife also attended). Following the assessment the social worker agreed a care package to assist Mr X with bathing and dressing.

Social care involvement: Mr X's admission to hospital

13. The social worker who carried out the community care assessment also made a referral to the memory monitoring service to review Mr X's prescription for Aricept, as Dr X requested. Her file note states that "*due to his advanced dementia, the Aricept might not be suitable for him anymore*". The records show that the memory monitoring service asked the social worker to complete a Mini Mental State Examination (MMSE) of Mr X and said that if he scored less than 10 out of a possible 30, it would no longer be appropriate for him to keep taking Aricept. The social worker agreed to complete the MMSE at the next review of the care package in a month's time.

14. At the end of March Mr X was admitted to hospital suffering from acute glaucoma. Dr X wrote to the social worker explaining that he believed that his mother had struck his father in the face and that this was the cause of the glaucoma. The social worker's notes show that she discussed the allegations with the ward staff. She advised the ward staff that she would assess Mr and Mrs X prior to Mr X's discharge to ensure appropriate services were still in place for Mr X.

15. The social worker's notes record her conversation with Mrs X. She notes that Mrs X denied hitting her husband: she records Mrs X said "*they were playing and she flicked his glasses*". The notes go on to explain that Mrs X had not retained any information from discussion on previous days about services and care needs, "*she was unable to demonstrate her ability to use the information in a reasonable and logical manner as part of a decision making process relating to services for her husband and support for herself in her caring role*". The social worker concluded that Mrs X believed she could manage to look after her husband without any support although Mrs X agreed to services offered as long as the carers did not interfere.

16. The social worker told us that this was the first safeguarding situation she had come across. She said that she did not think that the matter should automatically be processed as a safeguarding alert: she investigated instead by talking to Mrs X and exploring the options for more services at home and she says that Mrs X seemed amenable to an increase in services. She said that Mr X's discharge from hospital then happened more quickly than she expected because of Mr AX's view that the general ward was unsuitable for his father and that he would be better cared for at home. She told us that the ward staff agreed that Mr X should not be on a general ward because of his dementia, but unfortunately they did not request any mental health advice or suggest that Mr X was moved to a more appropriate ward. As Mr X was discharged from hospital on a bank holiday, it was too short notice to arrange the increased care package which she felt should be in place at that point. The social worker pointed out that Mrs X did not have a diagnosis of dementia at this stage. She acknowledged however that if a

safeguarding strategy meeting had taken place at that time, it is likely that Mr X's discharge could have been properly pre-planned with services available as soon as he arrived home.

17. The social worker's manager (who is also manager of the CMHT) told us that she believed a safeguarding alert should have been raised at the time of Mr X's admission to hospital when the information was received from Dr X that the injury to Mr X's eye had been caused by a blow from Mrs X; she told us it was likely that a more robust care package would have been put in place at the time if a safeguarding procedure had been implemented. She told us however that it was very early days in terms of the process of handling safeguarding procedures. Dr X says he discussed the possible assault by Mrs X on Mr X at the time with the CMHT manager. He says the CMHT manager later told him she had considered it a safeguarding matter.

18. The group manager for older people's services had recently moved to the Trust from a local authority role. She became responsible for safeguarding. She told us that at that time there had not been very much work done or training delivered on implementing safeguarding procedures at the Trust. She told us that if the allegations that Mrs X had struck Mr X had prompted the appropriate safeguarding alert, a new care package could have been arranged in line with the couple's needs.

Mr and Mrs X's increasing needs

19. Following Mr X's discharge from hospital, the social worker arranged for an occupational therapy assessment, a physiotherapy assessment and she also arranged an increase in the care package for the evenings, as it was proving too difficult for one carer to cope with Mr X's bathing needs. The social worker told us she was concerned because Mrs X was becoming increasingly disturbed by the number of professionals who were coming to the house to carry out assessments of Mr X. Mr AX was providing additional care for his father. In a meeting with her manager on 12 April, the social worker agreed to write to Mr AX expressing concerns about Mrs X's ability to care adequately for Mr X.

20. The social worker's notes of her contact with Mr and Mrs X over the next few months reflect her concerns that Mrs X was struggling with her memory problems. She notes that Mrs X was disorientated about the days of the week; she was unable to retain new instructions; she talked about Mr X as though he was a child. As a result of her concerns the social worker arranged for Mrs X to be assessed by the CMHT. Both the social worker and the community psychiatric nurse (CPN) who visited her also attempted to persuade her to stop driving but Mrs X refused.

21. The social worker arranged a case conference in July 2009 attended by Mrs X, Mr AX and his wife, a CPN and an independent mental capacity advocate (IMCA) -Dr X was away on an extended trip abroad and could not attend. The conference

discussed the problems Mrs X was experiencing in looking after Mr X. Mrs X said she didn't want Mr X taken away from her: the social worker assured her that everyone wanted Mr X to remain at home with support from the necessary services. Mrs X agreed to go away with Dr X for a holiday while Mr X went into respite care for a while. Dr X telephoned the social worker in July to let her know he was planning to take his mother away for a week in August. The social worker agreed to arrange a respite placement at a care home for Mr X.

22. A note on the social worker's file in August records that she told a member of CMHT nursing staff she would be unable to complete the MMSE of Mr X as requested. The nurse advised her to contact Mr X's GP to stop the prescription of Aricept. The social worker noted on the file her concerns that if Mr X's Aricept was stopped he might become unmanageable whereas at the moment his circumstances were stable. She also noted during a discussion with the memory service about Mr X her recollection that when Dr X had practiced as a GP, he had not prescribed Aricept for his patients. Dr X told us that he prescribed the drug when he was a GP only when advised to do so by a consultant psychiatrist.

23. The CPN visited Mr X at home on 7 September at the request of the CMHT. She noted that he was unable to complete any of the MMSE. She recorded "*it is debatable whether he would still satisfy the criteria for cholinesterase inhibitors (*Aricept is a cholinesterase inhibitor*); however, I am reluctant to advise even a trial period without the Donepezil (Aricept) at the moment due to the fragility of their home situation*".

Mrs X's hospital admission and the emergency placement of Mr X at the care home

24. Mr AX contacted the CMHT in September with concerns about his mother. He said his mother was having hallucinations about seeing strange people in the house, had driven the wrong way round a roundabout and had also recently put an incontinence pad under the grill. The CPN contacted the social worker and told her that the plan was to try to persuade Mrs X to go into hospital, and so Mr X needed an emergency respite placement.

25. Dr X says that when he returned from a holiday with his wife in September, he discovered that his mother had been admitted to hospital with an acute confused state caused by a urinary tract infection and an allergic reaction to the antibiotic first used to treat the infection. He says that in fact she had already improved by the time he visited her and was certainly no worse than when he took her on holiday in August. On that basis he requested her discharge as he says he saw no point in keeping her in hospital where she was clearly unhappy and he knew that ongoing investigations of her mental state were being undertaken on an outpatient basis.

26. Dr X says that he was subsequently telephoned by Dr Z who was Mrs X's consultant psychiatrist: Dr Z advised him against taking his mother out of hospital

at that time. Dr X says he could see no purpose in his mother staying in hospital when it would not make any difference to the outcome and so he collected her from hospital and took her home to his house. She stayed there for the next six weeks while a care package was being arranged.

27. Dr Z recorded his concerns in a file note on 9 October. He said he understood Dr X intended to advertise for a private carer for his father: he recorded that Dr X had said he felt this was necessary because there was a period when his father was not washed by the home-care staff on "*health and safety grounds*" because of the potential risk of violence. Dr Z noted Dr X said he would "*get round this nonsense*" by employing people directly. Dr Z told Dr X he was concerned this would not meet Mrs X's needs. Dr Z then wrote "*I suggested a compromise where there ought to be a multidisciplinary meeting with all the family members. However, he declined this saying he was not prepared to attend a meeting with either his brother or his nephew present*". Dr Z noted that he subsequently discussed the situation with the group manager for older people's services and they decided to write to Dr X with their concerns, arrange for an IMCA for Mrs X, and meet other relevant staff to discuss what they considered were safeguarding issues.

28. Dr Z wrote to Dr X on 8 October as planned. He reiterated his advice that it was in Mrs X's best interests to remain in hospital while a plan was made for her future care. He said "*your mother does not have the capacity to understand the issues to decide a future placement. It is my belief that you are making an unwise decision against medical advice*". However, he concluded that because he wanted to work with Dr X's family, he recognised that Dr X would be taking his mother home and he himself would continue to provide support through outpatients' appointments.

29. Dr X says that his mother settled on discharge to his home. He says that over the next two weeks he interviewed applicants for the post of carer and he appointed someone who was qualified as a registered mental nurse and who lived locally. He says he intended to employ her from 9am to 2 pm every day to get Mr X up and dressed, and given breakfast as well as bathed. She would then drive Mr and Mrs X out if they needed to go out, give them their medication and make sure they had a hot meal at lunchtime before making sandwiches for their evening meal. He says he intended that the Council-arranged domiciliary carers would continue to attend in the evening to get Mr X to bed.

30. Dr X says that he decided to employ a private carer for two reasons; it was important that his mother had a good relationship with a single private carer so that she would let the carer take responsibility for Mr X, as she would otherwise interfere with an irregular carer schedule. He also says that he was unimpressed with the agency carers who had looked after his father over the summer: he says their visits and care were cursory, they did not check that Mr X had eaten properly and one carer had described Mr X as "*mental*" in Dr X's presence.

The strategy meeting 20 October 2009

31. On 20 October a strategy meeting was held to discuss Mr and Mrs X which was attended by Dr Z, the CPN, the social worker, the CMHT manager and the IMCA. A member of the assertive outreach team[1] also attended. The meeting discussed the possible risks to Mr and Mrs X of Dr X's intended care package. There were concerns that Mr X might wander at night and that he could be aggressive towards carers. There were concerns that Mrs X had no capacity to make judgements; there was a fire risk as she put inappropriate items under the grill, and there was risk of abuse to Mr X — she had hit Mr X previously. The representative from the assertive outreach team said that Dr X had told his mother that if the care package was unsuccessful they would have to look at 24 hour care.

32. The meeting agreed that Dr Z would write to Dr X again with the team's specific concerns. Dr Z was recorded as asking whether safeguarding procedures needed to be followed now but it was agreed that Dr X's family needed to try at home with a "*good package of care*". The contingency plan was for emergency respite then long-term care.

33. Dr Z wrote to Dr X again on 21 October about the meeting. He said he had not understood from their previous telephone conversation that Dr X also intended for his father to come home, and he asked whether it was in Mr X's best interests to try living at home when there was a "*questionable*" chance of success. He asked how Dr X proposed to deal with the problem of his father wandering at night, when no carer was available. He reminded Dr X that Mr X had not been thriving at home prior to his placement in 24 hour care (despite the support package in place) whereas he was now settled in 24 hour care. He also asked whether there was any plan for an isolation switch to be installed for the cooker to prevent a repetition of the fire risk caused by his mother. He concluded, "*I hope you will find this letter helpful and supportive as we will do whatever we can to ensure the trial at home is given the best chance of succeeding*".

34. Dr X says that he found Dr Z's letter insulting. He said that Dr Z did not take into account Dr X's and his wife's long experience of medical practice. He did not respond to the letter.

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[1] The assertive outreach team operates in a similar way to the CMHT. It provides intensive care and support and can offer flexible interventions in response to changing risk and needs.

The visit of 4 November and the meeting of 10 November 2009

35. The social worker made a note in the records for 3 November that Dr Z was considering another strategy meeting for Mr and Mrs X: she added "*I do not consider this appropriate. Case conference with (Dr X) is required so that he is aware of the situation. Discussed the matter with (the CMHT manager)*." The social worker told us that in her view the situation should have been discussed openly with Dr X so that he knew the issues. However, she said that the CMHT manager was reluctant to ask Dr Z to include Dr X in the meeting and sought the advice of the group manager, who was in charge of safeguarding, instead. The group manager said that they needed a safeguarding meeting with an IMCA present.

36. On 4 November the social worker visited Dr X at home to discuss a reassessment of the care services for Mr X. The CPN also attended to visit Mrs X (her client). The notes of the social worker's visit show that they discussed the times that Dr X wanted home care services to attend, and that he wanted his father to continue to access day services and to have access to respite care. Dr X told them that he had employed a nurse to act as private carer for his father. The concerns about Mr X's night-time wandering were discussed: Dr X says that he told the social worker that if this was a problem they would appoint appropriate carers to deal with it. The CPN agreed to contact a night-sitting service to provide support if the night-wandering was going to be a problem.

37. The social worker told us that neither she nor the CPN offered an opinion to Dr X about the appropriateness of the care package he had planned. She told us she had no thought of voicing her concerns at that time; she was aware that the outcome of the strategy meeting of 20 October was to try a care package at home as a first option. She told us the amount of hours Dr X had employed a carer for was inadequate and it was unrealistic to think that Mrs X could provide the rest of the care. She told us that another reason why she did not raise any concerns at the meeting was because Dr X was a difficult person to engage with.

38. Dr X says he was given no warning at all at the meeting on 4 November that there was any dissatisfaction with his plan to bring his father home; he says as far as he was concerned, the discharge was going ahead on 16 November.

39. Dr Z visited Mr X at the care home on 10 November before the professionals' meeting to carry out an assessment of his capacity. He concluded that Mr X had no capacity to form any decisions about his future care.

40. The social worker recorded in her notes that all professionals present at the meeting on 10 November agreed that "*it is unsafe and unrealistic for Mr X to return home given the paucity of the care package that is to be put in place*". She added that it would be virtually impossible to obtain a care package at home from the private sector that adequately met Mr X's needs.

41. The group manager told us that it became clear after the social worker's visit to Dr X on 4 November that the extent of the care package he had planned for Mr and Mrs X was about 22 hours a week. She told us the outcome of the strategy meeting on 20 October had been that they should try to manage at *home* with a significant package of care. She told us that the decision that Dr X (or other family members) should not be included in the meeting of 10 November was made by Dr Z whose view was that it was a meeting for professionals only.

42. The group manager told us that Mr X had no capacity and Mrs X had fluctuating capacity to make their own decisions about their care needs. She told us the meeting of 10 November needed to look at all the options available for the couple, but had to balance the desire for a care package at home with the difficulty of Mrs X accepting that someone else would be providing care for Mr X which she had not previously been able to accept. She told us it was agreed that they needed more time to arrange a proper care package before Mr X could be discharged from the care home. The meeting therefore agreed that the CMHT manager would talk to Dr X about reconsidering a 24 hour care package. The group manager told us she had raised the option of seeking legal advice about applying for a Deprivation of Liberty order if Dr X insisted on trying to take his father home before a 24 hour care package was in place.

The decision to request a Deprivation of Liberty Order

43. Dr X says that on 12 November 2009 he had a telephone call from the CMHT manager. He says he was asked if he would consider revising the decision to take his father out of the home on 16 November: he said he would not, as the carer had already been employed to start on 16 November. He says the carer had already given notice from her previous job. He says the CMHT manager told him that there had been a meeting on 10 November from which he had been excluded — he says he understood that Dr Z had excluded him from the meeting because he had not replied to Dr Z's letter of 21 October — and that the meeting had decided the care he was intending to provide for his father was inadequate and so an urgent Deprivation of Liberty order would be applied for to keep Mr X at the care home.

44. The CMHT manager's notes of the telephone call say "*I have ...spoken with (Dr X) today to inform him of our disquiet about him taking his father home and asking him to reconsider his position. (Dr X) is absolutely determined to take his father home. I informed him of our intention to apply for an urgent authorisation for a Deprivation of Liberty order. (Dr X) was angry that we had left it until today to inform him of our concerns and intentions. I did point out to him that (Dr Z) had written to him on the 21st October outlining his concerns about taking his father home*."

45. The manager of the care home made a formal urgent application for a Deprivation of Liberty order on the grounds that if Mr X returned home he would be at risk of physical and mental abuse and that in order to prevent that he

should continue to reside in a 24 hour care environment where his needs were being met. The manager noted on the application that Dr X disagreed with the decision that Mr X required 24 hour care. The Council authorised the urgent order.

46. Dr X says that during the telephone call on 12 November, he asked the CMHT manager to inform Mrs X, who would be visiting her husband at the care home on the afternoon of 13 November, that she could not bring her husband home. Dr X says that he thought it was only right that a member of the staff who had made the decision should explain it to Mrs X. He took his mother to the hospital so the CMHT manager could explain to her directly that Mr X could not come home. He says that the CMHT manager could not provide a copy of the Deprivation of Liberty order when he asked for it but told him that it was the manager of the care home who had requested the authorisation. The group manager was asked to return to the hospital with a copy of the Order to show to him. The group manager says Mrs X was understandably very distressed but she also says that Mrs X kept referring to Mr X as her "*child*" and saying how difficult it was not to be allowed to take her child home. Dr X says that he now understood that someone had intended to call at Mrs X's house the following day to explain the situation to her.

47. Dr X says that he complained to the CMHT manager that it was unacceptable to give him three days' notice to change a care plan which he had spent weeks organising. He says that she apologised to him for that and for not overruling Dr Z to ensure that Dr X was invited to the meeting on 10 November. Dr X says that the group manager also apologised for not including him in the meeting of 20 October. The CMHT manager told us that Dr X should however have been aware from Dr Z's letter of 21 October about the concerns which were being expressed about the adequacy of the planned care package.

48. Dr X says that it is simply not true to say that he disagreed with his father's need for 24 hour care: he says however that he was not given the opportunity to assess how it was provided and by whom, once his father returned home to the care of Mrs X with the extra care which had been arranged. He says that no-one from the CMHT made any constructive suggestions prior to the imposition of the Deprivation of Liberty order about the sort of care package which should be provided for his father to return home.

49. The Council authorised a standard Deprivation of Liberty order, in effect for the next six months, on 19 November 2009.

Arrangements for Mr X to return home, and Mr and Mrs X's subsequent care

50. Dr X and his solicitor met the Council's solicitor, the social worker, the CPN, the CMHT manager and the group manager later in November to discuss a way forward. The Council's solicitor emphasised that the focus of the meeting should be what was in Mr X's best interests and whether that would be to return home.

Dr X's solicitor pointed out that Mr and Mrs X would be distressed if separated. She said that there was no dispute from Dr X that a 24 hour care package was required for his father. A case conference was scheduled for 10 December to allow Dr X and his solicitor to discuss how to put an acceptable care package in place.

51. At the meeting on 10 December, Dr X's solicitor presented a copy of a proposed care plan drawn up by a domiciliary care agency. The plan was to provide a 24 hour care package for Mr X at home. The group manager said that the Trust and Council were willing to agree to a comprehensive care package being provided at home because Mrs X would be more settled when Mr X was at home. Dr X's solicitor reiterated that nobody was disputing that a 24 hour care package was required. It was agreed that the care package should begin in January with suitable monitoring reviews scheduled to ensure that it was working.

52. Mr X returned home on 18 January. Unfortunately on 21 January Mrs X attacked one of the carers and Mr X returned to the care home. Dr X says that the carer was young and inexperienced and had tried to impose her authority on Mrs X, who then lost her temper. The carer reported that Mrs X had attacked her when she told Mrs X that she needed to take off Mr X's glasses at night so that he would not injure himself on them. She reported that Mrs X lashed out at her while she was trying to ring for help.

53. Dr X says that in March 2010, he took his mother to see Mr X. When he arrived home he found a letter from the social worker and her manager enclosing a report with recommendations about the future care of both his parents. The recommendations were for Mrs X to go into full time care but not to be placed in the same care home as Mr X, as she resented anyone else carrying out tasks for him. As Mr X did not have any capacity to decide where he should live, the report recommended that he should remain in full time residential care, in a home designed to meet his mental health needs. Dr X says that he discovered that the same letter had been sent to his mother who was extremely upset when she read it. Dr X says he believes that the staff who signed the letter behaved in an inept, unprofessional and insensitive way.

Dr X's complaints to the Council and the Trust

54. Dr X complained to the Council and to the Trust in April 2010 about the way his parents had been treated over the last year. He complained that:

- no-one had taken any action about the report that his mother had struck his father in the face causing his glaucoma;
- Dr Z had written to him in a patronising and insulting way about his parents' care;
- the care received by his father at the care home was poor;

- the meeting of 4 November with the social worker and the CPN had not raised any concerns about his plans for his parents' care;

- after he had appointed a carer, he was told that he had been excluded from a meeting which had made decisions about applying for a Deprivation of Liberty order;

- he was misrepresented about the amount of care he believed was necessary; and

- an insensitive letter was sent to Mrs X with recommendations for Mr X's care.

55. The Trust and the Council acknowledged Dr X's complaint. The Council said that it would work together with NHS colleagues to provide a response and contact him in the near future to let him know how the complaint would be handled.

56. The Trust appointed an investigating officer to look into Dr X's complaints. The investigating officer told us that Dr X and his wife were away most of the summer while she was carrying out her investigation of his complaint but she offered to meet him on his return. She told us that in her view there was a lack of clarity about the purpose of the strategy meetings held in October and November 2009, conceivably as a result of the lack of training which had been undertaken at that time on safeguarding procedures and on Deprivation of Liberty procedures. The investigating officer also told us that everyone acknowledged that the report which went to Dr X and Mrs X in March 2010 should not have been sent out in the way it was. She told us that the letter had been sent to all involved parties as a way of ensuring that everyone knew what was being proposed, given that there had been a problem previously with communication, but in this instance it had been inappropriate.

57. The Trust wrote to Dr X in October 2010 when the investigating officer had completed her work on the complaint. The Trust said that Dr Z had not intended his letters to be patronising and it had found no evidence to support Dr X's comments but the Trust apologised for any upset caused. The Trust said that the care at the care home was a matter for the Council and it could not look into the matter further. In respect of Dr X's complaint about the failure to raise concerns about his parents' care, the Trust said that action was taken to contact Dr X as soon as the relevant manager knew that the proposed care package was inappropriate. The Trust apologised for the way the report had been sent to Mrs X in March 2010 and said that managers were now responsible for checking the contents and intended recipients of reports.

58. Dr X was dissatisfied with the letter from the Trust and complained to the Health Service Ombudsman in January 2011. He said that the Trust had not answered many of his concerns. Dr X also complained again to the Council in February and March 2011 as he had not had a response to his letter of complaint of April 2010.

59. We contacted the Trust in February 2011 to ask why Dr X's complaint had not received a full response. The Trust responded in March that on the basis of information which had been discussed about Mr and Mrs X's welfare under safeguarding procedures, it had been considered reasonable to provide Dr X with only a limited response to his complaint. The Trust said that on reviewing the file it now felt able to provide a full response. It said that it had not had consent from Mrs X to investigate Dr X's complaint although it acknowledged that it had not told Dr X that only a partial response would be given.

60. In March the Council also wrote to Dr X apologising that there had been a misunderstanding about who would respond to his complaint. The Council said that it had now considered the aspects of his complaint which fell within its remit. It said that because at the time of Dr X's original complaint, Mr X was no longer being looked after in the care home which was the subject of Dr X's complaint, it had not been possible to investigate in detail the issues which Dr X had raised. The Council told us that contract monitoring visits to the home had taken place during 2010 and the matters identified as concerns then had been addressed.

61. The Trust wrote to Dr X again in April 2011 apologising for its failure to offer a full response to his original complaint; it said the decision not to do so had been taken in good faith "*in consideration of capacity and consent issues*" and in the best interests of his parents. In addition to expanding on the points it had previously responded to, it also explained that the decision to continue the prescription of Aricept was due to the recognised deterioration that could take place following its withdrawal. As a result of its review of his complaint, the Trust said it had made a number of recommendations:

- A review of the process for authorising release of information to carers was undertaken;
- Administrative arrangements were revised regarding documenting appropriate family contact;
- The status and purpose of all meetings will be clearly communicated to all participants and safeguarding meetings should be prioritised;
- Future lines of communication were agreed between staff, Dr X and Mr AX.

62. Dr X wrote to the Health Service Ombudsman again in 16 May explaining that he remained unhappy with the Trust's response, and that he intended also to complain to the Local Government Ombudsman.

Clinical advice

63. The clinical adviser commented on the Trust's response to Dr X's complaint regarding the decision to continue Aricept prescriptions for Mr X despite his advanced dementia.

64. The clinical adviser noted that there was no evidence that the Aricept was having a worthwhile effect, and although it had been clearly agreed that a MMSE should be completed, no proper assessment was carried out in March or April 2009. The adviser commented that when Mr X was assessed in September 2009, the appropriate course of action was for Mr X to stop taking the drug for a trial period, but this was not taken. In addition, although NICE states that the carer's views should be sought (Annex C), they were ignored for no obvious reason.

65. The clinical adviser said regarding Mr X's discharge from hospital in April 2009, a key factor was the evidence contained in the social worker's notes that Mrs X had failed to understand the implications of the allegation that she had hit Mr X. The clinical adviser noted that Mrs X's impaired capacity and the allegations of physical abuse should have triggered a safeguarding investigation and concluded that Mr X's discharge from hospital was not handled appropriately.

66. The clinical adviser also commented on the Trust's response to Dr X's complaint that he was unreasonably excluded from the meeting of 10 November which discussed his parents' care. The clinical adviser noted that the Trust did not give a reason why the meeting changed from a safeguarding strategy meeting to a professionals-only meeting and pointed out that the only reason to exclude a carer would be if the carer was the alleged abuser or lacked capacity to contribute to the meeting. The clinical adviser considered that the Trust's response on this point implied that carers were only welcome to contribute to certain meetings. She said that this was in contradiction of the principles in the relevant NICE guidance of the "*imperative*" of considering the needs of carers and enhancing their input to the person with dementia (Annex C).

Findings

The failure to implement the safeguarding process

67. In April 2009, the Council and the Trust should have acted to assess Mr X properly and prevent further deterioration when he was admitted to hospital with acute glaucoma. Dr X took the trouble to write and explain that it was likely that his father's injury had been caused by a blow from his mother. The social worker who interviewed Mrs X about the allegations then recorded a description of Mrs X which was clearly of a person who had, at best, fluctuating capacity and who did not have any recollection of or insight into the incident which had caused Mr X's injury. The failure then to implement the safeguarding process meant that the opportunity to put in place a much more comprehensive care package for Mr X was missed. Instead Mr X's discharge from hospital was hastily arranged and he returned home without the protection of the safeguarding process.

The delay in assessing Mr X

68. There was a delay in carrying out an assessment of Mr X despite his increased needs. The social worker should have carried out an assessment in April 2009 but it was not until August that she acknowledged that she had not reassessed him. The assessment which he needed was not carried out until September. There was a delay of 6 months in reassessing Mr X's needs.

The continued prescription of Aricept

69. Dr X had asked in March 2009 about the appropriateness of his father's continued prescription of Aricept given the severity of his dementia. Although the social worker referred the request for an assessment to the memory service, that service referred the request back to the social worker. It was not until August 2009 that the social worker raised the matter again, acknowledging that she had not been able to undertake the assessment. The clinical adviser said that a trial period without Aricept should have been arranged at the point of the CPN's assessment in September 2009. Instead, Mr X continued to be prescribed Aricept longer than appropriate. It was a further indicator to Dr X that his views were not taken into account by the professionals who were involved in his parents' care.

The decision to request a Deprivation of Liberty order

70. There was ample evidence available by early October 2009 that Mrs X was not able to cope with managing her husband's care at home: indeed, it was arguable whether she would manage her own care by that stage. However, the communication difficulties which arose when this issue came up for discussion triggered a series of events which led to the exclusion of Dr X from the relevant meetings and the imposition of the Deprivation of Liberty order.

71. Concerns were first raised by Dr Z when Dr X indicated that he intended to take his mother home from hospital. Dr Z advised against the discharge and indeed suggested a meeting so that everyone could discuss the best way forward. That meeting was declined by Dr X who would not meet with his brother present. Dr X also saw Dr Z's subsequent letter as patronising. Communication between the professionals and Dr X deteriorated further after it became clear to Dr Z that Dr X also intended to take his father home from the care home and implement a care package which, in the view of all the professional staff involved, was insufficient to manage the significant needs of his father. The decision was taken to hold a strategy meeting but Dr X was not invited. The outcome of that meeting was that Mr X could try to live at home with a "*good*" package of care, and Dr Z wrote again to Dr X with his concerns that the package he was intending to put in place would not meet his parents' needs. It has not been possible to investigate this aspect of the complaint in Dr Z's absence.

72. An opportunity to put matters right was missed on 4 November when the social worker and Mrs X's CPN visited Dr X to discuss his father's needs for services when he came out of the care home. Despite the recent discussions at the strategy meeting, no attempt was made to explain to Dr X at that meeting exactly what level of service should be put in place for his father to come home. It was not made clear to Dr X that his father would not be able to come home on the basis of the service he was then proposing.

73. There was disagreement and confusion over the nature and purpose of the meeting arranged for 10 November. The social worker saw it as a strategy meeting to which Dr X should be invited so that he was aware of the issues under discussion. The consultant, we are told, wanted a professionals-only meeting. It has not been possible to discuss with Dr Z his reason for wanting to restrict the meeting. As a result, however, while Dr X was continuing to make arrangements with a private carer in anticipation of his father's discharge, it appears that the multidisciplinary meeting was already considering possible legal action if Dr X did not agree to his father remaining in the care home until a 24 hour care package was put in place at home.

74. A further opportunity to clarify matters with Dr X and avoid the need for a Deprivation of Liberty order was missed when the CMHT manager telephoned Dr X on 12 November. There was a misunderstanding between Dr X and the professionals about what constituted 24 hour care. Dr X considered that he could not tell what care his father needed until he was settled back at home but that in any event, he would receive 24 hour care from the private carer and Mrs X (with support from Dr X and Mr AX). The professional staff considered that 24 hour care meant care provided by someone other than Mrs X. That misunderstanding led to Dr X's frustration that he had been misinterpreted when the Deprivation of Liberty authorisation request said that he disagreed with the need for 24 hour care.

75. A lack of clarity about the purpose of the meetings, unwillingness on the part of staff to talk directly to Dr X about difficult matters and an unwillingness to question Dr Z's decision to exclude Dr X from the meeting, led to the unsatisfactory and distressing situation of 16 November. If the safeguarding process had been properly implemented in April 2009 it is likely that the crisis would have been averted and a proper level of service implemented much sooner.

76. The evidence suggests that there was a failure by professionals to properly consult and inform Dr X and consider his views. The response to his request that his father's prescription of Aricept should be reassessed was much delayed and unfounded reference was made to Dr X's prescribing habits when in general practice, but there is no evidence that anyone discussed the prescription properly with him. Dr Z, having once invited Dr X to a meeting, subsequently excluded him from discussions about his father's care.

77. The Trust failed to provide a proper response to Dr X's complaints. Having decided that there were aspects of the complaint which it had to keep confidential in Mr and Mrs X's best interests, it failed to communicate that decision to Dr X. It failed to acknowledge its shortcomings in respect of the continued prescription of Aricept to Mr X, its discharge of Mr X from the hospital without proper safeguarding procedures and its decision to exclude Dr X from the relevant meetings to discuss his parents' care.

Summary

The NHS Trust

78. The Trust failed to make a timely reassessment of Mr X's continued prescription of Aricept in line with NICE guidelines. It discharged Mr X from hospital without raising a safeguarding alert. It failed to give Dr X proper advice about the care his parents needed to remain safely at home because it did not involve him appropriately in discussion. It issued a report to Mrs X about her and her husband's care which should never have been sent to her. It failed to respond appropriately to Dr X's complaints. The Trust did not 'get it right' in line with the Ombudsman's Principles.

The Council

79. The Council failed to follow the correct safeguarding procedures when Dr X raised an alert about his mother. It failed to give Dr X the proper information he needed so that he had the opportunity to provide a suitable care package for his father at home. It failed to challenge the decision to exclude Dr X from the meetings to discuss his parents' care. It failed to respond to his complaints in a timely manner. The Council did not 'get it right' in line with the Ombudsman's Principles.

Injustice

80. It is not possible to say with any certainty how long Mr and Mrs X would have been able to continue to live at home together with appropriate care. However, it is reasonable to say that if proper services had been put in place in April 2009, both Mr and Mrs X would have had the benefit of a more settled pattern of life for much longer than they had. As it was, there was a period of some months over the summer of 2009 when Mrs X was clearly struggling to cope without appropriate services in place, and Mr X may not have been looked after properly. They suffered a needless loss of dignity during that time.

81. In addition Dr X suffered injustice because of the actions of the Trust and the Council. He felt undermined and ignored; his efforts to put a care package in place were wasted because no-one explained to him that the requirement for a 24 hour care package meant care additional to that provided by himself and his wife, the carer he had employed and his mother. Understandably he was

shocked to find that legal restrictions were being put in place to ensure that he could not bring his father home.

82. Dr X also suffered injustice as a consequence of the poor handling of his complaints. There was confusion between the Trust and the Council over which body was responsible for handling separate aspects of the complaint. The Council belatedly responded that it could not investigate complaints about a care home which Mr X had now left, although it did not give any reasons. The Trust investigated Dr X's complaints but failed to be explicit that it would not respond to him fully in the absence of Mrs X's consent. As a result Dr X suffered the frustration of a long delay (from April 2010, when he first complained, to April 2011 when the Trust responded after our intervention) before he received a full response to his complaint against the Trust.

83. The Trust was wrong to send to Mrs X a report containing recommendations for her future care. Mrs X was very distressed to read the recommendations that she should be placed in permanent care separately from her husband. That was injustice arising from a fault on the part of the Trust.

84. Although there was a failure to follow NICE guidance in the continued prescription of Aricept to Mr X, we have not been able to identify any specific injustice as a result.

Recommendations

85. The Ombudsman's Principles for Remedy say that organisations should consider fully and seriously all forms of remedy, such as an apology, an explanation, remedial action, or financial remedy. The principles also say that organisations should use lessons learnt from complaints to ensure poor service and maladministration is not repeated.

86. Within one month of the date of this final report the Trust and the Council should make a proper acknowledgement and apology to Dr X for the failures in the way they handled the concerns about Mr and Mrs X's care and the impact this had on him and his parents. A copy of the apology should also be sent to us.

87. Within three months of the date of this final report the Trust and the Council should: review the way they include carers in assessing and planning for relatives with dementia; and review their joint arrangements for responding to complaints to ensure all aspects of complaints are met in a response. They should produce an action plan that describes what they have done to ensure that they have learnt lessons from the failings we have identified and details what they plan to do, including timescales, to avoid a recurrence of these failings.

88. Within three months of the date of this final report the Trust should review the way that patients are reassessed for prescriptions for Aricept in accordance with the NICE guidelines. It should produce an action plan which describes what it

has done to ensure that it has learnt lessons from the failings we have identified and details what it plans to do, including timescales, to avoid a recurrence of these failings in the future.

89. There was a clear failure by the Trust and the Council to implement the safeguarding process in April 2009. However, we are satisfied that both the Trust and the Council have subsequently put in place appropriate training for all staff to ensure that such events are not repeated in the future.

90. Within one month of the date of this final report the Trust and the Council should make a payment of £1000 to Mr and Mrs X which reflects the failure to provide a more robust care package for them between April 2009, when Mr X was discharged from hospital, and September 2009 when Mrs X was admitted to hospital and Mr X went into respite care. An additional payment of £250 should be made by the Trust in recognition of the distress caused to Mrs X by the way in which the report concerning her future care was sent to her. The Trust and the Council should also make a payment of £500 to Dr X for the distress and frustration caused by its failure to consult with him properly and the poor handling of his complaints.

91. The Trust and the Council have agreed to implement our recommendations.

Conclusion

92. Therefore we uphold Dr X's complaints. We found failings on the part of both the Trust and the Council which led to injustice for Mr and Mrs X and for Dr X.

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Annex A

The Ombudsmen's remit and powers

The Health Service Ombudsman's remit

1. 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.

2. 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

3. 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.

4. 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

5. 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.

6. 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.

Annex B

The basis for the Ombudsmen's determination of complaints

How we decided whether to uphold this complaint

1. 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.

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

The Ombudsman's Principles

3. The Health Service Ombudsman's Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong. These principles have been endorsed by the Local Government Ombudsman.

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

    - 'Getting it right' – which includes taking proper account of established good practice, acting in accordance with the public and guidance and taking reasonable decisions, based on all relevant considerations;

Annex C

Health and social care: relevant legislation, guidance, policy and professional standards

Deprivation of Liberty Orders

1. The Deprivation of Liberty Safeguards (or DOLS) Code of Practice was finalised in 2008 to accompany the provisions of the Mental Capacity Act 2005. The safeguards apply to people "*who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests*". In order to come within the scope of a DOLS authorisation the person concerned must be detained in a care home or hospital for the purpose of being given care or treatment in circumstances that amount to a deprivation of their liberty.

2. There are two types of authorisation: standard and urgent. A managing authority (in this case, the care home) must request a standard authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights. The request must be made to the supervisory body (the Council in this case).

3. The Code says: "*Whenever possible, authorisation should be obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interests before the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within seven calendar days*".

Safeguarding procedures

4. In 2000, guidance was issued by the Department of Health — "*No Secrets*" — about the procedures councils should adopt to monitor and respond to concerns about adult abuse. In 2005, "*Safeguarding Adults*", guidance produced by the Association of Directors of Social Services, formed a national framework for good practice in adult protection work.

5. Responsibility for coordinating and taking the lead in safeguarding matters lies with the local authority although partner agencies (including, for example, local health organisations) are expected to have effective arrangements for monitoring safeguarding adults work. "*Safeguarding Adults*" says, "*Each organisation is responsible and accountable for meeting national guidance and legal*

requirements in relation to implementing 'Safeguarding Adults' work, whether through working in partnership or through its own actions"

6. Each organisation should retain responsibility for training its own staff.

7. For people who are eligible for community care services and who have mental capacity, *"Safeguarding Adults"* procedures should enable them access to mainstream services that will support them to live safer lives - as well as providing specific services to meet additional needs.

8. "*Safeguarding Adults*" sets out a good practice timeframe for responses:

	Maximum time frame
Alert	Immediate action to safeguard anyone at immediate risk
Referral	Within the same working day
Decision	By the end of the working day following the one on which the safeguarding referral was made
Safeguarding assessment strategy	Within five working days
Safeguarding assessment	Within four weeks of the safeguarding referal
Safeguarding plan	Within four weeks of the safeguarding assessment being completed
Review	Within six months for first review and thereafter yearly

National Institute for Health and Care Excellence (NICE)[2] guidance on prescription of Aricept (technology appraisal III, 2007)

9. The National Institute for Health and Care Excellence guidance on prescription of Aricept (technology appraisal III, 2007) says *'Patients who continue on the drug should be reviewed every 6 months by MMSE score and global, functional and behavioural assessment. Carers' views on the patient's condition at follow-up should be sought. The drug should only be continued while the patient's MMSE score remains at or above 10 points and their global, functional and behavioural condition remains at a level where the drug is considered to be having a worthwhile effect".*

[2] NICE is the independent organisation responsible for providing guidance (for the NHS and anyone with a responsibility for commissioning or providing healthcare, public health or social care services) on promoting good health and preventing and treating ill health.

National Institute for Health and Care Excellence guidance on dementia ("Supporting people with dementia and their carers in health and social care", NICE 2006)

10. The NICE guidance on dementia ("*supporting people with dementia and their carers in health and social care*", NICE 2006) says "*The fourth principle emphasises the imperative in dementia care to consider the needs of carers...and to consider ways of supporting and enhancing their input to the person with dementia. ....Health and social care staff should take account of the views of carers and relatives who describe behaviour that could be in keeping with dementia. This information...will help with diagnosis and deciding on care*."