Ombudsman's Commentary

MARCH 2006 REPORTS

This month we are laying significantly more reports before Parliament as our new arrangements for reporting develop. As I outlined in my December commentary, we made a change in our practice last year following feedback received from organisations and stakeholders and particularly from complainants.

The rationale behind the new reporting procedures is that an important aspect of complaint handling is ensuring that valuable lessons are learned from the investigation of complaints in order to avoid the same problems arising for other members of the public and users of services. As the reports laid today make clear, wider lessons can be drawn from the specifics of an individual case. Best practice in complaint handling by bodies can be shared, and where there is room for improvement, they can also learn from one another.

My office laid eighteen reports today. Eleven relate to the local government sector, six to health and one to housing.

Health Overview

The health cases contain complaints about Lothian NHS Board and Tayside NHS Board, and a separate complaint about a dentist in Glasgow, which were not upheld.

However, the other three health cases raise significant concerns. These investigations reveal inadequate nursing care, clinical failures and deficient record keeping. Once again, poor communication between health professionals and between health carers and patients and their relatives resulted in confusion and distress. One report highlights the distress created by long waiting lists for hearing aids in Scotland, and another provides further support for the adoption of a Scotland-wide record for maternity services such as the Scottish Women Held Maternity Record (SWHMR).

Health reports

Forth Valley NHS Board
Maternity services

The complaint about Forth Valley NHS Board is a maternity case that concerns failure to provide adequate clinical care and treatment at Stirling Royal Infirmary. My investigation found that there were clinical failings and shortcomings in nursing care including that the mother was not given information about her baby's condition. I made recommendations to the Board including that they apologise to the complainant for:

- failure to perform any external examination;
- poor communication by midwives during her labour; and
- inadequate communication with her regarding aspects of her treatment and the condition of her baby.

I also recommended that the Board:

- ensure that staff comply with certain protocols and standards of care;
- audit their standard of record keeping and advise my office of the results of this audit; and
- consider adopting the SWHMR and advise my office of the outcome of their consideration.

On this last point, I would stress my view (made in a previous report to Parliament) that the SWHMR is a valuable document that would have been beneficial in avoiding some of the issues raised in this complaint. I recommended that a Scotland-wide record be adopted by all Health Boards. I note that Forth Valley have accepted my recommendations and I look forward to working with them towards making improvements.

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Argyll and Clyde NHS Board
Care of the elderly and provision of hearing aids

One complaint about Argyll and Clyde NHS Board concerned the Royal Alexandra Hospital's failure to provide proper care and treatment to an 82-year old patient. The report identifies 'a lack of overall care planning' in particular in relation to infection control. It also describes 'shortfalls in nursing care' and 'the inability of staff to provide her anxious family with the information they needed.'

In this case I made recommendations that the Board apologise for the failure to:

- adequately communicate with the patient's family regarding the reasons for her hospital admission;
- communicate and adequately assess the patient's changing needs;
- act proactively in communicating information to the family; and
- for the delay in responding to the complaint and the factual errors contained in the response.

In addition I recommended that the Board:

- undertake an audit of compliance with guidelines;
- consider how the risks inherent in staff shortages are accounted for and managed in their clinical governance management;
- consider how to ensure important information is adequately and promptly communicated to patients and/or relatives in the future;
- consider the use of a Communication Sheet to reflect discussions with patients and relatives; and
- review their procedures for responding to complaints to ensure that responses seek to resolve the broader issues identified in a complaint, not simply provide factual responses.

I am pleased to note that the Board have accepted the recommendations and have confirmed that they will act on them accordingly.

A second complaint about Argyll and Clyde NHS Board concerned the lengthy waiting list for replacement hearing aids. I regret the delays which are clearly distressing to patients, but concluded that delays being experienced by patients in Argyll and Clyde are in line with national averages. I did, however, criticise the Board for their failure to meet the expected standards of the NHS complaints procedure and recommended that the Board apologise to the complainant. The Board have accepted my recommendation.

Housing

I did not uphold the complaint about Irvine Housing Association, which was primarily about tree maintenance on the street outside the complainant's home. In this report I commended the Association for the professional, courteous and practical way in which they handled the complaint.

Local Government overview

Of the eleven complaints about local authorities, six were not upheld and the other five were either upheld in full or in part. In a number of these cases I criticised the way in which the Council dealt with the complaints. The subjects of the complaints were varied and included council tax payments, planning permission, tree maintenance and benefit fraud.

Local Government reports

The complaints that were not upheld included those about **Argyll and Bute Council** (objection to approval of development of a site); **The Moray Council** (siting of school signs); **The City of Edinburgh Council** (application for change of use of a property); **Perth and Kinross Council** (arrangements for publication of draft Local Plan; **Scottish Borders Council** (alleged failure to take objections into account in a planning application); and **Renfrewshire Council** (request for vehicular footway crossover).

A complaint about **Falkirk Council** concerned whether the complainants were given misleading advice by a council officer as to whether their neighbours needed planning consent for an extension and whether the neighbours had a building warrant. This complaint was partially upheld but the complaint that the Council did not fully respond to the complainants' concerns about other aspects of the extension was not upheld.

North Lanarkshire Council received a complaint from a woman regarding the installation of a camera at her home, which was to provide security for her daughters from anti-social behaviour exhibited by some children in her area. The complaint, which was investigated by my office, concerned the Council's refusal to allow the woman to retain the camera at her home. The complaint was upheld. I am pleased to report that the objection to the siting of the camera has now been withdrawn and the Council has confirmed that the complainant may use the camera for the purpose she had outlined.

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A council tax payer in Glasgow complained that **Glasgow City Council** had mishandled their demands of him for payment of council tax. Specifically he complained that for four out of five fiscal years the Council had requested more council tax than he was required to pay; failed to notify or reimburse him until he queried a final demand; and in issuing the final demand for a current shortfall the Council failed to recognise that he was in credit for a greater amount. All three aspects of the complaint were upheld. The finding on a fourth aspect of the complaint, namely that the Council had failed to explain the reasons for the overpayment and to apologise for their previous failure to disclose the overpayments, was inconclusive.

In this case, I recommended that the Council issue a written apology to the complainant and that they inform him of specific measures they intend to introduce to avoid recurrence of the problem.

A complaint was made about the way in which **Perth and Kinross Council** had handled a benefit fraud investigation. The complainant raised concerns about their refusal to inform him of the outcome of a fraud investigation and about a breach of confidentiality. These aspects of the complaint were not upheld. However, concern about the time taken by the Council in responding to the investigation, which was a third aspect of the complaint, was upheld.

Finally, a complaint was investigated into an allegation made about **East Dunbartonshire Council**. It concerned the complainant's request for the removal of trees owned by the Council that were overhanging his property. There were seven elements of this complaint, including a complaint that the Council had breached the complainant's human rights. Four out of the seven aspects of the complaint were not upheld. The other three, which related to delay on the part of the Council in responding to correspondence and the complainant's request to buy the land in question, were all upheld.

Ombudsman's overview

A recurring theme in the many of the reports relates to the poor handling of complaints and failure to resolve the problems when they first arise. If complaints are not dealt with openly and at the first opportunity, trust can break down and the matter can quickly escalate. For example, in the Argyll and Clyde case about the treatment of an elderly patient, my Investigator commented:

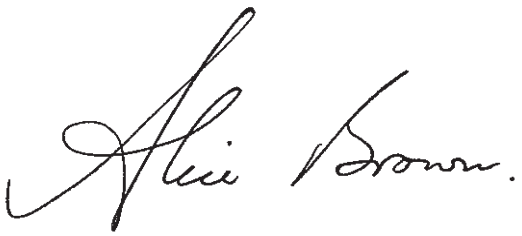
'The failures in early communication with Mrs A's family meant that Mr C and Mrs C (the complainants) had lost faith with the medical and nursing staff and discussions were often confrontational. Responses from staff became defensive. Errors and delays in responses made matters worse.'

A key message, therefore, is that communicating well and particularly at an early stage when a concern or complaint is raised can be effective. More generally, in delivering services to the public, being proactive and communicating effectively can also avoid problems from arising in the first place.

I am pleased to report that the bodies concerned have accepted all the recommendations made following the investigation of the above cases. My office will check to ensure that the agreed actions are implemented.

I encourage all bodies to consider the wider lessons that can be drawn from the reports.

The compendium of reports can be found on the SPSO website, www.spso.org.uk.



Alice Brown. 28.03.2006

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