



# Ombudsman's Commentary

## NOVEMBER 2007 REPORTS

I laid 32 investigation reports before the Scottish Parliament today. Eighteen relate to the health sector, 13 to the local government sector and one report (involving two separate complaints) about two sectors: Scottish Government and devolved administration and further and higher education. Details of the reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

## Ombudsman's Overview

### Operations

In the first half of the 2007-08 business year we saw a continuing rise in the number of enquiries dealt with by the SPSO. Complaint numbers have also shown a slight increase, but I am heartened to see that the additional resources made available by the Parliament are having a positive impact on the service we provide to complainants: the number of cases that our complaint investigators are working on has dropped considerably, allowing quicker response and turnaround times.

### Issues arising from casework

**Free Personal Care (FPC).** Last month, I reported on Lord Macphail's Opinion on the application by Argyll and Bute Council for Judicial Review of a decision of an SPSO investigation report into a complaint that the Council had not provided funding for the personal care of an elderly man. Lord Macphail reduced (overturned) my original decision to uphold the complaint and there has subsequently been considerable public debate on this issue.

As I said last month, I welcome the Scottish Government's commitment to review the FPC policy – this is the correct way for the kind of unremedied injustice suffered by the original complainant to be resolved for the future. I do not consider that it is in the public interest to appeal against Lord Macphail's decision, so I have not applied to reclaim the judgement. I do however intend to use, for the first time, my general reporting power to lay before the Scottish Parliament a Report commenting further on my reasons for not pursuing an appeal and on other, wider aspects of the case.

This month, I am reporting on two more NHS cases where patients have been inappropriately **removed from Practice lists** – an issue that I have commented on in previous reports. In both cases inadequate warning was given, and I have asked the NHS Boards concerned to review their policies and procedures to ensure that they are in line with NHS regulations and best practice.

In local government, **planning** cases continue to take up the lion's share of our complaints – six cases are reported on this month. There is considerable public confusion about the operation of the planning system – applicants are not always sure how to challenge or appeal the decisions reached by planning authorities and often approach the SPSO inappropriately. We cannot re-examine the merits of a decision – we can only investigate whether decisions have been reached following due process.

We have produced, with the help of a Planning Authority, two planning advice leaflets for members of the public. The purpose of the leaflets is to make clear exactly what types of planning issues the SPSO can and cannot investigate, and to signpost the public to other agencies and organisations that can offer support or advice on planning matters. One leaflet contains information and advice for objectors to planning applications and the other contains useful information for applicants. The leaflets can be found at: <http://www.spsso.org.uk/news/article.php?id=244>, or are available on request from our office.

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### Health

#### **Hospital Admissions**

Ayrshire and Arran NHS Board (200500940)

The complainant, Ms C, raised a number of concerns about her admission to hospital for a diagnostic procedure. I upheld her complaint that the hospital had failed to properly explain the error that occurred, which had caused Ms C to be admitted to hospital three days earlier than was required. The Director of Hospital Services has apologised to Ms C for the unnecessary distress caused. Also, new guidelines are being finalised for the admission of higher risk patients who require this particular diagnostic procedure. This should prevent a recurrence of the situation and I therefore have no recommendations to make. However, I have requested that the Board provide me with a copy of the guidelines when they are completed.

#### **Clinical treatment, communication**

Ayrshire and Arran NHS Board (200503321)

I upheld the complaint made by Mrs C that the nursing care her late mother, Mrs A, received was inadequate, specifically that there were major failings in the standard of care regarding the management of pressure sores. I also upheld her complaint that staff communication with Mrs A's family about her condition was poor. The Board have acknowledged failings in this case and have taken action to address the issues raised. In addition, I have recommended that the Board provide evidence that the measures implemented to improve the prevention of pressure ulcers has resulted in an increase in standards. With regard to the communication failures highlighted in my report, I am pleased to note that the Board have already taken action to improve communication and I have asked them to provide evidence that these changes in communication strategies have resulted in improved care.

#### **Policy / administration: removal from practice list**

A Dental Practice in Lothian NHS Board (200700667)

The complainant, Ms C, raised concerns about the fact that she was unfairly deregistered from a Dental Practice when she arrived late for an appointment. I upheld the complaint as the Practice did not follow its own guidance in this regard and the required warning was not given. I recommended that the Practice apologise to Ms C for deregistering her without warning and that they review the operation of their no-tolerance policy in light of NHS regulations and make any policies clear in the information which they give to new patients. The Practice have accepted my recommendations and I have asked that they notify me when these have been implemented.

#### **Policy / administration: removal from practice list**

A GP Practice in Lanarkshire NHS Board (200601998)

I upheld this complaint by Mrs C that she and four members of her family were inappropriately removed from their GP's list. Whilst I accept that a GP Practice has the right to ask for a patient to be removed from their list where there has been an irrevocable breakdown in the relationship with the patient (provided the appropriate regulations and guidance have been taken into account), I felt that in this case the Practice should have tried to resolve the matter with Mrs C first. I also found that the Practice did not adhere to the relevant regulations and guidance and did not provide Mrs C with a clear warning. As such, I recommended that the Practice put in place a process to ensure that the NHS regulations and guidance are adhered to before they ask for patients to be removed from their list and that they also apologise to Mrs C for not doing so before asking for her and her family members to be removed.

#### **Clinical Treatment**

Lothian NHS Board (200500714)

The complainant, Mrs C, raised a number of issues regarding her treatment and care following an ankle fracture. I upheld all aspects of her complaint and found that there was a failure by the Consultant to recognise the severity of the injury which resulted in the ankle healing in a poor condition due to the treatment given. I recommended that this case be discussed at the Consultant's next appraisal. I also raised concerns about the standard of record-keeping in this case and so recommended that the Board provide evidence that their records have been submitted to scrutiny via audit and address the issues highlighted in my report. Finally, I found that Mrs C left hospital without a full understanding of how to manage her injury. I therefore recommended that the Board introduce a protocol to give advice to patients on how to manage plaster cast injuries.

#### **Clinical treatment, record-keeping, communication**

Grampian NHS Board (200500951)

I upheld this complaint by Ms C who complained that her mother, Mrs A, had not received proper or adequate treatment whilst in hospital for a knee operation. I concluded that a failure to maintain adequate nursing and medical records, combined with a failure to complete some necessary documentation, meant that the Board could not provide evidence that Mrs A received adequate nursing or medical care. As such, I recommended that the Board review medical and nursing documentation and also introduce a system for the audit of clinical documentation and advise me of both the outcome of the review and proposed action. I also found that the Board failed to demonstrate that they communicated adequately with Mrs A's family (again due to poor record-keeping) and recommended that they consider whether there are training needs for staff in relation to communication with patients and relatives / friends. The Board have accepted my recommendations.

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## NOVEMBER 2007 REPORTS

### Health

#### **Hospital Discharge**

##### **Tayside NHS Board (200500782)**

I upheld this complaint by Mrs C that her late mother, Mrs A, had been inadequately assessed and inappropriately discharged on three occasions by the Accident and Emergency Department of a hospital. I concluded that there were major failings in the nursing component of the Department's documentation, which failed to show evidence that full nursing assessments had been carried out, and that there was a failure to fully investigate Mrs A's symptoms. I also concluded that staff did not take Mrs A's home circumstances into account when deciding whether to discharge her from hospital. I recommended that, as a matter of urgency, the Board undertake an audit of all nursing documentation, including observation charts in use in the Department, and conduct a review of chest pain protocol. The Board have accepted my recommendations and I have asked that they advise me when these have been implemented.

#### **Clinical treatment, record-keeping**

##### **Lanarkshire NHS Board (200601576)**

I upheld this complaint by Mr C about his late mother's (Mrs A) treatment in hospital. Mr C was also concerned that the cause of death in Mrs A's death certificate was completed incorrectly. I concluded that there was a lack of an adequate medical review in this case and a delay before appropriate medical advice was given about Mrs A's condition. I recommended that the Board apologise to Mrs A's family for the failures in her care. Since the events in my report, the Board have made substantial efforts to improve the standards of nursing records and the most recent nursing audit showed significant improvement. I therefore recommended that my report be passed to the Clinical Nurse Specialist responsible for the 2007 audit to see whether it should be reflected in the current action plan. I was pleased to note that similar audits have occurred on medical records and recommended that this be done on a regular basis. In my report, I also highlighted my concern that Mr C was given clinical information that could not be substantiated. Whilst I

commend the Board for meeting with Mr C, which is good practice, I have recommended that they ensure clinical staff are reminded of the importance of checking the accuracy of clinical information when asked to review meeting notes.

I have previously published a report (ref: 200503208) about this Board and an error in a death certificate. Although the Board have accepted the error in this case and have apologised to Mr C, I recommended that they consider whether death certification should be included in the continuing education of medical staff. I also recommended that they take steps to correct the error in Mrs A's death certificate and apologise to Mr C for their failure to respond appropriately to his concerns.

#### **District nursing care, complaint handling**

##### **Tayside NHS Board (200503486)**

The complainants (Misses C) raised concerns about the way that their late mother (Mrs C) had been treated by a district nurse during a home visit. I fully upheld one aspect of the complaint in that there were communication failures between nursing staff and partially upheld another in that there was inadequate care and treatment, which led to a loss of dignity for Mrs C. I commend the Board for taking the issue seriously and for ensuring that appropriate training was given to the Nurse concerned and also identifying the need for wider training on patient dignity for the district nursing team and student nurses. The Board also carried out a Significant Events Analysis (SEA) which identified and addressed areas where internal communications could be improved. Again, I commend them for taking the necessary action and learning from the issues raised and therefore have no recommendations to make.

#### **Clinical treatment, complaint handling**

##### **Greater Glasgow and Clyde NHS Board (200601034)**

I did not uphold Ms C's complaint that the care and treatment given to her son, Mr A, by mental health professionals was inadequate but I did find failures in the Board's handling of her complaints about

this matter and so upheld this aspect of her complaint. The Board have accepted previous recommendations that they review their complaints procedure (report number: 200500103) and audit this to ensure that responses are dealt with in line with NHS guidance (report number 200503649). Therefore, while I recommended that the Board apologise to Ms C for the failures identified in responding to her complaint, I made no detailed recommendations about the Board's complaint handling.

#### **Clinical treatment**

##### **Tayside NHS Board (200501660)**

I upheld one aspect of this complaint by Mrs C about the treatment that her sister, Mrs A, received in hospital. I found that there were significant delays in Mrs A having an MRI scan, particularly given her medical condition, which were clearly a result of system failures in the management of Mrs A's care. I recommended that the Board issue Mrs A with a full formal apology for the failures identified in my report, in accordance with my guidance on 'Apology' (<http://www.spso.org.uk/article.php?ssi=41>) I also recommended that the Board provide me with evidence of the steps taken to prevent a recurrence of the failures identified in my report. The Board have accepted my recommendations.

#### **Palliative care: clinical treatment, record-keeping**

##### **Ayrshire and Arran NHS Board (200601233)**

Miss C complained that the care and treatment provided to her mother, Mrs A, in hospital prior to her death was not appropriate. I partially upheld this complaint to the extent that Mrs A's needs as a dying patient were not fully recognised. However, I made no recommendations on the palliative care currently provided by the Board, as it is clear that they have made a substantial effort to review and improve their care for the dying and I commend them for their efforts in this area. I recommended that the Board apologise to Miss C for the failure to appropriately assess Mrs A's needs following the decision to end active treatment and also for failing to ensure that all relevant notes were made available to my office during the initial investigation of this complaint. The Board have accepted my recommendations.

# Ombudsman's Commentary

## NOVEMBER 2007 REPORTS

### Health

#### Care of the elderly: clinical treatment, communication, complaint handling

Ayrshire and Arran NHS Board (200602521)

I upheld two aspects of this complaint by Mrs C, who complained about the care her late husband, Mr C, received in hospital. Mr C suffered from dementia and had been admitted to hospital for assessment. I found that there had been a significant deficiency in Mr C's care and I recommended that the Board undertake training in the recognition of acute physical illness in patients on mental health wards. In response to the issues raised by the complaint, the Board has drawn up a service improvement plan and provided me with evidence to demonstrate progress made and I commend them for this action. I also recommended that the Board apologise to Mrs C for the failings identified in my report and for failing to provide an explanation for the deterioration in Mr C's physical health during his stay in the hospital. Finally, I recommended that the Board take steps to ensure that the findings of critical incident reviews are fully incorporated in their responses to complainants. The Board have accepted my recommendations.

#### Diagnosis, clinical treatment, complaint handling

Greater Glasgow and Clyde NHS Board (200501228)

The complainant, Mrs C, raised concerns about delays in diagnosing her father's (Mr A) cancer and the subsequent treatment he received in hospital, where sadly he died. She also raised issues about delays with the Board's complaint handling. I did not uphold the diagnosis aspect of the complaint. However, I fully upheld the clinical treatment aspects of the complaint. I found that the clinical management of Mr A's condition could have been better and that the seriousness of his condition and the clinical information already held meant that decisions on Mr A's management, including treatment options, could have been considered in advance of a full clinical diagnosis. I made a number of recommendations to the Board to ensure that, for similar cases, options for investigation, treatment and

non-treatment are considered as soon as possible and also discussed with patients and/or their families. I also fully upheld the complaint handling aspect of Mrs C's complaint and recommended that the Board review their methods of obtaining information from internal sources to ensure that there are no unavoidable delays in responding to complaints. The Board have accepted my recommendations.

I did not uphold four other complaints in the health sector about the following issues and bodies:

#### Clinical treatment

Lothian NHS Board (200603030)

#### Diagnosis, clinical treatment

A GP Practice in Greater Glasgow and Clyde NHS Board (200604106)

#### Clinical treatment, complaint handling

A Dental Practice in Greater Glasgow and Clyde NHS Board (200600276)

#### Clinical treatment

A GP Practice in Highland NHS Board (200602829)

### Local Government

#### Planning: complaint handling

The Moray Council (200502731)

I upheld this complaint by Mr C who was dissatisfied with the Council's handling of his complaints relating to a planning consent for his holiday park and their actions in serving an enforcement notice for a breach of a condition of that consent. I concluded that there had been delays in responding to Mr C's representations and that the Council failed to fully reply to these representations. The Council have acknowledged their failings and, as a result of this complaint, have reviewed their complaints procedure with a view to improving the service. Therefore, I am satisfied that the Council have taken steps to address the issues highlighted by this complaint. However, I also recommended that the Council review their enforcement

procedures, produce guidelines that can be audited and take steps to meet with Mr C and discuss his outstanding concerns.

#### Housing: repairs and maintenance, complaint handling

The City of Edinburgh Council (200502234)

I upheld one aspect of this complaint, made by Ms C, who raised concerns about the Council's response to her request for repairs to her floor coverings. I found that Ms C had received conflicting advice about whether the replacement of linoleum in her flat was her responsibility, as there was some ambiguity in the verbal advice she was given at the initial inspection. The Council have accepted this and I consider the apology and financial redress they have offered to Ms C is appropriate. Therefore, I have made no recommendations and I commend the Council for their remedial action.

#### Community Care

East Lothian Council (200603087)

The complainant, Mrs C, raised a number of concerns about the assessment of her mother's (Mrs A) financial assets by the Council. Mrs C considered that the Council had acted improperly by including the nominal value of her mother's home, ownership of which had been transferred to Mrs A's family some years previously. I upheld this aspect of this complaint in that I found that the Council's decision to include the value of the property was flawed as they did not show due consideration of relevant guidance and failed to demonstrate that the avoidance of care home fees was a significant motive for the transfer of ownership of the property. Therefore, I recommended that the Council undertake a new financial assessment of Mrs A's assets, disregarding the nominal value of the property. The Council have accepted my recommendation. In her complaint, Mrs C also raised concerns about the lack of an impartial appeals process for such matters. While I did not make a specific recommendation about this I did note in my report that *"the current system is confused and inconsistent throughout Scotland and in particular there is no recognised, independent, appeals process for such financial assessments and decisions"*.

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### Local Government

#### Handling of planning application, complaint handling East Dunbartonshire Council (200600867)

I upheld one aspect of this complaint by Mr C, who raised concerns about how the Council had dealt with a planning application submitted by his neighbour for an extension and also a subsequent application for a variation to the original application. He was also dissatisfied with the Council's complaint handling. I found that the Council failed to fulfil the requirements of their own complaints procedure and made a number of recommendations for the Council to review and improve their complaint handling, as well as review their procedures for responding to my office to ensure that there are no undue delays. The Council have admitted to their failings in the handling of this complaint and I commend them for doing so. I also recommended that the Council apologise to Mr C for their delay in responding to him and his MP. The Council have accepted my recommendations.

#### Handling of planning application, complaint handling East Dunbartonshire Council (200601465)

This complaint raised similar issues to the above complaint (ref: 200600867) and concerned the same planning application. I again made recommendations for the Council to review and improve their complaint handling and to apologise to the complainant. I also made an additional recommendation, specific to this complaint, that the Council enforce to all staff dealing with the public, in relation to planning and building regulation matters, the importance of communicating with them as clearly and accurately as possible. Again, the Council have accepted my recommendations.

#### Education: school transport Stirling Council (200601593)

The complainant, Mrs C, raised concerns about how the Council had handled her complaints about incidents involving her younger son (Child C) and the owner/driver of a coach contracted to take her son and other pupils on the return trip from school. I fully upheld one aspect of the complaint as I found that the Council did not take the action they had previously stated they

would in response to Mrs C's complaint and so I recommended that they apologise to Mrs C for this. I also partially upheld another aspect of the complaint in that the Council failed to properly investigate the incidents and recommended that the Council again apologise to Mrs C for the way they handled her complaints. I further recommended that the Council offer mediation to explore the basis on which Child C could return to using the service if there was no alternative transport available. The Council have accepted my recommendations.

#### Land and property: policy / administration, complaint handling Inverclyde Council (200500969)

This complaint concerned a housing association wishing to lease premises from the Council. The housing association's former director, Mr C, believed that the Council failed to act in a timely and efficient manner, which resulted in unnecessary financial loss to the association. I upheld this aspect of the complaint (failure to act in a timely and efficient manner) as evidence suggested that the absence of procedures and communication standards at the Council contributed to a lack of clarity on a number of issues. I made a number of recommendations to the Council to ensure that there is clear guidance for Estates staff when dealing with potential tenants, as well as recommendations to ensure clear and unambiguous communication. Mr C also raised concerns about the Council's complaint handling process and I partially upheld this aspect of his complaint. I welcome the proposals the Council have put forward to address my recommendations, which included a review of their complaint handling procedures. I also recommended that they clarify the role of ward Councillors in the process and remind staff of the importance of adhering to complaint handling timescales.

I did not uphold six other complaints in the local government sector about the following issues and bodies:

#### Handling of planning application Fife Council (200501344)

**Policy / administration: public consultation**  
South Lanarkshire Council (200601843)

**Housing: repairs and maintenance, transfers**  
West Dunbartonshire Council (200602514)

**Handling of planning application**  
Perth and Kinross Council (200603238)

**Housing: repairs and maintenance**  
Aberdeen City Council (200700021)

**Handling of planning application**  
Dumfries and Galloway Council (200600349)

### Further and Higher Education

I did not uphold this complaint in the Further and Higher Education Sector:

**Policy / administration**  
Moray College (200601808)

### Scottish Government and devolved administration

I did not uphold this complaint (linked to the above complaint - 200601808) in the Scottish Government and devolved administration sector:

**Policy / administration**  
Scottish Funding Council (200700764)

### Compliance and Follow-up

In line with SPSO practice, my Office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



**Professor Alice Brown**  
21.11.2007

The compendium of reports can be found on our website, [www.spsso.org.uk](http://www.spsso.org.uk)

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