Scottish Parliament Region: Glasgow

Case 200500083: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital, Care of the Elderly & Clinical Governance of NHS Funded Care delivered in the Independent Healthcare Sector; Joined-up complaint handling.

Overview

The complainant (Mrs C), supported by her family, raised a number of concerns about specific elements of the care and treatment of her mother (Mrs A) in two NHS hospital settings and the overall care provided by an Independent Care Home where she was a fully-funded NHS Continuing Care Patient. The complainant also questioned the oversight of the care provided in the Care Home by the NHS staff responsible for her mother. The complainant was dissatisfied with the quality of the Greater Glasgow and Clyde NHS Board (the Board) investigation into her complaint and the number of bodies she had to raise a complaint with in order to address all her concerns.

Specific complaints investigated and conclusions

The complaints which have been investigated are that the Board:

(a) failed in their care and treatment of Mrs A *(partially upheld)*;

(b) failed in their duty of care to Mrs A while she was in the Care Home *(partially upheld)*; and

(c) failed to adequately investigate Mrs C's complaint *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) use this case to learn lessons about the use of observations and comments made by relatives in decisions about case management and treatment plans;

(ii) ensure that procedures are in place to inform relatives about how to make contact with medical staff; and

(iii) consider adopting a policy of informing the family of continuing care patients of the current system of proactive clinical review and invite their input as appropriate. The policy should also indicate how families can contact the appropriate clinician in-between periodic reviews.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 20 April 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) that Greater Glasgow & Clyde NHS Board (the Board) had failed in their duty of care to her mother (referred to in this report as Mrs A) in the seven months from November 2002 until immediately prior to her death in May 2003. Mrs C raised a number of specific concerns about medical and nursing care at the Mansion House Unit of the Victoria Infirmary, Glasgow (the Hospital) and in the Independent Sector Care Home (the Care Home) where Mrs A was placed from 23 December 2002 to 26 March 2003 as an NHS funded Continuing Care Patient. Mrs C also complained about the apparent lack of oversight or input from NHS staff, in particular her mother's Consultant (Consultant 2), while Mrs A was a patient in the Care Home. Following Mrs A's readmission to the Hospital on 26 March 2003, Mrs C raised a specific concern about a delay in providing her mother with an x-ray.

2. Mrs C also raised a concern about the handling of her complaint by the Board and about the nature and complexity of the several routes she was required to follow to address her concerns.

3. The complaints from Mrs C which I have investigated are that the Board:

(a) failed in their care and treatment of Mrs A;

(b) failed in their duty of care to Mrs A while she was in the Care Home; and

(c) failed to adequately investigate Mrs C's complaint.

4. As the investigation progressed, I identified issues concerning the overall nature and complexity of the complaints processes involved where NHS care is provided in the Independent Healthcare Sector. A significant number of bodies had an interest in the care Mrs A received from the NHS and the Care Home. A complex inter-relationship exists between these bodies and their approach to complaint handling. The diagram at Annex 4 provides an overview of this. This complexity has caused considerable frustration and distress to Mrs C and as this issue does not amount to a complaint against any particular public body it is not the subject of a specific complaint. I have, however, considered the problems encountered by Mrs C and the difficulties raised by current systems of working in a separate heading (d).

5. I have not investigated the aspects of Mrs C's complaint that relate to concerns raised about the care provided by the Care Home. The Ombudsman's office has jurisdiction to investigate actions carried out by or on behalf of NHS bodies in Scotland and as such could consider these aspects of Mrs C's complaint. However, the Care Home itself is subject to regulation by the Scottish Commission for the Regulation of Care (the Care Commission). Since Mrs C brought her complaint to the Ombudsman's office the Care Commission reopened their investigation into Mrs C's complaints concerning the Care Home and fully upheld three of Mrs C's four complaints (making no finding on the fourth due to a lack of evidence). As a regulator the Care Commission is able, as it did in this case, to take direct action to address problems identified in an upheld complaint - the Ombudsman's office cannot. I consider, therefore, that as those aspects of Mrs C's complaint have been investigated and substantially upheld with appropriate action identified by the Care Commission there would be no added benefit to further investigation by the Ombudsman's office. I have advised Mrs C of this. The Care Commission's investigation does raise a further concern about 'joined-up' processes and this is referred to in (d) below.

Investigation

6. Investigation of this complaint involved obtaining and reviewing Mrs A's medical and nursing records both from the Board and the Care Home. I have reviewed the Board's complaint file and correspondence provided by Mrs C regarding her complaint to the several bodies involved. I have sought the views of both nursing (the Nursing Adviser) and medical (the Medical Adviser) advisers to the Ombudsman. I have met with Mrs C and her family. I have made a number of written enquires of the Board and (with Mrs C's permission) discussed aspects of this complaint with the Care Commission and the Nursing and Midwifery Council. I have reviewed the relevant processes, guidance and procedures of the several bodies involved and considered relevant guidance issued by the Scottish Executive Health Department in relation to care provided in the Independent Healthcare Sector.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on an original and revised draft of this report.

(a) The Board failed in their care and treatment of Mrs A

8. Mrs A was a patient in the Hospital from late 2001. The family had no complaints about her care prior to her transfer to Ward 3 South in November 2002. Mrs C complained that staff failed to arrange a timely scan for her mother following a suspected CVA in November 2002, delaying appropriate therapy being given. Mrs C also complained that staff failed to x-ray Mrs A following a fall which resulted in her fractured ribs going undetected and meant Mrs A had no pain relief for this injury. Mrs C also complained that a delay by the Hospital in obtaining an x-ray following the insertion of an NG tube in April 2003, meant her mother was not receiving the nutrition she needed for several hours at a point when her health was already severely compromised.

Delay in arranging a scan

9. Mrs A had had several falls during her admission and been assessed on admission as being at high risk of falling. Mrs C told me that the family became concerned about Mrs A's condition shortly after her transfer on 7 November 2002. On 10 November 2002 Mrs C noticed that her mother's vision and movements seemed badly co-ordinated. The family were concerned that Mrs A might have injured her head when she had a fall. It is noted in the Nursing Record that Mrs C raised questions about her mother's condition with nursing staff on 10 and 11 November 2002. Nursing staff asked for a medical review. The medical records indicate that doctors reviewed Mrs A on 11 and 13 November 2002 and were of the view that there was a possible urine infection which might account for the increased confusion and poor mobility. Mrs A was reviewed by Consultant 1 (the Consultant responsible for Mrs A's care from 7 November 2003 until her transfer to the Care Home on 23 December 2002) on 15 November 2002 who indicated that she would discuss Mrs A's condition with Consultant 2 (the Parkinson's Consultant) and Nurse 1.

10. Following her discussion with a junior doctor on 13 November 2002 Mrs C requested an optician visit her mother. The optician attended on 14 November 2002 and reported to Mrs C on 15 November 2002 that he was concerned about scarring he had noted on her mother's eye and recommended that in light of this, and Mrs C's concerns about her mother's vision and confusion, a scan should be arranged. Mrs C told me that she discussed this with nursing staff and was advised that she would need to contact a senior doctor about a possible scan but Mrs C was told she would be unable to arrange an appointment for several days so spoke instead with the Senior

House Officer (SHO 1) on the ward on 18 November 2002 to request a scan. SHO 1 referred the matter to Consultant 1 who visited Mrs A that day and noted she would contact Consultant 2 and Nurse 1 to discuss Mrs A's condition. On 19 November 2002 Consultant 2 visited Mrs A and requested a scan for a suspected CVA. The scan was performed on 20 November 2002 and noted evidence of a CVA. Consultant 1 reviewed the results on 21 November 2002 and prescribed 75mg of Aspirin daily.

11. During local resolution of the complaint the Board advised Mrs C that Consultant 2 did not consider there had been an undue delay in performing a scan and that the results were only used to confirm a diagnosis and would not have affected Mrs A's management. Consultant 2 stated that Mrs C's concerns were not ignored but that Mrs A's condition was complex and (because of her Parkinson's disease) staff had asked him to review Mrs A before any action was taken. In response to a draft of this report, Consultant 1 commented that there was no clinical indication for an urgent CT scan as per the Royal College of Radiologist guidelines. Consultant 1 noted that the clinical presentation of stroke in this case was unusual and that the involvement of Consultant 2 was important because of his prior knowledge of Mrs A and the management of her Parkinson's disease.

12. The records reflect staff awareness of Mrs C's concerns about an apparent change in her mother's condition shortly after Mrs A's admission to the ward. The Nursing Adviser told me that it can be difficult for staff to make a judgement where they do not have previous experience of a patient but that the family perception can be very helpful in detecting a change. The Nursing Adviser expressed concern that Mrs C was apparently told she would be unable to make contact with a senior doctor for several days as she would have expected that any doctor would be able to arrange a scan at an earlier date. The Nursing Adviser also expressed concern that the nursing records do not make any reference to Mrs A having had a CVA once diagnosed and there is no record of any review of her Care Plan following this significant incident as she would have expected. The Nursing Adviser also told me that any delay in the scan would have delayed the prescribing of Aspirin and that such a delay could have been significant although she does not consider that it was in this case.

13. The Nursing Adviser made a further comment on her overall review of the nursing records for the Hospital, particularly with respect to Mrs A's admission

to Ward 3 South in November and December 2002. The Nursing Adviser noted that:

> 'Mrs C was a patient who had multiple and complex needs with high risk factors for certain aspects of her care. As such I would have expected her care to have been planned according to her needs with regular assessment and evaluation and changes to her care based on that process. Unfortunately this is not reflected in the notes I have reviewed.'

14. The Board have told me that they accept there is no direct mention of the result of the scan in the nursing notes and that care plans and risk assessments were not always updated although changes were noted in the nursing notes. The Board noted that the existing nursing arrangements already in place for Mrs A would also have met Mrs A's needs after her CVA. The Board supplied me with copies of current care plans and documentation which the Nursing Adviser reviewed and found to be of an acceptable standard.

Failure to x-ray in December 2002

15. The Hospital nursing records for Mrs A for November and December 2002 indicate she suffered a number of falls. The medical and nursing records for 6 December 2002 refer to Mrs A having fallen several times and appearing to be in pain around her ribs on the right-hand side – pain relief was given. The nursing record for the 7 December 2002 indicates that SHO 1 had suggested waiting a few days to see if an x-ray was required. Mrs A is also noted not to be complaining of pain. In the event no x-ray was performed.

16. During local resolution of this complaint Consultant 2 stated that there is no treatment for rib fractures beyond pain relief and an x-ray would not have altered management of Mrs A. This view is supported by the Medical Adviser.

Delay in x-ray in April 2003

17. On her mother's return to the Hospital in March 2003, Mrs C reported to staff that her mother had experienced significant weight loss in the previous three months. Mrs C also noted that Mrs A's condition had deteriorated markedly and she had a large necrotic pressure sore. The dietician advised NG feeding and several attempts were made to pass a NG tube but due to her confused state Mrs A removed the tubes. A tube was inserted again on Saturday 5 April 2003 and an x-ray was requested to ensure that the tube had been correctly placed. The tube could not be used until such time as the x-ray confirmed the site of the tube. Mrs A's x-ray was carried out on 6 April 2003

and the results sent for review by medical staff. The nursing notes record that Mrs A removed the tube before medical staff were able to review the x-ray and it was decided on 7 April 2003 not to proceed with NG feeding at this time. Mrs C told me that staff had advised her at that time that they had been told to remove the tube.

18. During local resolution of this complaint the Board stated that the medical records contained an entry stating that 'x-ray apparently busy due to Old Firm Game' and the Board explained that the Hospital was the first point of call for an emergency when football games were being played at Hampden Stadium. In fact there was no such football game that day but this error was never noted and was allowed to persist throughout the complaints investigation by the Board. The Board also noted that the x-ray was considered to be non-urgent and that there might be a number of reasons why the x-ray could not be accommodated on a Saturday evening when the hospital is normally very busy.

19. The Nursing Adviser commented that while Mrs C's frustration at the delay is quite understandable, the delay was not detrimental to Mrs A's care as she continued with assisted, adequate feeding throughout this time and indeed continued in this way once it was decided that NG feeding could not practically be achieved.

(a) Conclusion

20. Based on the medical and nursing advice I have received I have concluded that there was no significant time delay in arranging a scan for Mrs A in November 2002 and consequently in her receiving prophylactic Aspirin therapy. Such delay as there was, was not unreasonable in view of the complexity of Mrs A's medical condition. I have also concluded that the decision not to x-ray Mrs A in December 2002 was clinically appropriate in the circumstances as confirmation of any rib fracture would not have altered Mrs A's management. In respect of the x-ray in April 2003 I conclude that the over-night delay was not unreasonable. I, therefore, do not uphold the clinical aspects of this complaint. However, there were a number of occasions when health professionals did not communicate clearly with Mrs A's family and when Mrs A's family were unable to contact an appropriate member of staff. The lack of a clear and changing overall care plan for Mrs A contributed to the growing unease of the family that their mother was not receiving an appropriate level of care. An overall plan which included reference to family discussions would also have altered staff to the concerns of the family and enabled the concerns to be

addressed in a timely manner. I conclude that these communication failures contributed significantly to this complaint and overall I, therefore, partially uphold this complaint

(a) Recommendation

21. The Ombudsman recommends that this case is used by the multi-disciplinary team to learn lessons about the use of observations and comments made by relatives in decisions about case management and treatment plans. The Ombudsman also recommends that the Board ensure that procedures are in place to inform relatives about how to make contact with appropriate medical staff.

(b) The Board failed in their duty of care to Mrs A while she was in the Care Home

22. Mrs C complained that Consultant 2 had not been sufficiently aware of her mother's condition and her deterioration while in the Care Home and that the Board did not ensure the necessary review and oversight of patients funded by them in the Independent Healthcare Sector. Mrs C told me that she had raised a number of concerns about her mother's condition following her admission to the Care Home and stated that it was only when the Parkinson's Nurse (Nurse 1) visited her mother in the Care Home that it was realised that an error had been made in her mother's prescription when she was transferred from the Hospital two months earlier.

Pressure Sore

23. Mrs C told me that she was told that her mother was noted to have a deteriorating necrotising pressure sore on 20 March 2003 and a doctor's visit was requested from the Hospital to review her overall condition. A review by a Tissue Viability Nurse was requested by the Care Home on 26 March 2003 and in fact Mrs A was admitted to the Hospital later that day because of her deteriorating condition. Mrs A had a blood infection thought to have been caused by the condition of the pressure sore. Mrs C expressed concern that the Board was not aware of these problems or actively reviewing her mother's condition.

24. The Nursing Adviser has commented that in view of Mrs A's overall medical condition and the degree and speed of the deterioration of the sore, nursing advice should have been sought at an earlier stage although she noted

that the Care Home had taken reasonable steps in changing the mattress system and in dressing the sore.

25. Following sight of the draft of this report Mrs C told me that she does not agree that the Care Home took reasonable steps as her mother had a bed sore for over two months before any action was taken to change the mattress or obtain external advice.

Prescription Error

26. During local resolution Consultant 2 said that there had been no error in the prescription written up for Mrs A on discharge from the Hospital but that it had simply been a change from the soluble form of Madopar to capsules. Mrs C remained unhappy with this explanation as she questioned why Nurse 1 had then changed it back again on reviewing the prescription in the Care Home.

27. The Medical Adviser told me that the differing prescription types for Mrs A's Parkinson's medication were not clinically significant. The Medical Adviser also noted that Mrs A had late stage Parkinson's disease and Type II diabetes mellitus. The Medical Adviser told me that weight loss and the probability of pressure sores developing are common features of late stage Parkinson's disease despite high quality nursing care. Diabetes also makes damaged tissues, such as pressure sores, much more prone to infection – and the presence of infection in diabetes makes the diabetes much more unstable and difficult to control.

Clinical Oversight

28. The Board provided me with a copy of the contract that existed between them and the Care Home at the time of these events. The Board stated that the nursing care provided by the Care Home would have been subject to monitoring by the Care Commission. The Board also informed me that they are currently reviewing their contracts to take account of recent guidance issued (after the events of this case) by the Scottish Executive Health Department regarding the quality of clinical services provided by the independent Healthcare Sector – *HDL (2005) 41, Quality of Clinical Services Provided by the Independent Healthcare Sector* (the HDL).

29. The contract in place in 2003 required that the Care Home meet certain prescribed standards and indicated that the Care Home was subject to

inspection, initially by the Health Board and from April 2002 by the Care Commission who took over responsibility for this role.

30. The contract also states that clinical responsibility remains with the NHS Consultant but that arrangements will be made for medical care to be provided where the nurse in charge at the Care Home considers it is needed. The contract allows for periodic review by the Consultant to determine whether the Care Home remains the appropriate setting to provide care. There is no set timescale or format for this review in the contract.

31. In response to a draft of this report the Board told me that the relevant policy for continuing care patients is that they should be reviewed on admission and formally thereafter at least six monthly unless indicated otherwise by changes in clinical condition. There are fortnightly Consultant ward rounds in the partnership homes and a daily visit by a clinical assistant. The Board further commented that in Mrs A's case the notes show that Mrs A was reviewed by the clinical assistant on her transfer on 24 December 2002. The records indicate Mrs A was reviewed by Consultant 2 (who was now responsible for her care) on 13 January 2003. A further visit occurred on 17 January 2003 when documentation for the Adults with Incapacity (Scotland) Act 2000 were completed. This included a statement of Mrs A's care needs by Consultant 2. He next reviewed Mrs A on 28 February 2003. Thereafter the Board advised me that the medical records for Mrs A are missing and they cannot advise how many other occasions Consultant 2 reviewed Mrs A before she was admitted to the Hospital on 26 March 2003.

32. In response to the Board's comments on the draft report Mrs C noted that the missing records coincide with the time of Mrs A's marked decline. Mrs C told me that the family repeatedly tried to contact medical staff through the Care Home but were advised by staff that there was no consultant available to visit at that time. Mrs C also noted that she had not been aware of the completion of the Adults with Incapacity (Scotland) Act 2000 documentation until this was raised by the Board in its response to the Ombudsman's office and that she did not consider Consultant 2 had discussed this with her as indicated on the completed forms.

33. There are no indications in any of the contemporaneous records that a consultant did visit Mrs A during March 2003 nor has the Board provided any other evidence of such a visit.

34. The HDL, issued after the events of this complaint, states that where the NHS services are secured through independent sector providers then the contract must ensure that suitable clinical governance arrangements are in place so that risks are managed and identified and planned outcomes are being delivered. The HDL also refers to the role of NHS Quality Improvement Scotland (QIS) and the Care Commission in monitoring and reviewing the quality of care in the independent sector. The HDL places a specific responsibility on Health Boards to ensure that quality standards are being met by suitable clinical governance arrangements. The Board have told me that they are currently reviewing their contracts with the independent sector to ensure that these meet the requirements of the HDL.

(b) Conclusion

35. The contract in place at the time of these events makes it clear that clinical responsibility for the patient remains with the NHS Consultant. There is then planned review of the patient by the Consultant or other medical staff through the Board's policy on continuing care patients. The HDL reinforces the responsibility of NHS Boards to ensure standards are being met through clinical governance arrangements. The HDL also highlights the role of NHS QIS and the Care Commission in setting and reviewing standards of care provided to NHS funded patients – a role which has developed since the events of this complaint.

36. Based on the medical advice I have received I do not consider there was any clinical failure by NHS staff with respect to the specific complaints made by Mrs C about Mrs A's medication or her deteriorating condition. However, I am concerned that given the missing medical records I cannot be certain that the Board's policy of fortnightly Consultant visits to the Care Home was followed in March 2003 for Mrs A. I also share Mrs C's concern at the apparent lack of family involvement in the clinical oversight on the part of the Board and the potential for delays in seeking appropriate medical or nursing input as illustrated by the short but significant delay in calling in the Tissue Viability Nurse. Given the lack of information provided to the family, if there were instances where the standards of the Board's policy were not met the family would not have been aware of that or have been aware of who to contact with any concerns. Therefore, while I do not consider there was any specific clinical failure in this case I consider there was not a sufficiently transparent system of clinical

oversight in place at the time of these events and, to that extent, I partially uphold this aspect of the complaint.

(b) Recommendation

37. The Ombudsman recommends that the Board consider adopting a policy of informing the family of continuing care patients of the current system of proactive clinical review and invite their input as appropriate. The policy should also indicate how families can contact the appropriate clinician in-between periodic reviews.

(c) The Board failed to adequately investigate Mrs C's complaint

38. Mrs C first raised a complaint with the Board on 17 May 2003. Following Mrs A's death on 30 May 2003 her death was reported to the Procurator Fiscal and a planned meeting was delayed until September 2003. Representatives of the Hospital and the Care Home were present at the meeting. Mrs C also approached the Care Commission in August 2002 with her concerns about the Care Home.

39. Mrs C was not satisfied with the responses of any of the organisations and continued to pursue her complaint through the NHS Complaints Procedure - requesting an Independent Review of her complaint in December 2003. This was refused by the Convener in March 2004 and referred back for further local resolution of two specific aspects of the complaint. Local resolution was in turn suspended pending the decision of the Procurator Fiscal's office whether or not to recommend that a Fatal Accident Inquiry (FAI) be held – a decision not to recommend an FAI was finally notified to Mrs C on 29 November 2004. On 21 December 2004 the NHS complaints officer wrote to Mrs C asking if the file could now be closed but Mrs C responded that her complaint had been referred back for further local resolution and that this had not yet happened. A further response on the points referred back was provided to Mrs C on 14 March 2005 in which Mrs C was advised that she could now seek Independent Review again or approach the Ombudsman's office. Mrs C opted for the latter course of action.

40. Mrs C told me that she did not feel that the Board had investigated her concerns about the Care Home but had simply accepted the Care Home's explanation of events.

41. Mrs C also sought to use the Care Home provider's own complaints procedure to address her concerns about the Care Home. This was refused by the Care Home provider as Mrs C had used the NHS complaints procedure. Mrs C told me that she was never told by the Care Home that she would lose her right to have the complaint considered under the Care Home's procedure if she proceeded with a complaint through the NHS.

42. Mrs C had first contacted the Care Commission in August 2003 but no formal investigation had been carried out at that time because of the involvement of the Procurator Fiscal. Mrs C was unhappy that neither the Board nor the Care Home had actively investigated her complaint about the Care Home and approached the Care Commission again with her concerns in January 2005. On reviewing the situation the Care Commission decided to investigate in September 2005 and reported its findings to Mrs C on 19 January 2006. The Care Commission upheld Mrs C's complaint that the Care Home had failed to satisfactorily address Mrs A's needs with respect to (a) a pressure area and wound care (b) management of her diabetes and (c) her nutritional needs. A fourth complaint with respect to improper restraint was not upheld as it could not be substantiated.

43. Mrs C told me that she felt the Care Commission's findings demonstrated that there were failures in the Care Home and that this proved that the Board's investigation had not been sufficiently vigorous. She also expressed concern that it had taken three years to reach the point where her concerns were being addressed and that this had only been achieved after considerable personal effort on her part.

44. The Care Commission do not routinely publish or pass-on the findings of their investigations other than to the complainant and the care provider (see also (d)). I provided the Board with a copy of the Care Commission's findings and sought their view on the implications of this for their investigation of the complaint. In response the Board told me that the usual method of investigating a complaint is to ask the manager responsible for a particular area, and where relevant the consultant responsible, to investigate the points raised. The views of the manager and/or consultant are reviewed by complaints staff who determine whether they have addressed the matters raised in the complaint and who will seek further clarification or information if necessary. The Board had reviewed the points noted in the Care Commission report and considered these had all been adequately addressed during the meeting (and subsequent

correspondence) in September 2003 which was held for the purpose of providing a factual response to the points Mrs C raised and at her request. However, the Board noted that while factual responses had been provided to Mrs C there was no indication that medical staff had been asked to consider some of the issues raised with respect to the care provided by the Care Home. The Board stated that on reviewing the complaint it would have been helpful to obtain written reports from managers and to have provided a formal response which might have highlighted gaps in the responses. The Board advised me that since the time of these events the Board has revised its procedure for investigating complaints and now sends copies of complaints to each relevant General Manager who also receives a copy of the draft response for comment. The Board told me that this brings an additional opportunity for external scrutiny to the procedure.

45. The HDL, issued after the events of this complaint, governing contracts between the NHS and the Independent Healthcare Sector states that any complaint in relation to clinical or other services provided to an NHS patient which cannot be resolved at local level should be referred to the Board. Thus the expectation is that the Board and not the independent sector provider will conduct a review of the unresolved complaint.

46. In response to the draft of this report Mrs C told me that she had tried to raise the issues about the care in the Care Home at the meeting in September 2003 and had taken the Care Home records along to the meeting for that purpose but the meeting was ended by the Board and she was not able to raise these issues. The Board have told me that they do not agree with this account of the meeting.

(c) Conclusion

47. The concern expressed by Mrs C is about the rigour of the NHS investigation of her complaint about care that was the clinical responsibility of the NHS but provided by the independent sector rather than any concern about the investigation of the NHS provided care. The current NHS complaints procedure expects that any NHS Board in this situation will provide joined-up complaint handling and I note that this was the intention of the meeting organised by the Board in September 2003. The HDL also expects that the Board would be involved in reviewing unresolved complaints and the revised procedure introduced by the Board would achieve this. I note though that it was never explained to Mrs C by the Independent Provider that the Board's

involvement precluded any further investigation by the Independent Provider and consider that it would have been of benefit to all parties involved had this point been clarified from the outset.

48. Mrs C's complaint was complex both in terms of the actual clinical issues raised and the processes which were used to address these. I am satisfied that complaints staff and clinicians took reasonable steps to provide answers and explanations to Mrs C but consider that the system of review then in place did not provide an opportunity for NHS staff to investigate the care provided in the Care Home. The Board have agreed that involving local managers in reviewing the issues raised would have been helpful in addressing Mrs C's concerns. I, therefore, uphold this aspect of the complaint. However, I recognise that the enhanced role of the Care Commission and NHS QIS now provides greater oversight to the general care provided in care homes and the Board's revised complaints practice is proactive in involving local managers in investigating complaints.

(c) Recommendation

49. In light of the changes to the Board's practice and the role now played by the Care Commission and NHS QIS in monitoring levels of service the Ombudsman has no further recommendation to make but notes that her Recommendation (b) would also be of benefit in reducing the opportunity for complaints such as this to arise.

(d) Concerns raised during the investigation of this complaint

50. Mrs C's principal concern has always been the care afforded to her mother, particularly by the Care Home which she believed contributed significantly to her mother's decline. Mrs C's complaint took two years to reach our office and it has taken several more months for the various agencies and regulators concerned to conclude their processes. When Mrs C approached the Ombudsman's office she also raised a further concern about the handling of her complaint – some of which is referred to in (c). However, a number of Mrs C's concerns about the handling of her complaint are not directed at the Board but at the current pathway for raising a complaint about care paid for by the NHS but delivered in the Independent Healthcare Sector, particularly where the complaint involves a death.

51. In the four years since she raised her complaint Mrs C always followed correct and appropriate procedures (see Annex 4). Mrs C has frequently

expressed her frustration at the inability of all those organisations concerned (including the Ombudsman's office) to be able to work together to address all her issues. Mrs C considers that a more joined-up system would give rise to a more effective investigation at a much earlier stage as information about all the issues raised could be shared and challenged rather than being treated in a piecemeal fashion according to the jurisdiction and authority of each organisation concerned. Annex 4 illustrates the complexity of the interrelationship between the current pathways. Mrs C expressed particular concern that the Care Commission investigation upheld a substantial part of her significant complaints but that the outcome of the investigation was not made known either to members of the public who might have an interest in knowing about it or to the NHS who paid for the care.

52. The recent Care Inquiry Report by the Parliamentary Health Committee[1] raised some of these concerns. The Ombudsman's office gave evidence to the inquiry including reference to the problems encountered by Mrs C in pursuing this complaint. The Scottish Executive response issued on 28 August 2006[2] indicated that there was to be an independent review of regulation, audit, inspection and complaints handling[3] chaired by Professor Lorne Crerar which would, amongst other things, be considering how people access a public service complaints system and how lessons are learned from complaints. The Scottish Executive response to my enquiries declined to make any further comment until the independent review had reported in the summer of 2007.

Further Action

53. The Ombudsman will send a copy of this report to the independent review chaired by Professor Lorne Crerar asking that this complaint be included as part of their overall consideration of the system for public service complaints and in particular the transparency of the outcomes of such a system.

The Board have accepted the recommendations and will act on them accordingly.

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[1] http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm

[2] http://www.scotland.gov.uk/Publications/2006/09/responsecareinquiry

[3] http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/IndependentReview

27 March 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Mrs A	The aggrieved – Mrs C's mother
The Hospital	The Victoria Infirmary , Glasgow
The Care Home	The care home where Mrs A was an NHS funded continuing care resident
Consultant 2	The Consultant in charge of Mrs A's care from 23 December 2002 to 26 March 2003
The Care Commission	The Scottish Commission for the Regulation of Care
The Nursing Adviser	Nursing adviser to the Ombudsman
The Medical Adviser	Medical adviser to the Ombudsman
Consultant 1	The Consultant in charge of Mrs A's care from 7 November 2002 to 23 December 2002
Nurse 1	The Parkinson's Nurse
SHO 1	The SHO who spoke with Mrs C in mid-November 2002
QIS	Quality Improvement Scotland
The HDL	HDL (2005) 41

Annex 2

Glossary of terms

CVA	Cardio Vascular Accident - commonly referred to as a stroke
FAI	Fatal Accident Inquiry
GMC	General Medical Council - the body appointed by the UK Parliament to provide professional regulation of doctors.
NG Tube/ feeding	Naso-gastric – artificial feeding by way of a fine tube inserted through the nose directly into the stomach
NMC	Nursing and Midwifery Council - the body appointed by the UK Parliament to provide professional regulation of nurses and midwives.

Annex 3

List of legislation and policies considered

HDL (2005) 41	Health Department Letter – Quality of Clinical Services Provided by the Independent Healthcare Sector

Annex 4

Overview of Complaint Procedures Followed by Mrs C