



Ombudsman's Commentary

JUNE 2007 REPORTS

I laid 38 investigation reports before the Scottish Parliament today. Nineteen relate to the health sector, 14 to local government and three to the Scottish Executive and devolved administration. My overview this month highlights issues relating to the process for assessing eligibility for NHS funded Continuing Care. These, and the other reports published this month, are summarised below. You can access all our reports and previous Commentaries on the SPSO website: www.spsso.org.uk.

This month's Overview focuses on complaints about Continuing Care. Two reports published today raise a number of broader policy issues including an urgent need to review the Scotland-wide guidance on NHS funded Continuing Care which was issued more than 11 years ago. This is not a matter that individual Health Boards can address and I have, therefore, drawn the problems identified to the attention of the Scottish Executive Health Department (SEHD).

The key document referred to in the reports is a circular issued in 1996 by the then Scottish Office Department of Health (MEL 1996 (22)) – referred to in this Commentary as the MEL – setting out the responsibilities of the NHS to arrange discharge and the criteria for NHS funded Continuing Care. Annex A of the MEL states that the NHS should arrange and fund an adequate level of service to meet the needs of people who because of *'the nature, complexity or intensity of their health care needs will require continuing inpatient care... in hospital ...or in a nursing home.'*

In one of my investigations (Case ref: 200501504), I state that the Board concerned consider that they are correctly applying the MEL. This, however, the report continues: *'begs the question of whether the MEL properly reflects the legal provenance for NHS funded Continuing Care. This is not a question that this office can determine, but leads me to conclude that unremedied injustice may be caused by the application of the MEL.'*

'The concern and belief that this unremedied injustice exists is at the core of all the complaints about Continuing Care brought to my Office. This will continue

to cause distress and anxiety for patients and their families at a time when they are especially vulnerable and to take up a considerable amount of NHS time and resources in addressing these. This Office will, in turn, continue to receive complaints which we are unable to determine.'

Further to the core concern about the legitimacy of the application of the MEL, the report lays out a number of other concerns about the operation of the MEL. I have previously drawn my concerns about the clarity, accessibility and transparency of the process for assessing eligibility for Continuing Care to the SEHD. They have advised me that they acknowledge the procedural gaps identified in the current guidance and are seeking to address this issue in draft guidance that they are in the process of developing.

The reports also raise questions about whether decisions by English Courts might be expected to have had a bearing on policy and practice in Scotland. As the report states: *'While the English decisions themselves do not have direct application, the legal principles which they established and the developments that have flowed from them in England demonstrate that clarification on the issues of provision, assessment and decisions on NHS Continuing Care is necessary and important in terms of the Scottish guidance.'* I have also raised this issue with the SEHD who have indicated that they will be considering the implications of these judgements carefully as part of the review of Free Personal and Nursing Care currently being undertaken by them.

For details of the reports, see the health section of this Commentary (Case refs: 200501504 and 200502634).

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Health

Communication

Greater Glasgow and Clyde NHS Board (200500228)

The complainant, Mr C, was unhappy with the information he was given about his spinal angiography (a radiographic technique). My investigation found that the information was conveyed to Mr C only when he was about to undergo the procedure and was *'wearing only a surgical gown, lying on a trolley at the theatre door and understandably nervous. He was, therefore, not in the best position to receive information and he clearly did not take it in.'*

I fully upheld Mr C's complaint that he was given insufficient information to allow him to make an informed choice of treatment. I also fully upheld his complaint that the procedure was not adequately explained and he was not appropriately warned about possible complications.

I made a number of recommendations to the Board, including that they review their protocols for consent and recording of consent especially for neurosurgical and radiological interventions; include details of procedures, alternatives and possible complications in standard letters and leaflets and that these be given to patients as soon as diagnosis is made. I also recommended that the Board apologise to Mr C for the failings in giving him information.

Clinical treatment

A GP Practice, Ayrshire and Arran NHS Board (200601278)

I fully upheld the complaint that there was a delay by the GP in referring the complainant's husband, Mr C, for a urology opinion. I was pleased to note the action that was taken by the Practice following the complaint. However, my medical adviser also felt that the action focussed on

the care of the patient's dementia rather than on an earlier diagnosis of prostate cancer. My adviser felt that the GP should have examined Mr C's prostate when Mrs C had first mentioned his symptoms. I recommended that the GP share the investigation report with his appraiser and reflect on the actions which had been taken.

Clinical treatment/ communication/recordkeeping Greater Glasgow and Clyde NHS Board (200501579)

The complainant, Ms C, raised a number of concerns that her ante-natal care was not properly managed and that in particular the Board failed to provide adequate monitoring for potential gestational diabetes. She considered that but for this failure her daughter's stillbirth might have been prevented. My investigation found failings in some aspects of Ms C's treatment, but I do state that in an expert's view, *'there was no clear evidence to suggest what caused the death of Ms C's baby, and nor was it clear what degree of impaired glucose tolerance Ms C developed and whether this may have had any consequences.'*

I fully upheld Ms C's complaint that the Board failed to perform adequate urinalysis throughout her pregnancy. I partially upheld her complaint that they failed to properly inform her of an appointment and that they failed to ensure that her maternity records were available as required. The latter two aspects of the complaint were dealt with by the Board to my satisfaction and I, therefore, made no recommendation in this regard.

In the course of the investigation it became clear that there is no national or international consensus on the management of gestational diabetes. The 2003 guideline on Routine Antenatal Care produced by the National Institute of Clinical Excellence (NICE) – an English NHS body - did not follow the same recommended path as a report quoted by my expert. It also differs from the

current Scottish guidance, SIGN 55, which predates the NICE guidance. I raised the question of national guidance with NHS Quality Improvement Scotland (NHS QIS) and they confirmed that there is no universal approach to gestational diabetes in Scotland. I understand that a review of SIGN 55 is planned (although there is no specific timetable for this) and, therefore, a copy of the report will be forwarded to NHS QIS for consideration as part of the forthcoming review.

The Board are currently reviewing all of their practice and protocols with respect to antenatal care, including gestational diabetes screening. This process will have regard to all available evidence and recent publications as well as any national guidelines. I recommended that the Board advise me of the outcome of their review.

Clinical treatment/ palliative care

Greater Glasgow and Clyde NHS Board (200503196)

The complainant, Mrs C, raised a number of concerns about the care and treatment of her husband, Mr C, and his death from mesothelioma. I was satisfied that the clinical management of Mr C was reasonable. His disease proved to be a very aggressive form of an aggressive cancer, and his decline was more rapid than would have been anticipated by the medical staff.

However, I found the lack of evidence of discussion in the medical record inadequate and that it failed to demonstrate compliance with the standard. Of even greater concern was the failure to communicate important information to Mr and Mrs C in a way that would have enabled them to properly consider the implications of Mr C's illness and the options for managing it. Poor communication caused real suffering on the part of Mr and Mrs C and, as the reports states: *'Mrs C still feels there was a lack of care and humanity given to Mr C and remains very critical of even the most basic nursing care.'*

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A biopsy was carried out soon after Mr C was admitted to hospital and the Board later stated that this was mandatory for compensation. However, my medical adviser was of the view that it may have been possible to avoid the biopsy and leave definitive diagnosis until post-mortem.

The issue of diagnosis is important because it is usually needed to support any legal claim for compensation for mesothelioma sufferers. In Scotland all deaths where mesothelioma is suspected must be reported (as was Mr C's) to the Procurator Fiscal who has the authority to order a post-mortem if he considers this necessary. Mrs C stated that no mention of the need for diagnosis or indeed the Mesothelioma Compensation Scheme was made to her or to Mr C. It was only after Mr C's death when she approached a mesothelioma charity to make a donation that she was advised by them that she may have a claim against her husband's former employers. She also stated that she was never asked whether or not she would consent to a post-mortem. I was critical of the fact that the decision to carry out a biopsy appears to have been taken without any discussion with the couple about the need for it or about the possible implications of any diagnosis. Nor was any mention made of the compensation scheme.

I recommended that the Board apologise to Mrs C for the failure to effectively communicate to her and Mr C. I further recommended that the Board consider using the events of this complaint to inform practise in communicating with patients affected by cancer and give consideration to improving written recording of discussions with patients and their relatives in situations where there are a number of clinicians involved in delivering care.

Clinical treatment/ communication

Lothian NHS Board (200502443)

The complainant, Mr C, raised a number of concerns about the care his late wife, Mrs C, received in hospital where she received surgery and subsequently died. I upheld the complaint that the full risks of surgery were never fully explained to Mrs C or Mr C and that the hospital failed to explain why Mrs C's drips were removed. I did not uphold two other aspects. I recommended that the Board audit their practice in obtaining informed patient consent and implement any necessary change.

Clinical treatment/ communication

Greater Glasgow and Clyde NHS Board (200601122)

The complainant, Mrs C, raised a number of concerns about the nursing care afforded to her late father, Mr A, during a hospital admission. I fully upheld the complaint that Mr A's fluid intake was inadequately monitored and there was a delay in commencing intravenous fluids. I partially upheld the complaint that there was poor communication between nursing staff and relatives.

I recommended that the Board apologise to Mrs C for their failings in nursing care.

Clinical treatment/ communication/ complaint handling

Greater Glasgow and Clyde NHS Board (200600460)

I did not uphold eight of the nine aspects of this complaint which concerned the removal of two facial lesions. I partially upheld one aspect, and I recommended to the Board that in addition to discussing with a patient any surgical procedure, its possible outcomes and common complications, they consider whether providing such information in written form would enhance the process

of obtaining the informed consent of the patient. I also recommended that a further apology be made to the complainant to acknowledge their initial failure to apologise to him in a timely manner. Finally, I recommended that the Board look to reducing the timescales between the dates of dictation, typing and issue of correspondence.

Clinical treatment/staff attitude/communication

Western Isles NHS Board (200600033)

There were four aspects to this complaint, which related to the care of a patient, Mr C. I made no finding on the complaint that a consultant's behaviour was inappropriate when he explained the results of his examination to Mr C and his wife, Mrs C. I upheld the complaint that the consultant did not reflect the urgency of Mr C's condition in his referral to another consultant, and I did not uphold the two other aspects. I recommended that the Board review their procedures for urgent referrals and apologise to Mr and Mrs C for the inadequate referral letter.

Communication

Lothian NHS Board (200501643)

I did not uphold two aspects of the complaint, but I did find that the Breast Screening Service's discharge letter was unclear and that they failed to fully address the complainant's concerns. I recommended that the Board consider reviewing the wording of their standard letter with a view to removing any possible ambiguity and review procedures to ensure that phone calls to the service are responded to appropriately.

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Clinical treatment/ communication/ record-keeping

Scottish Ambulance Service (SAS) and Greater Glasgow and Clyde NHS Board (200500505 & 200500510)

I did not uphold four of the five aspects of this complaint, which related to communication, a hospital's decision to transfer an elderly man and his journey by ambulance. I did uphold the complaint that the ambulance crew's record-keeping lacked detail and I made recommendations to the Scottish Ambulance Service about 'Do Not Attempt Resuscitation' orders (DNARs) and record-keeping.

Diagnosis/record-keeping/ complaint handling

Ayrshire and Arran NHS Board (200503633)

I did not uphold the clinical treatment or record-keeping aspects of the complaint, although I did note concerns and make recommendations in relation to these aspects. I found that complaint handling was inadequate and recommended that the Board conduct a review of their complaints procedure to ensure that staff are acting in accordance with the National Guidance.

Continuing Care

Fife NHS Board (200501504)

The complaint was brought by a firm of solicitors on behalf of their client, Mrs C, who complained that her husband, Mr C, had not been properly assessed by the Board and consequently had ceased to receive funding for NHS Continuing Care. Mrs C was also concerned that during her appeal against the decision not to fund Mr C's care she had been subjected to undue pressure by the Board. I did not uphold the second aspect of her complaint, but I partially upheld the first. Mrs C considered that her husband, who had early onset dementia, atypical Alzheimer's and cardiac problems, met the criteria for funding. She felt that his health care needs combined with his

rapidly degenerating and unstable condition meant that he should be eligible for NHS funding for his care notwithstanding that it could be provided outwith the hospital (i.e. in a nursing home). The Board, however, believed that Mr C did not meet the criteria and stated that they do not routinely contract with any nursing home to provide NHS continuing care for psychiatry of old age patients. Their policy for this group of patients, they stated, is to provide NHS Continuing Care in hospital settings.

I saw no evidence of clinical failings in the Board's dealing with Mr C. I noted that Mr C received a high standard of care and treatment in the hospital and that this view was endorsed by Mrs C. I found that the position that the Board took, and processes by which they arrived at it, were in line with those taken by other NHS Boards in similar circumstances.

I found, however, that there was miscommunication between some members of hospital staff and Mrs C, and that this, combined with the lack of clarity in the guidance about ongoing eligibility, made it not unreasonable for Mrs C to consider that Mr C's care should be funded by the NHS. I considered that there was maladministration in this regard.

Overall, I concluded that there was no clinical or service failure but that there was an element of administrative failure and for this reason I partially upheld the complaint. I recommended that the Board:

- (i) make a formal, evidenced record of decisions to discharge and that this record is provided to the patient and /or family in a timely manner;
- (ii) ensure that when a decision to discharge is reached such a decision is made known to the patient and/or family at the time the decision is taken and that where objections are presented the process for appealing against such a decision is clearly and fully explained;
- (iii) act on the recommendation of the Fife report (provision of NHS Continuing Care for Older People in Fife: Needs Assessment, July 2006, NHS Fife) to produce written information on ongoing eligibility for patients assessed as eligible for NHS funded Continuing

Care. The Board should ensure that there is a single approach to such funding and that this is commonly understood by all relevant staff; and

- (iv) make a written apology to Mrs C that the lack of clarity among staff about eligibility for Continuing Care led to miscommunication to Mrs C of Mr C's status and caused unnecessary distress.

Continuing Care

Fife NHS Board (200502634)

The complainants, a firm of solicitors, raised a concern on behalf of their clients, the family of Mr A, that Mr A had not been properly assessed by the Board and consequently was not receiving funding for NHS Continuing Care. The family were also concerned that they had not been able to appeal against the decision not to fund Mr A's care. I did not uphold the complaint that the Board failed to properly assess Mr A for his continuing health needs (for reasons similar to those outlined in report 200501504 above) and to provide details of the criteria used in deciding to discharge Mr A from inpatient care. I did uphold the complaint that the Board failed to consider an appeal against the decision to refuse funding. I recommended that the Board:

- (i) make a formal, evidenced record of decisions to discharge and that this record is provided to the patient and /or family in a timely manner; and
- (ii) ensure that when a decision to discharge is reached such a decision is made known to the patient and/or family at the time the decision is taken and that where objections are presented the process for appealing against such a decision is clearly and fully explained.

As in report 200501504 above, the broader policy issues relating to the guidance on NHS funded Continuing Care have been drawn to the attention of the Scottish Executive Health Department.

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Health

I did not uphold eight other complaints in the health sector about the following issues and bodies:

Clinical treatment

A Dentist, Greater Glasgow and Clyde NHS Board (200503583)

Diagnosis

A GP Practice, Argyll and Clyde NHS Board, now Greater Glasgow and Clyde NHS Board (200600120)

Clinical treatment

Highland NHS Board (200503286)

Clinical treatment/diagnosis

Lothian NHS Board (200402303)

Diagnosis

Grampian NHS Board and Highland NHS Board (200501582 & 200501993)

Clinical treatment

A GP Practice, Dumfries and Galloway NHS Board (200502326)

Clinical treatment

Lanarkshire NHS Board (200500993)

I did not uphold the complaint, but I made a recommendation that the Board review the hospital's appointment systems to ensure that changes of address are correctly recorded on all relevant databases.

Clinical treatment

A GP Practice, Argyll and Clyde NHS Board, now Greater Glasgow and Clyde NHS Board (200600644)

I did not uphold this complaint, but I did make a recommendation about record-keeping.

Local Government

Noise pollution/complaint handling

The City of Edinburgh Council (200503141)

I fully upheld the complaint that the Council failed to deal adequately with noise nuisance from a local bus station. I found that the Council had taken some actions to reduce the noise nuisance, but I was critical of the Council in several regards, particularly in relation to complaint handling. I recommended that the Council develop appropriate policies and procedures for dealing with noise nuisance and apologise to the complainant for their poor handling of his complaints. I also recommended that the Council undertake a thorough review of the complaint handling procedures of the departments involved to ensure that complainants and Council staff understand how complaints should be processed and dealt with. In this connection I drew the Council's attention to the SPSO's Valuing Complaints initiative, which provides guidance to bodies and can be found at: www.valuingcomplaints.org.uk

Building Control

East Lothian Council (200500176)

I fully upheld the complaint that the complainant, Ms C, was provided with inaccurate and misleading information about administration charges (in connection with a common repair scheme) that the Council would make. I recommended that the Council make a courtesy payment to Ms C, apologise to her for the misunderstanding and lack of clarity in their documents and advise owners of methods of payment, reasons for charges and methods of calculation in writing at the beginning of the common repairs process.

Handling of planning application

East Lothian Council (200503516)

This complaint concerned a balcony on a new building development near the home of the complainant, Mrs C. I upheld her complaint that the Council failed to take appropriate action when they became aware that the issue of loss of privacy had not been considered at the planning application stage. I did not uphold the complaint about the Council's response to the complaint.

I recommended that the Council approach Mrs C to seek her agreement in pursuing a joint reference to the District Valuer for an assessment of the impact of the overlooking from the balcony on the value of her home with a view to the Council reimbursing Mrs C for any loss in value and that the Council also meet the costs of the reference.

Handling of planning application

The City of Edinburgh Council (200503579)

I partially upheld the complaint that inadequate information was given about the standards required for a property to qualify as a house in multiple occupation. Since the events complained of, the Council had taken action to improve some of the issues of which I was critical, and in view of this I have no recommendations to make.

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Local Government

Housing: Policy/ administration

The City of Edinburgh Council
(200501752)

The complainant, Ms C, raised a number of concerns that the Council failed to carry out works which, under the tenancy agreement they were required to do. She also complained that they failed to take action to address racial harassment experienced by her grandmother.

I partially upheld the complaint that works were not carried out within satisfactory timescales and I fully upheld the complaint that the Council failed to provide details of their Racial Harassment procedure when asked to do so.

I recommended that the Council highlight to officers the importance of maintaining written records of contacts with tenants and potential tenants; review their adherence to their documented repairs policy; highlight to staff the importance of ensuring good communication between staff and members of the public; and ensure that sufficient training has been carried out to ensure that staff are familiar with their responsibilities under the Council's Racial Harassment procedure.

Anti-social behaviour/ recordkeeping

South Lanarkshire Council
(200600487)

The complainants, Mr and Mrs C, raised concerns about the way a tenancy offer made to them by the Council had been withdrawn. They also stated that an allegation of anti-social behaviour had been fabricated by the Council and that they had no opportunity to respond to the allegation. I did not uphold three aspects of the complaint, but I did find that Mr and Mrs C were not given the opportunity to respond to the complaint of anti-social behaviour that had been made against them.

As the investigation progressed, I identified further concerns and my report concluded that the Council failed to keep adequate records of their investigations and failed to follow their Estate Management Procedures. I recommended that the Council use

the report to inform their review of the Estate Management Procedures and address the identified failures in record-keeping; address concerns regarding failures to follow procedures as part of their planned review of the Estate Management Procedures; and apologise to Mr and Mrs C for their failure to follow the Estate Management Procedures in investigating the allegations made against them.

School Transport

East Renfrewshire Council
(200600466)

The complainant, Ms C, whose child attended a local primary school, was concerned about the Council's decision to withdraw provision of free school buses for children of primary school age without risk assessment, impact analysis or transport assessment. She believed that their decision-making process was flawed. She also complained about the handling of her complaints.

I did not uphold the complaints about the Council's decision to withdraw the free buses, but I did find that the Council had not adhered to their complaints process. I did not find that the Council's conduct in communicating with Ms C was unprofessional and inappropriate, but I did uphold the complaint that a letter sent by the Chief Executive was inappropriate and intimidating.

I recommended that the Council apologise to Ms C for failing to accept her complaint under their complaints procedure; put in place measures to ensure that, in future, complainants are given accurate information straightaway when their complaints will not be accepted under a particular paragraph in the Councils' complaints procedure, and apologise to Ms C for sending what I consider is an inappropriate and intimidating letter.

I did not uphold or made no finding in seven other complaints in the local government sector this month about the following issues and bodies:

Outdoor recreation facility

East Ayrshire Council
(200600026)

Common Repairs

South Lanarkshire Council
(200600950)

Education: Policy/ administration

North Lanarkshire Council
(200601123)

Building Control

Glasgow City Council
(200502320)

Policy/administration

The City of Edinburgh Council
(200602052)

Social work: assistance for elderly relative

East Renfrewshire Council
(200600075)

Although I did not uphold the complaint, I recommended that the Council review the issue of advice to relatives of patients previously relying on support from the Council's Social Work Department on discharge from hospital to a relative's care.

Planning/policy/ administration

East Ayrshire Council
(200500770)

I did not uphold the complaint, but I did recommend that the Council highlight to staff in the Planning Department the particular issues which can arise when Agricultural Prior Notification is received and continue to work closely with the complainant in an attempt to find acceptable solutions to the outstanding building control and planning problems.

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Scottish Executive and devolved administration

I fully upheld two complaints and did not uphold a third complaint about the following issues and organisations.

Delay in providing legal aid Scottish Legal Aid Board (200502372)

The complainant, Ms C, was concerned that it was not until six years after the conclusion of her divorce that she was presented with her bill for legal services. She believed that this was an unreasonable length of time to have elapsed and that the actions of the Scottish Legal Aid Board (SLAB) had been responsible for causing a delay to the presentation of her final liability.

I fully upheld the complaint. Prior to the publication of this report, SLAB apologised to Ms C for the delay as I had recommended in a draft version of the report. The procedural deficiencies brought to light in the report are also being addressed and therefore, I have no further recommendations to make.

Complaint handing

The Scottish Commission for the Regulation of Care (200601206)

I fully upheld the complaint that the Scottish Commission for the Regulation of Care (the Care Commission) failed to accept the complainant, Ms C's, complaint about the performance and competence of two members of their staff, which disregarded the requirements of the Regulation of Care (Scotland) Act 2001 and the Care Commission's own complaints procedure. Given that the Care Commission did effectively consider Ms C's concerns (albeit outwith their complaints procedure), acknowledged fault and issued an apology, I have no recommendations to make in this case.

Policy/administration

Student Awards Agency for Scotland (200602414)

Although I did not uphold the complaint that the Student Awards Agency for Scotland (SAAS) would not award a grant to any person aged over 55, I did recommend that the SAAS, when explaining their position to students, inform them that they have taken into account current guidance when reaching their decision and what this guidance says.

Compliance and Follow-up

In line with SPSO practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



Professor Alice Brown

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The compendium of reports can be found on our website, www.spsso.org.uk

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