SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: South of Scotland

Case ref: 201600834, Dumfries and Galloway NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C, who works for an advocacy and support agency, complained on behalf of Mr A about a number of issues relating to Mr A's discharge to a nursing home following an admission to Newton Stewart Hospital. First, Mr C complained about the length of time it took clinicians to tell Mr A that an operation to help with a complex medical condition was not going to be possible for him despite it being initially proposed. Had Mr A known that the operation would not be possible, Mr C said Mr A would not have allowed himself to be discharged to the nursing home. Instead, when Mr A was discharged, he believed that he would be able to return home after a short time in the nursing home following the operation. Second, Mr C said that Mr A had not been given the option to return home with a funded care package before being discharged to the nursing home. Third, Mr C said that board staff had failed to explain clearly to Mr A the financial repercussions of his discharge to the nursing home before discharge and then, given his mental health issues, unreasonably failed to arrange an advocate for him to help him throughout the discharge process. Finally, Mr C said that Mr A's time in the nursing home should be considered as NHS continuing care because he was waiting for an NHS funded operation.

We took independent advice from a consultant in care of the elderly and considered guidance on choosing a care home on discharge from hospital and on hospital-based complex care (ongoing hospital care) in place at the time of the complaint. We found that when Mr A was discharged, he did not need hospital care and so it was reasonable to discharge him given his clinical needs at the time. Given this, we also found that the board's decision not to pay the nursing home charges was made in line with the guidance on ongoing hospital care. In relation to the time it took the board to reach a decision about Mr A's operation, the advice we accepted was that the operation was specialist and complex and so it was reasonable for the decision to take as long as it did. However, we identified a number of significant failings about the way Mr A was discharged.

We found that the board failed to take all reasonable steps to ensure Mr A was in a position to make an informed decision about the move to a nursing home and that an opportunity for discharge home was missed. Staff failed to explore with Mr A the option of discharge home with a care package in a reasonable way, and failed to provide clear written information to Mr A about his discharge, particularly around the financial implications of the move. Staff also let Mr A retain an over-optimistic view about the potential of an NHS-funded operation to improve his health when clinicians considered this was unlikely. Finally, we found that the board should have offered advocacy services to Mr A given his mental health problems to support him during a complex and uncertain time with extremely significant implications.

We upheld two of Mr C's complaints and made a number of recommendations to address the issues identified.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C and the aggrieved as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Redress and Recommendations

What we are asking the Board to do for Mr A:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) and (b)	The Board failed to take all reasonable steps to ensure Mr A was in a position to make an informed decision about the move to a nursing home, in line with the guidance, and an opportunity for discharge home was missed	Cover the costs of the nursing home fees Mr A has paid for the time he was in the nursing home on production of an invoice or receipt (or other evidence it was paid). The resulting payment should be made by the date indicated: if payment is not made by that date, interest should be paid at the standard interest rate applied by the courts from that date to the date of payment	Evidence of payment By: 22 January 2018
(a) and (b)	The Board failed to take all reasonable steps to ensure Mr A was in a position to make an informed decision about the move to a nursing home, in line with the guidance, and an opportunity for discharge home was missed	Apologise to Mr A for failing to ensure he was discharged in a reasonable way and, in particular, in a position to make an informed decision about the move to a nursing home. The apology should comply with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 22 December 2017

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	Staff failed to follow elements of the guidance on choosing a care home on discharge from hospital and hospital-based complex clinical care to ensure Mr A was discharged in a reasonable way	Staff should comply with the relevant guidance when arranging discharge	Evidence the guidance has been raised with relevant staff, and that staff are complying with the terms of the guidance. This could be via an audit, undertaken regularly, to evidence compliance By: 22 January 2018
(a) and (b)	Staff failed to provide clear written information in line with the hospital-based complex clinical care guidance about discharge to Mr A to ensure Mr A was discharged in a reasonable way	Staff should ensure information is provided as part of the hospital based complex clinical care guidance	Evidence that the process relating to the provision of information has been reviewed to ensure it complies with guidance By: 22 January 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	Staff failed to offer advocacy service to Mr A to ensure he was in a proper position to make an informed choice about his discharge	Staff should ensure patients are offered advocacy services where appropriate	Evidence Mr A's complaint has been raised with the staff responsible for advising advocate services in his case in a supportive way; and to staff involved in advising advocate services in cases such as this By: 22 December 2017

Introduction

1. Mr C (an advocate for Mr A) complained to my office about a number of issues relating to Mr A's discharge to a nursing home following an admission to Newton Stewart Hospital.

2. Mr C complained in particular about the length of time it took clinicians to tell Mr A that an operation was not going to be possible for him despite it being initially proposed. Mr C told us that, had Mr A known the operation would not be possible, he would not have allowed himself to be discharged to the nursing home. Mr C also told us Mr A had not been given the option to return home before being discharged to the nursing home.

3. Mr C told us that Dumfries and Galloway NHS Board (the Board)'s failings have had a detrimental effect on Mr A's physical and mental health in addition to significant financial consequences. Mr A has been charged for the nursing home costs for the full period he was there, November 2015 to July 2016, and has had to use his life savings and other assets in order to pay.

4. The complaints from Mr C I have investigated are that:

(a) the Board's decision to move Mr A from the hospital to a nursing home was unreasonable (*upheld*);
(b) it was unreasonable that the Board did not make it clear to Mr A before he accepted the move to a nursing home that he would be charged for his stay there (*upheld*);
(c) the Board's decision not to pay the nursing home charges themselves was not made in line with policy (*not upheld*); and
(d) the Board's delay in reaching a decision about Mr A's operation was unreasonable (*not upheld*).

Investigation

5. Mr C contacted the Board on 16 February 2016 appealing their decision not to consider Mr A for continuous care. A joint response from social work and the Board was issued on 11 March 2016. Mr C wrote again to the Board on 29 March 2016 raising a complaint about the handling of the matter and the Board responded on 31 March 2016. Mr C wrote to the Board once again on 6 April 2016 advising that he was progressing the complaint to this office. In that letter, he raised additional points of concern, which the Board responded to on 21 April 2016. Mr C brought Mr A's complaint to my office on 3 May 2016.

6. I and my complaints reviewer:

- considered Mr C's letter of complaint and supporting documentation carefully;
- reviewed a copy of Mr A's clinical records, the Board's complaint file and the relevant guidance[1];
- considered the Board's response to my complaints reviewer's enquiries with them; and
- obtained and considered independent advice from an adviser who specialises in care of the elderly (the Medical Adviser).

7. In this case, I have decided to issue a public report on Mr C's complaint because the circumstances of this complaint resulted in significant injustice to Mr A.

8. This report includes the information required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

9. Mr A has a complex medical history including problems swallowing food and liquids, and mental health issues. The difficulty swallowing is caused by an unusual condition[2], and one potential treatment initially discussed with Mr A was a surgical procedure on the neck bones to try and relieve the obstruction in his oesophagus.

10. Mr A was admitted from his home following a chest infection first to Galloway Community Hospital and then to Newton Stewart Hospital[3], on 6 July 2015 for rehabilitation. On 3 August 2015 a PEG tube was inserted to allow liquid feed and fluids to be given to maintain his nutritional and hydration needs. This tube 'bypassed' the obstruction and allowed Mr A to receive food and fluid in a safer and more consistent manner.

[1] Scottish Government (2015): Hospital-based complex clinical care; Scottish Government (2013): Guidance on choosing a care home on discharge from hospital.
[2] Disseminated idiopathic sclerotic hyperostosis – a condition whereby the bones in the neck grow forward and compress the oesophagus (feeding tube).
[3] A small community hospital that provides rehabilitation services for adults.

11. Mr A was discharged from hospital to a nursing home on 25 November 2015. Mr C told us it was Mr A's understanding that this move to a nursing home was due to the NHS making efforts to find a surgeon with appropriate skills and knowledge to carry out the specialised surgical procedure. Mr A said he was not made sufficiently aware of the financial repercussions of moving to the nursing home beforehand.

12. On 17 February 2016, a specialist surgeon (in another health board) decided that an operation was not a viable option. Mr A said he became aware of this at the end of March 2016 and social work started to consider alternative options for him. Mr A then learned how to use the PEG feeding system at this point, and he was discharged back to his home on 27 July 2016.

(a) The Board's decision to move Mr A from the hospital to a nursing home was unreasonable; (b) It was unreasonable that the Board did not make it clear to Mr A before he accepted the move to a nursing home that he would be charged for his stay there; and (c) The Board's decision not to pay the nursing home charges themselves was not made in line with policy

13. Mr C told us that:

- Board staff had told Mr A he must move into the nursing home to await an operation (from the NHS);
- Mr A had not been given the option to return home with an (NHS) funded care package;
- Mr A had not been encouraged to learn how to use the PEG tube feeding system, which would have helped him to have returned home;
- Board staff failed to explain clearly the financial repercussions of Mr A's transfer to the nursing home to him before the transfer;
- the Board failed unreasonably to arrange an advocate for him to help him throughout the discharge process because of his mental health issues; and
- Mr A's time in the nursing home should be considered as NHS continuing care because he was waiting for an NHS funded operation.

The Board's response

14. The Board noted Mr A had been admitted to Galloway Community Hospital following a number of falls at home. He had not been eating or drinking well in the days before his admission, and, on admission he had a

chest infection and was dehydrated. He was started on antibiotics and worked with physiotherapy to improve his mobility. He was transferred to Newton Stewart Hospital on 6 July 2015 as he began to improve, so that his care could continue closer to home.

15. Mr A had also been investigated for a number of years for dysphagia (difficulty with swallowing). During admission to Newton Stewart Hospital, he had a PEG tube fitted to help with his significant swallowing difficulties.

16. The Board maintained Mr A was physically fit for discharge from Newton Stewart Hospital and he could have, at that point, returned to his home with a care package in place. Nursing and social work staff noted that Mr A was not keen to engage with staff when they raised the possibility of going home. He felt that he would prefer to be in an environment where he would receive help and people would be around him, and that if he was at home he would not eat or take his medication properly.

17. The Board went on to explain that Mr A was unable to accept he would receive the same level of care from a care package in his own home as he would in a nursing home setting. Newton Stewart Hospital took his views into consideration and it was agreed that an assessment for a return to his home would be undertaken.

18. Following the assessment, Mr A was transferred to the nursing home. Details of staff's conversations with him about his discharge were recorded in social work documentation and Mr A's medical records.

19. The Board went on to say it was not the case that Mr A was discharged to the nursing home against his will on the basis that he was told he would get an operation to try and help his dysphagia. The Board clarified that he was discharged from hospital to the nursing home because he did not wish to return home when he had recovered and was fit to leave NHS hospital care.

20. The Board also stated that an operation was only ever a possibility. Due to the complex and unusual nature of Mr A's condition, this was not a procedure that could be performed by the Board. Therefore, a Board consultant surgeon explored possible options with colleagues in Glasgow and Edinburgh: this had no bearing on Mr A's transfer to the nursing home. According to the Board, the

decision on whether or not he would have an operation for his dysphagia was not a factor in his transfer.

21. Additionally, Mr A did not fit the criteria for NHS continuing care which would only be provided to a patient who required on-going care within an NHS facility, ie transfer from one NHS facility to another NHS facility. The nursing home was not an NHS facility, it was a private nursing home and therefore the Board maintained that Mr A was liable for the associated fees.

22. Mr A appealed his financial contribution to Dumfries and Galloway Council and the Board. The joint response from social work services and the NHS detailed each of the conversations with Mr A and his friend regarding options for returning home with a care package, his decision to be assessed for a nursing home placement, and discussion on financing costs. For example, it was noted that:

- at meetings with Mr A on 27 July 2015, 31 August 2015, and 7 September 2015 financial aspects of a care home placement were discussed by social workers.
- following discussion with Dumfries and Galloway Council's financial team, Mr A was told at a meeting on 30 September 2015 that he would be liable for the full cost of placement.
- a member of the financial team wrote to Mr A's friend on 28 October 2015 outlining, amongst other things, the weekly charge.

23. The findings of the joint social work and NHS appeal review were that both Mr A and his friend were aware of the cost implications of Mr A's transfer to the nursing home. It was accepted that whilst these conversations were well documented in his records, a written record should have been provided to Mr A and his friend to ensure their understanding of the situation.

24. The Board accepted this recommendation as a learning point that they should ensure communication with patients and their carers/representatives was clear and concise. This learning had been shared with local teams and with general managers and other directors across the Board as well as social work colleagues.

Relevant guidance

25. The relevant guidance is the Scottish Government (2015): Hospital-based complex clinical care (the 2015 Guidance); and Scottish Government (2013):

Guidance on choosing a care home on discharge from hospital (the 2013 Guidance). The 2015 Guidance states that:

> 'This new guidance is to make the clinical decision more transparent with the primary eligibility question simply being 'can this individual's care needs be properly met in any other setting than a hospital?' The outcome of this question needs to be discussed, documented and explained fully with individuals, families and carers.
>
> If, following a period of intermediate care, the specialist multidisciplinary team, in consultation with patient, family or carer, considers that the individual requires long-term care and support that cannot be provided at home or in alternative housing, they will move on to a care home as described in the Guidance on Choosing a Care Home on Discharge from Hospital ... In that situation, accommodation and non-health care costs will be liable to charging dependent on their personal financial circumstances.
>
> In line with the findings of the independent review and previous reports from [this office], it is vital that a comprehensive record of all aspects of the process and outcomes of any decision are recorded appropriately. It is important that patients, families and carers are involved throughout the discharge process and all options and decisions fully explained. They should be provided with clear written information about how hospital discharge procedures operate and what will happen if any on-going care of any sort might be required. This should include information on how to appeal the decision to discharge and the NHS Complaints Procedure. As with current medical practice, the patient is entitled to a second opinion. However, when a final decision has been reached that someone is clinically ready for discharge then there should be no delay. No individual has the right to choose to remain in hospital when there is no longer a need for in-patient care.'

26. The 2013 Guidance (on choosing a care home on discharge from hospital states) that:

> 'Information relevant to the discharge process, will be provided to the patient, family or proxy. This should be written in plain language, and in a format appropriate to the patient, and should clearly explain:
>
> Admission, transfer and discharge policy.

The local choice policy.
Why a home is the most appropriate place for the person to move to.
Why remaining in hospital is not an option.
The need to make realistic choices from suitable, available care homes.
Procedures for interim moves, if a home of choice is not available.
Any costs to the individual.
NHS and local authority complaints procedures.'

Medical advice

Assessment of Mr A's care needs

27. The Medical Adviser said the assessment of Mr A's care needs was a continuous process with some documented evidence of this throughout his admission. This showed staff concern about Mr A's ability to manage at home.

28. The specific assessment of his needs before his discharge from hospital was undertaken in Newton Stewart Hospital, where Mr A was receiving care in terms of rehabilitation and feeding[4]. The documentation of the discussions with him (provided by social work) included his needs and ability to return home (part of the assessment documentation). The hospital records of this process (specific assessment of Mr A's needs) showed frequent and detailed assessments of his physical health by doctors and his mental health by specialist psychiatric nurses.

29. These assessments showed that his physical health remained poor and that initially Mr A needed a Zimmer frame and two members of staff to walk safely. During his admission to Newton Stewart Hospital, the Board's surgeon discussed the prospect of surgery with colleagues in Glasgow and Edinburgh. The Medical Adviser said the available evidence indicated an active process of trying to determine if surgery was possible for Mr A. The multi-disciplinary team meeting records showed that they considered Mr A was fit for discharge on 26 August 2015 (and this multi-disciplinary team process was in line with the 2015 Guidance). The Medical Adviser also confirmed the primary responsibility for the decision to discharge Mr A from hospital would have been made by the clinicians caring for him and as part of the healthcare 'team' process.

[4] The Medical Adviser considered Newton Stewart Hospital as equivalent to the intermediate care settings described in the 2013 Guidance, as it performed a similar function to intermediate care units in other health boards

30. The Medical Adviser's view was that, in general, Mr A's care was good during this period and aspects of the discharge planning process were in keeping with guidance. There were several entries in the clinical records concerning Mr A's physical and mental health issues and healthcare professionals discussed his future with him several times. The Medical Adviser agreed that Mr A seemed to engage in these conversations in a way that suggested he had capacity for decision making.

31. However, none of these discussions documented the possibility of an operation changing his health to the extent he would be able to return home afterwards as he would no longer need nursing home care. This was at odds with Mr A's understanding of the situation, that he would be discharged to a nursing home to await an operation that would improve his health and allow him to return home.

32. The Medical Adviser stated that the nature of Mr A's condition, with some separate and on-going physical and mental health problems, would not be resolved by surgery alone to resolve a swallowing problem. This led the Medical Adviser to conclude that he would still have needed the same level of care even if his swallowing problems could have been addressed. This was because Mr A was already receiving nutrition via his PEG tube and the Medical Adviser could not see any specific health gain an operation would add.

33. The Medical Adviser said that this process was not documented sufficiently to show Mr A did not need hospital based complex care. However, it was also generally accepted that if staff believed an individual's needs could be met in a nursing home, then they clearly do not need on-going hospital care. The Medical Adviser was satisfied that staff discussed and explained to Mr A that his care needs could be properly met in a setting other than the hospital. Also, the Board's documentation, while it did not specifically refer to the 2015 Guidance, was sufficiently detailed to allow the Medical Adviser to determine that this was the correct interpretation of the guidance for Mr A's particular needs.

34. The Medical Adviser explained that the criteria for requiring on-going hospital based complex care were usually high levels of illness and disability. Although the Medical Adviser agreed that Mr A had complex problems, these were not at a level which would be above what could be provided in a nursing home. The potential need for an operation would not justify the need for on-

going hospital care particularly where the likelihood of an operation was low, as was the case for Mr A.

35. The Medical Adviser concluded the clinical team had provided good care by seeking all possible alternatives for Mr A. However, this appeared to have raised Mr A's hopes in an unrealistic manner. Having said that, during the process of discussing nursing home care the clinical records did not record significant discussion of the operation with him and the Medical Adviser's view was that this was not an overriding concern at the time. The Medical Adviser also concluded that the assessment of Mr A's care needs before discharge and the discussion about the lack of need for on-going hospital based complex care was reasonable as a result, and agreed that Mr A did not need on-going NHS care at this time. However, the Medical Adviser had significant concerns about other parts of the discharge process.

Discharge Process

36. The Medical Adviser was asked if there was evidence that discharge home with a (funded) care package in place (including personal care and district nursing care) was reasonably explored with Mr A.

37. The Medical Adviser responded that there was no evidence of a significant discussion of this possibility. Clinical staff believed that Mr A needed nursing home care, whatever the decision about a future operation, whilst Mr A believed he would only need a short period of nursing home care as an operation would allow him to return home. As a result, returning home was never seriously considered an option for him by staff and was not sought by him at this time.

38. The Medical Adviser noted that the possibility of returning home was initially and briefly discussed with Mr A, but that he was not initially keen on this. The issue clouding this process was the weight Mr A gave to the operation, its potential success and his subsequent ability to return home. Clinical staff were not as optimistic as he was about this potential for future improvement which is why they were so clear in their recommendation of a nursing home. They had concerns about his ability to manage home even before his hospital admission and his PEG tube was inserted. Managing a PEG tube at home required a high level of organisation, motivation and technical competence and staff felt that this would be beyond Mr A and did not make specific attempts to teach him this or to discharge him home.

39. It was the Medical Adviser's view that Mr A probably could have been discharged home with a care package in place, rather than discharged to the nursing home, particularly if more effort had been made to train him to use the PEG tube and inform him in more detail about the operation. It was hard to be absolutely certain, however, because healthcare professionals did not make these assessments.

40. Also, contrary to the 2015 and 2013 Guidance, the Medical Adviser found no evidence that Mr A was provided with clear written information about the discharge process, all options and decisions or how to dispute the decision to discharge him if he was uncertain or unhappy. This was common where staff assumed a person was happy with the process but made it difficult to defend the decision when there was a subsequent dispute because of lack of evidence. On the basis that Mr A was not provided with written information about the discharge process contrary to the aforementioned guidance, the Medical Adviser said that his care was not reasonable.

41. Turning now to whether healthcare professionals should have compiled a care plan in relation to Mr A's discharge; the Medical Adviser said the discharge plan for Mr A's care needs would have been described by ward staff at the time he was transferred to the nursing home, but there was no evidence of a final discharge care plan in the clinical records. The records of nursing, medical and other healthcare professionals prior to discharge were all consistent with NHS care standards and, other than the failings already identified, the discharge process in terms of transferring his care was likely to have been reasonable but as there was no care plan it was difficult to judge this with certainty.

42. In relation to advocacy; the Medical Adviser agreed Mr A had the right to an advocate if he wished and noted this was not requested by him or offered by the Board. Board staff felt that he was capable of making his own decisions with the support of family and friends, which was usually why advocacy is not required.

43. However, the Medical Adviser was concerned about a note by one of the ward nurses. This was made in response to hearing a conversation between Mr A and another person. The content of the conversation related to his will and inheritance and the note indicated that staff had concerns about the involvement of the other person. Given Mr A's mental health issues, staff concerns about the involvement of the other person and the magnitude of the

decisions he was making, it was the Medical Adviser's view that staff should have offered him advocacy services to help support his independence and decision-making. The Medical Adviser considered that his care fell below the level Mr A could expect and was unreasonable as a result.

44. The Medical Adviser noted the uncertainty about Mr A's decision-making - documented in a record by his community psychiatric nurse - which further cast doubt on his ability to make an informed decision.

45. The Medical Adviser reiterated that despite Mr A's significant physical and mental health problems, he did not receive written information about the discharge process and he was not offered an advocate to help. The Medical Adviser found that staff were not as optimistic as he was about the likelihood of a successful operation and return home, but they allowed his optimism to go unchallenged and as a result caused this optimism to be reinforced.

46. The Medical Adviser went on to say Mr A had received some information about the costs in the form of a financial assessment, but noted this document was very technical. It contained phrases such as 'capital over savings limit' without explaining what this meant and abbreviations such as 'CRAG' which were not explained. This did not meet the criteria of written information (in line with the 2013 Guidance) and a reasonable person would not be clear from reading this letter what financial liability they were being exposed to.

47. In addition, there was evidence that social workers shared the same view as Mr A that the placement was likely to be temporary on the basis that an operation may reverse things. Therefore, social work and the information they provided reinforced Mr A's over optimistic view of the temporary nature of his placement in a nursing home. This was particularly pertinent in this case given the capital value applied to land Mr A owned but which now the social work department recognised would be difficult to sell. They also recognised that this may mean Mr A would incur debt. The word 'debt' was not used in information given to Mr A even though social work staff were clearly aware of this potential outcome for him.

48. Given this potential difficulty and uncertainty for Mr A, which social work clearly foresaw, it would have been reasonable for them to take greater steps to ascertain how likely an operation would be and how likely his return home afterwards would be. The main opportunity to clarify this seemed to have been

at a meeting on 19 November 2015 between Mr A, social work and ward staff where it was noted that 'the costs were fully discussed and it was suggested that the debt to the council would initially be paid from selling the premium bonds and may be at a later date, the house and the land; although this might not be required depending on the outcome of the surgery'. Mr A was subsequently discharged on 25 November 2015.

49. The Medical Adviser said both the Board and Mr A highlighted the parts of the case that supported their own conclusions but that this was more marked for the Board and it was important to note the Board had a duty of care to Mr A. The lack of written information about the discharge process (highlighted in the 2015 and 2013 Guidance) would have been a crucial piece of information to judge how much Mr A knew. In the absence of this information, it was reasonable to assume that Mr A's optimistic view of his potential operation and return home was allowed to persist longer than it needed to.

50. The Medical Adviser said that Mr A should have been specifically told at the time of discharge that an operation may not be possible or successful. Mr A should also have been told his other physical and mental health conditions were additional factors staff were using to recommend nursing care for him. In their own records, clinical staff described his placement at the nursing home as temporary on 19 November 2015, so it was understandable Mr A also took this view.

51. In the final notes before his discharge, medical staff also noted that he had seen the surgeon but medical staff doubted if they would operate and they also noted that Mr A was worried about the financial implications of this discharge to a nursing home. Board staff therefore appeared to have reinforced his belief in the temporary nature of his placement in the nursing home and had awareness of his financial concerns while at the same time they were aware that the operation was unlikely.

52. The Medical Adviser went on to say Mr A had appealed against the Board's decision that he did not meet the criteria for hospital based complex care (and outcome). This was on the basis that he was waiting for the NHS to arrange an operation that would have seen him fit to return to his home. The Medical Adviser reiterated that such an operation, even if it could have been performed, would not have provided this level of certainty given that operations could be unsuccessful or conditions could re-occur.

53. The Medical Adviser noted that the joint response (of social work and the Board) rejected his appeal but did not specifically address the issue Mr A had raised of his need for continuing care for which the NHS should bear the cost. On 19 November 2015, it was noted (in a meeting between Mr A, social work and ward staff) that he was fit to be discharged from hospital. The Medical Adviser said, on balance, when clinical staff determine that someone is fit for discharge from hospital they are implying that they do not need on-going hospital care.

54. The Medical Adviser also explained there was never a clear plan for an operation or a date proposed. The issue of him returning home and using a PEG tube managed by himself was discussed and staff had determined he would not be able to manage this process himself (and that this concern was shared by Mr A). There was also evidence that Mr A was made aware of some of the financial obligations of the move in meetings with him and staff made some efforts to make sure he understood this. If Mr A had been so clear about his plans to return home after an operation the Medical Adviser would have expected implications of the move (such as having to use assets such as land and premium bonds) to feature in the discussions and financial plans, but there was no evidence of this. The Medical Adviser would also have expected discussions of the potential for an operation to be unsuccessful by clinical staff given the very specialist difficult nature of the problem, but there was no evidence this had been raised by Mr A or discussed with him by staff.

55. The Medical Adviser said staff and Mr A had discussed the potential for him to return home after his operation and they were clearly using the word 'if' in relation to his operation and not when. The main issue in this case was that although social work staff made some efforts to explain the funding arrangements, the issue of the likelihood of a successful operation did not undergo a similar level of scrutiny by healthcare staff. Mental health staff had already noted Mr A's over optimistic assessment of his ability to manage home without a care package and on 21 July 2015 they reminded him of his inability to manage his medication (and his broken fridge).

56. In conclusion, the Medical Adviser said there were five main areas of concern, which were the responsibility of the healthcare team:

- Board staff allowed Mr A to retain an optimistic view of his future including an operation and the ability to return home when healthcare professionals believed and documented that the operation was unlikely.
- Board staff failed to provide Mr A with clear written information about the plan to go to a nursing home and implications of this.
- Board staff failed to arrange an advocate to help Mr A through the process, particularly given the factors outlined above and his underlying mental health issues.
- There was a lack of action by Board staff following their concern about his will being discussed.
- There was inadequate consideration of the financial welfare of Mr A and his future.

57. Overall, the Medical Adviser said Board staff had the primary responsibility to ensure Mr A was in a position to make an informed decision about his discharge. The unusual feature of this case, the potential operation, and information about this (both to Mr A and social work) was solely within the responsibility of Board staff.

58. There was no evidence provided to justify the need for NHS care or for the NHS to pay for his care on the basis of his clinical needs. However, the Medical Adviser considered that in view of the above failings and because Mr A should have been specifically told when he was discharged that an operation may not be possible or successful (and should not have had to wait until February 2016 to learn the likelihood of this) then his nursing home fees should be reimbursed.

59. The Medical Adviser said the Board should:
- review how written information is provided as part of the 2015 Guidance,
- review the promotion of advocacy services in Newton Stewart Hospital
- reimburse Mr A's nursing home fees.

(a) Decision

60. Mr A complained the Board's decision to move Mr A to a nursing home was unreasonable.

61. In reaching my decision on this part of Mr C's complaint, I have considered: (i) whether the decision to discharge Mr A was reasonable; and (ii) whether the way Mr A was discharged was reasonable In doing so, I have

taken into account Mr A's clinical records; the advice I have received, and the 2015 and 2013 Guidance (see paragraphs 24 and 25).

62. Turning first to whether the decision to discharge Mr A was reasonable, I accept the advice I have received that Mr A's needs on discharge were such that he did not require hospital based complex care. In these circumstances I consider the decision to discharge was reasonable. However, I have significant concerns about the way in which Mr A was discharged.

63. As the Medical Adviser highlighted, there was no evidence the option of discharge home with a care package was reasonably explored with Mr A. I also note the evidence that clinical staff believed Mr A required nursing home care, and Mr A agreed but believing that he would be able to return home after a short time following an operation. It is my view that Board staff failed to ensure Mr A had all the information he needed to make an informed decision about discharge, including that they were taking into account his other physical and mental health conditions when they recommended nursing home care.

64. I accept that some financial information was given, but the Board failed to follow the relevant guidance and provide clear written information about the plan to go to a nursing home, including the financial implications of this (I address this in more detail under the decision on complaint (b)). This, together with the failure to provide an advocate, leads me to doubt strongly that Mr A understood properly the proposed discharge to a nursing home and its implications. Therefore, on the evidence available, I conclude that he was not fully informed in line with the relevant guidance.

65. I also agree with the Medical Adviser that the Board let Mr A retain an overoptimistic view about the potential of an (NHS funded) operation to improve his health when clinicians considered this was unlikely. The Board's failure to adequately document and explain to Mr A the clinicians' view that the operation was unlikely to be carried out was significant; especially given the Medical Adviser's advice that it was the Board's primary responsibility to ensure Mr A was in a position to make an informed decision. The Board provided no clear evidence that clinicians properly discussed with Mr A how his clinical needs could be met at home.

66. This leads me to conclude that Board clinicians failed unreasonably to give Mr A sufficient information to properly understand what he was deciding, and

also missed an opportunity to consider and discuss discharge home with Mr A in any detail, contrary to the 2015 and 2013 Guidance.

67. In cases where I find maladministration that has caused injustice to an aggrieved person, my primary objective is to put the aggrieved person in the position he or she would have been in, had the maladministration not occurred in the first instance (where it is possible).

68. The circumstances of some of the complaints we receive mean it is not always possible: this complaint is one such case. It is not possible to determine definitively what the outcome would have been had the failings not occurred, although I am clear that it cannot be said with certainty, on the facts available, that at the time Mr A would have gone into the nursing home. Therefore, in coming to a decision on redress in this case, I have carefully considered the financial implications of the decision making. While the Board's decision to discharge Mr A was a reasonable clinical decision (in that he was medically fit to be discharged), I am extremely concerned the Board failed to follow the guidance and provide Mr A with written information about the discharge process including all options and decisions, and challenge his optimistic view of an operation.

69. The 2015 guidance is clear that all options should be considered and the outcome and the process fully explained to the patient; family and carer. My investigation has established that all options were not fully considered and the option of returning home with a funded care package was not fully explored. Neither was Mr A fully informed prior to reaching a decision as he should have been. While the Board have indicated Mr A was clear he did not want to return home, had he been fully informed that the possibility of an operation was unlikely, as he should have been, Mr A has advised he would not have allowed himself to be discharged to the nursing home. I consider these are significant failings.

70. The failure to follow the 2015 and 2013 Guidance and all that flows from that leads me to conclude that the Board's actions were unreasonable. Taking this into account, I uphold the complaint and make a number of recommendations at the end of this report to address the failings identified.

71. In relation to financial redress, I appreciate Mr A feels strongly that he should be refunded all of the nursing home costs. On the other hand, there is

evidence to suggest he was reluctant to return home and it is not clear what decision he would have made had he been fully informed.

72. However, in recognition of the impact the failings had on the outcome for Mr A in that a potential opportunity for Mr A to be discharged home (with a funded care package) was missed, I recommend that the Board apologise to him and cover the costs of the nursing home fees he has paid for the time he was in the nursing home. This is because I have been unable to establish with any certainty that had the appropriate guidelines and processes been followed the outcome would have been Mr A's discharge to the nursing home.

(b) Decision

73. Mr C complained the Board failed unreasonably to make the financial implications of moving to a nursing home clear to Mr A.

74. While there was evidence of some discussion with Mr A about the financial implications, it is clear that there was a lack of clear written information about this, which is a significant failing. The Medical Adviser noted that staff failed to offer Mr A advocacy services, which was unreasonable, particularly in light of his mental health issues and staff concern following the discussion about his will. I agree. Also, as I indicated above, the advice I have accepted is that Board staff allowed Mr A to retain an optimistic view of his future about an operation and ability to return home.

75. In reaching my decision on this complaint, I have considered the medical Adviser's advice that the Board had a duty of care to Mr A. I accept that advice, and I am satisfied the evidence indicated clear failings by the Board in supporting an adult with mental health problems and who had no advocate during a complex and uncertain time, with extremely significant implications. I uphold the complaint.

(c) Decision

76. Mr C complained the Board's decision not to pay the nursing home charges was contrary to the guidance on hospital based complex care. Clearly, the Board maintained that Mr A was fit for discharge and so the decision not to pay the nursing home charges was reasonable. While I have determined that there were significant failings in the process, the advice I have accepted is that Mr A did not require on-going hospital care. In the circumstances, I do not uphold the complaint.

(d) The Board's delay in reaching a decision about Mr A's operation was unreasonable

77. Mr C said the delay in reaching a decision about Mr A's operation was unreasonable and he would never have moved to the nursing home if he had been made aware that his operation was not going to go ahead. Had the decision on the operation been taken earlier, provision would have been put in place to allow Mr A to move home with a care package and he would have learned how to use the PEG feeding system earlier.

The Boards response

78. The Board accepted that it took several months to reach the decision that surgical intervention was not an option and the Board apologised for the distress and anxiety this caused Mr A.

79. The Board's consultant surgeon was hopeful that some surgical procedure could be performed which would help Mr A's condition and consulted with colleagues to ensure that all possible options were explored. The correspondence between the consultants, Mr A's GP and Board consultant surgeon noted that Mr A's condition was unusual and complex and the consultants in Edinburgh therefore required further tests and conversations with their colleagues in order to reach a decision on whether or not to operate.

80. In the end, the decision not to operate was made with Mr A's best interests and safety in mind: the video fluoroscopy showed that he had lost significant sensory awareness of fluid at the superior airway meaning that if he aspirated fluid he was not demonstrating the reflux to cough and clear the airway. Therefore, the operation to remove the mechanical obstruction alone would not have addressed this issue, and it was not feasible to put Mr A through the operation.

81. It took several months to reach this decision but the Board considered there was no delay on the Board's part in instigating the referrals out with their area to Glasgow and Edinburgh. Unfortunately, appointment times for consultations and tests were out with their control although they were confident that thorough investigation and consideration was given to all possible options and a decision was made in Mr A's best interests.

Medical advice

82. The Medical Adviser's view from the evidence of the clinical records was that staff had indicated to Mr A they would seek the opinion of specialist but there was no guarantee the procedure would be performed given the complex and specialist nature of the operation. The Medical Adviser said the lack of guarantee is what most people would expect in a process such as this. By 17 February 2016, it was clear that an operation was not going to be offered to Mr A. Given the specialist and complex nature of this, it was reasonable for this decision to take as long as it did. The Board's surgeon emailed the surgeons regularly and worked hard to try and achieve this outcome for Mr A. However, it appeared they had raised his hopes about the process and this led to changes in his thinking and decision-making.

(d) Decision

83. Mr C complains the Board delayed unreasonably in reaching a decision about Mr A's operation.

84. It is clear Mr A feels strongly that if the decision not to operate had been considered and made sooner, then he would not have stayed in the nursing home as long and been charged for the costs. The advice I have accepted is that the operation was specialist and complex and given this, it was reasonable for the decision to take as long as it did and that there was no unreasonable delay by the Board's surgeon. In light of this, I do not uphold the complaint.

85. The Board have accepted the recommendations and will act on them accordingly. We will follow up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Recommendations

What we are asking the Board to do for Mr A:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a) and (b)	The Board failed to take all reasonable steps to ensure Mr A was in a position to make an informed decision about the move to a nursing home, in line with the guidance, and an opportunity for discharge home was missed	Cover the costs of the nursing home fees Mr A has paid for the time he was in the nursing home on production of an invoice or receipt (or other evidence it was paid). The resulting payment should be made by the date indicated: if payment is not made by that date, interest should be paid at the standard interest rate applied by the courts from that date to the date of payment	Evidence of payment By: 22 January 2018
(a) and (b)	The Board failed to take all reasonable steps to ensure Mr A was in a position to make an informed decision about the move to a nursing home, in line with the guidance, and an opportunity for discharge home was missed	Apologise to Mr A for failing to ensure he was discharged in a reasonable way and, in particular, in a position to make an informed decision about the move to a nursing home. The apology should comply with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 22 December 2017

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	Staff failed to follow elements of the guidance on choosing a care home on discharge from hospital and hospital-based complex clinical care to ensure Mr A was discharged in a reasonable way	Staff should comply with the relevant guidance when arranging discharge	Evidence the guidance has been raised with relevant staff, and that staff are complying with the terms of the guidance. This could be via an audit, undertaken regularly, to evidence compliance By: 22 January 2018
(a) and (b)	Staff failed to provide clear written information in line with the hospital-based complex clinical care guidance about discharge to Mr A to ensure Mr A was discharged in a reasonable way	Staff should ensure information is provided as part of the hospital based complex clinical care guidance	Evidence that the process relating to the provision of information has been reviewed to ensure it complies with guidance By: 22 January 2018

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a) and (b)	Staff failed to offer advocacy service to Mr A to ensure he was in a proper position to make an informed choice about his discharge	Staff should ensure patients are offered advocacy services where appropriate	Evidence Mr A's complaint has been raised with the staff responsible for advising advocate services in his case in a supportive way; and to staff involved in advising advocate services in cases such as this By: 22 December 2017

Explanation of abbreviations and terms used **Annex 1**

disseminated idiopathic sclerotic hyperostosis	a condition whereby the bones in the neck grow forward and compress the oesophagus (feeding tube)
dysphagia	difficulty or discomfort in swallowing
Mr A	the aggrieved
Mr C	the complainant, advocate for Mr A
PEG tube	A tube placed through the skin directly into the stomach to bypass the blockage in his oesophagus
the Board	Dumfries and Galloway NHS Board
the Medical Adviser	a consultant in care of the elderly who gave independent advice on this case

List of legislation and policies considered **Annex 2**

Scottish Government (2015): Hospital-based complex clinical care

Scottish Government (2013): Guidance on choosing a care home on discharge from hospital