



Annual report  
2019, the Health  
and Social  
Services  
Ombudsmen

## Foreword

Our life expectancy is constantly on the rise. Some of us live healthily for longer while others live longer but suffer from health problems and need more help. We are also witnessing major changes in available treatments. The use of gene technology, artificial intelligence and medication customised to the individual represent challenges in terms of organisation of the health services and current patient rights. New treatment methods are developing at a rapid pace. Some of these methods can be purchased from private health services or abroad, but are not offered by the national health service.

In the summer of 2019, the Norwegian Board of Health Supervision stipulated that it would be unjustifiable to refuse follow-up of treatment provided by a private health service, even if the treatment was not offered by the national health service. This resolution was followed up in a directive from the Ministry of Health and Care Services in October, providing guidelines for such decisions. In our role as Health and Social Services Ombudsmen, we have been and remain concerned that this may result in a split in the health services. Opinions on the issue vary.

One further concern is whether decisions relating to introducing treatment at group level will result in patients of a nonconforming age or who have unusual diagnoses not receiving life-saving treatment.

The role of the Ombudsmen is to safeguard the rights and interests of individuals and at the same time help ensure improvements to the quality of health services. This requires good dialogue, both with those receiving and those providing health services, while critically monitoring the services for errors and faults. It is a fine line to walk, not least when treatment that will benefit one individual may result in a poorer health service for others. This is a matter of prioritisation, and represents the most important and most difficult challenge for all parties involved in the welfare state - from nursing home employees to the Norwegian Storting. We must all be vigilant to prevent prioritisation for those who make their voices heard the most, those with the best network, the strongest health and social services organisations, the strongest relatives and the best contacts in the media.

The Health and Social Services Ombudsmen's annual report is not a status report about health and care services. The majority of us have access to good health services. The experiences are primarily important for identifying weaknesses and improvement potentials.

Please read our annual report, listen to what the patients, users and relatives have to say about their experiences and contact us if you would like more information!

Oslo, 21 February 2020

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## Issues and recommendations in the annual report for 2019

The report presents a selection of issues that the Health and Social Services Ombudsmen want to highlight. The issues have been selected as they are deemed relevant at a nationwide level. To read more about experience gained during work in the individual Ombudsman offices, please refer to the local annual reports.

Below is a list of recommendations and issues detailed in the report.

- The Ombudsmen call for improved information and participation in the design of services. Health-related competencies are a requirement for user involvement. This requires information – with an interpreter present for some.
- The GP programme requires modernisation.
- Increased competencies relating to case administration and complaints management is required.
- Rehabilitation – described by many as secret services. Information about the services requires improvement.
- Inadequate interaction represents a threat to patient safety and could have expensive consequences.
- Transport is become an increasingly important part of the health services. Transport requires better planning, based on the patient's requirements.
- The reporting requirement represent a risk for patient safety. Does the reporting requirement for zero patients in corridors result in improvements for the patients? Individual cases and the introduction of inspection reports show that being admitted to the “wrong” ward represents a risk to patient safety.
- Are the steps too high on the municipal health and care ladder?
- User-controlled personal assistance – a programme with undesired variations.
- Services offered to the mentally ill and addicts – are we doing enough and are we taking the right measures?
- The right to free dental health care is for many a hidden secret. Information requires improvement.

## About the Health and Social Services Ombudsmen

The Ombudsmen are mandated to safeguard the needs, interests and rights of patients and service-users vis-à-vis the national specialist health service and the municipal health and care service. As of 1 January 2020, the Ombudsmen were assigned an extended mandate to also cover the public dental health service. The Ombudsmen shall contribute to improving the quality of these services. Norway is served by 15 Health and Social Services Ombudsmen offices staffed by a total of approximately 80 employees.

The Ombudsmen's work is characterised by close and direct contact with patients, service-users, relatives and service-providers. The Ombudsmen also work actively to raise awareness of patients' and service-users' rights and the Ombudsman service among the general public and for employees in the health and care services in particular. By participation in the health trusts' quality committees, attending meetings with politicians, managers and employees in the municipalities, we are able to share experience gained from our work, to benefit patients and service-users.

## Number of inquiries

In 2019, as in previous years, we received just over 15,000 new inquiries, specifically 15,116 inquiries. In 73 per cent of these inquiries, the service provider was disclosed. Of these, 59 per cent applied to the specialist health service and 41 per cent were linked to the municipal health and care services. 18 per cent of the cases did not relate to a specific service-provider, e.g. general inquiries concerning patient rights. Eight per cent of inquiries dealt with topics outside of our mandate, such as NAV (the Norwegian Labour and Welfare Administration).

## Causes of the inquiries

More than half of the inquiries involved dissatisfaction with the actual performance of the service, such as delayed diagnosis, uncaring treatment, questions relating to incorrect treatment, patient injuries, interaction difficulties and patient care pathway failures, referrals that are inadequate or delayed, inadequate information, communication and language problems.

Of all the inquiries, 28 per cent involved breach of patient and service-user rights such as denied applications for services, questions regarding access to medical records or lack of patient/service-user involvement and information.

17 percent of the cases concerned organisation and routines, disorder and inefficiencies, long waiting time, lack of availability, inter-service coordination, lengthy case-handling times or deficient case-handling.

## Common focus area for all Health and Social Services Ombudsmen offices

The Health and Social Services Ombudsmen decided that all offices shall have mental health work in the municipalities as a special focus area for 2019. The Health and Social Services Ombudsmen offices have focused on those services the municipalities provide/do not provide/should have provided to

patients suffering from mental disorders, and the interaction between the municipalities and the specialist health services for this group of patients.

A special report on this is planned for publication.

## The Ombudsmen call for improved information and participation in the design of services.

Deficient or defective information is an element in very many of complaints lodged with the Ombudsmen. These failings occur in dealings with both the specialist health service and the municipal health and care service.

Patients and service-users have a statutory right to involvement in the provision of health and care services. This requires adequate and customised information.

Information is also required before you have actually become a patient. Many local authorities send out brochures by post to citizens to describe the standards they can expect from their local authority when it comes to technical services such as snow clearing, water supply and sewage. Local authorities should similarly inform citizens about health and care services.

Language and understanding language are essential for proper treatment. The Health and Social Services Ombudsmen are aware that budgetary constraints are used to justify non-provision of interpreting services. Other topics are a lack of procedure for booking an interpreter, the lack of availability of local interpreting services and poor quality of interpreter services, and these inquiries also come from the employees in the services.

Many organisations still lack information when something goes wrong. We meet patients and relatives who are left feeling uncertain and with unanswered questions. This creates unnecessary stress. A positive conversation can provide necessary explanations and show that the service is taking the incident seriously and is working to prevent re-occurrence. During such conversations, the employees of the services can also provide statutory information regarding the right to notify the Norwegian Board of Health Supervision, issue complaints to the County Governor, to contact the Health and Social Services Ombudsmen and to claim compensation. Our experiences show that such conversations are also beneficial for healthcare personnel. Undesired incidents have an effect on us all.

## The GP programme requires modernisation

Of the 2,000 inquiries issued to the Ombudsmen about the GP programme in the previous year, the main content related to quality, continuity and availability.

An increasing number of people do not have a fixed GP. The positive aspects of the GP programme are challenged by problems with recruitment and use of temporary staff. The positive aspects of the programme are having the same GP for a long period of time. Most agree that we need more GPs, but the programme also faces other challenges. The results of the pilot tests of the primary health team will be of major interest. In addition, employees with administrative responsibilities will be able to have more time to work with patients. Funding schemes must be put in place to support this development.

In efforts to ensure more efficient and a higher quality clinical pathway, interaction between GPs, hospitals and the home care service must be reinforced, for example by using joint video consultations where appropriate. In addition, the process to improve the quality of referrals must continue.

The municipalities must assume more responsibility for monitoring the work conducted within the GP programme – not in relation to the individual patient but in monitoring the GP regulations and other quality-related work.

### **Increased competencies relating to case administration and complaints management is required.**

The right to issue complaints shall help ensure patients and service-users equal services, irrespective of who you are and where you live. This is currently not the case, for numerous reasons.

In the municipalities, we have observed that problems may emerge as soon as a need is reported. It is not the case that everyone is provided with information on the different services and application procedures. There still remain cases where persons receive incorrect advice and guidance. The next stage of the process is when applications for services are rejected, and the applicant wants to appeal. In such circumstances, we have also registered cases where the person is advised or guided not to appeal. In cases where a person has applied, a decision has been made and appealed, it is our experience that the level of knowledge regarding appeals management is poor. This is evident both in the municipalities and the health trusts.

There are cases where the original decision is reversed without the introduction of any new information. What does this mean? That the service wants to avoid further processing of the complaint? Or does it imply that the original decision was based on insufficient grounds? Both give grounds for concern. Not least as they indicate that a much higher number of persons could have appealed and been granted their application. Numerous persons do not appeal, even if they disagree with the decision. In our experience, this may be because they do not have the energy to appeal or that they do not have the necessary competencies relating to health matters. Again, both explanations give grounds for concern.

With appeals where the service maintains its original decision, the service is responsible for ensuring that the decision is submitted to the supervisory authorities for review. This allows for an external judgement of the service's own assessment of the case. There are failures in this procedure also. We have observed cases where an unnecessarily long period of time passes before the case is submitted to the County Governor. A specific deadline for case processing will help change this.

The case processing time with several County Governors is also in part very long. Cases regarding patient and user rights, appeals involving rights, shall be processed at the latest within three months. We regularly experience that this process can take from six to 12 months. At some of the merged county governor offices, we have also observed an even longer case processing period than before. Lengthy processing of cases is a threat to both patient safety and rule of law for the patients and service-users.

### **Rehabilitation – described by many as secret services. Information about the services requires improvement.**

The regulations regarding rehabilitation in the specialist health service and in the municipalities are not the same, and knowledge about the regulations is insufficient. It gives grounds for concern when

patients who have been granted rehabilitation say that they requested it personally and were not offered it as a service. Rehabilitation was the result of their own initiative. What happens to those who do not request rehabilitation?

The Ombudsmen continue to hear that there are insufficient resources for rehabilitation in both the specialist health service and in municipal primary care. Great disparities persist in the local authority rehabilitation service, which is often characterised by a long waiting list, a shortage of physiotherapists and occupational therapists, and rehabilitation programmes which appear to be the bare minimum for each individual. We receive reports from patients who feel that they have lost their potential for maximum recovery because the waiting time for rehabilitation was too long. This has consequences for the patient's future health and function and is disadvantageous for social economics. It is important to remember the patient's right to necessary health care also when it comes to rehabilitation.

### **Inadequate interaction represents a threat to patient safety and could have expensive consequences.**

Inadequate interaction is a threat to patient safety and for the experience of safety and predictability. We also observe poor utilisation of the total resources in the health and care services.

The purpose of patient pathways and the establishment of pathway coordinators is to ensure better organised and more predictable clinical pathways. Not all cases can or shall follow patient pathways, but the method applied is relatively similar. Coordination of the different services in a pathway is necessary, and it must not be left up to the patient or relatives to ensure coordination.

Various schemes have been established to ensure better coordination; hospital coordinators, municipal coordinators, pathway coordinators and individual pathways. Nonetheless, a high number of inquiries to the Ombudsmen mention coordination problems as a particular challenge – coordination between hospital departments, between hospitals, between municipality and hospital and internally in a municipality.

We receive complaints from the municipalities and GPs relating to poor and delayed epicrisis from the hospitals. The hospitals issue complaints relating to inadequate referrals. Changes are made to medication lists for patients without all persons responsible for medication being informed. **It is essential to establish medication reconciliation for patients.**

Not all hospitals have established a pathway coordinator programme. One patient was asked: "*Oh, am I your pathway coordinator? I was not aware of that, and I don't have time for it either.*" Another patient had three pathway coordinators but no coordinator. Who then should safeguard the integrity of the patient pathway?

One patient questioned why the hospital was not more concerned about their own organisation – in the best interests of the patient but also for the many doctors who treated the same patient, and who all had to independently uncover information on what had happened since the last time the patient had received treatment. The patient recalled:

*"I've been receiving treatment and check-ups at an outpatient's clinic for cancer for more than one year. Over the past 15 months, I have been in contact with seven different doctors. The department has apologised for not being able to provide my treatment with a pathway coordinator. After I received a new appointment where I could see that I would have to be met by yet another new doctor, I contacted the department. I was surprised to find that there was no problem changing over to the doctor I had seen on my last consultation. I gained the impression that there was a lack of a system where patients were assigned to one fixed doctor."*

Patients are discharged with insufficient information about how to follow-up on their hospital admission. Patients are transported home from hospitals at times of the day that are in breach of agreements entered into with the municipalities.

The Health and Social Services Ombudsmen are calling for more flexibility and willingness to cooperate about and with patients across all levels of the services. One prerequisite is that the funding schemes support such cooperation, that efforts targeting digital systems for coordination are intensified – not only for one patient or one journal but also use of e.g. video consultations between patient, GP and the home care service or specialist – and that the attitudes of employees towards coordination are reinforced.

### **Patient transport is becoming an increasingly important part of the health services**

Patient transport is becoming an increasingly important part of the total health services. Increased specialisation requires treatment by different hospitals and an increased requirement for transport between and to/from the hospitals. Well-organised transport is absolutely essential in ensuring good and appropriate patient pathways.

We hear stories of patients, often elderly patients, being sent home from the hospital during the night. Everyone views this practice as disgraceful, yet it still happens. The most frequent explanation is that there was no transport capacity at any other time of the day – an unacceptable explanation. Organisation and prioritisation for patients require review.

Patients report very different experiences of patient transport. The requirement for transport is assessed differently, depending on the doctor you meet, the waiting time is long and the option to have an escort is assessed differently.

For the citizens of North Norway, 2019 was a particularly difficult year. A new air ambulance provider won the contract for air ambulance services, and numerous problems occurred, with delays caused by training for crew, aircraft unable to land on the short take-off and landing runways, technical faults in the aircraft and employees on sick leave. The situation was continuously monitored by the Northern Norway Regional Health Authority (Helse Nord RHF), and extra resources were recruited, with helicopters. Nonetheless, patients can report experiences that show that emergency preparedness has been insufficient, and the County Governor has opened several supervisory cases as a result. The Ombudsman has also received feedback from relatives relating to incidents that are censurable. Access to treatment and health care for persons who fall ill is vital. No matter where we live in Norway, we all have the right to health care. Problems reported recently have caused anxiety and worries for many.

## The reporting requirement represents a risk for patient safety

Hospitals regularly have to place patients in corridors due to lack of space and logistic problems, despite the requirement for zero patients in corridors in their mandates. This situation is unsatisfactory for the patients and a challenge for healthcare personnel. At the same time, the only other option – admitting the patient to a different ward – is not merely a good solution to the problem. A study in Sweden has shown that such practice increases the incidence of patient injuries. Moving patients to different wards also occurs in Norway, and was reported as a special risk area in a memorandum for learning from the Norwegian reporting scheme in 2016. The County Governors are currently conducting a nationwide audit of the hospitals' somatic wards in this regard.

The Health and Social Services Ombudsmen receive inquiries relating to both placing patients in corridors and in the “wrong ward”. In the choice between a bed in a corridor or a bed in a satellite ward, many actually seem to prefer the corridor to the “wrong ward”. From the perspective of the Ombudsmen, neither solution is optimal. Several questions have to be asked. Can the situation be explained by the fact that patients spend too much time in hospital due to lack of capacity in the municipality to care for them, or is the reason that the individual wards do not have the necessary capacity for beds?

## Does work to improve quality actually have an effect and lead to a reduction in undesired incidents?

The work to ensure patient safety is governed by the Regulations relating to management and quality improvements in the health and care services. Put simply, this involves the organisation's duty to

PLAN – IMPLEMENT – EVALUATE – RECTIFY

The organisations make use of various options to work on patient safety, such as use of reported nonconformances, work with quality committees/councils, target areas from the Patient Safety Programme, Global Trigger Tool, user surveys, specific complaints or feedback from patients, service-users and relatives and from the Health and Social Services Ombudsmen, internal nonconformance reports, “Si din mening” (Tell us your opinion), incident analyses, decisions by the County Governor and by the Norwegian System of Patient Injury Compensation (NPE).

Does this quality work result in improvements to patient safety?

Relatively stable high figures are registered for the share of patient injuries at Norwegian hospitals. In 2018, records showed 11.9 per cent patient injuries during hospital admissions. We lack corresponding data about the scope of such injuries for the municipal health and care services.

The Norwegian System of Patient Injury Compensation (NPE) recently conducted a survey to identify the level of conformity between cases where the patient received compensation from the NPE due to unsatisfactory treatment, and cases reported in the nonconformance systems at the hospitals. The purpose of the survey was to determine whether injuries caused by unsatisfactory treatment and accepted by the NPE for compensation can be found as registered nonconformances in the local reporting systems. The survey uncovered relatively high irregularities between the different hospitals included in the survey (correlation between 19% and 59%). On average, a correlation could be found between compensation cases and registered nonconformances for 33% of cases, ref.

<https://www.npe.no/no/Om-NPE/aktuelt/33-prosent-av-npe-saker-blir-funnet-igjen-i-sykehusenes-meldesystemer/>

On the basis of this survey, there are grounds to reflect on the quality of the systematic quality work performed. The failure to report such cases may be attributed to the employees' lack of knowledge or understanding of the purpose of reporting nonconformances, employees not being informed of how nonconformances are followed up, or lack of arena for joint reviews in order to ensure learning within an organisation. Providing feedback on nonconformance follow-up to those who report nonconformances is essential if such persons are to trust the systems.

Moreover, by learning from the errors made by ourselves and others, the systems become more well-known and applicable. Healthcare personnel must be allowed the time to document and report. Those who do so must be praised.

Transparency involving undesired incidents is in many organisations still lacking. The Ombudsmen are of the opinion that this mainly involves management, systems and culture.

### **Are the steps too high on the municipal health and care ladder?**

The main objective is to ensure as many people can stay at home for as long as possible. This requires good, safe services for people with ill health. In turn, this requires more people and increased competencies in the home care services. We are living longer, and our elderly live longer with an increased number of diseases, we spend less time in hospitals and shall receive more assistance in the municipality.

We often hear reports of insecurity, unpredictability and too many helpers in the home care service. Not only do the helpers not arrive at the scheduled time, they are not able to schedule times for visits and the visits are often too short. Many municipalities assign a specific number of minutes to performing the services, with little room for flexibility.

The care ladder is a concept introduced to visualise the municipality's responsibility for offering services at different levels, from low to high level of care, from practical assistance such as helping with home cleaning to places in 24-hour institutions. Inquiries issued to the Ombudsmen indicate that at times there is disagreement about the position of the individual on the care ladder. Persons applying for services disagree with the municipality as to the need for more services. Relatives, GPs and representatives of the specialist health service may also have other opinions. In situations where the municipality offers a lower service than recommended by other healthcare personnel in their statements, both the recipient of the service and their relatives may feel insecure. In such situations, the municipality has a particular responsibility to make the individual feel secure by explaining the requirement analysis they have performed and the services they can offer.

For many, home care personnel are the only persons they meet. Given that we have a clear objective to allow the elderly to live at home for as long as possible, we must also discuss loneliness and the opportunities for social contact. For many, it is not enough to just provide a meal. Some need help to eat their meals, while others quite simply need company. We know how important nutrition is and this has to be part of the discussions about how to allocate the time available.

At the top of the care ladder are those patients with long-term places in nursing homes or similar institutions. The Ombudsmen receive a number of inquiries involving this service. In principal, these inquiries relate to rejected applications for nursing home places or the quality of the service offered. The relatives of patients in nursing homes tell us about variable quality, with variation from one section to another in the same home. They mention inadequate medical attendance or insufficient assistance with basic needs such as eating or toileting. We hear about fall injuries that are not detected, bedsores, incorrect medication, and cases of malnutrition and dehydration.

We also receive reports of poorly elderly patients who are moved multiple times throughout their clinical pathway. They are moved between their home, the emergency medical centre, short-term places, hospital admissions and municipal emergency help places in a continuous cycle. Some of these patients are in end of life care, and this practice is very undignified.

Language is a relevant challenge at every stage of the care ladder. Both healthcare personnel and citizens are now more multi-cultural than ever before. This is a particular challenge with elderly patients who, as they age, will only understand their mother tongue. A number of cases involve insufficient knowledge of health legislation among employees. These range from elementary regulations about access to medical records, to regulations on the use of coercion of patients.

### **User-controlled personal assistance – a programme with undesired variations**

The purpose of user-controlled personal assistance is to provide persons with a high need for assistance the freedom to control the services and their daily life, and to have an active and independent life, to the greatest extent possible. Since 2015, user-controlled personal assistance has been an individual, statutory right for persons with a long-term and high need for personal assistance. The scheme involves providing persons with disabilities the option to participate on an equal footing with others.

The inquiries received by the Health and Social Services Ombudsmen relating to the user-controlled personal assistance scheme involve both rejected applications for the right to the scheme and the scope of the number of hours provided. The inquiries involve assessment of need, issues connected to the role of supervisor and control of the number of hours. In several cases, we have observed a major discrepancy between the need reported by the user and the service deemed sufficient by the municipality.

Some decisions are difficult to understand. A number of the decisions made are so detailed that they count the minutes for how long an activity is estimated to take, without taking into account the differences in the condition of the user from day to day or unforeseen incidents. The user-controlled personal assistance scheme has undesired variations between municipalities with regard to allocation of the services, both in terms of scope and how the scheme is viewed in relation to other services.

We have information on cases where the users have chosen to move to municipalities that offer a better service. This may be attributable to the service suppliers with which the municipality has signed an agreement, but also the extent to which the municipalities view the scheme from an equality perspective.

The scheme is of major importance for many persons with a high need for assistance. Our experience is that the scheme does not sufficiently fulfil the objective for independent lives, equality and freedom. The scheme's objective must be met, irrespective of the municipality where the user lives.

The user-controlled personal assistance scheme involves practical assistance. A number of the users also receive health-related services as part of the scheme. We have noted a number of challenges in this regard when it comes to ensuring reliability, as the decisions have been inadequate. The Ombudsmen would like to remind the municipalities of their responsibility to ensure the scheme is reliable.

### Services offered to the mentally ill and addicts – are we doing enough and are we taking the right measures?

*"People who struggle with mental disorders and substance addiction have a life expectancy that is 20 years shorter than the general population. In my mind, this is one of the biggest inequalities we have in our country. One important reason for this is that they do not receive sufficient examinations and treatment for somatic diseases."*

This quote is from Norway's Minister of Health and Care Services, Bent Høie.

The reality of the situation he is describing must have a greater impact on how society provides healthcare services to this group of patients.

Many also suffer problems with housing and finances. Some need assisted living facilities. If we are to improve and stabilise the daily lives of the individual, these needs must also be charted and addressed.

Patients with both substance addictions and psychiatric disorders (known as ROP patients in Norway) experience insufficient collaboration between the mental health service and interdisciplinary specialised treatment services. Relatives report increased stress and responsibility.

The threshold to ask for help for mental illness is high for many. Fortunately, the feelings of shame about mental illness are on the decrease in society, partly due to the increase in the number of individuals who are open about their problems. However, less shame and the message to "talk to someone" are not enough. Patients, employees in the health services, patient organisations and the Norwegian Medical Association are all calling for a reduction in the number of patients who are not offered treatment.

One patient expressed despair over feeling like a ball thrown backwards and forwards between the different services, in the following words:

*"The municipality and the specialist health service argue about who is responsible for me, and I do not want to have to go through that again."*

For persons who have developed a mental disorder, it is important to receive good, caring assistance, irrespective of whether this is provided at municipal level or from the specialist health services.

In a report from the Norwegian Medical Association entitled *Improved psychiatry and treatment for substance addiction* from 2019, it is recommended e.g. that referrals from a GP shall not be rejected by the specialist health services without specific advice being given as to how the patient can be assisted by the primary health services. This is an initiative supported by the Ombudsmen, provided

that the individual municipality has the required competencies. The same report expresses concern about whether the escalation plans in relation to mental health have resulted in a boost for patients with mild and moderate mental disorders, while the services offered to the more severely mental ill are impaired. The dismantling of the 24-hour service must be stopped if we are to ensure a sufficient service to those who suffer most. We have received reports of this concern from several parties.

Should the golden rule be replaced by a new escalation plan?

People with a substance-use disorder also often need different types of intervention at different times. This entails coordination of such interventions. Inquiries to the Ombudsmen deal in particular with vulnerable transitions, and the patients' experience of a lack of user involvement in the treatment, inadequate continuity when a person providing treatment leaves the organisation or is on leave, a lack of focus on follow-up care, including housing and activities. These arrangements must be planned, ideally before treatment begins.

Tommy Sjøfjell from A-larm raised several important points during one of his many excellent lectures, one of which was: *"The older you get, the harder it is to get a place for treatment. Patients think this is stupid as their motivation increases with their age."*

For this patient group, as for others, the entirety of the treatments offered is decisive for the results. The overall living situation, including the patient's somatic health, must be in focus in order to ensure appropriate assistance.

## Relatives – an invaluable resource

The Health and Social Services Ombudsmen often receive complaints from the relatives of patients and service-users. Some of the relatives have questions about their own role and their independent rights as relatives.

In recent years, the rights of relatives have been reinforced, and the general regulations have been incorporated into the Act relating to Patients' Rights. This also applies to the rights of children as relatives. Many of the rights are relatively consistent with the patient's and user's rights in the health service, unless the patient or service-user does not want relatives to be involved. Knowledge of and compliance with these rules vary.

Relatives are extremely important and an absolutely necessary resource, both for the individual who needs help and for society at large.

The local authorities are responsible for offering training and counselling, respite and care-giving assistance to individuals with an especially heavy care burden. In the Ombudsmen's experience, relatives do not know enough about this and therefore do not receive the information and help they are entitled to or need. Relatives are concerned about:

- Good information and the opportunity to get involved
- Respite options
- To be listened to.

Relatives often have very useful information that can be beneficial for the patient and that can prevent undesired incidents.

The Directorate of Health has prepared national, professional guidelines regarding relatives in the health and care services, <https://www.helsedirektoratet.no/veiledere/parendeveileder>. Efforts should be made to familiarise health professionals with these guidelines and ensure compliance.

### **The right to free dental health care is for many a hidden secret**

As of 1 January 2020, the Health and Social Services Ombudsmen's mandate was extended to also cover public dental health services. Even before the change in the mandate, we had received some inquiries about dental health services, and we now want to follow up this area more actively.

Under the Regulations on Fees for Dental Care, patients in healthcare institutions or patients who receive health services at home, who are financed directly through public spending, have the right to free dental care, according to certain conditions. There is no information and follow-up from the municipality in this area. It cannot be left to the individual to be aware of and request this.

We are calling for more activity from the services to ensure the individual's rights. They must receive information about the scheme and, not least, about how and whom to contact to receive this service. The information must be repeated. The municipalities must provide training of their employees so that they can communicate important rights to patients and service-users.