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SELECTED INVESTIGATIONS
COMPLETED
OCTOBER 2003 - MARCH 2004



Selected Investigations Completed

October 2003 - March 2004

2nd REPORT – SESSION 2003-2004

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Foreword

Selected Investigations completed between October 2003 and March 2004

The challenge to the Health Service to deliver its modernising agenda - putting the patient at the heart of the service - is immense. Everyday competing demands can distract attention from the bigger picture of the patient's full needs and experiences. Clear and comprehensive communication between health professionals, patients and families backed by full and accurate documentation is an essential foundation of building that big picture. Sometimes failures in these areas can have damaging, or even devastating, consequences for patients. The selected cases reported here illustrate what can happen when things go wrong and what can be done to prevent them from happening in the future.

In this latest volume of selected cases I have highlighted cases which demonstrate the need continually to review and reflect on different aspects of practice and procedures in our health care system. Some of the cases reported here focus on a specific aspect of a complaint. Others reflect the full complexity of the complaint showing how a succession of small failings work together to compound the problem for the patient.

In the section on teaching and learning I report on one case (E2451/01-02) which shows how lack of thought about the patient and their family's perspective led to the generation of a complaint in the first instance. Mr C was admitted to hospital after falling down stairs and on the following day was given too high a dose of his routine medication as a result of wrongly recorded dosage levels by the doctor. But it was the subsequent handling of the situation that gave rise to the complaint. When the patient's wife came to take her husband home that day she found him in a semi-conscious state and vomiting. She was told to return later but the reasons for this were not explained until she returned that evening and discovered him lying in more vomit. On discharge Mr C continued to suffer distressing hallucinations for a further 10 days and was generally weak and debilitated. However, the nursing and medical staff did not communicate with Mr C or his wife to explore potential side-effects of the medication overdose. Finally, the handling of Mrs C's complaint compounded her views on the inadequacy of the Trust's performance. If the Trust's staff had thought about the issue from the complainant's perspective in the first place I am convinced that this case would never have reached me.

A number of cases in this volume show how easy it is for first assumptions to become embedded in the treatment approach with serious consequences. One particularly distressing case (E 65/02-03) concerns Mr N who was admitted to A&E with a range of symptoms including chest and abdominal pain, vomiting and headache. The notes of his admission revealed Mr N as a heavy drinker and, despite various symptoms to the contrary, Mr N's treatment focused on this fact without considering the possibility of the heart problems which had been raised as a potential diagnosis by the admitting GP. Whilst prompt treatment for the dissection of the aorta that Mr N had in fact experienced may not have saved his life, any chance of recovery was eliminated by the blinkered nature of his treatment.

Finally, in our section on essence of care, I report on cases where nurses have failed to document adequate planning for the patient, failed to record observations properly and failed to maintain accurate documentation. In Case E1635/02-03 for example, the patient's medical notes indicated that his dehydration needed to be managed appropriately. But the patient did not receive the amount of fluid

required. Nursing records were poor and there was no evidence of a plan of care. This patient should have had clear recordings of his fluid intake and output and this should have been reported regularly by nurses to the medical team. Given the critical nature of the care on this ward, the lack of records and protocols was severely criticised and the complaint upheld.

Also included in this volume are a number of cases which centre on totally inadequate arrangements for discharge of patients. Lack of communication is evident between healthcare professionals themselves, between professionals and their GP colleagues, and between professionals and carers. Case E1637-03/04 caused me great concern. An elderly man who had been in hospital for a prolonged period of time was discharged home whilst his main carers, his son and daughter-in-law, were on a pre-arranged holiday. He was discharged back to his warden-controlled flat, without the warden being told and the only person to be informed was another elderly relative. Whilst at home, he became unwell with vomiting and diarrhoea and died alone following a heart attack. His immediate family were unaware that he had been discharged. I found that the patient's son and the warden of his sheltered home should have been involved in the planning of his discharge.

In the last six months I have seen a number of serious cases involving GP deputising services. The quality of care, communication with patients and record keeping in these cases is a real cause for concern.

Once again, I have included several cases that indicate the poor standard of complaint handling. Two are of particular note.

In the first, (Case E1480-02/03) I was concerned about the adequacy of a response to a request from a patient for payment of taxi fares to hospital for haemodialysis. The patient was agoraphobic and I concluded that there had been a failure to consider properly the request. The Trust agreed to reimburse the taxi fares on my suggestion. This case illustrates how a small amount of financial redress can be appropriate to recognise the hardship faced by some patients as a result of the actions - or inactions - of the Health Service.

In the second, (Case E1980-03) the quality of the Independent Review report was exceptionally poor and addressed only two of the four issues being investigated. Both the Trust and the Strategic Health Authority considered that they had no responsibility to ensure an Independent Review report was of sufficient merit before despatch. Following my investigation the Strategic Health Authority accepted its responsibility for the standard of performance of lay chairs and their work. This stage of the process will, in future, be conducted by the Healthcare Commission and it is my hope that it will be greatly improved. It is essential that appropriate clinical advice is obtained at this stage and that, if a report is produced, it is of a high standard.

Finally, I have published in full for the first time my report on the complaint made by Mrs Pointon (E22/02-03) concerning the criteria used by the Health Authority and Primary Care Trust to fund continuing care for her husband. A summary of the case can be found on our website at www.ombudsman.org.uk

My purpose in publishing the results of these investigations is to encourage health care professionals to read, reflect on and learn from them. I hope that in doing so the mistakes of the past will not be repeated - thus achieving the aim most often expressed by the complainants who contact my Office.

Ann Abraham
Health Commissioner for England
July 2004

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Discharge Procedures

Case No.E.1947/02-03

Poor transfer arrangements and nursing care

Complaint against

BUPA Care Homes and Bexley, Bromley and South East London Strategic Health Authority (formerly Greenwich Health Authority)

Summary of case

In 2001 Mrs N, aged 59, was suffering from terminal cancer. She was being cared for at a hospice, supported by the local palliative care team. The hospice, the palliative care team and Mrs N agreed that she should transfer to a private nursing home, where she would be funded by the health authority. The manager of the nursing home conducted a pre-admission assessment prior to Mrs N's transfer. On the day of her transfer, Mrs N did not arrive at the nursing home until approximately 7.00pm. On arrival some of the transfer documents were not available which led to a nurse questioning Mrs N and her son about her medication and dosage. The nature of the exchanges caused some distress and concern to the patient and her son. In addition, in the absence of the appropriate documentation Mrs N's room had not been prepared adequately including a lack of bed rails and a call alarm which did not work. Finally, a continence assessment was not made and on the night of the transfer Mrs N was given an incontinence pad which she did not want or feel she needed. Over the next few days Mrs N experienced a number of problems which caused her real distress including handling by a nurse which she believed to be rough and falling from her bed (this is disputed by the home who said she slid from a chair). Mrs N's son, Mr N, was unhappy about the transfer to the nursing home and the quality of care his mother was receiving. He complained to the nursing home and to the health authority but remained dissatisfied about the way in which his complaint had been managed.

Findings

The Ombudsman found that the nursing home's

procedures for handling Mrs N's transfer were unsatisfactory. Full information about Mrs N's needs had not been available to staff admitting Mrs N, and her arrival at the nursing home late on the day of the transfer caused her distress. The nursing home was not registered to care for terminally ill patients, did not have adequately skilled and experienced staff to care for Mrs N and the nursing home's own standards of nursing care were not adhered to. The Ombudsman upheld those aspects of the complaint.

The Ombudsman also found that aspects of the handling of Mr N's complaint were unsatisfactory.

Remedy

The strategic health authority apologised. BUPA Care Homes apologised and agreed that: it would ensure that it had copies of transfer forms and care plans before patients arrived at the nursing home; that the home's admission times for patients would be audited; that the home would produce a set of standards for record-keeping and ensure that staff received training for those standards; that the home would regularly audit nursing records, and that it would develop a recording policy for accidents and adverse incidents, which would be regularly reviewed by the home's manager; that all staff would receive training about continence assessments; and, that staff would be fully trained in BUPA's policy relating to bed rails.

Case No.E.2050/02-03

Inadequate assessment and inadequate discharge planning of a mentally ill patient

Complaint against

Royal Berkshire and Battle Hospitals
NHS Trust

Summary of case

Mr B's son (Mr C), aged 40, suffered from severe bi-polar disorder, a form of mental illness. For 12 years, he had been stabilised through a successful medication regime. His prescription was changed in January 2002 and Mr C began hearing voices and hallucinating. On 11 April, as a consequence of his relapse, he tried to kill himself by taking a large overdose of paracetamol. He called his GP,

who arranged his admission to one of the Trust's hospitals. During his admission, both Mr C and Mr B on several occasions requested a referral to and assessment by the psychiatrist who had been treating him up to the point of his admission, but this did not happen. On 14 April, Mr C told his father that he was feeling very insecure and that he wanted to remain in hospital for several more days. Despite this, he was discharged from the hospital on 16 April following an assessment by a mental health nurse who had been supervised at the time by another mental health nurse. A psychiatrist had not seen him during his admission, nor had he been prescribed medication for his bi-polar disorder.

The first mental health nurse (who was employed by another Trust - not subject to this complaint and who was undertaking work for the Trust as a member of the mental health service) arranged an appointment for Mr C with his GP on the afternoon of his discharge and an out-patient appointment with his psychiatrist the following week. However, she did not arrange for Mr B to be informed of his son's discharge. When Mr B learned about the discharge, he thought that the arrangements were inadequate, not least because they relied upon the voluntary compliance of his son. As it was, once discharged, Mr C failed to keep the appointments; he self-harmed again and was subsequently made the subject of a compulsory detention order under the Mental Health Act. Mr B complained to the Trust about the inadequate assessment of Mr C whilst in hospital; the failure to prescribe appropriate medication and the inadequate discharge arrangements. He remained dissatisfied with the Trust's response and on 1 July, requested an independent review (IR). The convener failed to take appropriate clinical advice before refusing this on 2 September.

Findings

Taking advice from her professional assessors, the Ombudsman concluded that it was not necessary for Mr C to be assessed by a psychiatrist in the hospital and that this was not detrimental to his care. She accepted that it had been necessary to stop Mr C's psychiatric drugs in order to deal with the paracetamol overdose. Whilst it was not possible to determine the effect on Mr C of stopping this medication, she did not uphold this aspect of the complaint. However, the mental health assessment completed by two mental health nurses and the discharge arrangements made by them were found to have been inadequate. This was largely due to poor collaboration between the two mental health nurses, a failure to conduct background checks in relation to Mr C's medical history and poor discharge planning, relying as it did on a degree of commitment and co-operation from Mr C. The Ombudsman found that neither Mr C's psychiatrist, nor the community mental health team had been informed of the discharge. Furthermore, the first mental health nurse only made contact with the GP practice after the planned consultation. This aspect of the complaint was upheld. The Ombudsman found that the convener had not taken clinical advice from a mental health professional; he had taken advice from the medical director of the Trust and

had felt confident that the medical director could advise if she had felt a more specialised opinion was required. The Ombudsman accepted that the source of his advice was appropriate. This aspect of the complaint was not upheld.

Remedy

The Ombudsman recommended that the Trust should work together with the employing Trust of the mental health nurses to ensure the deficiencies identified in Mr C's mental health assessment were not taking place more generally.

In addition a shared information system should be developed for the liaison psychiatry service to allow staff to access appropriate medical records and ensure information about all patients known to the mental health service is available including all appointments and current care plans. The Trust was asked to ensure that referrals from the Trust to the Liaison Psychiatry Service are made at the earliest possible time i.e. when the patient is fit for interview, and not delayed until the patient is declared to be medically fit.

Assessment and discharge protocols, particularly around patients with a history of serious mental illness and suicide attempts should also be reviewed and a central point for the community mental health team should be established at which all referrals may be collated and checked by a clinician rather than an administrator.

Case No.E.1667/02-03

Decision to discharge an elderly patient from hospital

Complaint against

Chelsea and Westminster Healthcare NHS Trust

Summary of Case

In 2000, Mr L, who was 85 years old, underwent a hip replacement, following which he developed an intestinal obstruction and other problems, and needed to remain in hospital for five weeks. Eventually, he was discharged home on a Friday afternoon, but four days later needed to be readmitted to hospital with an abnormal heartbeat, pneumonia and dehydration. Five days after that he died. Mrs T, his daughter, complained to the Trust about the care her father had received and about the decision to discharge him. An independent review into Mrs T's complaints was held, which concluded that Mr L's medical management had been appropriate, but that there had been a number of serious failings in his care as a whole. However, Mrs T remained dissatisfied about the decision of the Trust's medical staff that Mr L had been fit to be discharged.

Findings

Based on advice from two professional assessors, the Ombudsman upheld the complaint. She found that although Mr L had been admitted for a routine procedure, he developed a number of potentially serious complications, including pneumonia, which left him in a very weakened state. In deciding to discharge Mr L there had been an over-reliance on laboratory findings, which were not adequately confirmed by clinical examination or X-rays. In particular, there was inadequate follow-up to ensure that the problems Mr L had experienced post-operatively had indeed been adequately resolved prior to discharge. This, combined with his poor nutritional state, weakness and impaired mobility meant that Mr L had not been sufficiently fit for a safe discharge. The Trust did have criteria against which to assess discharges, which were generally useful but not thorough enough in this case to identify Mr L's risk of developing further problems.

Remedy

The Trust apologised to Mrs T and agreed to review the work it had already undertaken as a result of its own investigations and of the independent review. The Ombudsman recommended: that there should be a more formal system for recording and exchanging multi-disciplinary information and improved communication with families and carers; Friday discharges should be avoided; and senior medical staff should be more closely involved in decisions to discharge frail elderly patients.

Case No.E.797/02-03

Needs assessment of learning disabled clients and resettlement in the community

Complaint against Northamptonshire Healthcare NHS Trust

Summary of Case

Miss L and Miss M, born in 1962 and 1965 respectively, had been continuously resident in the Princess Marina Hospital (the hospital) since 1970. Their parents, Mr and Mrs W, had had their daughters for home visits at regular intervals from 1970 to October 1999; these visits then stopped owing to Mr and Mrs W's deteriorating health. Mr and Mrs W were able to continue to visit their daughters on a daily basis however, because of the close proximity of their home to the hospital. As part of the Trust's learning disability service's move towards the provision of care in the community, all their clients,

including Miss L and Miss M, were assessed as to their suitability to be moved into a community home.

The learning disability directorate commissioned the building of six new bungalows within the Trust's district, one of which was to be built on the hospital site. However, Miss L and Miss M were allocated to a client group to be housed in a bungalow some five miles distant from Mr and Mrs W's home. On several occasions over the following years, Mr and Mrs W raised their concerns about their daughters' relocation and group allocation, particularly with regard to the distance from their home, and the detrimental effect this would have on their ability to maintain their current level of contact with their daughters. They also raised concerns about the safety of resettling their daughters in the community, as they were worried that this would provide a lower level of supervision, support and activity for them. These concerns were discussed at a meeting with the Trust's chief executive in April 2000. Further meetings and correspondence with Trust staff followed but Mr and Mrs W remained dissatisfied with the explanations that they received. They requested an independent review of their complaint in November 2001 but the Trust's convener decided not to grant an independent review. Following resettlement in June, Miss M died.

Mr and Mrs W complained that the Trust had failed to provide a comprehensive and current needs assessment of Miss L and Miss M in relation to their resettlement in the community and had not considered and addressed the impact of resettling Miss L and Miss M in a more distant locale on Mr and Mrs W's relationship with their daughters.

Findings

The Ombudsman was advised by a professional assessor with extensive experience of learning disability services. The Trust initiated client resettlement assessments in 1995 and subsequently updated them on an ad hoc basis. The professional assessor said that the Trust took into account Mr and Mrs W's concerns regarding their daughters' allocation to specific resettlement schemes and had made considerable efforts to include Mr and Mrs W throughout the process. The Ombudsman upheld this aspect of the complaint only insofar as the Trust did not carry out regular reviews of learning disabled clients' assessments.

The Trust had complied with Mr and Mrs W's request that the community home to which their daughters were relocated should be not more than five miles distant from their home. Mr and Mrs W subsequently made representations to the Trust that their daughters should be reallocated to a group to be rehoused on the hospital site. The Trust considered this option but deemed that this might have put Miss L and Miss M at some physical risk and might also have compromised the assigned groupings. In order to maintain Miss L and Miss M's routine Mr and Mrs W continued to visit their daughters in their new community home at the same time in the morning as they had when Miss L and Miss M lived on the

hospital site. This had caused some disruption to the community home's arrangements for transporting clients to their day centres. However, the community home's staff had tried to accommodate Mr and Mrs W's wishes in this regard as they recognised the importance of Mr and Mrs W maintaining their relationship with their daughters. The professional assessor stated that regular contact continues and that there is no evidence to suggest that the relationship between Mr and Mrs W and their remaining daughter, Miss L, has been adversely affected. The Ombudsman did not uphold this aspect of the complaint.

The Ombudsman also considered a complaint from Mr and Mrs W about the handling of their case. The Ombudsman upheld this aspect of the complaint to the extent that there had been some unnecessary delays in the complaints process.

Remedy

The Ombudsman recommended that the Trust should consider the introduction of formal annual client reviews and that they should be incorporated into the Trust's clinical governance programme. The Ombudsman also recommended that the Trust audit, within 12 months, that these reviews had taken place. The Trust agreed to the recommendations and apologised to Mr and Mrs W for the shortcomings identified.

Case No.E.1637/03-04

Need for main carers to be fully involved in relatives' hospital discharge plans

Complaint against

Sussex Downs and Weald Primary Care Trust

Summary of Case

In February 2002, Mr A's father, Mr Q, aged 84, who lived alone in a warden controlled flat, was admitted to Crowborough Hospital for rehabilitation following treatment in another hospital for congestive cardiac failure and mobility problems. Whilst in hospital, Mr A and his wife, who were his main carers and lived nearby, visited on a regular basis to offer support. In due course, plans were put in place by the hospital community rehabilitation team for Mr Q to be discharged home with a care package but this was delayed until after he had undergone a previously planned hernia repair. The operation, which was to take place in another hospital, was scheduled for the summer, with the intention that Mr Q be returned to the hospital to recover from the surgery. Mr and Mrs A, who understood that Mr Q would not therefore be fit for discharge for at least several weeks,

went on a pre-planned two-week holiday. In the event, however, the hernia operation was cancelled and, because Mr Q was keen to return home, the hospital decided to discharge him back to his warden controlled flat. However, neither Mr and Mrs A nor the shelter warden were told of these plans; the only relative contacted was Mr A's 83 year old mother-in-law, who agreed to undertake some shopping. A few days after discharge, Mr Q became unwell with vomiting and diarrhoea and, two days later, he died alone following a heart attack.

Mr A complained that, as his main carers, he and his wife should have been consulted about the projected discharge date. Mr A also complained that his mother-in-law was elderly and in poor health and therefore should not have been involved with the discharge arrangements for his father. The matters investigated were that the discharge arrangements were inappropriately handled and the care package was not properly implemented.

Findings

The Ombudsman found that although, in the main, satisfactory discharge plans were made for Mr Q, the Trust should, from the outset, have more fully involved Mr and Mrs A in the discharge planning process and given appropriate notice to them and the shelter warden of its plans to return Mr Q home. However, as the investigation made it clear that an appropriate discharge care package had been satisfactorily implemented, the Ombudsman did not consider that these omissions contributed to Mr Q's unexpected death.

Remedy

The Trust apologised to Mr A for the shortcomings identified and accepted the Ombudsman's recommendations that a protocol be introduced to ensure that carers are appropriately involved in the discharge planning process and that, in future, shelter wardens should be told of their residents' discharge dates.

Essence of care

Case No.E.2775/02-03

Planning and implementation of nursing care in hospital

Complaint against

Milton Keynes General NHS Trust

Summary of Case

Miss C, who was 25 years old, was admitted to hospital in 2001 suffering from chest pain. She also suffered from severe spina bifida and congenital hydrocephalus. Independent and capable Miss C used a wheelchair, self-catheterised and lived with a carer. Whilst in A&E Miss C had been prescribed antibiotics but they were not administered until six hours later, over three hours after she had been transferred to the Medical Assessment Unit (MAU). Over the next two days spent in the MAU Miss C's condition deteriorated significantly. Miss C complained of significant pain on the first day and was prescribed painkillers. Overnight her oxygen saturation levels became low and she was reported as very hard to rouse. Mrs C's mother became very concerned in the morning at her daughter's condition, believing that she had not taken enough fluid (people with congenital hydrocephalus are prone to dehydration) and she had a urine infection. Mrs C reported her concerns to nursing staff on several occasions but believes she was ignored. As the day progressed Miss C's condition worsened and she was admitted to intensive care where she died a few weeks later.

Miss C's parents complained that the standard of care was very poor before admission to intensive care. In particular they complained about the assessment of her presenting symptoms, the prescription and administration of medication, the management of Miss C's fluid levels and the Trust's response to their daughter's deterioration.

Findings

The Ombudsman found that the planning and implementation of nursing care and the level of nursing documentation were inadequate before admission to intensive care. During Miss C's admission her condition deteriorated significantly, no detailed assessment of continence care or of hygiene needs were made nor were nutritional and fluid needs adequately considered. Despite it being known that people with spina bifida are prone to urine infections, Miss C's urine was not tested until a considerable period of time had elapsed. There was an unacceptable delay in the administration of a prescribed drug. The Ombudsman also found that nursing staff did not communicate sufficiently well with Miss C's family or carer either in conveying the deterioration of Miss C in a timely way or listening to concerns about her condition.

Remedy

The Ombudsman made a number of recommendations about nursing care, which the Trust agreed to implement. Those recommendations related to documentation and audit, policies and procedures, patient care, and the management of people with disabilities. The Ombudsman also made recommendations concerning communication with families. The Trust also agreed to apologise to Mr and Mrs C for the shortcomings the Ombudsman identified.

Case No.E.3814/02-03

GP practice nurse's use of inappropriate leg dressing

Complaint against

A GP practising in the West Norfolk PCT area

Summary of Case

Mr K, aged 49, who had diabetes, sustained a minor leg injury. In November 2001, when the wound became ulcerated, he attended his GP surgery. The practice nurse treated the wound, and continued to do so, over several months, using Inadine, an iodine-based wound dressing, which Mr K felt caused him significant pain and discomfort. Finally, in April 2002, Mr K saw a district nurse who recommended a different type of dressing and the ulcer began to heal. He complained to the Ombudsman that it had been inappropriate to use Inadine.

Findings

After taking advice from three professional assessors, (a GP and two nurses) the Ombudsman found that there was deserved criticism of the care and treatment Mr K received at the practice. The medical records were not as complete as they should have been, and the practice nurse, who had not received any specific training on ulcer care (but who had previously supervised Mr K's diabetic care) did not adhere to the practice's protocol for the management of leg ulcers. The use of the Inadine dressing had been inappropriate, as it is only usually recommended for the treatment of fresh wounds. It was used for too long and it should not usually be applied to diabetic patients. The GP had had some contact with Mr K throughout, and had overall responsibility for Mr K, but the practice nurse was also accountable for her practice and had owed a duty of care to Mr K. The Ombudsman upheld the complaint.

Remedy

West Norfolk PCT agreed to a number of recommendations aimed at improving the practice's management and assessment of cases where a GP and a practice nurse were both involved. They also agreed to

ensure that the practice nurse attended appropriate professional training in ulcer care and to review record-keeping at the practice. The GP apologised and agreed to consider implementing similar measures in any practices where he might work in the future.

Case No.E.1635/02-03

Failure to treat a myeloma patient adequately and inadequate nursing documentation

Complaint against
Mid Staffordshire General Hospitals
NHS Trust

Summary of Case

In 2001, Mr J, who was 68 years old, was diagnosed with advanced multiple myeloma (malignant disease of the bone marrow). He underwent chemotherapy treatment at a Trust hospital. About a week later Mr J developed severe diarrhoea and vomiting and was referred to the A&E department at the hospital; he was admitted, first to a general medical ward and then, a day later, he was transferred to the haematology ward under the care of a consultant haematologist. The day after his transfer it became clear that Mr J's condition was deteriorating and plans were made for a blood transfusion and dialysis (a procedure used to filter waste products from the blood and remove surplus fluid from the body in someone who has kidney failure). However, he developed acute renal failure and died as a result of a sudden cardiac arrest the following day. A post mortem was not carried out.

Mr J's wife subsequently complained to the Trust about the care and treatment provided to her husband and the appropriateness of his chemotherapy. Mrs J had been concerned that, during his admission, there appeared to be no sense of urgency in treating his myeloma. She felt that appropriate investigations were not carried out and treatment, including intravenous (IV) fluids, had been delayed. She was concerned that he had been given too much medication and had been frightened and alone during his final hours. Local resolution failed to resolve her concerns and in 2002 Mrs J requested an independent review, which was refused. The matter investigated was that the Trust failed to manage Mr J's myeloma adequately. Mrs J died during the course of the investigation and her daughter, Ms J, continued the complaint on her behalf.

Findings

The Ombudsman was advised by two professional assessors. The haematology assessor advised that it was

imperative that Mr J received chemotherapy treatment as soon as possible and that his initial management was entirely appropriate. The Ombudsman accepted this advice. Following Mr J's admission, it was imperative that his severe dehydration was managed appropriately, in order to avoid kidney failure; however, the initial plan by the senior house officer in the A&E department included IV antibiotics but did not specify IV fluids. Mr J's consultant was on-call at that time, but confirmed that he was not contacted. It was not until 12.30am, over seven hours after his arrival in the A&E department, that Mr J received the fluids he so vitally needed. For such an acutely ill patient, the Ombudsman found this delay unacceptable.

During Mr J's admission, it appeared that little was done to monitor his condition and to make sure he received the appropriate therapy, as had been requested by the consultant. The clinical notes did not contain any specific reference to the need for careful fluid management. Nursing staff confirmed that IV fluid was not received continuously and they could not adequately explain why that was so. Both the assessors agreed that the administration and monitoring of fluids was totally inadequate. The nursing documentation on the first ward was scant and there was no evidence to suggest appropriate nursing care planning or careful monitoring of Mr J's condition.

The nursing assessor advised the Ombudsman that when Mr J was transferred to the haematology ward, the nursing notes were, again, of a poor standard. There were no written care plans and no written protocols documented either on the patients' notes or in separate reference folders which staff could then access. Therefore, there was nothing to provide information or supportive prompts for any of the staff, whether trained, untrained, regular or bank staff, to assist them in caring for haematology patients. The Ombudsman concluded that nursing practice on both wards, in terms of assessment, care planning and documentation was well below standards set out in the Nursing and Midwifery Council's 'Guidelines for records and record-keeping'. The Trust has accepted that and has since undertaken extensive work in regard to training and record-keeping.

With regard to the amount of medication administered, the haematology assessor confirmed that all medication administered was appropriate and unlikely to have contributed to Mr J's death. The family was also reassured that a senior nurse had stayed with Mr J from the time of his deterioration until his cardiac arrest, so he was not isolated or without help at this time.

Whilst criticising these failings, the Ombudsman acknowledged the stressed environment and pressures within which the staff, particularly the nursing staff, were trying to function. She was concerned to note the poor staffing levels and high turnover of staff on the haematology ward.

She concluded that the care and treatment provided to Mr J by the Trust was inadequate and upheld the complaint.

Remedy

The Ombudsman recommended that the Trust undertake an urgent review of staffing levels, skill mix and risk assessment on the second ward with particular reference to the ward case mix and patient dependencies, especially the haematology patients. It was also asked to continue to review the standard of nursing documentation on both wards and, if appropriate, provide training to ensure that nurses' record-keeping is of a consistently good standard in line with NMC guidelines. The haematology team should review their specific protocols of care and ensure they are accessible to all staff who are required to care for haematology patients. This should include a protocol for the management of acute renal failure in myeloma including a direction for early consultation with the renal unit. In addition, all patients being treated by the haematology team, when presenting as emergency admissions, should be admitted directly under their management and into a haematology bed, as recommended by the British Committee for Standards in Haematology.

Finally, the Trust should ensure in all instances where there are unusual test results, for instance when a paraprotein is discovered on serum electrophoresis, the haematology department is informed.

Case No.E.425/02-03 & 1543/01-02

Discharge from a surgical ward to a care of the elderly ward; inadequate nursing care

Complaint against

Southampton University Hospitals NHS Trust and East Hampshire Primary Care Trust (formerly Portsmouth HealthCare NHS Trust)

Summary of Case

In March 2000 Mrs L, who was aged 66 years, suffered a fractured leg. During her recovery she developed deep vein thrombosis and pulmonary embolism (a blood clot on the lung) requiring anticoagulant medication. As a result of this medication she suffered a bruise around the spine which required a neurosurgical operation in Southampton General Hospital. She subsequently developed abdominal pain and peritonitis (inflammation of the lining of the abdomen) due to a perforated bowel and underwent abdominal surgery in May 2000. Five weeks later Mrs L

was transferred to Queen Alexandra Hospital, which was managed by Portsmouth HealthCare NHS Trust (now East Hampshire Primary Care Trust). After a further ten days Mrs L was diagnosed as having an abscess within the abdomen and was transferred to a surgical ward in Queen Alexandra Hospital (managed by Portsmouth Hospitals NHS Trust, and not part of this investigation), where further abdominal surgery was done.

Mrs L's husband complained that she was inappropriately discharged from a surgical ward in Southampton General Hospital to a care of the elderly ward before she had completed her recovery from abdominal surgery and without arrangement for surgical review. He also complained that there was an unreasonable delay in medical staff on the care of the elderly ward recognising that she was developing an abscess within her abdomen, and that the nursing care his wife received on that ward was inadequate.

Findings

The Ombudsman accepted the advice of her professional assessors that at the time in question, Mrs L was fit to be transferred to the care of the elderly ward, which was within an acute NHS hospital with comprehensive facilities. The Ombudsman did not uphold the complaint against Southampton University Hospitals NHS Trust that Mrs L's discharge from a surgical ward to a care of the elderly ward (Victory Ward) was inappropriate. The Ombudsman did not consider that the investigation revealed any shortcomings in the arrangements for patients being transferred between the two neighbouring hospitals.

With regard to the complaint concerning delay in medical staff on the ward recognising Mrs L's abdominal abscess (East Hampshire Primary Care Trust), the Ombudsman accepted the advice of her professional assessors that diagnosis of Mrs L's abscess was not a straightforward matter, and did not uphold the complaint.

The Ombudsman upheld the complaint that the nursing care given to Mrs L on the ward was inadequate. However, she was pleased to note that a number of appropriate measures had been introduced to improve nursing practice, and that steps had been taken to fully implement the Department of Health's 'Essence of Care' document.

Remedy

East Hampshire Primary Care Trust apologised through the Ombudsman's report and also agreed to apologise directly to Mr and Mrs L for the inadequate nursing care Mrs L received.

implement the Department of Health's 'Essence of Care' document.

Remedy

East Hampshire Primary Care Trust apologised through the Ombudsman's report and also agreed to apologise directly to Mr and Mrs L for the inadequate nursing care Mrs L received.

GP deputising service

Case No.E.1853/03-04

Inadequate care and treatment of an adolescent

Complaint against

Heart of Birmingham Teaching NHS Primary Care Trust

Summary of case

During a home visit in the early hours of September 2000, Dr A examined a 15 year old boy, Mr C, diagnosed abdominal pain and gave him an opiate analgesic. Mr C was taken to his GP on the following morning, and admitted to hospital immediately with a burst appendix. His mother, Mrs D, complained that during the visit Dr A gave no indication that her son could be suffering from appendicitis, nor did he advise her how to proceed if her son's condition deteriorated. In response to Mrs D's complaint, Dr A wrote that he had diagnosed appendicitis and had advised admission, but Mrs D had been reluctant to take her son to hospital. Dr A later cited a language barrier as the reason for Mrs D's misunderstanding. Mrs D and her son strongly denied Dr A's account of events. An independent review was held, which found no fault in Dr A's care and treatment. However, Mrs D remained dissatisfied and complained to the Ombudsman.

Findings

Dr A did not record a diagnosis of appendicitis in his notes of the visit and at interview he told the Ombudsman's investigator that he had considered, but discounted, appendicitis. The Ombudsman was therefore concerned to note that during local resolution of the complaint Dr A had said that he had diagnosed appendicitis. The Ombudsman agreed with Mrs D that Dr A had changed his story as the complaint went on, and said that she found Mrs D's account of the events more convincing. Two professional assessors provided comments on the clinical aspects of the case. They said that on the basis of Dr A's records it was impossible to determine precisely what care or advice was given. However, they pointed out that if Dr A had discussed with Mrs D the possibility of appendicitis and any ongoing care needed, Mr C's developing condition would have been detected earlier, and serious complications could have been avoided. The professional assessors concluded that, at minimum, Dr A's record-keeping needed improvement. The Ombudsman's pharmaceutical adviser also commented upon Dr A's provision of an opiate analgesic to a 15 year old of Mr C's slight build, explaining that this would have had the effect of masking any deterioration in Mr C's condition. The Ombudsman was concerned about this and also expressed

concern about Dr A's communication skills and his response to the complaint. She found that the inadequacy of Dr A's actions, and his lack of advice to Mrs D, had affected ensuing events and she upheld the complaint that his care and treatment were inadequate.

Remedy

Dr A apologised to Mrs D for the shortcomings identified. The Ombudsman was of the view that Dr A needed assistance and monitoring to enable him to bring about improvements in his communication, record-keeping and clinical practice. She therefore shared her report with Dr A's local Primary Care Trust, who agreed to work with Dr A to effect an improvement.

Case No.E.187/02-03

Failure to respond to a complaint

Complaint against

Healthcall (now called Primecare) and a GP in the South Birmingham Primary Care Trust

Summary of case

Mrs W telephoned NHS Direct at around 3.00am having experienced a 'dead' right hand with pins and needles for 24 hours. She was advised to contact her GP immediately. Healthcall, which provided the GP out-of-hours service for her practice, took the call, and she later talked with a Healthcall GP. He attempted to reassure Mrs W that if her symptoms were heart-related, she would have left-sided symptoms; she was therefore likely to be suffering from a trapped nerve. The Healthcall GP advised her to see her own GP the next day if she remained worried or to call an ambulance; he also suggested physiotherapy. He kept no record of his consultation. The symptoms did not improve and Mrs W saw her own GP ten days later. He arranged admission to hospital immediately for tests which confirmed a diagnosis of a brain tumour. Sadly, Mrs W died three and a half months later. Her daughter, Mrs Y complained that the Healthcall GP had been rude and dismissive of her mother's distress in his telephone consultation, and had failed to establish that her symptoms were more serious than a trapped nerve. She felt that he should have arranged for a doctor to attend Mrs W immediately. She also complained that the Healthcall GP had completely failed to respond to her complaint.

Findings

The Ombudsman, who took advice from two GP assessors, did not uphold the complaint about the Healthcall GP's diagnostic thinking and advice, because his advice was appropriate given Mrs W's presentation. She found that if he had called a doctor out in the middle of the night it probably would not have helped Mrs W. However, the

Healthcall GP's failure to keep appropriate records of his consultation with Mrs W was criticised, and the Ombudsman asked him to give careful consideration to Mrs Y's criticisms of his telephone manner.

The Ombudsman upheld the complaint about the Healthcall GP's failure to respond to the complaint, and was severely critical of him for this. She noted that in ignoring Mrs Y's letter and Healthcall's Medical Director's attempts at encouraging him to respond, he had compounded Mrs Y's grief at the loss of her mother and reinforced Mrs Y's view that his attitude had been dismissive. The Ombudsman also noted that the Healthcall GP had declined to respond to her statement of complaint until he was tracked down by her investigator. She commended the actions of Healthcall's Medical Director, who had taken robust steps to encourage the Healthcall GP to respond and then removed him from Healthcall's employment when he failed.

Remedy

The Healthcall GP agreed to respond to complaints as a priority in future, and to ensure that he kept adequate records in every area of his future clinical practice. He also agreed to write to Mrs Y to reiterate his sincere apologies for his failure to accept her complaint. The Ombudsman asked the Primary Care Trust in the area covering Mrs W's GP practice to forward a copy of her report to the Primary Care Trust covering the Healthcall GP's practice area, to ensure that her recommendation about his handling of future complaints was implemented.

Case No.E.444/02-03

Out of hours GP care

Complaint against

Healthcall (now called Primecare) in the North East of London

Summary of case

Over the Christmas period of 1999 Mr Y, a 32 year-old man, complained of feeling unwell with 'flu-like' symptoms. By the evening he was feeling much worse and at 10.20pm his parents telephoned their own GP whose out-of-hours service, Healthcall, said that a GP would visit. Mr Y's parents rang the service again shortly after midnight when they described their son as seriously ill. A GP eventually arrived at 3.44am, over five hours after the first call had been made. Mr Y's condition had deteriorated: he was delirious, vomiting and had a non-blanching rash (which does not disappear when pressed) all over his body. The GP examined Mr Y and told his parents that he was very concerned: however, he did not give him any medication. He contacted a local hospital to arrange admission and dialled 999 for an ambulance. The GP wrote two letters of referral and left. The ambulance arrived at 4.46am and Mr Y was taken to hospital where he died shortly afterwards;

the cause of death was meningococcal septicaemia. Mr Y's parents subsequently complained about the standard of care provided by Healthcall and the GP employed by them.

Findings

The initial request from the patient's own GP to Healthcall had not indicated the urgency of the case. Equally Healthcall had not made it clear to the GP that the service was under pressure from large number of calls over the holiday period seeking advice on conditions with 'flu-like symptoms'. The second call to Healthcall from the patient's family was taken by a Healthcall Controller. The Controller, although he was not medically qualified, did not seek a further medical assessment of the situation and finally passed the call on some three hours later thus losing valuable time. In addition, the Ombudsman found that the GP had failed to respond appropriately to Mr Y's probable presentation of meningococcal septicaemia, by failing to administer an appropriate antibiotic. The GP further failed in his duty of care by not waiting until the ambulance arrived. The Ombudsman could not say whether early intervention might have changed the eventual outcome. However, because of the shortcomings identified, any opportunity for Mr Y to make a recovery had been lost.

Remedy

Healthcall undertook to implement recommendations about the handling of emergency calls, and standby cover, during holiday periods. The GP accepted the Ombudsman's recommendation to seek guidance from the clinical governance lead of the Trust in the area in which he now works as an assistant Primary Care GP, and to draw up a supervised education plan to remedy deficiencies identified in the report. He also agreed for his consultations to be audited, with particular regard to emergency presentations. Healthcall and the GP apologised for the shortcomings identified.

Case No.E.535/02-03

Inadequate clinical management by deputising GP, and unsatisfactory and unacceptably delayed response to a complaint

Complaint against

Healthcall (now called Primecare) and a GP in the area of Middlesborough Primary Care Trust

Summary of case

Mrs W, who had non-insulin diabetes and ischaemic heart disease was waiting for a coronary bypass. She experienced pains in her arms and chest. Her husband telephoned Healthcall, which provided the out-of-hours service for their GP practice, and a GP advised him to bring his wife to the Healthcall Centre. A GP examined Mrs W and advised her to take ibuprofen to assist with the pain. The next day the pain increased, and after a telephone consultation with a second deputising GP, Mrs W returned to the Healthcall Centre, where a third deputising GP advised her to take stronger painkillers. The day after, Mrs W's pain increased further and her own GP confirmed that she had suffered a heart attack over the weekend. Mrs W was admitted to an intensive care unit that day.

Mrs W's GP practice went on to forward her complaint about her care and treatment to Healthcall, but Mrs W did not receive a full response to her complaint from Healthcall for three and a half months. An independent review was held a further four months later, but Mrs W remained dissatisfied. She complained to the Ombudsman that the third deputising GP's clinical management had been inadequate, and that his response to her complaint had been unacceptably delayed. She also complained that Healthcall's handling of her complaint had been unsatisfactory.

Findings

The Ombudsman, who took advice from two GP assessors, found that the third deputising GP might have considered that Mrs W had suffered a heart attack, since he knew about her diabetes and impending bypass surgery. However, she was not critical of him for deciding that there was a musculo-skeletal cause for Mrs W's symptoms. Mrs W had complained that the third deputising GP had not examined her but had simply copied the comments on the original consultation (made by the first deputising GP). Because there was no independent record of his consultation, the Ombudsman was unable to reconcile the differences between the third deputising GP's account of the consultation, and that given by Mr and Mrs W. However, she upheld the complaint about the third deputising GP's clinical management to the extent that his clinical assessment had been incomplete and that the records did not show evidence that he took a full history. She was pleased that he had changed his clinical practice in those areas.

The Ombudsman also upheld the complaint about the delay in the third deputising GP's response to the complaint. Although she welcomed his later apology to Mrs W, she considered that his failure to respond to the complaint only confirmed Mrs W's belief that he had failed to consider her clinical needs during his consultation with her.

The Ombudsman also upheld the complaint about Healthcall's handling of the complaint. She found that the main culprit as far as delays were concerned was the

third deputising GP. However, other delays had occurred in forwarding documents to the practice. The Ombudsman welcomed Healthcall's implementation of a revised and improved complaints procedure.

Remedy

The Ombudsman recommended that the third deputising GP should provide prompt and thorough responses to any complaints about him that arise in any practice environment.

Complaints Handling and Financial Redress

Case No.E.3762/02-03

Complaints handling

Complaint against

The Dudley Group of Hospitals NHS Trust

Summary of case

Mr B complained to the Trust in July and August 2001 about the way that it had managed aspects of his wife's care. The Trust replied in September but Mr B was not satisfied and, in October, he requested an independent review. In December the convener referred back to the Trust for further local resolution two of Mr B's complaints that had not previously been addressed. The Trust confirmed to Mr B that enquiries would be made into those matters. Mr B sent reminders to the Trust in February and March 2002. In March the Trust confirmed that the outstanding complaints were being investigated. Mr B sent further reminders in July and October. In March 2003, still having received no reply from the Trust, Mr B complained to the Ombudsman. The Ombudsman's Office contacted the Trust to ascertain the cause of the delay. In April the Trust apologised to Mr B for the delay and offered him a meeting to discuss his complaints. In May the Trust wrote again to Mr B to remind him about the offer of a meeting and said that if he did not reply within ten days they would assume he no longer wished to pursue his complaints. Mr B continued with his complaint to the Ombudsman. In June the Trust sent a substantive reply to Mr B but he remained dissatisfied.

Findings

Mr B received no substantive reply to his outstanding complaints, in spite of his reminders, for 17 months and he was not kept informed of the reasons for the delay. It was the responsibility of a nurse manager in the surgical directorate to deal with the further investigation of Mr B's outstanding complaints and to reply directly to him. The complaints manager checked progress on the response by sending reminders to the nurse manager but he did not actively follow up those reminders. In October 2002, the nurse manager told him that she had prepared a draft response which would be sent to Mr B. The complaints manager put the complaint file aside to await a copy of the letter before closing the case. In the event, he never received a copy of the letter, but that only became apparent in March 2003 when he checked all the outstanding convener cases and found Mr B's complaint file still open. By that time, the nurse manager had become overwhelmed with the volume of work that she had to deal with unassisted, and she had taken extended

sick leave. Her draft letter to Mr B was never found. The Trust's chief executive acknowledged that the complaints process in operation at the time had failed and he highlighted changes put into practice across the Trust to deal with complaints, including targets for speed of reply and monitoring of performance. To prevent work overload, more staff had been allocated to deal with complaints in the surgical directorate. The Ombudsman was pleased to note that the measures taken had resulted in an increase from 31% to 59% in the proportion of cases responded to within the target time of 20 days. However, she was critical of the excessive delays that Mr B had experienced and upheld the complaint that the Trust's attempts at further local resolution of Mr B's complaint were inadequate.

Remedy

The Trust apologised to Mr B for the shortcomings identified and agreed to carry out an audit of its new complaints monitoring system and to report the results of that to the Ombudsman at the end of the financial year.

Case No.E.2485/03-04

Handling of a request for information about a patient's death and subsequent independent review request

Complaint against

West Hertfordshire Hospitals NHS Trust

Summary of Case

In 2002 Mrs E died after she had been given an overdose of chemotherapy. Two weeks later Mr E wrote to the Trust's chief executive requesting an explanation of his wife's death. The chief executive told Mr E that she would commission an investigation and write to him again with a report. However, he did not receive that report until nearly three months later. The report was dated two days after Mrs E's death, and Mr E complained that it had been withheld from him for nearly three months and the chief executive had told him she would commission an investigation when one had already taken place and a report completed. The Trust's chair responded to Mr E's complaints but he remained dissatisfied, and requested an independent review of his complaint that the chief executive had failed to provide him with information. The chair turned down his request on the grounds that he was seeking compensation for his wife's death.

Findings

The Ombudsman found that when Mr E requested

information about his wife's death, his query had been treated as a formal complaint. A serious untoward incident report had been completed immediately after it was discovered that Mrs E had been given a chemotherapy overdose. However, after receiving Mr E's request, the chief executive had asked for the matter to be further investigated. The Trust's director of operations was responsible for providing a response to Mr E and the quality assurance department was responsible for monitoring the timeliness of that response. However, the Ombudsman found that the director of operations was concerned about the legal implications of releasing the serious untoward incident report and failed to act on Mr E's request. The quality assurance department's monitoring systems also failed, and Mr E's request was not responded to in a timely manner. The Ombudsman found that the difficulties that Mr E had experienced in obtaining a response were indicative of a wider problem in complaints handling in the Trust and she was pleased to note that changes had been made. These included a review of the staffing structure of the quality assurance department; action taken to address the time taken to respond to complainants' letters; divisional managers assuming greater responsibility for complaints within their division; use of more personalised letters to complainants; improved tracking of complaints; revised complaints procedure and literature and training for all new staff. The Ombudsman was satisfied that this would bring about an improvement in complaints handling at the Trust but upheld the complaint that there had been an unacceptable delay in providing Mr E with information. The Ombudsman also upheld Mr E's complaint about the way his request for an independent review had been handled. She found that the request had not been passed to the Trust's convener, as required by the NHS complaints procedures. The Trust's chairwoman had refused the request on the grounds that Mr E was taking legal proceedings against the Trust. However, Mr E had requested an independent review of the failure to provide him with information. That was separate to the matter of the circumstances of his wife's death (for which he had sought legal advice). The Ombudsman therefore concluded that the reasons for refusing the request had been inappropriate.

Remedy

The Ombudsman was pleased to note that the Trust had taken steps to improve the efficiency of its complaints process. She recommended that the Trust should monitor the success of those measures to ensure that they were appropriate. The Trust board had also agreed to appoint an independent convener from outside the Trust in cases where the complaint was about senior members of Trust staff and the Ombudsman recommended that this was done in future. The Trust agreed to the recommendations and apologised to Mr E.

Inadequate handling of a complaint made about a Trust employee

Complaint against

Leicestershire Partnership NHS Trust
(formerly Leicestershire and Rutland
Healthcare NHS Trust)

Summary of Case

Mrs A originally complained in November 2000 about the lack of a follow-up to psychiatric treatment which she had received. As Mrs A was physically ill her husband, a senior employee of the Trust, continued with the original complaint on her behalf and also complained about the handling of Mrs A's complaint. Initially, the Trust decided not to deal with the complaint through the NHS complaints procedure. However, Mr A requested an independent review, which was held in 2001. Mr A complained to the Ombudsman that the report produced by the panel did not address the complaint. The Ombudsman also investigated one element of Mrs A's care.

Findings

The Ombudsman, with advice from a professional assessor, concluded that the department should have ensured that there was a system in place so that no patients, including Mr A's wife fell through the net of care when they could not be contacted or refused to attend the clinics. There were concerns that Trust staff and their families were not given the option of being treated outside the Trust area. There was also concern that letters, placed on file, were sometimes later amended before distribution, giving rise to inaccurate records.

The Trust did not follow the Directions and Guidance either initially or at the independent review stage. Following the request for independent review, the convener did not seek clinical advice. At the independent review there were no clinical assessors. The panel's report did not adhere to its terms of reference and went beyond the remit of an independent review. The lay chair produced a report which did not fully address the terms of reference and, in part, was outside the panel's remit. In addition, the report's circulation did not adhere to the need for confidentiality of the parties concerned.

Remedy

The Ombudsman recommended that the Trust implement protocols

- to ensure systematic reviews of patients who do not attend the department of liaison psychiatry or cannot be contacted, so that no patient falls through the net of care;

- which set out the need for a full and careful consideration of individual cases where staff and their partners require care and that under a formal arrangement appropriate cases be transferred to another Trust;

- to ensure that all necessary amendments to letters sent by the Trust be retyped before dispatch;

In addition, the Ombudsman insisted, due to the inadequacy of the original report, and that it had been circulated to inappropriate personnel, that the Trust recall all copies of the report. At the Ombudsman's request, the lay chair redrafted the report to ensure that it reflected the panel's consideration of Mrs A's complaint as set out in the terms of reference and nothing else. The report was reissued to those who had a right to see it.

Case No.E.1980/02-03

Inadequate independent review report

Complaint against

Royal Liverpool and Broadgreen University Hospitals Trust and Cheshire and Merseyside NHS Strategic Health Authority

Summary of Case

Following Mrs A's dissatisfaction with the Trust's response to her complaint about the care and treatment offered to her late mother whilst an in-patient at the Royal Liverpool University Hospital, she requested an independent review (IR) in July 2001. Four issues were to be covered by the IR including the nursing and clinical care received by her mother and the subsequent handling of her complaint. The IR was held in early 2002 and in the autumn, Mrs A received a copy of the panel's report, along with the reports of three independent clinical assessors. Mrs A complained to the Trust that, not only was the IR report superficial, inconsistent and, in many places, almost unintelligible but it also covered only two of the four issues under consideration and failed to refer to the findings of the clinical assessors. In addition, whilst glad that the IR report stated that panel members accepted the recommendations of the assessors and wished the Trust to action them, Mrs A was unclear what those recommendations were. The Trust did not respond. The matter investigated by the Ombudsman was that the IR report was incompetently drafted and did not reflect the clinical advice the panel had before it, or the views of its members.

Findings

Although the Trust accepted that the panel report was of a poor standard, it understood that it had no locus to intervene in the independent process and that the views of

IRs and lay chairs could not be challenged. The SHA also considered that, given the independent nature of the review process, it had no role in monitoring the conduct of individual IRs. The Ombudsman found however that, as the panel report was of such an unacceptable standard and the issue was essentially one of capability, the Trust should not, pending guidance from the SHA, have circulated the report. She also found that, as the SHA had responsibility for recruiting, training and overseeing the work of lay chairs, it should have been prepared to take steps to ensure that a report of the required standard was produced, particularly as it knew that the lay chair's drafting skills had previously been the subject of complaint. The Ombudsman criticised the lay chair for failing to consult appropriately with other panel members and for drafting a report that was palpably not of the required standard. The convener and third panel member were also criticised for not calling the lay chair to account.

Remedy

The Trust and the SHA agreed to apologise to Mrs A for the shortcomings identified and to meet with the Department of Health to discuss their respective roles in situations where the capability of lay chairs was an issue. The SHA also agreed to review the lay chair's capability to continue in that capacity and to ensure that, in future, only persons able to undertake the full range of duties required of a lay chair are recruited. The Trust agreed to remind conveners and third panel members of their responsibility to ensure that panel reports are produced on time and of the required standard, and the SHA subsequently circularised all PCTs and NHS Trusts within its ambit to this effect.

Case No.E.2345/03-04

Unsatisfactory complaint handling; unsatisfactory handling of request for independent review; failure to arrange an independent review panel

Complaint against

Norfolk and Norwich University Hospital NHS Trust

Summary of Case

On 12 and 17 October 2001 Mr P complained about aspects of his mother's care, including the standard of nursing care and the fact that on one occasion her soiled

bedclothes had not been changed for over six hours. The Trust responded in November but did not address Mr P's complaint about the bedclothes. A further response in December also failed to clarify or apologise for this issue. In January 2002 Mr P requested an independent review. However, the Trust's complaints manager telephoned him in February and said that he would be able to answer Mr P's complaints. Mr P agreed to this. However, he then heard nothing further until May, when he received a letter which again failed to address his complaint about the bedclothes. Mr P again requested an independent review, but the complaint was returned for further local resolution. This was unsuccessful and Mr P made further requests for an independent review. His request was eventually passed to the convener in October, and in December she agreed to convene a panel. However, Mr P heard nothing more about it, and in March 2003 he wrote to the Ombudsman requesting that she intervene. The Ombudsman's staff made enquiries of the Trust who confirmed that the panel was being pursued but that no firm arrangements had yet been made. No further progress was made and in July Mr P approached the Ombudsman again, having lost all faith in the Trust's ability to hold a panel.

Findings

The Ombudsman found that in December 2001, nursing staff had investigated Mr P's complaint about his mother's bedclothes, but the outcome of that investigation had not been passed on to him. In February 2002 the complaints manager had undertaken to address Mr P's complaint but failed to do so in a timely manner, due to an increase in the complaints department's workload (which had been brought about by the hospital's move). The chief executive said that at various points, Mr P had requested an independent review, pursued local resolution and approached the Ombudsman all at the same time. The Ombudsman's view was that this confusion had occurred, in part, because the complaints procedures had not been followed; throughout, the Trust had continued to attempt to resolve the complaint - even after the convener had agreed to set up a panel. The Ombudsman found that Mr P's complaint had not been handled as well as it should have been.

Following previous investigations into the Trust's complaints handling the Ombudsman had recommended that the Trust should remind staff that all requests for independent review should be passed immediately to the convener (Case E.977/02-03; case E.1368/02-03: Investigations Completed December 2002 - March 2003, HC 787). In this case, too, requests were not passed to the convener as they should have been. The Ombudsman also found that once the convener had agreed to convene a panel the Trust had failed to take action to set up the panel; had not appointed a third member or sought to determine the availability of clinical assessors to advise the panel. The Ombudsman was critical of that. The chief executive sought to blame the lay chair for the failure to establish a panel. However, the Ombudsman pointed out that this was the Trust's responsibility; a lay chair is responsible for the conduct of the panel once it is set up,

but in this case the panel never existed. The Ombudsman upheld Mr P's complaints that the Trust's handling of his complaint and his requests for independent review had been poor and that they had failed to set up panel.

Remedy

At interview, the chief executive said that new IT systems were being put in place to monitor ongoing correspondence. However, the complaints manager said that the existing system already allowed him to do this, but he had not monitored Mr P's complaint adequately due to pressure of work. The Ombudsman considered that a new IT system was of little use if outstanding correspondence across the whole complaints department was not dealt with efficiently. She therefore recommended that the complaints department should monitor work in progress on complaints, and the Trust board should review that information regularly. She also recommended that staff should again be reminded that all requests for independent review should be passed to the convener and the Trust should review its procedures for setting up independent review panels in line with the requirements of the NHS complaints procedures. The Trust agreed to those recommendations and apologised to Mr P.

Case No.E.798/02-03

Inadequate handling of independent review request

Complaint against

South Tyneside Health Care NHS Trust

Summary of Case

Mr J complained to the Trust in June 2000 about the recent care and treatment of his uncle, Mr K, aged 68, at South Tyneside District Hospital. After Mr J made an independent review request in October 2000, one of the Trust's conveners referred his complaint back to the Trust for further local resolution. Mr J remained dissatisfied and made another IR request in March 2001. In July 2002 the Trust informed him that it had only just received, from another hospital, medical records needed to consider his IR request, but that it would respond shortly. Mr J still received no answer. When the Ombudsman decided to investigate Mr J's complaint, in October 2003, Mr J still had not received a response. In January 2004, another of the Trust's conveners informed Mr J of her decision to refuse his IR request.

Findings

The Ombudsman found that Mr J's initial IR request had been processed promptly by the Trust's director of quality and first convener, although the convener did not obtain clinical advice as she should have.

The Ombudsman found that the Trust's delay in responding to Mr J's second IR request was extreme and unreasonable. The Trust attributed most of the delay to a recently recruited complaints manager's failure to progress the matter. However, the complaints manager's account was that she was unaware of Mr J's outstanding request until July 2002, and the Ombudsman found no evidence to the contrary. Thus, responsibility for processing the request appeared to rest with the director of quality who accepted that, against national guidance, she had not passed the request immediately to the convener. Although the director of quality claimed to have informed the convener orally of the request, the Ombudsman found it unlikely that she had done so at any time between March 2001 and August 2003. The Ombudsman concluded that that was a very significant failing. The director of quality claimed that initial progress was hampered by difficulty in obtaining Mr K's clinical records from the other hospital. However, there was no evidence of such a request ever being made. The complaints manager believed that once the records were located, she arranged for a secretary to pass them to the Trust's medical director; he, in turn, was certain that he was not involved in the matter until August 2003. That discrepancy could not be resolved. The Ombudsman concluded that Mr J's second IR request was simply allowed to drift although Mr J had repeatedly prompted the Trust for information about progress. Workload pressures, problems with secretarial support and lax supervision seemingly contributed to the delays that occurred. The Ombudsman had no hesitation in upholding the complaint.

Remedy

In an earlier investigation the Ombudsman had criticised the Trust's complaint handling procedures, at which stage the Trust undertook to introduce a more rigorous complaints monitoring system. The Ombudsman remarked that the Trust's handling of Mr J's request showed that the Trust still had some way to go to ensure that IR requests, in particular, were dealt with in a timely manner. The Ombudsman recommended that the Trust should maintain efforts to improve and monitor its performance in complaint handling; particularly regarding IR requests. The Ombudsman also recommended that the Trust make an ex gratia payment to Mr J, in recognition of the trouble to which he had been put in pursuing the matter over such a long period. The Trust agreed to implement all of the Ombudsman's recommendations. It also agreed to apologise to Mr J for the shortcomings the Ombudsman had identified.

Case No.E.95/02-03

Failure to provide timely information about the policy determining eligibility for NHS IVF treatment

Complaint against

North Cumbria Acute Hospitals NHS Trust

Summary of Case

After receiving a diagnosis of non-specific infertility, Mr and Mrs P were placed on the Trust's waiting list for NHS-funded in vitro fertilisation (IVF). When they learned that this waiting list was two to three years long, they decided to fund their initial treatment themselves. At no stage were they informed that one of the criteria for eligibility for NHS-funded treatment was that 'neither partner should have living children from this relationship or any previous relationship'. This criteria was contained in a subfertility policy covering north Cumbria, produced by North Cumbria Health Authority, and inherited by Carlisle and District Primary Care Trust.

Happily, Mr and Mrs P conceived a child during their second attempt at private IVF treatment; they went on to ask the Trust, at a post-natal appointment, whether they remained on the waiting list for NHS-funded treatment. They were informed that they had been removed from the waiting list because they had a child. Mr P went on to complain that the Trust's failure to inform them of the provisions of the subfertility policy prevented them from making an informed choice about treatment.

Findings

The Trust did not present any evidence that Mr and Mrs P had been informed of the subfertility policy, and conceded that the couple may not have been told. The Ombudsman therefore upheld Mr and Mrs P's complaint that they had been denied the opportunity to make an informed decision about IVF treatment, and welcomed the Trust's acceptance that responsibility for informing patients about the subfertility policy rested with the staff of its fertility clinic.

Remedy

The Trust agreed to reimburse Mr and Mrs P the £2,600 cost of their first and second cycles of private IVF treatment. The Ombudsman welcomed this along with the measures which the Trust had implemented since the complaint, which included providing patients with an information leaflet about the subfertility policy and recording patients' understanding of the policy in clinical notes.

Response to request for reimbursement of taxi fares

Complaint against

Newcastle upon Tyne NHS Hospitals Trust

Summary of Case

Mr Y, aged 52, who suffered from diabetes, abnormally elevated blood pressure and agoraphobia attended hospital three times a week for haemodialysis (removal of toxic substances and excess fluid from the blood). The free ambulance transport provided was in Mr Y's view unreliable and unsuitable and caused him to suffer stress and panic attacks. In consequence he paid to travel to and from hospital by taxi. In 2002, with the support of a psychologist who was treating him, he applied for reimbursement of taxi fares, having learned they could be reimbursed in exceptional circumstances. The Trust refused to reimburse Mr Y's request on the grounds that the ambulance service provided had improved and that special arrangements had been made to take account of Mr Y's agoraphobia. The Trust continued to refuse Mr Y's subsequent requests for reimbursement despite evidence provided about the unreliability of the ambulance service. In October 2002 the Trust advised Mr Y that he might gain reimbursement of his fares from his local Primary Care Trust. The PCT subsequently agreed to fund Mr Y's fares. Mr Y remained dissatisfied with the earlier responses he had received from the Trust.

Findings

The complaint was upheld. The Ombudsman did not make a finding as to whether Mr Y should have succeeded in his request, but found that the Trust's decision had been made without full and proper consideration of his particular circumstances. The Trust had not tested the exceptional nature of Mr Y's claim by obtaining specific information about the performance of the ambulance service or whether such transport was appropriate. Thus, Mr Y had never had his request properly considered.

Remedy

The Trust apologised to Mr Y for the shortcomings identified in its decision making process and agreed to take all relevant circumstances into account in any future requests for exceptional treatment. The Trust also agreed to the Ombudsman's suggested remedy that it reimburse Mr Y for the taxi fares incurred between his initial written application in February 2002 and the referral to the PCT in October.

Teaching and learning

Case No.E.65/02-03

Inappropriate transfer to a convalescence unit after failing to undertake necessary clinical investigations; poor record-keeping

Complaint against

Taunton and Somerset NHS Trust (the Trust)

Summary of Case

In 2001, whilst driving home from work, Mr N experienced the sudden onset of chest pain, headache, vomiting and pain in the abdomen. He was admitted later that day to Taunton and Somerset Hospital (the Hospital) as an emergency patient by a locum GP who was concerned he had a heart condition. He had had a heart valve replacement 4 years earlier and was taking Sinthrome, a blood-thinning drug. By the time Mr N arrived at hospital he had severe problems with his breathing and could not walk. Initial examinations recorded his high alcohol intake; an ECG was normal but a chest X-ray reported abnormalities.

The following day Mr N was feeling worse with continuing breathlessness, and on the succeeding day Mrs N reported to staff her concerns that he was becoming bloated. The Consultant reviewed him, but no reference was made to the chest X-ray and no diagnosis recorded. On the following day, after another episode of breathlessness, an ECG showed fast atrial fibrillation and a second chest X-ray showed similar abnormalities to the admission X-ray. Despite Mr N's ongoing severe symptoms, on the 5th day of admission, he was transferred to Dene Barton House, a convalescent unit described by the Trust as a medical 'stepdown' facility. He was placed in a room on his own.

After transfer Mr N spent two further days with ongoing symptoms of breathlessness, raised temperature and blood in his stools and urine. On the night of his death, Mr N could not sleep. Staff put this down to anxiety and provided medication for nausea, anxiety and insomnia at 10pm and at 11.30pm. An observation was due on Mr N at 6.00am but was not undertaken because the night nurse decided to leave Mr N to sleep after his disturbed night. She said she had heard regular breathing from his room at the time. Similarly, on handover to the morning shift, Mr

N was left to sleep until 9.15am, when he was found dead already stiff with rigor mortis. A dissection of the aorta was subsequently diagnosed.

Mrs N complained about her husband's poor clinical care, inadequate nursing care and poor record keeping.

Findings

In considering the complaint the Ombudsman took advice from two professional assessors (one consultant general physician and one director of nursing). On admission Mr N was suffering from a range of symptoms which could have resulted from a number of conditions including a heart condition and excessive alcohol intake. During Mr N's admission the medical notes recorded many symptoms and test results, some of which could be attributed to alcohol abuse and withdrawal and some of which could not. However, despite the evidence from two abnormal chest X-rays, the possibility of a cardiac problem was not investigated further and the opinion of a cardiologist was not sought. On transfer to Dene Barton House, Mr N did not appear to be in a stable condition and a definitive cause for his problems had not been diagnosed.

The Ombudsman found that there was no basis to conclude that the patient was suitable for transfer and that there was a clear failure to undertake or complete a number of investigations, including following up evidence of abnormality in two chest X-rays. She found little evidence to persuade her that the investigations went beyond Mr N's alcohol dependency and its effects. She upheld this aspect of the complaint.

On the night of Mr N's death, the nursing staff had visited Mr N but this was not recorded in the nursing notes. The night nurse said that she had sat close enough to Mr N to hear regular breathing movements and she was certain that he was alive at 6.30am. The Ombudsman did not find it credible that given where the night nurse sat, it was possible to hear regular breathing movements with any degree of certainty. Given Mr N's rigor mortis when found at 9.15am it was highly likely he had died while the night nurse was on duty. Nevertheless, the Ombudsman's professional assessor did not believe that the lack of the observation check amounted to inadequate nursing care and even if the observation had been carried out the outcome was unlikely to be different. The decision to leave Mr N to sleep had been a compassionate one. However, the Ombudsman did conclude that his vital signs should have been checked and upheld the complaint to that extent. The quality of the nursing records for Mr N's care did, however, raise a number of concerns. They were too brief, did not describe clearly Mr N's condition, progress or care plan and they did not record Mrs N's requests to discuss her husband's condition with doctors. The Ombudsman upheld this aspect of the complaint.

Remedy

The Ombudsman was concerned by the inadequacy of the investigations into Mr N's symptoms and asked the Trust to review the case through its clinical governance

arrangements in order that the lessons learned would be incorporated into future practice. Although the observations undertaken by nursing staff did not amount to inadequate nursing care, the Ombudsman did recommend that the Trust undertake a review of the training needs of staff in observing sleeping patients, to ensure they check their vital signs without waking them unnecessarily and to use the Department of Health toolkit 'Essence of Care' to benchmark and improve standards of care. Finally the Ombudsman recommended that the Trust audit routinely its nursing records and improve standards by acting on the results.

Case No.E.803/01-02

Inadequate care and treatment

Complaint against

Ashford and St Peter's Hospital NHS Trust

Summary

In 1999 Mrs Y's husband, aged 78, suffered a heart attack and was admitted to Ashford Hospital from the A&E Department. He was disorientated and had poor eyesight and hearing. A week later he was seen for the first time by a consultant who told Mr Y he could go home the following day since his condition had improved. He was discharged the next day but readmitted later that evening to a different ward suffering respiratory distress. During the next 10 days his condition deteriorated. He had difficulty swallowing and was in increasing pain. Mrs Y said she told medical and nursing staff of her concerns but was ignored. On the ninth day of his readmission a decision was made not to resuscitate Mr Y and he died the following day.

During the first admission Mr Y had twice attempted to wander off the ward and at the second attempt had left the hospital building.

Mrs Y complained to the Ombudsman that the care and treatment provided by medical and nursing staff during both admissions was inadequate and that delays by the Trust in responding to her concerns were avoidable and unacceptable.

Findings

The Ombudsman took advice from two professional assessors on the clinical aspects of the case. They were of the view that it would have been good practice to keep Mr Y in the hospital and not discharge him when they did. They were also of the view that although the overall medical care and treatment provided to Mr Y was generally adequate, there were a number of concerns. First he was reviewed by a consultant only once during his admission due to holiday leave and during Mr Y's last

48 hours over a weekend he was only seen by a House Officer and there was no handover policy in force. The junior medical staff did not recognise that he was dying and as a consequence he was not made as comfortable as he could have been during his final hours, as more appropriate drugs could have been administered. Medical staff did not talk to Mrs Y about her husband's deterioration and the implications nor did they discuss with her the decision not to resuscitate Mr Y. Despite these failings the professional assessors concluded that the eventual outcome would have been the same. Turning to nursing care, the assessors were of the view that on the two occasions when Mr Y attempted to leave the ward and when he had left the hospital building the nurses acted appropriately. Although the overall nursing care and treatment provided to Mr Y was adequate, it fell below standard in certain areas. Monitoring of his fluid balance by nursing staff was poor and incomplete. There was no reference to his problem with swallowing in the care plan and it should not have been left largely to his wife to assist him to drink. The Ombudsman upheld the complaint to the extent of the failings identified.

Remedy

The Ombudsman recommended that all patients admitted should, ideally, be seen by a consultant within 24 hours, and subsequently by a qualified deputy, i.e. registrar or SHO, at least twice a week. She also recommended that the Trust consider ways of improving communication between medical/nursing staff and patients and their families. They should also consider reviewing their guidance on palliative care. The Trust should put in place a formal mechanism for handing over and reviewing sick patients outside normal working hours to ensure continuity of care. The Trust should emphasise the importance of maintaining accurate fluid balance charts, and ward systems should be introduced for checking that charts are completed. The Trust agreed to implement the recommendations, and also gave details of other practices that they have already implemented, or will implement, and that they will be reviewed regularly. The Trust also offered its apologies to Mrs Y.

Case No.E.2739/02-03

Inadequate risk assessment and decision to mobilise

Complaint against

North Bristol NHS Trust

Summary of case

In September 2001 Mrs K, who was 81 and had a left leg below-knee amputation, was admitted to Southmead Hospital with breathing difficulties. Mrs K was discharged two weeks later, but she fell out of bed at home and injured the base of her amputated limb. She was

readmitted to the Hospital late at night and placed on the medical assessment unit (the unit). Mrs K usually mobilised with a Zimmer frame but a staff nurse walked her to the toilet using her prosthesis and without the frame. As the staff nurse turned to close the door to the toilet, Mrs K lost her balance and fell, sustaining serious injuries. Another patient on the ward witnessed the events leading up to the fall. Mrs K later told a senior house officer (who assessed her injuries) that she had been reluctant to walk to the toilet. Mrs K died in the Hospital a month later. Her son, Mr K, complained about the care given to his mother, the decision to mobilise her and how this was carried out.

Findings

Mrs K had arrived in the unit very late at night, and at interview Trust staff said that a full nursing assessment was inappropriate at that time. Staff did not complete new documentation, but updated information by writing on the original documentation. The professional assessor appointed to advise the Ombudsman commented that, given the brief time between Mrs K's discharge and her readmission, it was reasonable to reuse the previous care plan, but a new risk assessment should have been completed. Mrs K presented a different clinical picture to that on discharge; she was clearly more frail than during her previous admission and had additional injuries. The professional assessor commented that the annotations made to the previous nursing assessment did not indicate an adequate reassessment of Mrs K's current risk factors. The Trust advised that as a result of this complaint, all patients at the Hospital now have a reassessment of risk, on a more comprehensive form, at every admission. The professional assessor confirmed that that was good practice. The Ombudsman upheld the complaint to the extent that the risk assessment had not been adequately revised.

The professional assessor considered that the staff nurse's decision to mobilise Mrs K was appropriate and in Mrs K's best interests, even though Mrs K herself was reluctant to mobilise. However, the professional assessor commented that the method used to walk Mrs K may not have been best suited to her given her previous reliance on a zimmer frame and was unlikely to have promoted the patient's confidence. The staff nurse had given careful thought about the decision and had concluded that she was in a position to support her. Mrs K was clearly weak and tired and used to moving around with her frame. There were conflicts in accounts about whether or not she was uncomfortable and dizzy whilst walking but it is evident that the staff nurse had supported her all the way to the toilet area without her falling. Once at the toilet the staff nurse left Mrs K holding on to the bars at the side of the toilet while she went to shut the door for the sake of privacy. In that moment Mrs K had fallen, as she had attempted to remove her underwear instead of holding on to the bars. The staff nurse did not consider that she had left Mrs K unsafe but said, in hindsight, that she wished she had seated Mrs K on the toilet properly before going to close the door and would always do that in future. The professional assessor commented that the

staff nurse had had the option of preserving the patient's safety or her dignity, but pointed out that safety should have taken precedence; it was not safe to assume that the patient would just stand there. He concluded that the staff nurse left Mrs K vulnerable and at risk, albeit for a brief moment only. It was understandable that Mrs K had not waited for the staff nurse: she had already been waiting to use the toilet for a considerable time. The complaint was partly upheld.

Remedy

The Trust apologised to Mr K for the shortcomings identified; and agreed to conduct an audit to ensure that risk assessments were carried out on all patients at each admission. The Trust also agreed to remind all nursing staff of the need to assess the relative risk of safety and dignity in each activity they undertake with a patient.

Case No.E.1889/02-03

Management of an elderly patient's abdominal problems following hip surgery

Complaint against Bromley Hospitals NHS Trust

Summary of case

In September 2001 Mr B's 79 year old mother, Mrs B, underwent surgery at Farnborough Hospital for hip replacement. She had a past history of bowel cancer and diverticular disease. Her initial post-operative recovery had seemed to go well but, two days later, she complained of abdominal pain and feeling unwell. However on that day no ward round took place and the beginning of her deterioration was not noted until the following day when she was assessed by the Orthopaedic surgeon who had carried out her hip surgery and SHO on their next ward round. Mrs B reported her symptoms to the surgeons and X-rays were taken. The consultant orthopaedic surgeon diagnosed a possible paralytic ileus (spasm of the bowel), increased her intravenous (IV) fluids and prescribed strong painkillers. Mrs B remained unwell.

The next day, a surgical registrar reviewed Mrs B and requested further X-rays. Various diagnoses were suggested until an associate specialist in general surgery saw her that evening. He decided to treat her conservatively and prescribed antibiotics. Mrs B continued to deteriorate and, the following day, it was decided to send her to Bromley Hospital for urgent exploratory surgery. However, at Bromley, she was found to be too ill for surgery and she died there from peritonitis resulting from a perforated sigmoid diverticular abscess

(where septic material contaminates the abdominal cavity with bowel contents and pus.)

Mrs B's family complained to the Trust, primarily about the failure to diagnose her post-operative problems.

Findings

The Trust had maintained that when the associate specialist first saw her, Mrs B was having a recurrence of diverticulitis, and that it was only the next day that she deteriorated dramatically. However, Mr B felt that both the orthopaedic surgeon and the associate specialist had failed to identify soon enough that his mother had developed peritonitis during her post-operative recovery.

Having taken account of the advice of two professional assessors' opinion the Ombudsman agreed with Mr B. She found that the doctors responsible had failed to recognise quickly enough the deterioration in Mrs B's condition and to take appropriate and timely action. The Ombudsman found that the orthopaedic surgeon had made an error of judgment when he attempted to manage an acute abdominal problem which was outside of his area of expertise. During the investigation, the orthopaedic surgeon acknowledged his error. However, the associate specialist had inappropriately decided to treat Mrs B conservatively when he should have instituted emergency resuscitation procedures and an immediate transfer to intensive care. He maintained during the investigation that his responses to her symptoms were appropriate. Overall, the Ombudsman concluded that there were serious failings in the care provided to Mrs B caused by a combination of a delayed diagnosis, questionable professional judgments, and system failures. She was concerned about the associate specialist's failure to recognise his own failings here.

Remedy

The Trust apologised and agreed to take steps to reinforce the lessons of this investigation, particularly ensuring that orthopaedic surgeons would seek advice in cases which lie outside their own expertise; they also agreed to a review of arrangements for ensuring that daily ward rounds are carried out. The Trust agreed that in future X-rays ordered as an emergency on the orthopaedic ward would be seen by a radiologist, whose report would be communicated directly to the doctor who ordered them.

Finally, in response to the Ombudsman's serious concerns about the actions and judgment of the associate specialist in this case, the Trust agreed that his work should be closely supervised and that there would be a thorough review of his performance, possibly involving a body such as the National Clinical Assessment Authority.

Case No.E.245/02-03

Use and monitoring of clozapine and sensitivity to cultural issues for a patient with schizophrenia

Complaint against

Cheshire and Wirral Partnership NHS Trust (formally Wirral and West Cheshire Community NHS Trust)

Summary of case

Ms F, who was 43 and of Chinese origin, had been treated successfully for mental illness for about 19 years. She started clozapine (a drug for the treatment of schizophrenia) treatment in late 1996. In early 1997 a consultant psychiatrist took over responsibility for her care. In March that year her brother, Dr F, wrote to the consultant psychiatrist expressing concern about the possible side-effects of clozapine. In 1999 Ms F collapsed and died at her home. A post mortem report recorded her cause of death as acute haemorrhagic pancreatitis; Ms F's blood clozapine level was found to be much higher than normal therapeutic levels and a report to the coroner noted that a side-effect of acute pancreatitis due to clozapine could not be discounted.

Both of Ms F's brothers had doubts about their sister's diagnosis and believed that a lack of cultural understanding exaggerated her symptoms.

Dr F complained to the Trust about his sister's care and treatment. He was concerned that her death was directly related to her treatment with clozapine. He was also concerned that the consultant psychiatrist had failed to take into account Ms F's Chinese origins, and said that this had resulted in the consultant psychiatrist misinterpreting Ms F's behaviours.

Findings

The Ombudsman took advice from a professional assessor, and her pharmaceutical adviser also provided comments on Ms F's medication. The professional assessor noted that Ms F suffered from a severe and debilitating mental illness, and he was satisfied that she was accurately diagnosed and that the team responsible for her care had attempted to support her in the least restrictive environment. He pointed out that the notes showed that Ms F suffered from treatment resistant schizophrenia and he was satisfied that clozapine was appropriate treatment for her illness. Ms F had shown evidence of benefits from the clozapine compared with her previous medication. She had a history of failing to comply

with her medication. However, the procedures around the administration of clozapine are strictly controlled. The professional assessor said that this provided an additional benefit to Ms F as it allowed consistent monitoring of her mental and physical health. Overall, he was of the view that the dose prescribed was appropriate and within recommended levels. The Ombudsman's pharmaceutical adviser concurred, stating that the clinical notes gave a clear picture that Ms F's medication was handled correctly. He noted that there have been isolated reports of pancreatitis associated with clozapine, but explained that these are rare and usually occur soon after a patient begins treatment. Ms F had been on clozapine treatment for almost three years and it would be unreasonable to conclude that the consultant psychiatrist should have suspected pancreatitis. The professional assessor commented on the cultural issues pertinent to this case. Ms F's key worker (a social worker) was aware that such differences were important to Ms F's care and treatment and spoke of seeking appropriate advice. However, the consultant psychiatrist did not consider this necessary. The professional assessor said that this could have affected the quality of care, treatment and communication with the patient and their family and he urged greater awareness and sensitivity to cultural issues in future. The Ombudsman shared that concern and she felt that specific training in this area might be of benefit to the consultant psychiatrist. However, it was noted that Ms F's care and treatment was of a reasonable standard and the Ombudsman did not uphold the complaint.

Remedy

The Ombudsman recommended that the Trust should work with the consultant psychiatrist to find appropriate training so that he may, in future, be aware of, and more sensitive to, the needs of those with mental illness in the Chinese community. The Trust agreed to this recommendation and apologised for the shortcomings identified.

Case No.E.2559/01-02

Contested consent and inadequate handling of complaint

Complaint against

The Derbyshire Mental Health Trust

Summary of case

Ms C complained that, in November 2000, a community psychiatric nurse (CPN) visited her house to administer two injections: an anti-psychotic and a contraceptive. Ms C said that she agreed to receive the anti-psychotic medication but did not consent to the contraceptive injection; both injections were administered. Ms C complained through her solicitors to the CPN's employers, the Derbyshire Mental Health Services Trust, who

investigated her concerns. A senior nurse interviewed the CPN, who claimed that Ms C had given implied consent when she did not object to the second injection. She also interviewed Ms C's community support worker, who had been present at the time; she confirmed that Ms C had not given consent to the contraceptive injection. The senior nurse concluded in her report of the incident that whether consent had been obtained was ambiguous and that the assumption could not be made that that blanket approval had been obtained.

The Trust subsequently wrote to Ms C's solicitors and said that it considered the CPN's version of events to be the most reliable and that Ms C had given her consent when she did not object to the second injection. Ms C remained dissatisfied but, when she requested an independent review, the convener recommended further local resolution. The convener however wrote to the Trust's chief executive, voicing her concerns that the conclusions of the Trust's investigation into Ms C's complaint had not been reflected in its response to her. The Trust conducted a second investigation and interviewed both the CPN and the community support worker again but did not interview Ms C. The Trust confirmed its defence of the CPN. The convener rejected Ms C's second IR request as she considered that views had become so entrenched about what had happened that nothing would be achieved through a panel.

Findings

The Ombudsman was unable to reach a finding about whether or not consent had been given for the contraceptive injection because of the conflicting versions of events. However, she upheld Ms C's complaints about the handling of her concerns. In spite of the three different accounts of the incident, the Trust chose to defend the CPN and made inappropriate comments to the convener and to the Ombudsman's investigating officer about Ms C's motivation and criminal history. The Ombudsman also concluded that the convener should have held an IR given her misgivings about the Trust's investigation into Ms C's complaint.

Remedy

The Ombudsman recommended the Trust should review its processes and training on consent in line with best practice. This should include encouraging users to sign care plans, recording any reluctance to accept treatment and where there is doubt over the clarity of consent a drug should not be administered. The Trust was also asked to reinforce the CPN's obligation to be well informed about the treatments they were giving. On the complaints handling process, the Ombudsman welcomed the introduction of a more robust procedure.

Provision of a clinical psychology service to an adolescent with emotional problems

Complaint against
Doncaster and South Humber
Healthcare NHS Trust

Summary of case

In June 2001, Mrs J took her 14 year old daughter to their GP, as she was concerned about her emotional well-being: she was experiencing mood swings, having bad dreams and was harming herself. Miss L was referred to the Trust's psychology service, which predominantly dealt with adult clients. A trainee psychologist began to see Miss L regularly, excluding Mrs J from their sessions, which continued until February 2002. During the sessions, the trainee became concerned that a member of Miss L's family might be abusing her and contacted the local Social Services department which later invoked child protection procedures. Mrs J complained to the Trust that the trainee was inexperienced in working with adolescents, had not been properly supervised, had effectively led Miss L to believe that her dreams reflected reality, and thus to suspect that abuse had actually taken place.

Findings

It was not the purpose of the Ombudsman's investigation to establish whether abuse actually took place, but to decide whether the overall service provided to Miss L had been reasonable. The Ombudsman found that although the psychology service did not usually accept referrals of adolescents, and was extremely busy with adult clients, it had made an exception in this case at the request of Miss L's GP. Based on the advice of two assessors, the Ombudsman found that the trainee had not been supervised effectively. That was particularly so when she continued to see Miss L, even after her training placement at the psychology service had come to an end. This had been the trainee's first placement, and Miss L was allocated to her without effective supervision and monitoring. Because the trainee was regarded as very competent, her supervisor at the service, who was very busy, did not observe her during the placement. Poor supervision, recording and monitoring, meant that a well-intended treatment approach was inadequate. In addition, the psychology service had not fully or appropriately addressed the concerns that the trainee herself had identified; neither had it sufficiently involved the trainee's academic tutors in dealing with her concerns. On balance, reasonable practice was not followed in the treatment provided to Miss L, even though it had been undertaken in good faith.

Remedy

The Ombudsman endorsed a number of recommendations made by the assessors, which included redefining the referral criteria for the service, auditing caseloads to identify and monitor more complex cases, exploring new ways of responding to heavy demand and providing appropriate training for supervisors. The Trust apologised and agreed to implement the recommendations.

Unsatisfactory anaesthetic management; arrangements for consent; inadequate management of post-operative complications

Complaint against
King's Lynn and Wisbech Hospitals NHS
Trust

Summary of case

In 2001 Mrs Q, who was 68 and had a long history of disabling asthma, fell and fractured her arm. She attended the A&E department at The Queen Elizabeth Hospital, which is managed by the Trust. Mrs Q's arm was put in a hanging plaster and she was sent home with an appointment for the fracture clinic. When she attended the clinic a week later it was decided that she should undergo a procedure to reset her arm. Her daughter, Miss N, signed the consent form, as Mrs Q was unable to do so due to her injury. Miss N understood that the procedure would be carried out under a general anaesthetic. However, after Miss N signed the form her mother was seen by a consultant anaesthetist, who decided that a local anaesthetic nerve block would be better. During the procedure the nerve block caused Mrs Q to go into respiratory failure; she was ventilated and transferred to the intensive care unit. The following day, her arm was manipulated under general anaesthetic and she was returned to the unit. Mrs Q remained on ventilation and further complications developed. The option of a tracheostomy to assist her breathing was discussed with Mrs Q and her relatives, but they refused. Mrs Q died four days later.

Findings

The Ombudsman was advised by a professional assessor. He noted that the consultant anaesthetist had been aware that Mrs Q had significant chronic lung disease and that the fracture, by making her breathing difficult, was making her lung condition worse and contributing to a

deterioration in her overall condition. The consultant anaesthetist had been of the opinion that the procedure was necessary and should go ahead without further delay. The professional assessor was satisfied that this was appropriate and advised the Ombudsman that Mrs Q's pre-operative assessment was adequate and that waiting for further tests to be carried out, or referral to a chest specialist, would have caused unnecessary delay. This would not have been in Mrs Q's best interests. The professional assessor also confirmed that local anaesthesia offered the best possibility of avoiding ventilation (particularly when compared with a general anaesthetic) and that this was the only option for Mrs Q. The Ombudsman therefore did not uphold the complaint that Mrs Q's pre-operative assessment was inadequate.

Miss N said that, as she had signed the consent form, she should have been asked about the change of anaesthesia. She was concerned that her mother would not have understood, and said that Mrs Q was incapable of giving informed consent. The professional assessor was critical of the way that consent was handled in this case. Asking Miss N to sign the form gave her the impression that she was party to the consent. However, the professional assessor advised that if a patient is capable of providing consent then the patient should sign the consent form, even if injury to the patient's dominant arm means that the signature bears little resemblance to his or her normal signature. If a patient is mentally unable to give consent then the decision to go ahead rests with clinicians; no-one can give consent for someone else. The Ombudsman found that irrespective of Mrs Q's physical or mental ability to give consent, Miss N should not have been asked to sign the consent form; she upheld the complaint that communication, and the arrangements for consent, were inadequate.

Miss N also complained about her mother's post-operative care in the unit. The Ombudsman criticised the Trust's failure to locate all of Mrs Q's records for the unit, which had hampered her investigation somewhat. Mrs Q remained on ventilation throughout her admission to the unit. The professional assessor advised that that was appropriate, and also explained that it was necessary to keep Mrs Q sedated during the admission. Mrs Q had been given an infusion of insulin and Miss N was concerned about that, as her mother did not have diabetes. However, the professional assessor explained that Mrs Q's blood sugar levels were measured regularly in the unit and they gradually increased to a level where an insulin infusion was clinically warranted. Mrs Q had suffered a myocardial infarction whilst in the unit. The Ombudsman shared the professional assessor's view that Miss N should have been told about that. A consultant in the unit acknowledged that the care given to Mrs Q was open to criticism in that infusions were started before appropriate monitoring lines were inserted, and blood tests should have been performed shortly after Mrs Q was admitted. Protocols were in place, but they had not been followed due to pressure of work. The Ombudsman was critical of that failure. The professional assessor advised the Ombudsman that although there were deficiencies in Mrs Q's care they did not represent inadequate care, and the

shortcomings identified were not associated with Mrs Q's death. The Ombudsman accepted that, but said that she remained concerned about those shortcomings and upheld the complaint to that extent.

Remedy

The consultant anaesthetist's record-keeping on the anaesthetic chart was poor and the Ombudsman recommended that the Trust should draw to his attention the importance of clear and accurate records. The Ombudsman was also concerned that staff in the unit had not followed protocols, and she recommended that the Trust should remind staff of the importance of this. The Trust agreed to those recommendations and apologised to Miss N for the shortcomings identified. The professional assessor pointed out that the decision not to persist with aggressive treatment was correct, compassionate and rational. The Ombudsman paid tribute to the courage that Mrs Q and her family had shown in taking that decision.

Case No.E.1453/01-02

Care and treatment at a regional neurological centre

Complaint against

Preston Acute Hospitals NHS trust

Summary of case

Mr A, who was 24 years old, was admitted to his local hospital in 2000 with the onset of fits and a two to three day history of headaches. A brain scan revealed a small brain lesion and his condition was described as critical. Mr A was thought to have suffered a stroke and he was transferred to the Royal Preston Hospital for more specialist neurological input. When Mr A's father (Mr B) arrived at the Hospital, he was told that his son had suffered further brain damage but should make a full recovery. However, during the night and the following morning Mr A's condition rapidly deteriorated. A MRI scan was performed and showed extensive abnormality over the whole of the brain. Mr B subsequently received a telephone call from the Hospital to say that Mr A was having difficulty breathing. He had been transferred to the intensive care unit (ICU) and placed on a life support machine. Mr A failed to regain consciousness and died the following day.

Mr B complained to the Trust about Mr A's care and treatment. He remained dissatisfied following a meeting with the first consultant neurologist and a substantive response from the chief executive. When the convener refused his request for an independent review, Mr B complained to the Ombudsman. He was particularly concerned that his son had not been admitted immediately to the ICU at the Hospital and that there had been a delay in obtaining a MRI scan. Finally, Mr B worried that his son

might have been treated as a drug abuser because of his history of occasionally using recreational drugs, and that this had influenced Mr A's clinical management.

Findings

An autopsy report gave the cause of Mr A's death as cerebral infarction. However, as a result of this investigation, it was established by two consultant neuropathologists appointed by the Ombudsman as professional assessors, that Mr A's death had been caused by acute haemorrhagic leucoencephalitis (AHLE) which is an extremely rare neurological disease. Three other professional assessors - a consultant neurologist, a consultant neurosurgeon and a consultant neuroradiologist - were also appointed to advise on the clinical aspects of this case.

The consultant neurologist assessor considered that the timing of the MRI scan had been reasonable. Mr A's admission to the neurological ward at the hospital, as opposed to the ICU, had also been reasonable since the neurological ward nursing staff were trained in the management of patients with neurological problems. He found nothing to suggest that Mr A's illicit drug taking had influenced his clinical management.

However, the consultant neurologist assessor advised that some aspects of Mr A's care and treatment were unsatisfactory. He was concerned about consultant neurological supervision and believed that had a consultant seen Mr A on the Saturday after he had been admitted, that would have been the appropriate time for the consultant to make a decision in respect of elective intubation and ventilation. The consultant neurologist assessor had concerns that a relatively junior doctor had reported the emergency MRI scan. However, he concluded that it was unlikely that the correct diagnosis of Mr A's condition would have been made and even if it had been made, that it would have influenced the outcome for Mr A.

Remedy

The Ombudsman recommended that decisions relating to elective intubation and ventilation should always be taken by the consultant in charge of the case and documented in the records. She further recommended that a consultant neuroradiologist should be available in emergency situations and at weekends to report on MRI scans. The Trust stated that a consultant neuroradiologist would be available at a hospital within the region to perform this task. The Ombudsman obtained an assurance that a recommendation concerning regular ward rounds by the consultant neurologist on call and that emergency admissions should be seen on the day of admission or within 12 hours thereof, would receive serious consideration within the ongoing discussions about consultant contracts. The complaint was upheld to the extent indicated above. It was recognised that Mr A's disease was extremely rare and that it had not been entirely surprising that neither of the consultant neurologists involved in Mr A's care had previously

encountered the condition of AHLE. The Ombudsman suggested that Mr A's case be presented to a clinical meeting of the neuroscience division of the Trust as a pure diagnostic problem so that some clinical benefit might arise from Mr A's case.

Case No.E.82/02-03

Failure to diagnose; poor complaint handling

Complaint against

Sherwood Forest Hospitals NHS Trust,
formerly the Central Nottinghamshire
Health Care Trust

Summary of case

Mr P attended the A&E department at Newark Hospital having suffered for twelve days with abdominal pain, and latterly with rectal bleeding and diarrhoea. Although an X-ray led staff in the A&E department to note that his colon was abnormally dilated, it was noted that he was suffering with a form of food poisoning which was attributed to his having eaten tinned steak. His wife was recorded as suffering similar symptoms which had improved: Mrs P later completely refuted this assumption.

Stool cultures were sent for analysis and Mr P was referred to the medical team the next day and was seen by a consultant physician (who was based at another Trust and employed at Newark Hospital for two mornings a week). Further stool cultures and antibiotic medication were arranged: no stool culture during the admission confirmed the diagnosis of food poisoning. Nonetheless, Mr P was seen by a succession of junior medical staff who continued, under the direction of the consultant physician, to treat Mr P for food poisoning. On the tenth day of his admission, following concern on the part of a junior doctor at Mr P's unremitting pain, the consultant physician asked a consultant gastroenterologist for a second opinion. The consultant gastroenterologist ordered an urgent X-ray and rectal biopsies. He suggested that Mr P's condition should be treated as a serious complication of ulcerative colitis known as toxic dilation. This was confirmed by X-ray. Mr P was promptly transferred into the care of a consultant colorectal surgeon at a hospital run by another Trust, on the eleventh day of his admission. His condition went on to improve superficially and he was discharged from the second Trust, but he then deteriorated, and was readmitted there. Mr P died just over three weeks after being discharged from the former Trust.

Mrs P complained about the first Trust's failure to diagnose and treat her husband and a meeting was held with staff to which the consultant physician was not invited, despite the family's explicit request. Mrs P remained dissatisfied and an independent review was

eventually held over two years after Mr P's death. The consultant physician's decision not to attend the independent review, along with the first Trust's failure to make a timely diagnosis and to include the consultant physician in the earlier meeting, was investigated by the Ombudsman.

Findings

The Ombudsman noted that the hospital admission subject to her investigation had been to the Trust's predecessor organisation, and that progress had been made since Mr P's death in improving the services at Newark Hospital. She also emphasised that Mr P was under the care of another Trust when he died. She was advised by two consultant physicians who identified a number of serious failings in Mr P's medical management by the former Trust.

The Ombudsman found that the initial diagnosis of food poisoning was questionable given the duration of Mr P's symptoms. She noted that the X-ray undertaken on Mr P's admission and his subsequent blood serum albumin levels pointed to a diagnosis of ulcerative colitis, which would also have been supported by the succession of negative stools. She criticised the continued assumption that Mr P's illness resulted from contaminated tinned steak despite substantial evidence to the contrary and expressed surprise and dismay that crucial test results were not heeded by the former Trust staff. The Ombudsman accepted the advice of her assessors that a more timely diagnosis should have been made and would probably have led to life-saving treatment for Mr P.

The Ombudsman also expressed concern about the absence of a 'medical firm' structure at Newark, which led to a succession of junior doctors examining Mr P. She was very critical of the lack of leadership on the part of the consultant physician, which she found had led to an unacceptable delay in Mr P's referral to the consultant gastroenterologist. She went on to express great disappointment at the lack of involvement of Mr P's family in the former Trust's attempts to diagnose Mr P's illness, given family members' concern about the extent and origin of his pain. The Ombudsman learned that Mr P's family had arrived at the correct diagnosis somewhat sooner than the former Trust, but had not been listened to.

The Ombudsman shared the consultant physician's concerns about the former Trust's omission of him from the local resolution process. However, she was more critical of his own decision to further his personal protest against the former Trust at the expense of answering Mr P's family's questions in the IRP. She upheld the clinical and complaints handling parts of the complaint in full.

Remedy

The Ombudsman welcomed the Trust's identification of safety and clinical staffing arrangements as areas for improvement since the complaint was made and also the extensive work that had been undertaken in formulating

and implementing a clinical strategy for Newark Hospital. She recommended that the Trust prioritise measures that address the issues in Mrs P's complaint in its implementation of its clinical strategy. She also recommended that the Ombudsman's report be used as a training tool for the doctors involved in Mr P's care and also that the Trust's senior nurses use it for the training and development of nursing staff.

The Ombudsman recommended that the Trust adopt a collaborative and robust approach when liaising with lay chairs to facilitate the attendance of appropriate medical staff at IRPs. She also recommended that a copy of the report be sent to the chief executive of the Trust where the consultant physician is based, so that his contribution to future IRPs could be monitored. The Trust extended its sincere apologies to Mr P's family for the failings identified by the Ombudsman and went on to implement the Ombudsman's recommendations in full.

Case No.E.2451/01-02

Failure to complete a timely incident report and poor nursing care

Complaint against

St Helen's and Knowsley Hospitals NHS Trust

Summary of case

Following a fall at home in December 1999, Mr C went to the A&E department at Whiston Hospital where a doctor took down details of his usual medication from a GP printout. Mr C, who had a history of heart problems, was admitted to the medical admissions unit overnight for tests and observations. The next morning he received 1000mg of carbamazepine, an anticonvulsant, instead of 100mg because a house officer had incorrectly copied a prescription from the badly written records of the A&E doctor. The ward sister endeavoured to confirm the prescription before administering the drug to Mr C. She failed to record these checks in the medical records, including that she had consulted the British National Formulary.

The clinical pharmacist noticed the error when making a routine visit to the unit. She went through the correct procedure, recording the incident in the records and asking a doctor to rewrite the prescription. However, a formal incident report was not completed by nursing staff on the ward. The consultant physician was told about the overdose by the house officer and then explained what had happened to Mr C, telling him that he would suffer no lasting damage. He was kept under observation and his heart rate and pulse were monitored. Mrs C arrived in the afternoon to find her husband semi-conscious and confused. He subsequently vomited and returned to bed.

It was not until Mrs C returned in the evening that she learned of his incorrect medication. A doctor explained that the side effects experienced by Mr C would cease as soon as the carbamazepine was out of his system in three or four days time. Mrs C noted that although Mr C had eaten and vomited, no fluid chart was started and he had been left to lie in a his vomit. Later, a doctor arranged for Mr C to be cleaned up and changed. Two days later Mrs C went to collect her husband, unprepared for the distressing side effects he had experienced. He recounted details of bizarre hallucinations but these were ignored when she queried them with the doctor. Mrs C was convinced that her husband was unfit to be discharged but the consultant physician concluded that he was fit to go home. Once at home he could not feed himself or go the lavatory unaided and continued to experience hallucinations over the next ten days.

Mrs C complained to the Trust but local resolution and a response from the chief executive failed to resolve matters. A claim made by the Trust that the poisons centre had been contacted about the overdose of carbamazepine was later revealed as false. The Trust took advice from a consultant endocrinologist who was also head of the Trust's Service for Medicine and Chairman of the Drugs and Therapeutics Committee. He advised that the dosage had not produced an extraordinarily high level of the drug in Mr C's blood but this advice was erroneously based on a test result taken before the drug was given. This advice was later corrected when Mrs C pointed out the test relied upon was irrelevant. Mrs C twice requested an independent review, which was refused by the convener who failed to take independent nursing advice.

Findings

The incorrect dose of carbamazepine was clearly documented, but the Ombudsman's professional assessors did not consider that Mr C's medical management thereafter had been unsatisfactory. The Ombudsman upheld the complaint that Mr C had received an excessive dose of carbamazepine and that his management thereafter had been unsatisfactory because of the poor standard of nursing care provided for Mr C. When the overdose came to light, the ward sister failed to complete an incident report and this was not done until several months later. The Ombudsman upheld the complaint that the Trust's system for incident reporting was inadequate. She also found that the Trust's handling of the complaint had been inadequate and that Mrs C had received misleading and inaccurate responses to her concerns.

Remedy

The Ombudsman recommended that TOXBASE, a national database providing advice on the management of poisoning, should be made available on-line in the Trust's A&E department, and that a copy of the information provided should be placed in the clinical notes to assist with the management and care of the patient concerned. The Ombudsman welcomed the fact that the Trust now included in its induction programme and health and safety awareness course; sessions based on its policies and

procedures for incident reporting. She advised that the investigation of incidents should involve all relevant staff, and that they be informed of the outcomes. The Ombudsman further recommended that the national reporting system for medication errors, due to be introduced in autumn 2003, should be implemented as soon as practically possible. She welcomed the improvements made in the Trust's management of complaints and the mechanisms to provide timely and satisfactory responses to complainants. Finally, the Ombudsman recommended that when considering requests for independent review, the convener be reminded of the importance of obtaining independent advice on all aspects of a complaint which involved clinical judgment.

Other

Case No.E.22/02-03

The criteria used by the Health Authority and by the Primary Care Trust to test eligibility for NHS Funding for a patient's care was misapplied

Complaint against

The former Cambridgeshire Health Authority and South Cambridgeshire Primary Care Trust

Complaint as put by Mrs Pointon

1. The account of the complaint provided by Mrs Pointon was that when he was 52 years old, her husband Mr Pointon, was diagnosed with early onset dementia. Mr Pointon's physical and mental state deteriorated steadily and in 1998 he was admitted to a nursing home. Initially, he settled in well but by early 2000 he had become less mobile and was suffering from regular falls. Mrs Pointon decided to bring her husband home and care for him herself with the aid of two full-time carers working alternate weeks. This care was financed by Direct Payments from Social Services (monies paid directly to Mr Pointon) and contributions from Mr and Mrs Pointon.

2. Between April 2000 and June 2001 Mr Pointon received NHS funded respite care in a psychiatric unit for up to five days every five weeks. However, this had to be discontinued when he began to suffer from car sickness and panic attacks during the journey to and from the ward. In August 2001 Mrs Pointon asked the former Cambridgeshire Health Authority (the Health Authority) to fund either Mr Pointon's continuing health care costs, or the cost of two full-time carers every fifth week, in order to provide her with a break similar to that formerly provided when Mr Pointon was in the hospital ward. After a care assessment and a multi-disciplinary meeting a suggestion was made for possible funding of one extra carer for three and a half hours a day, for six days, every five weeks.

3. Mrs Pointon complained to the chief executive of the Health Authority in January 2002. She was dissatisfied with the amount of funding that had been suggested and challenged the Health Authority's interpretation of their eligibility criteria for funding continuing care. On 1 April 2002 the Health Authority ceased to exist. The budget for funding such care passed to South Cambridgeshire Primary Care Trust (the PCT). On 20 May, after a nursing

assessment of Mr Pointon's needs and further meetings between the PCT and Social Services, it was decided that all Mr Pointon's health care needs were already being met by the NHS, that the respite care required was social care and therefore he was not eligible for any extra NHS funding. Mrs Pointon remained dissatisfied.

4. The matters investigated were that:

- (a) the Health Authority misapplied their local eligibility criteria and relevant Department of Health guidance; and
- (b) the PCT also misapplied the local eligibility criteria and relevant Department of Health guidance, and in particular they relied on inaccurate or inadequate information, failed to take account of relevant facts in their assessment and took account of irrelevant factors; and that this resulted in Mr Pointon wrongly being refused NHS funding for respite care at home.

Investigation

5. The statement of complaint for the investigation was issued on 22 October 2002. Comments were received from the PCT and relevant papers were examined. A professional assessor - a mental health nurse - was appointed to advise on the clinical aspects of the case; her report is reproduced in paragraph 37 of this report. One of the Ombudsman's Investigators took evidence from Mrs Pointon and PCT staff involved. I have not put into this report every detail investigated; but I am satisfied that nothing of significance has been overlooked.

Background

6. The statutory framework for the provision of health services is outlined in paragraph 7 below; paragraphs 8-12 summarise relevant national guidance; relevant Health Authority policy and criteria are summarised in paragraph 13.

Statutory framework

7. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that it is the Secretary of State's duty to provide services 'to such extent as he considers necessary to meet all reasonable requirements ... including such facilities for ... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service...'. The National Health Service and Community Care Act 1990 (the 1990 Act), the relevant parts of which were implemented in April 1993, significantly increased the responsibilities of local authorities so as to include provision of accommodation for people who need it by reason of illness. Section 47 of the 1990 Act required local authorities to carry out an assessment of a patient's needs before deciding whether or to what extent they were required to provide services to meet those needs.

National guidance

8. In 1995 the Department of Health issued guidance (HSG(95)8) on NHS responsibilities for meeting continuing health care needs. The guidance detailed a national framework of conditions for all health authorities to meet, by April 1996, in drawing up local policies and eligibility criteria for continuing health care and in deciding the appropriate balance of services to meet local needs. The guidance stated that '[health authorities] ... will need to set priorities for continuing health care within the total resources available to them. While the balance, type, and precise level of services may vary between different parts of the country in the light of local circumstances and needs, there are a number of key conditions which all health authorities ... must be able to cover in their local arrangements. These are set out in Annex A ...'. Annex A includes the following passages:

'F Respite health care

'For many people local authorities will have the lead responsibility for arranging and funding respite care. The NHS however also has important responsibilities in this area and all health authorities ... must arrange and fund an adequate level of care. In particular however they should address the needs of:

'...

'- people who are receiving a package of palliative care in their own homes but where they or their carer need a period of respite care.

'In making arrangements for respite care health authorities ... should pay careful attention to the wishes of patients and their carers.

'Local policies should include details of arrangements and eligibility criteria for people who require respite care from the NHS.

'H Community health and primary care services for people at home or in residential care homes

'Community health services are a crucial part of the provision of continuing care for people at home ... Health authorities should work closely with local authorities ... to agree the likely demand for continuing community health services support, taking account of the impact of:

'- changes in the number of people who need care in their own home as a result of the new community care arrangements;

'- changes in acute sector practice and provider plans to reduce hospital lengths of stay;

'...

'This should be reflected in health authorities' policies on continuing health care ...'

9. In August 1999 the Department of Health issued further guidance on continuing health care in a circular HSC 1999/180. This was in response to a Court of Appeal

judgment in the case R v North and East Devon Health Authority ex parte Coughlan (the Coughlan case). Miss Coughlan was described in the judgment as tetraplegic, doubly incontinent, requiring regular catheterisation, and with difficulty in breathing. The judgment summarised its conclusions as follows:

'(a) The NHS does not have sole responsibility for nursing care. Nursing care for a chronically sick person may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's means ... Whether it was unlawful [to transfer responsibility for the patient's general nursing care to the local authority] depends, generally, on whether the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected to provide. Miss Coughlan needed services of a wholly different category. ...'

10. The Department's guidance included in its description on the judgment:

'(b) The NHS may have regard to its resources in deciding on service provision.

'(c) ... HSG(95)8 ... is lawful, although could be clearer.

'(d) Local authorities may purchase nursing services under section 21 of the National Assistance Act 1948 only where services are:

(i) merely incidental to the provision of the accommodation which a local authority is under a duty to provide to persons to whom section 21 refers; and

(ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide.

'(e) Where a person's primary need is a health need, then this is an NHS responsibility.

'(f) Eligibility criteria drawn up by Health Authorities need to identify at least two categories of persons who, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a Health Authority. Secondly, there are those whose nursing services in general can be regarded as the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.'

11. Authorities were advised by the Department to satisfy themselves that their continuing care policies and eligibility criteria were in line with the judgment and existing guidance, taking further legal advice where necessary. If they revised their criteria they should

consider what action they needed to take to re-assess service users against the revised criteria.

12. In June 2001, the Department of Health issued guidance in circular HSC 2001/015, on the new arrangements for continuing health care embodied in the Health and Social Care Act 2001. This required health authorities to comply with the guidance by October 2001 and, working in conjunction with primary care trusts, to agree joint eligibility criteria and set out their respective responsibilities for meeting continuing health and social care needs by 1 March 2002. The guidance specified clearly that one of the key issues to consider when establishing continuing care eligibility criteria was that 'the location of care should not be the sole or main determinant of eligibility. Continuing NHS health care may be provided in an NHS hospital, a nursing home, hospice or the individual's own home'. A further circular - HSC 2002/001, was issued in January 2002 which provided guidance on the implementation of the single assessment process for older people, as part of the National Service Framework for Older People.

Local guidance

13. The Health Authority's policy and criteria for eligibility for meeting continuing health care needs, dated April 2000, which superseded the criteria of North West Anglia, and Cambridge and Huntingdon, Health Authorities, was written with regard to the principles of the Coughlan finding and reviewed in line with the requirements of HSC 2000/015 (paragraph 12) in March 2002. It included the following references to NHS funded health care in an individual's home:

'9.0 WHERE IS CAMBRIDGESHIRE HEALTH AUTHORITY'S CONTINUING HEALTH CARE PROVIDED?

'...

'9.2 Where clinically appropriate and possible, people may receive their continuing health care at home. At other times, because of the complexity and intensity of a person's illness ... or in order to ensure the most effective use of resources, it will be necessary to receive this care as an in-patient ...

'9.3 Initial assessment for continuing health care can take place in hospital, the patient's own home or in a residential or nursing home setting ...

'10.0 HOW DOES THE SOCIAL SERVICE DEPARTMENT FIT IN?

'Many patients with less than 100% continuing health care needs may also require support from the Local Authority Social Services Department. Both agencies are committed to working in partnership to provide comprehensive and co-ordinated services to people needing services and support ...

'11.0 CAN NHS CARE BE FUNDED IN A PERSON'S OWN HOME?

'Yes, community and specialist nursing and therapy

services are either available to people through direct access or on referral from their general practice. Specific nursing services may include, for example, continence advice, palliative care, Parkinson's disease, diabetic care or stoma care.

'...

'14.0 WHAT ABOUT PEOPLE WHO DO NOT FALL WITHIN THE ELIGIBILITY CRITERIA ...

'...

'The difference between "social" and "health" care is not an easy distinction to make. The picture is confused by the willingness of the NHS in earlier years to care for people who were frail and dependent, without assessing whether their needs really were for health, rather than social care. ...

'There is still a public perception that people who need help with activities of daily living should, on account of their dependency, remain the responsibility of the NHS (and this is particularly so in the case of dependency arising from an illness such as dementia). This is not something that this Health Authority subscribes to but that, dependent on assessed need, the necessary services should be provided by the most appropriate agency or agencies.

'PEOPLE WITH PHYSICAL AND/OR SENSORY DISABILITY

'...

'People in a Community Setting

'Those living at home ... need a multi-agency reassessment to ascertain whether additional resources can be provided or whether they are eligible for full NHS care.

'Eligibility Criteria

'... Below are some of the clinical characteristics for guidance but there should not be an over-reliance on having a certain number of these. Eligibility may come from one condition alone ... or from several lesser factors. ...

'PEOPLE WITH DEMENTIA (OF ANY AGE)

'...

'Those living at home ... may also have specific health needs that can no longer be met within usual community health, community mental health and social care resources. Such people need a multi-agency reassessment to ascertain whether it is appropriate to provide additional resources in the community to meet their health needs and/or whether they need "in patient" care.

'Eligibility Criteria

'...

'Below are some behavioural and physical characteristics for guidance, ... Eligibility may come

from one condition alone [such as persistent risk of harm to self ...] ...

'Patients with advanced dementia that also have a severe degree of behavioural disturbance ... [such as] a risk to self or others if not receiving observation and intervention.

' ...

'... who also have physical problems which require specific care management by appropriately skilled staff in order to reduce the risk of significant deterioration of physical health and safety. Consideration will be given to the level of risk of further deterioration if the patient should be relocated ...

' ...

'SHORT TERM ADMISSION/RESPITE

'... It provides relief and health gain for individuals or their regular carers ...

'Eligibility Criteria

'The need for NHS funded health respite care is guided by the following eligibility criteria:

'The patient meets the criteria for continuing in-patient care but their care plan specifies care outside hospital.

'The main informal carer has been delivering a high level of skilled nursing care but is temporarily unable to continue and the patient therefore needs hospital admission. ...'

Ombudsman's report on NHS funding for long-term care

14. In February 2003 the Ombudsman published a report (HC 399) incorporating the texts of four completed investigations following complaints made to her about the arrangements for funding long-term NHS continuing care. In the report, she expressed concern that patients receiving such care may have suffered injustice because of failings in these arrangements, and she called for redress from the authorities involved. She also recommended that health bodies should review the criteria used by their predecessor bodies, and the way that those criteria had been applied, and that efforts should be made to remedy any injustice to patients who had been wrongly assessed. The Ombudsman's report also highlighted her concerns about lack of information given to patients and carers, and the continuity of assessments. The introduction to the report included the following:

'... Looking at most sets of criteria we have seen, it is fairly easy to identify a group of people who would definitely not be eligible for funding, and a very small group of people who definitely would be eligible (many of whom would not be well enough to leave hospital). But there are a large number of people in the group in between. Now and in the past, a line has to be drawn through that group, and

this is done using generally quite subjective and broadly drafted criteria. Yet which side of the line a patient's needs are judged to fall can make an enormous financial difference to the patient and their family.

'Some authorities have attempted to address this problem by producing detailed guidance and procedures on the assessment of patients and the application of criteria. Some use specific assessment "tools". Where the guidance and procedures are well-drafted and properly promulgated and understood by those doing assessments, they can at least assure some degree of consistency in the application of the criteria within the authority's area. But unless they are published alongside the criteria themselves, patients and carers can be left inadequately informed as to how decisions about eligibility are actually being made.

'Other health authorities have little or no practical guidance about the application of criteria, and it is left to clinical staff in the community or hospitals to interpret them as best they can when assessing patients. This will almost inevitably lead to inconsistency ...'

Key events

15. I set out below a summary of key events drawn from records and supporting evidence:

1998 - Mr Pointon was admitted to a nursing home as his wife could no longer manage him at home. An NHS fully funded bed was offered as the Health Authority had purchased a block of beds that had to be paid for, whether they were used or not, but Mrs Pointon decided to use the nursing home of her choice. Cambridgeshire Social Services Department funded this placement under the Community Care Act.

January 2000 - Mrs Pointon was distressed at her husband's deterioration and decided to employ carers, through the Social Services Direct Payments scheme, to assist her in caring for her husband at home. She requested a health assessment in January 2000.

March - Mr Pointon returned home and was eventually cared for by Mrs Pointon and two 24-hour carers. This was part funded through Direct Payments (in line with the Carers and Disabled Children's Act 2000) by Social Services.

April - Mr Pointon received respite care in a specialist unit for one week in every five; this was NHS funded.

June - Social Services requested an assessment to determine whether trained nurse input was required or whether a carer could provide care. This assessment was carried out by the district nurse. She concluded that there was a requirement for 'carers with experience of looking after people with challenging behaviour', but qualified nursing input was not required.

July - an occupational therapy assessment identified that for effective and appropriate care to be provided to deal with Mr Pointon's challenging behaviour, more help was required from staff experienced in the management of dementia.

February 2001 - an assessment on behalf of the Health Authority was undertaken by the special needs case manager (the manager), the Social Worker, and the Occupational Therapist. The assessment report stated that Mr Pointon's health needs were being met and that no additional health funding was required; Social Service Direct Payments continued.

July - Mr Pointon's consultant psychiatrist (the consultant psychiatrist) and the community psychiatric nurse (the CPN) visited Mr Pointon. He was no longer able to cope with travelling to the specialist unit for respite care. The CPN advised that, as the dementia was now advanced, the in-patient team, who had a greater level of expertise, should assess Mr Pointon's needs.

August - Mrs Pointon requested NHS funded continuing health care to pay for two additional full-time carers every fifth week; a letter from their General Practitioner and the consultant psychiatrist supported additional ongoing care in the community.

22 August - the district nurse and the CPN carried out a further assessment.

November - after taking advice from the consultant psychiatrist that extra care was needed in the home the manager, the district nurse and the district nurse's manager offered one extra carer for three and a half hours a day, every fifth week.

January 2002 - Mrs Pointon asked for a review of this decision and made a formal complaint regarding the application of the Health Authority's eligibility criteria for NHS funded continuing care. Meanwhile a complaint was lodged with the Health Service Ombudsman.

March - a record of the assessment of 22 August 2001 was received from the CPN, who supported the request for extra respite care to be provided by someone with some knowledge of dementia and good communication skills.

April - the newly formed PCT requested a further assessment, which was performed on 15 April by the district nurse. The purpose of the assessment was to determine whether Mr Pointon needed frequent intervention by a trained nurse during a 24-hour period. The district nurse concluded that Mr Pointon was receiving excellent care and that a regular visit by the district nurse every three weeks was sufficient.

April - the PCT decided that Mr Pointon's health care needs were being met through the involvement of a multi-disciplinary NHS team who would continue to provide the

same level of care on an ongoing basis, including during periods of respite.

May - members of the PCT took a letter confirming this decision to Mrs Pointon at her home.

July - Mrs Pointon disputed the PCT's decision and sought an independent medical opinion.

September - the independent medical report was reviewed by the PCT at a multidisciplinary meeting; the report concluded that Mr Pointon could not be in a more severe condition and that he met the criteria for 100% continuing care as his needs were entirely health related. The consultant psychiatrist agreed with this view although the manager and the Director of Primary and Community Services (a nurse) did not. The view of a community consultant geriatrician (the consultant geriatrician) was sought.

October - the consultant geriatrician decided that Mr Pointon did meet the eligibility criteria for NHS funded continuing care.

November - December - the PCT and Social Services discussed various options available to support Mr Pointon and the implications involved. If Mrs Pointon decided to apply for 100% NHS funding she would have lost the Direct Payments from Social Services and the carers would be supplied and employed by the NHS. The PCT accepted the consultant geriatrician's opinion that Mr Pointon met the criteria for continuing care but chose to defer application of the eligibility criteria to enable continuity of care in the home setting through Direct Payments. Mrs Pointon decided to accept a joint package which combined her Direct Payments and NHS funded respite care.

Complaint (a) - the Health Authority misapplied their local eligibility criteria and relevant Department of Health guidance

Mrs Pointon's evidence

16. Mrs Pointon said that from 1998 until 2000 Mr Pointon was cared for in a nursing home. The Health Authority had offered him a fully funded place in a nursing home where they had purchased a block of beds but Mrs Pointon did not feel that that home suited Mr Pointon's need for a balance of peace and seclusion with adequate supervision. She asked the Health Authority if they would agree to pay for his care in a different nursing home of her choice, but was told that they were not able to do this. Nevertheless Mrs Pointon proceeded with the home of her choice.

17. Mr Pointon remained in the nursing home for two years. By 2000 however, his health had begun to deteriorate and Mrs Pointon decided to care for him at home. The severe behavioural problems, which had characterised his illness during its earlier stage, had now

diminished. Photographs of Mr Pointon when he returned home and one month after his return, showed a very noticeable improvement in his physical well being. At this time Mr Pointon's care expenses were supported by Direct Payment contributions from Social Services. As agency live-in carers had proved unsatisfactory in the past, Mrs Pointon recruited and trained a team of carers.

18. Mrs Pointon described the Health Authority's assessment of Mr Pointon's needs, which was undertaken in February 2001 by the manager. She was not convinced that the assessment tool that had been used, with its bias towards physical conditions, was an appropriate one for assessing the needs of people with dementia and, in her opinion, it did not address her husband's needs. It did not reflect the constant vigilance necessary in order to respond to the unpredictable elements of her husband's condition.

19. Until June 2001 Mr Pointon had attended a psychiatric unit for respite care for one week in every five. However, as his illness progressed, the staff at the centre advised that Mr Pointon's condition was too advanced for the scope of their facilities. The centre's resources were not able to respond to Mr Pointon's need for constant supervision and he also became unable to cope with car journeys to and from the centre. Therefore, it was necessary for alternative respite care arrangements to be established.

20. Because of that need Mrs Pointon requested a reassessment of her husband's condition in August 2001, with a view to the Health Authority contributing to the cost of a respite care package. This further assessment involved input from both the district nurse and the CPN who had met Mr Pointon between January and May 1998 when he had been in hospital. Mrs Pointon thought that this had been a helpful assessment. (Note: Unfortunately, there is no written record of the assessment, only a brief letter from the CPN to the manager dated 25 March 2002, four months after a suggestion from the PCT for three and a half hours respite care had already been made, in November 2001.)

21. Mrs Pointon explained that from March 2000, Mr Pointon's care at home had been supported by Direct Payments from Social Services; however, there was a sizeable shortfall between those payments and the actual cost of the care. The largest of these occurred when the NHS funded respite care had to stop in June 2001. From then on, Mrs Pointon paid personally for a respite carer to take her place at home for one week in five, (initially at a cost of £405 per week, rising to £455 in 2002).

Complaint (b) - the PCT also misapplied the local eligibility criteria and relevant Department of Health guidance, and in particular they relied on inaccurate or inadequate information, failed to

take account of relevant facts in their assessment and took account of irrelevant factors

Mrs Pointon's evidence

22. The district nurse undertook a further assessment on behalf of the PCT in April 2002. Mrs Pointon said that this assessment was based on a very informal discussion with the district nurse during a 20 minute visit, early in the morning. During this time Mrs Pointon had been attending to her husband's needs. Previous assessments had taken between one and three hours. Mrs Pointon said that it had not been made clear to her that the purpose of the district nurse's visit had been to complete a formal assessment of Mr Pointon's needs. Mrs Pointon said that she had learned subsequently that the district nurse had been asked to complete the assessment at very short notice, following her return from a period of leave. Mrs Pointon said the assessment had contained a number of errors of fact and gave only a partial view of Mr Pointon's needs. It had not indicated the unpredictability of his needs.

23. It had not been made clear to her at any of the assessments whether her husband was being assessed against eligibility criteria for NHS continuing care or those for Social Service funded care with a limited, incidental, element of nursing care. She believed that this confusion had characterised the whole case and created the situation where her husband apparently met the criteria for social/nursing care but not for NHS funded continuing care. Mrs Pointon felt that the two processes should be meshed together more closely. She thought that neither the nursing care criteria nor the PCT's eligibility criteria for continuing care took sufficient account of patients' psychological needs.

24. Mrs Pointon thought that there was a very narrow definition of nursing care in the eligibility criteria which was biased towards acute care and discriminated against people with dementia and other long-term degenerative conditions, all demanding nursing skills of a different kind. She believed that the PCT had unfairly applied to a domestic setting the criteria for funding care in a nursing home, thus imposing conditions that were impossible to meet at home, such as the frequent intervention of a trained nurse in a period of 24 hours. When Mr Pointon was later deemed to meet the continuing care criteria for 100% NHS funding in November 2002, the PCT offered no realistic provision for funding Mr Pointon's care at home, only in a nursing home or hospital.

25. Mrs Pointon said that she had found the manager difficult to work with around the assessment of her husband's needs. She felt that the manager had been concerned to ensure that the conclusions of all subsequent assessments had corresponded to those that she had reached in February 2001. Mrs Pointon said that she had greatly valued the support that the CPN had been able to give her and she had been very distressed when this help had been withdrawn. She had been advised that the CPN would no longer be able to offer her support, as

their responsibility was restricted to work with people suffering mild to moderate levels of dementia. She believed that the family carer had an even greater need to have strong psychological support in the end stages of caring for someone with dementia, especially when difficult decisions have to be made on behalf of a patient who is unable to communicate his wishes.

26. Mr Pointon was now totally reliant on others for his needs to be met. He was also subject to epileptic seizures, muscular spasms, panic attacks and episodes of choking, and he required constant supervision. The arrangement for funding Mr Pointon's care utilised Direct Payments from Social Services, which met the majority of the costs, and a contribution from the PCT, to cover the respite element of his care. However, as part of the care is funded by Social Services Mr Pointon had been assessed to make a contribution to the cost. Mrs Pointon had been advised by her solicitor that there were legal means by which the PCT would be able to contribute to Mr Pointon's care costs by the transfer of funds to the Social Services Department, in order to maintain the Direct Payment arrangement.

PCT's response to the statement of complaint

27. In her formal response of 5 December 2002 to the statement of complaint the chief executive of the PCT wrote:

'... Since taking on the responsibility for this case in April 2002, the PCT has sought the views of the various professionals involved in Mr Pointon's care ... The case has been complicated because of the differing professional opinions expressed ... in particular, differences ... [about whether the] aspects of care he now needs are health or social in nature.

'... We met with Mrs Pointon and her solicitor ... to discuss the outcomes available ... [Mrs Pointon's] preference would be for ... continuation of the existing package of care through Direct Payments ... but with supplementary NHS funded respite care provided in the family home.

'... The PCT opinion [was] informed by:

'[the consultant geriatrician's] professional opinion that Mr Pointon does meet the eligibility criteria for NHS Continuing Care. Given the range of differing professional opinion received ... we had sought [the consultant geriatrician's] independent assessment ... to reach a conclusion about the nature of his clinical needs;

'what we believe ... to be the most appropriate way of meeting these needs;

'confirmation from [the consultant geriatrician and the consultant psychiatrist] , that they are confident that the care package ... will be clinically appropriate ...

'... The NHS cannot make these Direct Payments to a patient ... [so] the PCT has worked with Social Services to construct a joint package of care that can be provided through Direct Payments. ... Social Services ... have therefore, supported the PCT in agreeing to jointly fund the package, and hence enable us to continue direct payments. ...

'I have given Mrs Pointon my sincere apologies ... As part of investigating this complaint we have ... agreed a range of actions across our agencies to help ensure this type of delay does not occur in future ...

'Response to paragraph 4 [of the statement of complaint]

'...

'The PCT would respond that:

'The PCT became responsible for provision of Mr Pointon's health care provision on 1 April 2002. ... we have sought the opinion of a wide range of health and social care professionals in assessing Mr Pointon's health care needs. These assessments have informed the PCT's decision in relation to whether:

'Mr Pointon's health care needs are being met by the provision of continuing health care in the community

'Mr Pointon's needs are so complex, unpredictable and unstable that he meets the eligibility criteria for NHS funded continuing care and thus whether he should be in receipt of health care services over and above those [provided by the community]

'The PCT should be funding additional respite care

'...

'Summary of health professional views sought

'...

'... [the] consultant psychiatrist believes that Mr Pointon does meet eligibility criteria. ...

'[The] district nurse concluded that Mr Pointon's physical and mental condition had NOT deteriorated to a point where they were unpredictable and unstable requiring frequent intervention by a trained nurse ...

'...

'Given that Mrs Pointon remained unhappy ... the PCT sought one final independent view from [the the consultant geriatrician] ... specifically to consider Mr Pointon's needs in relation to the eligibility criteria for NHS funded continuing care ...

'[The consultant geriatrician] undertook an assessment of Mr Pointon's needs on 29 October 2002 ... and concluded that in his opinion Mr Pointon DID meet the eligibility criteria for NHS continuing care for people with physical and/or

sensory disabilities. ...

'Conclusion

'...What has delayed resolution of this case is the differences in professional opinion ... which have ranged from one end of the spectrum of continuing care needs to the other ...

'Summary of proposal being recommended:

'... that the PCT accepts ... that Mr Pointon meets the PCT's eligibility criteria for NHS Continuing Care

'... as none of the options currently available to the PCT offers the most appropriate means of meeting Mr Pointon's care needs, ... with Social Services we have agreed to fund a joint package of care:

'Social Services will continue to make Direct Payments ...

'the NHS will continue to provide ongoing health care in the family home ...

'the NHS will provide additional respite care in the family home one week in every five ...'

Evidence of PCT staff

28. The manager explained that she was a qualified nurse and became the special needs case manager for four Primary Care Groups in October 2001. Following the establishment of the PCT in April 2002 her role had been as a co-ordinator rather than an assessor.

29. She had previously met Mr Pointon when she had been involved with the inspection of a nursing home in which he had been living. Although she had not had the responsibility for continuing care assessments, because of her role as the special needs manager and her experience in evaluating nursing care needs, she had been asked in February 2001, to convene a meeting with appropriate professionals to evaluate Mr Pointon's requirements. Her responsibility had been to ensure that the group looked at Mr Pointon's needs at that point in time, but had also taken account of the past and looked to the future. She stated that, at that stage, the question of continuing health care provision for Mr Pointon had not been raised.

30. She said that she had undertaken a joint health and social care assessment of Mr Pointon's needs. Financial considerations had not played a part in the assessment. She emphasised that her decisions were always based on the needs of the individual patient and that other people with a high level of need were being supported in the community by the PCT, including people with tracheostomies (a surgical opening through the neck to relieve obstructions to breathing). She was aware that Mrs Pointon had access to support from the consultant psychiatrist when she required it.

31. For the assessment she had sought the opinion of the early onset dementia nurse, the district nurse and the CPN, who had jointly agreed that Mr Pointon's needs could be met by the community healthcare and nursing

services supporting the care provided by Mrs Pointon and paid for by Social Services Direct Payments. At that time Mr Pointon also received respite care in an NHS psychiatric unit where his needs were monitored.

32. In June 2001 Mr Pointon's needs changed and it was no longer possible for him to receive respite care in the psychiatric unit. The manager was asked to convene a further assessment of Mr Pointon's needs, in order to advise on the way in which his respite care at home should be provided. She sought opinions from the professionals involved in Mr Pointon's care, the district nurse, the early onset dementia nurse, the CPN and the consultant psychiatrist. The manager said that she had referred to the consultant psychiatrist for advice, and not because she thought that this was a continuing care issue. She said that she had been very concerned to ensure that Mrs Pointon did not lose the Direct Payments as these enabled her personally to manage her husband's care. The information from this assessment was used to formulate the proposal, which was put to Mrs Pointon in November 2001. This was, that Mr Pointon's respite needs could be met by the addition of one extra carer visiting for three and a half hours a day, for six days, every five weeks. The manager accepted that the arrangements had not taken into account the full time carer's requirement for time off during the day, and that the visit time would have been increased to cover this. It was expected that this would have provided respite for Mrs Pointon.

33. Until June 2001 Mr Pointon had been in receipt of NHS funded respite care which was, in the manager's view, based on the clinical opinion provided by the consultant psychiatrist, inappropriate at that time. The respite care provision he received was for people with behavioural problems due to their dementia, as opposed to the physical needs that Mr Pointon presented. His needs could have been met in a nursing home with a joint Health and Social Care package.

34. The manager said that part of her role was to deal with complex cases where health needs could not be met within local NHS services, whether they were 100% health funded or joint packages with Social Services. She said that continuing care was a NHS provision and would be provided within the local NHS services. In the PCT there was a specific unit for continuing in-patient care and a NHS community service for people who wished to be cared for in their own homes.

35. The manager said that because of the complexity of the case she had involved other professionals. She agreed that family carers could perform more tasks than social carers due to their one to one knowledge and, as they are not employed by Social Services, they can perform tasks that a social carer would not be able to, because of Health and Social care regulations. The test she applied to determine whether a task was a nursing or non-nursing was whether she would need to replace a carer with a qualified nurse. When considering replacing a family member, who that person is, is one of the factors

involved but not the only one. The assessment and judgment of those who are closely involved i.e. the district nurse and the general practitioner are also taken into account. Mr Pointon's needs as well as those of the carers were considered.

36. The manager said that Mrs Pointon had not been able to accept that, although her husband had previously been offered an NHS continuing care bed, this was because a number of block purchased continuing care beds were not being utilised and were being paid for by the Health Authority whether they were occupied or not. It did not mean that he met the eligibility criteria or that his needs were such that the funding of a community package would be the sole responsibility of the NHS. She said that the third assessment in April 2002 had taken place at a time when the PCT was being formed. It had subsequently been suggested that an assessment of Mr Pointon's needs should be undertaken by appointing an independent nurse who would assess Mr Pointon's needs over a three-day period whilst he was being cared for at home. However, this action was not initiated as Mrs Pointon's solicitor sought an opinion from the independent consultant. The manager said that the independent consultant had not spoken to the professionals involved with Mr Pointon's care. The chief executive of the PCT had subsequently sought the consultant psychiatrist's opinion and she had confirmed that Mr Pointon met the criteria for continuing NHS care. However, the PCT was unable to obtain a written assessment of Mr Pointon's needs from the consultant psychiatrist. Both the consultant psychiatrist and the consultant geriatrician had been in agreement with the independent consultant's assessment.

37. I produce next, the report prepared by the Ombudsman's Assessor for this case.

Report by the professional assessor to the Health Service Ombudsman for England of the clinical judgments of staff involved in the complaint made by Mrs Pointon:

Professional assessor: Ms H, RGN, RMN, SCM, MSc in Nursing

i. Basis of report

This report has been compiled after referring to relevant documents, including correspondence from the solicitors (acting on behalf of the complainant) and from South Cambridgeshire Primary Care Trust including 'Policy and Eligibility Criteria for NHS funded continuing health care'. I accompanied one of the Ombudsman's Investigators at interviews with Mrs Pointon and the manager.

ii. Background

Please see chronology at paragraph 15.

iii. Application of the continuing care criteria

There are key issues that need to be considered surrounding the case, these are:

iii(a) That the Health Authority's policy and eligibility criteria used to assess Mr Pointon's needs did not comply with the relevant Department of Health guidance

The Department of Health's guidance (HSC 1999/180:LAC (99) 30 and HSC 2001/015:LAC (2001) 1) makes a clear distinction between specialist nursing and general nursing services. It clearly outlines that a local authority could provide nursing care if it is incidental or ancillary to the provision of accommodation and of a nature which can be expected to be provided by an authority whose primary responsibility is to provide social services.

Comment

From the documentation provided (the Health Authority's April 2000 policy and eligibility criteria) and from the interview with the manager, the following issues arose. Mr Pointon had been assessed using different criteria, which seemed dependent specifically on what was being requested at the time, and not based on his continuing health care needs.

The assessment that took place on 15 April 2002 used the eligibility criteria for people with dementia. This assessment focused on whether the patient could no longer be nursed at home or in a residential setting and required in-patient care. Therefore, if the carer preferred a patient to be nursed at home, even if they were eligible for an in-patient bed, NHS continuing health care funding was precluded in the home setting. One of the criteria in the assessment considered the risk to self if not receiving observation and intervention. As had been previously identified, Mr Pointon needed 24-hour care and always had someone with him as he was likely to choke, and was subject to both minor and major epileptic fits. The PCT stated that because the myoclonic jerks (sudden spasms) and fits were being controlled by medication and observation Mr Pointon was not 'at risk'. The consultant psychiatrist thought that Mr Pointon's needs were mainly physical (although Mr Pointon had advanced dementia). Another assessment was carried out by the consultant geriatrician in October 2002. The eligibility criteria used on that occasion related to people with physical and/or sensory disabilities. In assessing those criteria it is my opinion that Mr Pointon met four of them, but his needs also encompassed those criteria for people with dementia. It appears that Mr Pointon's eligibility for continuing health care funding may have been compromised since 1998 when Mrs Pointon identified a more conducive environment for her husband to be cared for in than the one offered by the Health Authority and funded the extra cost herself.

The Health Authority policy relates to the appropriate guidance HSG(95)8 and HSC 1999/180:LAC (99) 30 that required each health authority to have a plan for the delivery of appropriate services to meet the continuing health needs; in the case of Mr Pointon this was in

relation to people with dementia. The policy states clearly that where the primary need for care is a health need, the service responsibility rests within the NHS and is provided free at the point of delivery, whereas the local authority would be eligible to fund a placement if the need for care was a social need. Joint funded packages would also be available where applicable.

The policy reflects the requirements of the Department of Health guidance but it is the interpretation of the guidance by individuals involved in the process that appears to be where the difficulty arose. This is because the eligibility criteria are somewhat ambiguous in nature. The criteria offer a list of possible characteristics to judge patients against, instead of a more comprehensive and holistic, domains of care approach. The ambiguity of both the eligibility criteria and the Department of Health guidance led to confusion.

iii(b) The Health Authority's eligibility criteria and assessment tools are focused towards acute care

The Health Authority's eligibility criteria for people with dementia and also for people with physical and/or sensory disabilities appear to have an over-emphasis on the physical aspects of care rather than the requirements for psychological support for individuals.

The assessment criteria for dementia focus on the difficulties of behaviour, particularly violence and risk, but do not include the mood changes, delusions and hallucinatory experiences, and visual spatial difficulties which are common problems associated with advancing dementia. They also include the advice that, if patients with advanced dementia also have specific care management needs relating to mood etc, requiring care by skilled staff, that these criteria are covered by the assessment for people with sensory and/or physical disabilities. However, the criteria for individuals with sensory and/or physical disabilities appear to be based solely on physical needs and the requirements of individuals with illnesses which require palliative care, ventilation and medical intervention. There is no part of the criteria which relates to the psychological needs of the patient.

Comment

Mr Pointon was assessed using the criteria identified above. He suffered from mood changes and some behavioural disturbance. These have now reduced due to the advanced stage of dementia. He also experienced visual spatial difficulties (and still does) and hallucinatory experiences. None of these problems are reflected in the eligibility criteria or the assessment tools. However, assessments in September and October 2002 by the consultant psychiatrist and the consultant geriatrician clearly stated that Mr Pointon had continuing health care needs. The assessment carried out by the independent consultant stated that Mr Pointon was in the terminal stages of dementia that could hardly be more severe. The independent consultant disagreed with the PCT's

assessment of the severity of Mr Pointon's condition and said that he had health care needs well beyond anything that the average care worker was competent to deal with. The consultant psychiatrist also agreed with this assessment. However, the manager and the Director of Primary and Community Services (the Director) who is also a nurse, disagreed. It seems that the PCT's decisions were based on the nurses' assessments.

iii(c) The definition of nursing care used by the PCT

The eligibility criteria and the assessments reflect the amount of nursing input required and the level of provision to be supplied. This relates specifically to the requirement for qualified nurse input for any particular interventions that have been identified. The interventions relate to criteria that have a bias towards acute physical care.

In the multi-disciplinary meeting in September 2002, when the report by the independent consultant was discussed, there was debate around the definition of nursing care. The consultant psychiatrist agreed with the independent consultant that the care that Mrs Pointon was providing was 'equal to if not superior to that provided by many qualified nurses who specialise in the area of dementia care'. Both the manager and the Director felt strongly that Mrs Pointon 'was not providing nursing care, that it took many years to gain nursing qualifications and skills and that these could not be self taught'. They agreed that Mrs Pointon was giving highly personalised care; with a high level of skill, which she had acquired due to the vast knowledge she had about her husband's needs. The manager stated that the care given could not be highly professional, as it was not provided by a qualified nurse.

Comment

Mr Pointon has required nursing care for the past nine years, during which time it has been delivered by the District Nursing team and his wife, assisted by carers. Some periods of time have been spent in a nursing home and in an NHS continuing care mental health facility where he was monitored during periods of respite care.

When I visited Mr Pointon, it was clear that the care he received was of a particularly high standard and addressed all his physical needs, but in addition catered for his psychological needs. The care was delivered in a professional manner with consideration to the dignity and privacy required for such care. The atmosphere was not one that could be replicated in a continuing care ward. Mrs Pointon has trained the carers, who cover the 24-hour period, how to care for her husband.

In the last assessment the consultant psychiatrist felt that again, Mr Pointon did meet the continuing care eligibility criteria but that if he required an in-patient bed he could be nursed in a general continuing care ward.

iii(d) That proper consideration was not given by the PCT to Mr Pointon's eligibility for NHS funded continuing care in his own home

The Health Authority's, and subsequently the PCT's policy, seems to be focused on hospital care and is restrictive in the criteria used to assess caring for people in their own homes. In this case NHS funding has not been forthcoming because Mrs Pointon chose to provide individualised care at home. On each assessment this preferred provision of care has precluded Mr Pointon from receiving NHS funding unless given in a location chosen by the Health Authority/PCT.

Comment

Mr M has received excellent care from his wife and carers in his own home. The Department of Health guidance outlines the importance of patient/carer choice, as does the Carers Act 2002. The Department of Health guidance HSC 2001/015 (paragraph 12) refers to the location of continuing care. The Health Authority/PCT policy briefly mentions in points 9.2 and 9.3 that continuing health care can be delivered at home. Then the content of the policy quickly returns to the view that in-patient or nursing home care would be most appropriate to ensure the most effective use of resources. The reference to NHS care being funded in a person's own home in point 11.0 refers only to palliative care, continence advice, Parkinson's disease, diabetic and stoma care as examples. The policy outlines criteria for people who do not fall into the eligibility criteria for NHS continuing health in-patient care; it states that 'there is still a public perception that people who need help with activities of daily living should, on account of their dependency, remain the responsibility of the NHS (and this is particularly so in the case of dependency arising from an illness such as dementia)'. They comment that this is not something they subscribe to, but that it is dependent on assessed need.

Within the policy there are brief statements about 'people in a community setting'. All that is actually said relates to a multi-agency assessment to determine whether additional resources are required to meet health needs or whether in-patient care is required. Little is said about 100% NHS funding, especially in patients' own homes. A chart on page 6 demonstrates that if 100% funding for NHS care is required this will be provided in a nursing home for more advanced stages of illness, not in the individual's own home.

Comment

It is not clear how the Health Authority and the PCT would provide full NHS funded care in a person's own home. In Mr Pointon's case the NHS could only provide 100% funding if he was cared for in hospital or a nursing home. Because of this, Direct Payments continue, but do not meet the full cost of having two carers; the additional cost continues to be met by Mrs Pointon even though her husband would be eligible for an in-patient continuing care

bed. Mrs Pointon is also unable to claim for Invalid Care Allowance due to her age.

iv. Conclusions

- The policy and eligibility criteria, which were used to assess Mr Pointon's needs, although Coughlan compliant, did not fully comply with the relevant Department of Health guidance, in that the assessment tools are focused towards acute care and make no provision for the psychological needs of the individual with a mental health problem.

- The continuing care criteria for 100% NHS funding appeared to offer little provision for caring for individuals in their own homes and are mainly focused on acute care. That practice may not be compliant with the Department of Health guidance HSC 2001/015:LAC (2001) 18. Proper consideration was not given to Mr Pointon's eligibility for NHS funded continuing care and Mrs Pointon's preference to nurse him at home caused them to be penalised.

- The PCT may need to take into consideration the needs of carers, in accordance with the Carers Act 2000.

Findings (a)

38. Mrs Pointon complained that the two assessments of her husband's eligibility for NHS funded respite care, which were commissioned by Cambridgeshire Health Authority in February and August 2001, did not address Mr Pointon's psychological needs and were biased towards physical symptoms. They did not take into account the vigilance that was needed to deal with the increasing possibility of Mr Pointon having an unpredictable physical episode such as choking or fitting, as a result of his reactions to any visual or spatial changes.

39. The assessments were made against the Health Authority's 'Policy and Eligibility Criteria for NHS Funded Continuing Health Care'. This policy, which had been produced by the Health Authority in April 2000, was reviewed in March 2002 in light of HSC 2001/015, which consolidated the guidance on continuing care, particularly in light of the Coughlan judgment. In making my findings I have taken account of the advice of the Assessor, who in paragraph iii(a) of her report stated that although the local policy reflected the relevant Department of Health guidance, it had been misinterpreted by staff, was focused towards acute care and made no provision for the assessment of psychological needs of patients with illnesses such as dementia.

40. The manager undertook the first assessment in February 2001. At that time Mrs Pointon was caring for her husband at home, helped by carers partly funded by Social Services Direct Payments. The NHS were funding respite care in a psychiatric unit for one week in five. The manager has stated that this assessment was not intended to test Mr Pointon's requirement for continuing care. The Health Authority's policy stated that such assessments should be performed by a multi-agency

team, and I accept that a record of the assessment was sent to the consultant psychiatrist who felt that the input of an Occupational Therapist was more appropriate, given Mr Pointon's physical and mobility needs. The decision was that no further funded care was needed at that time. However, given Mr Pointon's condition I believe that assessment should have been performed against the Health Authority's criteria for continuing health care, in that medical input should have been included and it should have taken note of the Coughlan requirement to judge both the amount and the type of nursing care required.

41. Furthermore, in a situation such as this, with a patient whose mental and physical condition was inevitably going to deteriorate, it would seem short-sighted not to explore both the physical and psychological problems, with a view to the kind of support that would be needed in the near future.

42. The second assessment on 22 August 2001, on behalf of the Health Authority, was undertaken by the district nurse and the CPN. This was in response to Mrs Pointon's request for NHS funded respite care at home when Mr Pointon was no longer able to travel to the psychiatric unit. Mr Pointon's general practitioner supported the request for additional ongoing funding. After taking advice from the consultant psychiatrist, who advised that extra help should be provided within Mr Pointon's home, the Health Authority suggested that a carer for a few hours a day, for six days, every five weeks would be sufficient. The decision appeared to have been taken without any regard to the Health Authority's policy on short-term admission or respite (end of paragraph 13). I would question whether, even if Mr Pointon had become less mobile, the need for funded respite care should drop so dramatically when he was permanently placed in his own home. It appeared that full NHS funding for respite care would only have been available if he had been an in-patient. Surprisingly, a letter from the CPN who assisted at that assessment, but was not received by the Health Authority until March 2002, supported Mrs Pointon's request.

43. I understand that the Health Authority ceased to exist on 1 April 2002. However, I agree with the Assessor that the local eligibility criteria reflected the guidance from the Department of Health, but that the ambiguities within the criteria, particularly those referring to dementia and sensory and/or physical disabilities, caused staff to produce inappropriate assessments that concentrated solely on Mr Pointon's physical needs. I uphold this complaint.

Findings (b)

44. I turn now to the actions of the PCT who took over the responsibility for continuing care cases in April 2002. They also took over the Health Authority's eligibility criteria. Mrs Pointon had complained in January 2002 to the Health Authority about their decision not to fund an extra carer every five weeks to maintain the pattern of respite care. She had also complained to this Office. The incoming PCT agreed with Mrs Pointon that a further assessment of her husband's condition should be carried

out on 15 April. It was completed by the district nurse and was headed 'Health Needs Assessment'. Once again this assessment followed the pattern of assessing purely physical and nursing needs against very specific criteria (paragraphs 17 and 18) that it would be very difficult to provide in the home setting. The consultant psychiatrist was consulted by the manager, but once again was asked very specific questions about the type and frequency of professional input that Mr Pointon needed at that time and gave no recognition either to Mr Pointon's psychological needs or to the unusually high standard of care that Mrs Pointon and her team were providing.

45. The Assessor criticised the range of this assessment and confirmed that the questioning rendered funding for respite care at home practically impossible. The PCT and Social Services decided that Mr Pointon's health needs were being met, that the respite care was purely social and refused funding in May.

46. In subsequent discussions the clinicians and the nurses agreed that Mrs Pointon was giving highly personalised care with a high level of skill. This was later described by the independent consultant as nursing care equal if not superior to that that Mr Pointon would receive in a dementia ward.

47. In September 2002 the independent consultant commissioned by Mrs Pointon produced a report which confirmed that Mr Pointon's symptoms stemmed solely from a health condition that was severe, complex and unpredictable, needing 24-hour care and frequent interventions to prevent him harming himself. After the consultant psychiatrist and the consultant geriatrician had confirmed the independent consultant's opinion that Mr Pointon did meet the eligibility criteria for NHS continuing care, a package of care was agreed with Social Services whereby the NHS would fund the cost of an additional carer every fifth week. The PCT have explained that they can only make Direct Payments within a package of payments with Social Services. However, they have also agreed that should Mr Pointon require in-patient care at a future date, then he would be admitted to an in-patient facility agreed by Mrs Pointon. It is sad to reflect that this solution is the one that Mrs Pointon suggested in January 2002. Whilst I am pleased that agreement was reached eventually, I agree with the Assessor's opinion that the PCT assessed Mr Pointon against the wrong criteria, once again focusing on physical needs and also failing to recognise that the standard of care provided by Mrs Pointon was equal to that that a nurse could provide. I uphold the complaint.

48. In May 2003 in the light of the Ombudsman's report (paragraph 14), the Department of Health issued guidance to Strategic Health Authorities and PCTs on the procedure to use when reviewing continuing care cases dating back to April 1996. It is my opinion that they should also review the eligibility criteria to ensure that the criteria for funding care at home, and the recognition of patients' psychological as well as physical needs, are clearly defined. While I am aware that the continuity of her

husband's care is one of Mrs Pointon's main concerns, I recommend that the PCT discuss with Mrs Pointon, in the light of the Department of Health guidance, the provision of Mr Pointon's current funding, and determine whether any retrospective payments are indicated.

Conclusions

49. I have set out my findings in paragraphs 38 to 48. The PCT has agreed to my recommendation in paragraph 48 and has asked me to convey through my report - as I do - its apologies to Mrs Pointon for the shortcomings I have identified.

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