Scottish Parliament Region: Central Scotland

Case 200401800: Lanarkshire NHS Board

Introduction

1. On 23 December 2004 the Ombudsman received a complaint from a group of patients (referred to in this report as the Group) representing the former patients of a general practitioner (GP A). The Group complained that Lanarkshire NHS Board (the Board) failed to properly manage, advise and involve them in the retiral of GP A and the application process for his replacement. There were two re-appointment processes leading up to a new appointment. The Group also complained about the quality of GP services they experienced while awaiting a replacement and since October 2004 when patients were transferred to a new GP practice (the Practice). My investigation did not uphold the Group's central complaints. The sequence of events leading to the complaint was unusual and the Regulations surrounding the replacement of GPs are complex and changed during the period. However, I found there were shortcomings in the Board's communication with the Group which caused them injustice. In the light of that finding a need for action from the Board with respect to public involvement has been identified. This is relevant to the work of the Scottish Health Council (see paragraph 8) and this office will be drawing this complaint to their attention.

2. The complaints investigated *(and my conclusions)* are that the Board:

(a) did not adequately inform GP A's patients of his resignation/retiral *(partially upheld – paragraphs 17 to 20)*;

(b) did not adequately inform GP A's patients of arrangements for cover while appointing his replacement *(not upheld – paragraphs 26 to 28)*;

(c) did not properly advertise the vacancy for GP A's replacement *(not upheld – paragraphs 37 to 37)*;

(d) did not adequately fulfil commitments made to involve the Group in

the application process on either occasion *(upheld – paragraphs 44 to 48)*;

(e) did not adequately inform the Group of changes in personnel at the Board or arrange a hand-over of the necessary information to the new post holder *(upheld – paragraphs 52 to 54)*;

(f) allowed unacceptable delays in responding to requests for information and for meetings *(partially upheld – paragraphs 57 to 59)*;

(g) did not adequately inform GP A's patients of the precise nature of the regulations to be applied to the re-running of the vacancy *(not upheld – paragraphs 62 to 63)*;

(h) did not provide all the necessary information to the Local Medical Committee members prior to the second interview panel held on 17 August 2004 *(no finding – paragraph 66)*;

(i) did not adequately inform GP A's patients of the decision to merge with the new GP Practice *(not upheld – paragraph 69)*;

(j) failed to properly involve patients in the appointment process by not giving due weight to a 1,500 name petition during either the original or re-run interview process *(not upheld – paragraph 73)*;

(k) did not give consideration to the views of patients as represented by the Group on several occasions *(no finding – paragraph 76)*;

(l) did not provide an adequate GP service between 7 January 2004 and 30 April 2004 *(not upheld – paragraph 79)*;

(m) did not ensure adequate provision of GP services after 1 October 2004 (the date of the merger with the Practice) *(not upheld – paragraph 83)*.

Background to the Complaint

3. GP A operated as a sole practitioner and was ultimately replaced by a GP who was part of a multi-GP practice (the Practice). A significant number of GP A's patients had formerly been patients of a GP within the Practice and left because they were not satisfied with the service provided.

4. There were two re-appointment processes leading up to the new appointment. Following the first appointment process for a replacement there was an appeal by the unsuccessful applicant (GP B). The appeal was successful and a second appointment process was initiated. The Group complained that the Board did not properly apply the appropriate regulations governing GP appointments on either occasion.

5. The Group also raised a complaint with this office against the Scottish Executive Health Department (the SEHD) concerning some of these matters. The investigation of that complaint is the subject of a separate report (reference 200402200).

6. A detailed chronology of events appears at Annex 1, a list of names used appears at Annex 2 and a summary of the background regulation and legislation appears at Annex 3. The Group and the Board have had the opportunity to comment on a draft of this report.

Statutory and Administrative Background

The status of GPs

7. Most GPs are not employees of the NHS but are self-employed and contract with Health Boards to provide NHS services. That arrangement is governed by a standard, nationwide contract – the General Medical Services (GMS) contract. In April 2004 a new GMS contract came into force. This established a new basis for the relationship between a GP practice and the local area Health Board. The new contract exists between the Health Board and the GP practice – previously a contract existed with each individual GP. This was a major change intended to give practices greater freedom to decide how to design their services to best meet local needs. This change was implemented during the time of the events of this complaint.

Arrangements for the NHS to consult with the public

8. NHS Boards have primary responsibility for involving people in decisions about health services. Boards are expected to carry out their duty of involvement in line with Scottish Executive policy on patient focus and public involvement. The Scottish Health Council, a national body established on 1 April 2005, has a responsibility to scrutinise how well NHS Boards are involving people.

The Ombudsman's jurisdiction

9. Much of this complaint relates to the process of appointing a GP. The Scottish Public Services Ombudsman Act 2002, Schedule 4, paragraph 8 excludes this office from investigating 'Action taken in respect of appointments or removals, pay, discipline, superannuation or other personnel matters'. While this has not precluded my consideration of all the matters raised by the Group, it limits the scope of findings and recommendations. Where this is the case I have mentioned it in my findings.

Investigation and Findings of Fact

10. The investigation of this complaint involved reading all the documentation supplied to me by the Group and the Board. This included records of meetings with Board staff, letters sent by the Group and the Board, press cuttings, correspondence with a Member of the Scottish Parliament (MSP 1) and extracts from Scottish Parliamentary questions. In particular I have seen copies of all letters referred to unless stated otherwise. I have made written enquiries of the Board and met representatives of the Group and the Board. I have considered current legislation, guidelines and published documents on possible future developments regarding public involvement in the development of the NHS in Scotland. I have referred to several regulations and several policy documents – these are detailed in Annex 3.

Complaint (a): that the Board did not adequately inform GP A's patients of his resignation/retiral

11. GP A tendered his resignation to the Board in October 2003, having previously been on long-term sick leave since August 2003. He officially retired on 6 January 2004, at which time, the Group told me, a notice was placed on the surgery notice-board by surgery staff advising patients of this fact. The Group have complained that only those patients attending the surgery from

6 January 2004 were made aware of this change and that no patients were formally made aware of any forthcoming or actual changes until a letter was sent from the Board dated 10 March 2004. They also complained that patients were not given any notice of the closure of GP A's surgery after 30 January 2004.

12. The Board told me that GP A ceased to be responsible for the Practice from 30 January 2004. They further told me that on that date, they endeavoured to notify patients of this change by placing a notice on the Practice door. The Board have told me that from the time of advertising the vacancy (27 November 2003) they answered all enquiries from the press, members of the Group and other individuals who contacted them seeking information about the appointments process.

13. The Board also told me that they acted to inform each patient individually with a letter from the Director of Clinical Standards and Health Improvement (10 March 2004). They considered that prior to this date they had insufficient information to usefully communicate with GP A's patients.

14. Members of the Group told me that they were present at the surgery on the evening on 30 January 2004. At that time they were not aware of any notice having been posted on the surgery door.

15. The Board told me that there was no direction requiring them to notify patients of such a change of arrangements. This has been confirmed to me by the SEHD. The Board advised me that in other situations where a GP retired the onus had been on the individual leaving to inform patients which ensured proper continuity for patients. GP A did not appear to have been proactive in informing patients of his retiral. This situation was problematic as it relied on the voluntary efforts of the retiring practitioner. The Board have referred me to the revised guidance issued in conjunction with the new GMS contract introduced in April 2005 (commonly known as '*The Blue Book*'). Paragraph 23 of this states:

> 'It will be necessary to ensure that branch surgery closure decisions are taken only after full consultation with local communities and other interested parties; and that they are not

> taken in isolation from other local strategies designed to improve patient access to services'.

Investing in General Practice. The New General Medical Services Contract. Supporting Information for Scotland: Published 16 May 2003

This would not address all situations where a GP retires but would ensure patient involvement in decisions where a GP branch surgery is to be closed. The Board have pointed out that the new guidance would not have applied in this case as this was not a branch surgery.

16. The Board have acknowledged that the events in this complaint highlight a difficulty for NHS Boards in ensuring patients are aware of significant changes in their service provision where the only onus for notification is on the retiring GP (or other independent contractor). As a consequence of this complaint the Board produced a draft proposal for the management of appointment processes specifically for single-handed GPs in Lanarkshire which will involve the Community Health Partnership (CHP) establishing a short-life working group, including patient representatives. Under this proposal, where a vacancy occurs the CHP will be involved in considering the options for replacement, prior to the selection process itself. The Board have also made a commitment to inform patients in writing of the new appointment following such a process.

Conclusion on Complaint (a)

17. The NHS regulations do not place a duty on a Board to inform patients of a GP's retiral or any other change in their GP provision. In the majority of circumstances where there are several GPs in a Practice, a change in GP is easily affected and has a minimal impact on most patients. In most cases it would be a costly process for the Board to notify all patients of any change of GP circumstances and there would be no significant benefit to the patient. Where patients are facing material changes to their service provision: that is a change in GP, GP Practice and/or physical surgery location it would be good administrative practice to notify patients of the impending changes. There was no regulatory duty on the Board to inform patients in this case. I accept that the Board acted to inform patients in a way it believed was reasonable based on previous experience. The difficulties in this situation were caused by a lack of specific guidance or regulation requiring patient involvement. I am pleased to

note that the revised guidance within *the Blue Book* quoted in paragraph 15 establishes a requirement for public engagement and involvement which would have addressed many of the concerns of the Group.

18. The Board's proposals for managing single-handed practitioner vacancies sets out to meet and extend this new guidance. The proposal I have reviewed is not yet sufficiently detailed to allow me to comment on whether it would be effective. The Scottish Health Council is the NHS body with lead responsibility for setting achievable standards for user involvement for NHS organisations throughout Scotland. I consider it would be beneficial for this organisation to review and comment on the Board's proposals.

19. The regulation of the time placed no obligation on the Board to inform patients but I consider it would have been good administrative practice in the circumstances to do so. I partially uphold this complaint and welcome the action already taken by the Board to address this problem.

20. In light of these conclusions the Ombudsman recommends that the Board seek input from the Scottish Health Council prior to finalising the proposals for single-handed GP appointments and notify this office of these proposals. This office will also draw this matter to the attention of the Scottish Health Council and ask for their view of the proposals and how these might be of relevance throughout NHS Scotland.

Complaint (b): that the Board did not adequately inform GP A's patients of arrangements for cover while appointing his replacement

21. Between 30 January 2004, when GP A handed the management of the surgery back to the Board, and 20 May 2004, cover was provided at GP A's former surgery premises by a number of locum GPs. The locum GPs were arranged by a local GP Practice, under an agreement between the Practice and the Board. From May 2004 to September 2004, GP cover was provided by a long-term locum, GP C. The Practice assumed formal responsibility for GP A's former patients on 1 October 2004.

22. The Group complained that patients were given no information about who was arranging or providing their GP services until the letter of 10 March 2004. They have told me that this letter was only sent as a result of their considerable

lobbying and the intervention of MSP 1. They further complained that they were not kept updated on the impact of the appeal against appointment and re-appointment, or on the temporary GP cover.

23. Arrangements for temporary GP cover in January 2004 were governed by Regulation 24(2) (a) of the National Health Service (General Medical Services) (Scotland) Regulations 1995. This did not place an obligation on the Board to notify patients of the interim locum arrangements.

24. The Board told me that the letter of 10 March 2004 makes reference to the temporary arrangements made for GP cover. Further letters were sent to patients by the Board on 25 May 2004 regarding the outcome of the appeal and on 18 and 24 August 2004 regarding the new appointment. As detailed in paragraphs 16 and 17, the Board have now committed to informing patients, in writing, of their new GP details at the conclusion of any such future appointment process.

25. There had never previously been an appeal against an appointment decision (either in Lanarkshire NHS or elsewhere in Scotland).

Conclusion on Complaint (b)

26. The arrangement for provision of locums was not in breach of the applicable Regulations. There was a considerable time delay (six weeks) before patients were initially informed of the provisional arrangements. Such a prolonged period of uncertainty caused anxiety to patients. Further anxiety was caused by the need to re-run the process and the uncertainty which followed this. Much of the anxiety in this case was a result of the particular circumstances of this case – a retiring sole GP and a successful appeal against an appointment decision. This was not a situation that the Board had encountered or could reasonably be expected to have anticipated.

27. There was no statutory requirement on the Board to notify patients in these circumstances. I note the commitment to inform patients at the end of the appointment process and acknowledge that this would alleviate some of the anxiety of patients. The revised guidance referred to in paragraph 15 and the proposals from the Board for managing single-handed GP vacancies should further help to ensure no repeat of the distress in this case.

28. I do not uphold this complaint but welcome the changes outlined in paragraphs 15 and 16.

Complaint (c): that the Board did not properly advertise the vacancy for GP A's replacement

29. The first application process was initiated with an advertisement in three publications on 27 November 2003. This followed the direction to the Board from the Scottish Medical Practices Committee (SPMC) on 13 November 2003. The advertisements did not mention that the GP who was retiring was a sole practitioner.

30. The second application process was initiated with similar advertisements on 10 June 2004. Again, there was no reference to the status of the retiring GP.

31. The Group complained to me that the Board did not properly advertise the vacancy for either application process. They referred to the specific 'statutory' recommendation of the SMPC as passed to the Board on 13 November 2003, which required that the vacancy be advertised as 'a single handed GP practice'.

32. There was a meeting on 19 February 2004 between the Group and Board representatives. The Group's record of this meeting indicates that it was the view of Board representatives that the SMPC had considered whether the vacancy should be advertised as a single-handed practice and given a direction to the Board to this effect.

33. The Regulations governing the work of the SMPC state that the committee can direct a Board to advertise the nature of a vacancy by reference to its existing status, that is how the current post-holder undertakes the task. The regulation does not empower the committee to dictate the future status of the vacancy as either a single GP practice or multi-GP practice. These Regulations are contained in section 23 of the 1978 Act and in Regulation 11 of the 1995 Regulations.

34. In their response to me the Board stated that the SMPC did not have the remit to dictate the sole/joint practitioner nature of the replacement GP.

35. The successful grounds of the appeal by GP B to the first appointment process were that the vacancy had been awarded to an application from a group practice rather than a sole practitioner. Prior to the introduction of the new GMS contract on 1 April 2004 this was not legally possible and, therefore, the appeal was successful. The appeal was not on the grounds that the vacancy had to be awarded to an individual GP.

Conclusion on Complaint (c)

36. I consider that the limitation to the remit of the SMPC was not initially fully appreciated by the Board or explained to the Group members. This led to a considerable misunderstanding on the part of the Group because they did not receive a sufficient explanation of the role of the SPMC or the eventual reason for the success of the appeal. I am mindful that the SMPC no longer exists and that, with regard to the first application process, this issue has already been the subject of a successful appeal to the SEHD. I note that this confusion illustrates the general lack of clarity in the Board's dealings with the Group.

37. While I conclude that the Board were not as clear as they could have been in the information they provided to the Group regarding the nature of the vacancy, I do consider that they administered the process properly, in accordance with Regulation and for that reason I do not uphold this aspect of the complaint.

Complaint (d): that the Board did not adequately fulfil commitments made to involve the Group in the application process on either occasion

38. The Group showed me a number of letters and referred me to a number of meetings at which they consider they were promised an involvement in the process of appointing a replacement GP (both the original and re-run). They complained that despite this they had no input into the wording of the advertisements or the short-listing of candidates and were only given a moderate role at the final stages of the re-run.

39. The Board responded that the vacancy was advertised as required by section 23(2) (a) of the NHS Scotland Act 1978 and Regulation 11 of the 1995 Regulations. The Board also stated that they did fulfil their commitment to involve the Group in the re-run interview procedure by giving a representative of the Group a place on the second interview panel for the re-run application.

40. I have not seen any official/agreed written record of meetings between Board staff and representatives of the Group. The Group provided me with a typed record of the meeting on 19 February 2004. Because this record was never formally agreed by both parties I cannot regard it as conclusive but give it the same weight of evidence as if it was being told to me by the Group.

41. Key relevant points contained in the Group's record of the meeting include:

- The Group were told that the Board had been advised by the SMPC that the vacancy should be advertised as 'a single-handed vacancy'.
- The Group were also advised that it was the intention of the two part-time doctors from the new Practice to go full-time.
- The meeting also discussed the then relationship between the Board and the GPs and how this would change significantly on 1 April 2004 with the new GMS contract. At that time the Board would become the employer of the GP rather than acting as an agent for the Scottish Health Minister. The Board staff implied that this change would significantly improve the ability of the Board to involve patients in the selection process and thus if the appeal succeeded the Group might expect to have far greater input than before.

The records of the meeting suggest there was a very poor level of understanding on all sides of how the appeal process worked or would work post 1 April 2004, and a number of clarifications were to be sought following the meeting. Some of this lack of knowledge is understandable as the appeal was a very rarely used mechanism and the new regulations were still emerging at that time and the final version of the GMS contract had not yet been published.

42. I reviewed the Board's framework for Public Involvement: *Putting People First.* This document sets out the way in which the Board will involve users of services in line with the Scottish Executive Policy: *Patient Focus and Public Involvement (2001)*. That document defines public involvement as:

> 'Public Involvement is understood as the active participation of the

public, both individually and collectively, in the decision making process which influence service provision and planning'.

Section 2 of this document defines what is meant by Public Involvement and distinguishes between indirect influence where views are fed into the decision making process and direct influence where participants have the potential to modify decisions or outcomes by their actions. The document goes on to set out a process for implementing this and for establishing a system for evaluating its effectiveness.

43. The Board provided me with their proposal for managing future vacancies for single-handed GPs (paragraph 16) and I have already referred to revised guidance issued with the new GMS contracts (paragraph 15). The Board have also told me that they provide advice and support to Practices to assist them in involving their patients in informing local service delivery. As the primary responsibility rests with the practice the Board itself is not in a position to instruct the Practice as to how this must be done.

Conclusion on Complaint (d)

44. The Group had a high expectation of what the Board's commitment to user involvement meant throughout this process. From the documentation they showed me and the conversations they reported to me it is clear that they considered that the Board understood the level of commitment the Group was looking for. The Board did not appreciate the extensive nature of the user involvement the Group were seeking – nor was it always within the Board's power to deliver the involvement the Group envisaged. For example, as the matter was governed by law there would be no opportunity for the Group to have input into the wording of the job advertisements and the primary responsibility for communication lies with the GP or GP Practice.

45. I do not consider that the Board were sufficiently clear in their communications with the Group. In meetings prior to the changes on 1 April 2004 the Board led the Group to believe that there would be a major change in their ability to involve patients following the introduction of the new GMS contracts. Changes did not materialise as the Group had anticipated and the Group considered that the Board was in fact merely paying 'lip service' to the idea of user involvement.

46. The distinction in *Putting People First* between indirect and direct user influence is very relevant here. The Group were seeking direct involvement when only an indirect influence was envisaged by the Board. There are valuable lessons to be learned here to ensure future user involvement is effective and to avoid the dissatisfaction and perceived injustice felt by the Group in this instance.

47. I uphold this aspect of the complaint but welcome the proposals for managing future single-handed vacancies and the new guidance issued in conjunction with the new GMS contracts. These will help ensure these communication difficulties do not recur.

48. In light of these findings the Ombudsman has no specific recommendation to make. As part of the recommendation in paragraph 20 this office will be drawing this complaint to the attention of the new Scottish Health Council and will also ask that they consider how the events in this case can be used to inform future practice regarding effective patient involvement throughout the NHS in Scotland.

Complaint (e): that the Board did not adequately inform the Group of changes in personnel at the Board or arrange a hand-over of the necessary information to the new post holder

49. During the time that the Group were raising their concerns with Health Board staff, there were a number of changes of personnel. The Group complained to me that they were not informed of these changes – in particular the change of Chief Executive. They considered that this caused delays and confusion for them. They were not clear where their responses should be coming from. The Group told me that on several occasions when they contacted the new person in post he/she did not appear to be aware of the concerns expressed to, or the undertakings made by, previous post-holders thus losing the Group valuable time and opportunities.

50. The Group expressed particular concern that following the meeting in February 2004, the then Chief Executive asked for details of complaints against a GP in the Practice made by the former patients of that Practice. This information was to be provided on an anonymous basis and with no intention of

invoking the complaints procedure. When details of the complaints were sent by the Group, this letter was passed on to the new Chief Executive who forwarded on the information as a complaint to the Complaints Department, for forwarding to the GP Practice. The Group took immediate action to correct this error but this episode caused considerable anxiety. The Group told me that they considered that the commitments made to them were not properly passed on when there was a personnel change.

51. The Board have apologised if correspondence or telephone enquiries did not make the change in Chief Executive clear. The Complaints Department had previously apologised for the anxiety caused at the time of the error in progressing the complaints.

Conclusion on Complaint (e)

52. Several members of NHS staff were involved in meetings and correspondence with the Group regarding the process for the new appointment. I have not seen evidence of any intention to cause confusion or deliberately mislead the Group. There were no agreed objectives between the Board and the Group and no clear plan of action (see conclusions in paragraphs 44 to 46). When there was a personnel change there was no structured information to hand over. The Group was not advised when personnel changes occurred and this, combined with the lack of a plan of action, caused delay and confusion for the Group. I consider that the Board's error in handling the confidential complaint information provided by the Group is evidence that there was no organised 'hand-over' of the Group's concerns. I uphold this complaint.

53. The Board's proposals for managing vacancies for single-handed GPs and the new guidance in *the Blue Book* referred to in paragraphs 15 and 16 will help avoid the lack of clarity and consequent confusion in this case.

54. The Ombudsman's recommendation regarding input from the Scottish Health Council in paragraph 20 is relevant here.

Complaint (f): that the Board allowed unacceptable delays in responding to requests for information and for meetings

55. The Group told me that on a number of occasions it took several days and sometimes weeks of frequent reminders for meetings to be arranged. In

particular it took two months, from 7 May 2004 to 6 July 2004, for the meeting to be arranged with MSP 2, the Group and the Chief Executive. The Group indicated that the Chief Executive was certainly aware of the request by 18 May 2004. The Group have also complained that the Divisional Medical Director was slow to respond to several requests for information throughout the process.

56. The Board responded that delays were unintentional and unavoidable. They were due in part to the complexity of the information requested and the availability of the senior staff involved.

Conclusion on Complaint (f)

57. There were delays in arranging meetings and providing responses and this was a cause of additional frustration and anxiety for the Group. I have seen no evidence to suggest a deliberate attempt to delay matters or avoid answers and accept the Board's explanation for the delays. There was a lack of clarity in communication between the Board and the Group. There was also a lack of clarity about the actions expected and the likely timescales. Such clarity is crucial to effective user involvement. I partially uphold this complaint.

Complaint (g): that the Board did not adequately inform GP A's patients of the precise nature of the regulations to be applied to the re-running of the vacancy

58. Following GP B's successful appeal against the original appointment, the Group were informed in writing (received 24 May 2004) by the SEHD that the Board had been directed to re-advertise the post. On 25 May 2004 all patients received a letter from the Board to this effect. The Group received a further letter from the Board dated 16 June 2004 specifying that that vacancy was to be filled with due regard to the National Health Service (General Medical Services) (Scotland) Regulations 1995. At a meeting with the new Chief Executive on 6 July 2004, The Group told me that the Chief Executive confirmed the re-run would be in the same format as before, a fact confirmed when he wrote to the Group on 12 July 2004. The Group complained that it was not until a further letter dated 18 August 2004 (from the Divisional Medical Director) informing patients of progress towards an appointment that there was any indication that the General Medical Services (Transitional and Other Ancillary Provisions) (Scotland) Order 2004 applied to the vacancy and that there was no facility for appeal.

59. The Board commented that all the information provided was accurate and that the SEHD confirmed this view.

Conclusion on Complaint (g)

60. The regulations governing the initial appointment, the appeal and the re-run are many and changed significantly over the time of these events. The appeal and subsequent re-run was a unique sequence of events and could not occur again under the new regulations. It would not have been possible at the outset of the appointment process for the Board to predict the exact course of events or the new regulations. As events unfolded the Board always gave the Group correct information although this was not always complete. I do not consider there was a deliberate attempt to mislead the Group.

61. It is not the role of this office to judge on the correct legal interpretation of the regulations – that is a matter for the courts. I am satisfied that the Board acted reasonably in applying the regulations as they did and in seeking to ensure their actions were correct by confirming matters with SEHD. I do not find any administrative failure in respect of the information provided to the Group and do not uphold this aspect of the complaint.

Complaint (h): that the Board did not provide all the necessary information to the Local Medical Committee members prior to the second interview panel held on 17 August 2004

62. A member of the Group was invited to sit on the second interview panel on 17 August 2004. He was aware of his attendance for a number of weeks prior to this event and received a degree of training from Board staff to equip him for this task. The Group have complained that on the day, the permanent members of the committee were not expecting him to be there and were unclear as to his role. There was a discussion held in private by the permanent members and as a result of this the Group member was only given the opportunity to cast a vote because the Health Council representative agreed to being disenfranchised. The Group have further complained that this effectively halved the patient representative vote on the committee.

63. The Board responded that the responsibility for the general oversight of general medical services in the area was delegated by the Board to Lanarkshire

Primary Care Medical Committee and its membership is dictated by Board standing orders. While it was agreed by the Board to extend the membership, on the day of the panel the professional members of the committee were not clear as to the decision-making process for all the extended membership and requested an adjournment to consider the matter in private. It was consequently agreed to restrict the voting rights of the lay representatives to two. The Board provided me with a statement from the Local Medical Committee that they were aware in advance of the attendance and voting right of the Group representative. The Board advised me that the discussion held by the professional members concerned the voting rights of the representative of the Health Council.

Conclusion on Complaint (h)

64. Who was or was not entitled to vote is not a matter I can consider nor is it the disputed issue. The problem is that the statutory members of the committee had not considered and decided on the voting rights of all the patient representatives before the second interview panel met. This led to confusion on the day and did not contribute to proper and effective user involvement. The Group told me that their representative felt alienated from the appointment process and that his presence was unwelcome. They considered that this was another case of the Board paying 'lip-service' to user involvement. I have evidence that the Board took steps to make the Local Medical Committee members aware of the Group representative and his intended involvement. I am precluded from commenting on the actions of the Local Medical Committee with respect to the conduct of the appointment process beyond noting the distress caused to the patient representatives by the privately held discussions and limitations placed on their overall voting rights. I make no finding in this complaint.

Complaint (i): that the Board did not adequately inform GP A's patients of the decision to merge with the new GP Practice

65. The Group have told me that ultimately patients were not given any notice of the intention of GP D to close the surgery and merge with the new Practice with effect from 1 October 2004 and patients who had strong personal reasons for not wishing to be part of the new Practice were forced into obtaining GP services in this way. The Group also told me that in the event of the merger the surgery premises were physically closed with no forwarding number being left

on the telephone line leaving patients with no short-term means of knowing where to direct their requests for appointments.

66. The Board responded to my enquiries that patients were kept fully advised. A letter was sent to all patients on 25 August 2004 and a further letter was sent from Practitioner Services on 23 September 2004. Both these letters advised patients of the changes and the letter from Practitioner Services advised what action they might take if they did not wish to obtain services from the new Practice.

Conclusions on Complaint (i)

67. Once the decision had been reached to appoint GP D and effectively merge with the new Practice, I am satisfied that patients were given adequate and timely information by the Board. I do not uphold this complaint.

Complaint (j): that the Board failed to properly involve patients in the appointment process by not giving due weight to the 1,500 name petition during either the original or re-run interview process

68. The petition was handed to Board staff on 26 January 2004 prior to the first interviews. The Group were later informed that, while the interview panel were aware of the petition, they did not take account of it. The Group have also told me that the petition was not discussed by the re-run panel (on which they had a representative).

69. The Board told me that the existence of the petition was made known to the panel members at the re-run interview. The Board have provided me with a written statement from the Local Medical Committee whose members, alongside the patient representatives, composed the interview panel. This states that the members of the committee were aware of the patients' petition.

70. The regulations make no provision for patient involvement in the recruitment process and consequently provide no procedure for dealing with petitions.

Conclusions *on Complaint (j)*

71. While there is no requirement that the Board notify the panel of a petition, the Board undertook to make the petition known to the Panel on both

occasions. I have evidence that the petition was known to panel members on both occasions. On the basis of the evidence I have seen I am satisfied that the Board met their commitment to make the petition known to the Panel. I do not uphold this complaint.

Complaint (k): that the Board did not give consideration to the views of the patients as represented by the Group on several occasions

72. The Group complained that despite several meetings during which they raised the concerns of patients the Board did not give due consideration to these views in considering how to replace GP A. The concerns raised were that losing a single-handed GP would result in poorer service provision, that interim arrangements were inadequate, that patients did not wish to be forced to return to Practice D and that there was a shortage of GP coverage in the area.

73. The Board commented that the views of the Group and other patients were sought on a number of occasions and made known to the Local Medical Committee members of both the original interview panel and the re-run panel. The Board have pointed out that they were obliged to run the interview process in accordance with the regulations and thus the interview panel was obliged to take account of the applicants' preferences to work with other GPs in the area or to limit their hours of work, irrespective of the patients' preferences. The Local Medical Committee was delegated the authority to make the new appointment and it was for the appointment panel to consider the views of the patients represented by the Group.

Conclusions on Complaint (k)

74. I am precluded from commenting on whether or to what extent the panel considered the views of patients as this is a matter specifically relating to action taken with respect to an appointment. I note the lack of formal arrangements for input from patient representatives and again welcome the Board's proposals for managing vacancies for single-handed GPs and the new guidance in *The Blue Book* referred to in paragraphs 15 and 16. The Ombudsman's recommendation regarding input from the Scottish Health Council in paragraph 20 is relevant here. I make no finding on this aspect of the complaint.

Complaint (l): that the Board did not provide an adequate locum GP service between 7 January 2004 and 30 April 2004

75. The Group complained that the cover provided from the time of GP A's retiral until the long-term locum took over (20 May 2004) was wholly inadequate. They complained that one of the locum GPs was beyond the required retirement age for a GP and that he was unable to operate the computer system which caused protracted delays in appointment times and a reduction in the overall level of services provided. The Group further complained that, had they not brought this matter to the attention of Board staff, it might have carried on being a problem for a considerably longer time.

76. The Board commented that there is no longer any upper age limit for inclusion on the Primary Medical Services Performers List and that, at the time, the applicable Regulation, NHS (GMS Supplementary Lists)(Scotland) Regulations 2003, also permitted certain locums to practice beyond the upper age limit of the revoked 1995 Regulations. It was, therefore, this 2003 regulation that applied. This permission continued when the NHS (Primary Medical Performers Lists) (Scotland) Regulations 2004 came into place on 1 April 2004, replacing the previous regulations. The Board commented that it ensures all applicants comply with the requirements of the Performers List Regulations prior to their inclusion on the list.

Conclusion on Complaint (l)

77. I consider that the Board fulfilled its obligation to provide a GP service in accordance with the applicable regulations. I do not uphold this complaint.

Complaint (m): that the Board did not ensure adequate provision of GP services after 1 October 2004 (the date of the merger with the Practice)

78. The Group told me that the patients of GP A experienced a high level of involvement with and service from him. They complained that the level of family health services provided to GP A's former patients seriously deteriorated after the merger with the new Practice. They had no complaint against any individual GP but were unhappy with the overall service provided since that time. They cited as examples, considerable delays in obtaining an appointment time, fewer clinics available, for example no baby clinic, and the lack of provision for taking blood samples at the surgery. The Group advised me that they raised all these issues in September 2004 during a meeting with the Chief Executive and were

advised that other GPs' hours would be increasing to cover the shortfall caused by GP A's (and another GP's) retiral. The Chief Executive agreed to provide details of the revised working hours of the GPs but this did not happen.

79. The Board told me that they have not received any complaints against the practice and have passed on comments from the Practice itself stating that appointments are available within 48 hours and that baby clinics and blood taking services are available. Although there had been problems with the latter these were now resolved.

80. The Board also told me that the new GMS contract obliges contractors to provide essential and additional services at certain core times but that it is for each practice to decide the exact detail of surgery hours and which members of staff will provide this. Thus the Board has no record of the exact hours worked by any GP and cannot provide this or details of GP hours per head of population. Since the time the new GP took over and the subsequent merger with the new practice, it is the responsibility of the new Practice to ensure adequate provision of service in accordance with the terms of the contract agreed with the Board.

Conclusions on Complaint (m)

81. The Group have told me that they are now not experiencing the level of service they formally had and they are understandably unhappy at this. I accept that the service they are now receiving does not meet the standards they had come to expect. However, I have not seen any evidence that the service they are receiving is below the standards set by regulation. I conclude that the Board met its responsibility to provide GP services and I do not uphold this aspect of the complaint.

Summary Recommendation

82. In this report I have identified a number of failings in internal and external communication and response times. These are set out in complaints (d), (e) and (f). In light of these findings the Ombudsman recommends that the Board make a written apology to the Group for the failings identified in this report.

30 May 2006

Annex 1

Chronology of Events

August 2003	GP A goes on sick-leave
October 2003	GP A tenders his resignation
6 January 2004	GP A officially retires
30 January 2004	the Practice takes over responsibility for providing locums to GP A's former patients
30 January 2004	GP B is unsuccessful in his application for the vacancy - he later lodges an appeal
19 February 2004	Meeting between the Group and Board representatives
10 March 2004	All patients received a letter of notification of GP A's retiral and arrangements for cover
1 April 2004	New GMS Contract comes into effect
13 May 2004	The Group advised by telephone that GP B's appeal has been upheld
25 May 2004	All patients received a letter advising of the successful appeal
6 July 2004	Meeting between the Group and Board representatives
17 August 2004	Meeting of second interview panel –

	GP D is successful
1 October 2004	the Practice formally take over responsibility for GP A's patients

Annex 2

Explanation of abbreviations used

GMS Contract	General Medical Services contract – the contract between an NHS board and a GP or GP practice
GP A	The GP whose retiral caused the vacancy to arise
GP B	The GP who was unsuccessful in his application to replace GP A and whose appeal against the decision was upheld
the Practice	The group GP practice who took over responsibility for GP A's patients on a temporary and then permanent basis
GP C	The locum GP from 20 May 2004 to 30 September 2004 and the unsuccessful applicant at the second application process
GP D	The GP who was successful following the second application process (a member of the Practice)
The Group	A group representing patients of GP A
MSP 1 & 2	Members of the Scottish Parliament representing constituents within the Board area
SEHD	Scottish Executive Health Department

SMPC	Scottish Medical Practices Committee. Formerly the body responsible for determining the need for a replacement GP in Scotland (although not for the process of making the appointment)

Annex 3

List of Legislation and Regulation referred to in the report

National Health Service (Scotland) Act 1978

National Health Service (General Medical Services) (Scotland) Regulations 1995

National Health Service (GMS Supplementary Lists) (Scotland) Regulations 2003

The General Medical Services (Transitional and Other Ancillary Provisions) (Scotland) Order 2004

List of Documents referred to in the report

Patient Focus and Public Involvement (2001) Scottish Executive Health Department

Putting People First – a Framework for Public Involvement in Health in Lanarkshire