Ombudsman's Commentary

SEPTEMBER 2008 REPORTS

I laid twelve reports before the Scottish Parliament today. Six are about the health sector, five about local government and one about higher education.

Ombudsman's Overview

In this month's Overview I want to begin by highlighting the information we publish about complaints to our office. Annual statistics detailing enquiries and complaints made to and determined by the SPSO in 2007– 08 were posted on our website at the end of last month. We also published letters that I sent to all Local Authority Chief Executives detailing the complaints received and determined about their Council during the year, with an overview of complaints investigated and recommendations made. The statistics and letters are available at **http://www.spso.org.uk/statistics/index.php**.

A number of concerns reflecting the wide range of issues that members of the public bring to my office are illustrated through this month's investigations. In one case, a Council failed to resolve environmental issues about an unauthorised campsite inhabited by travellers (Ref: 200700383). My report draws to the Council's attention the need to take enforcement action when it is appropriate to do so, and to ensure that travellers and local residents are given equal consideration when resolving disputes. In another complaint, a Council was found to have refused a late claim for Education Maintenance Allowance, although they had not themselves provided all the information necessary to allow the child's mother to properly make the claim on time (Ref: 200700850). I recommended that the Council increase an ex-gratia payment to the family to the amount to which they would have been entitled had the claim been submitted on time.

Half the complaints reported on this month relate to health issues, and yet again a common theme is the poor care and treatment of older people. I report on four complaints where these issues were raised. I upheld one complaint in full (Ref: 200700033) and partially upheld two other complaints (Refs: 200702270 and 200702661). In each of these cases I found that the Health Boards had failed to provide appropriate care to patients shortly before their deaths. The families of these patients were understandably extremely distressed by the failures identified, which included poor or insufficient communication between hospital staff and relatives.

I am pleased, however, that one of those investigations (Ref: 200700033) also demonstrates that where hospitals take action as a result of complaints, processes and practices do improve. In this case steps had been taken to address concerns over a patient's care. Record-keeping was also an issue within the complaint but our investigation showed that there had been a clear improvement since the complaint was made. This was as a result of action the hospital took to audit record-keeping in line with a recommendation in a previous report (Ref : 200500103).

I also reported on two cases where Accident and Emergency staff failed to diagnose fractures. In one complaint (Ref: 200702892) the injury was a broken neck and in the other, a fractured leg (Ref: 200600637). In each case, I recommended that the complaints be reflected on and used as a learning tool for staff.

Professor Alice Brown, Ombudsman 17.09.2008

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case summaries

The reports are summarised below and the full reports are available on the SPSO website at http://www.spso.org.uk/reports/index.php

Health

Accident and Emergency, diagnosis, complaint handling

Fife NHS Board (200600637)

Mr C complained that when he attended hospital with a fractured leg, staff failed to diagnose the fracture and the Board later failed to handle his complaint adequately. I upheld both complaints and recommended that the Board share my report with the relevant staff to allow them to reflect on it. I also recommended that the Board remind staff of the importance, when handling complaints, of obtaining information from all relevant sources and of responding in a timely manner. I could not reach a finding on a complaint that staff ignored Mr C's indication of the location of his pain, and did not uphold his complaint that earlier diagnosis would have brought about different treatment.

Care and treatment of the elderly, complaint handling

Greater Glasgow and Clyde NHS Board (200700033)

Mr B and Mrs C raised concerns about the care and treatment that their late mother, Mrs A, received in hospital. Mrs A was admitted via the Accident and Emergency Unit, and died in the hospital shortly afterwards. The complainants raised a number of issues with the Board but did not receive a reply they considered to be satisfactory. The Board admitted failings in the care provided to Mrs A, and our investigation showed that they had in fact taken significant steps to address these. As they had not explained these steps fully to Mr B and Mrs C, however, I upheld the complaint, and recommended a further apology for the failure to provide appropriate care. As the Board had taken steps to improve in a number of areas, including record-keeping and supervision of junior staff, I did not consider it necessary to make other recommendations. I upheld a further complaint about unacceptable delays and poor supervision in handling of the complaints, and recommended a further apology for these failings.

Care and treatment of the elderly

Greater Glasgow and Clyde NHS Board (200702270)

Ms B and Mrs C raised a number of concerns about the care provided in hospital to their late mother, Mrs A. I partially upheld the complaint that the Board failed to provide appropriate care to Mrs A. I recommended that the Board consider specific ways to try to ensure that there is an effective mental assessment of all older people on admission, review their policy for handling hearing aids and other assistance and that they advise me how they plan to take action on relevant reviews and ward audits that they have undertaken.

Care and treatment of the elderly, record keeping

Tayside NHS Board (200701333)

Miss C raised concerns about the care and treatment of her mother in hospital prior to her death. She raised a number of issues about nursing, which I consider that the Board took seriously and on which they acted appropriately. I did, however, find issues about record-keeping during the investigation and upheld the complaint to that extent. I did not, however, make any recommendation as I am satisfied that action has now been taken to address the problem. I did recommend that the Board provide me with evidence of appropriate monitoring of guidelines about long-term feeding lines for diabetic patients.

Care and treatment of the elderly, delays

Lothian NHS Board (200702661)

Mrs C raised a number of concerns about the care and treatment that her late mother, Mrs A, received in hospital. I upheld complaints about delays in carrying out a CT scan, in Mrs A being seen by a dietician and in ensuring she received an adequate level of nutrition. I also upheld the complaint that communication with Mrs A's family was inadequate. I made a number of recommendations as a result of this complaint. These included reviewing communication links between clinical and radiology staff; reviewing procedures for requesting a CT scan at weekends as well as policies for nutritional assessments/dietetic referrals; auditing clinical and nursing records on the ward to ensure appropriate completion, and providing evidence of clinical benchmarking of communication. I also recommended that the Board reflect on comments made by my professional medical adviser about a lack of urgency in the clinical investigation and consider whether the degree of patient orientation or clinical leadership at ward level is appropriate and, finally, that they apologise to Mrs C for the failings identified. I did not uphold a complaint that it was inappropriate for staff to assume Mrs A was suffering from bowel cancer.

Accident and Emergency

Forth Valley NHS Board (200702892)

Mr C complained that he received inadequate treatment when he attended an A&E Department. Mr C was involved in a road traffic accident in which he sustained a neck injury. This was initially diagnosed during two visits to A&E as a whiplash injury, but when investigated by x-ray some weeks later it turned out that his neck was in fact broken. I upheld the complaint and recommended that the Board apologise to Mr C for the failings identified, share the report with the doctor concerned and consider using the complaint as a learning tool for junior staff in A&E.

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Local Government

Unauthorised campsite
The Moray Council (200700383)

Mr C complained that the Council failed to find a permanent campsite for travellers in the Moray area or to deal effectively with environmental problems arising from an unauthorised campsite. I found that there was no obligation on the Council to provide a permanent site, so did not uphold that element of his complaint. I did, however, uphold the complaint about environmental problems, as there was evidence that these were not being handled in accordance with the relevant guidelines. I recommended that the Council consider taking appropriate enforcement action where they have evidence of unacceptable behaviour, and that they review their protocol to ensure that the rights of the settled community and of travellers are given equal consideration.

Application for an Educational Maintenance Allowance
Renfrewshire Council (200700850)

Mrs C complained about several aspects of the Council's handling of her application for an Educational Maintenance Allowance (EMA) for her son. She said that he was not awarded an EMA because the Council failed to provide her with appropriate and accurate information although she complied with what was required of her. I upheld all her complaints and recommended that the Council increase their original offer of an ex-gratia payment to reflect the amount to which Mrs C's son would have been entitled had the original application been accepted.

Complaint handling
Scottish Borders Council (200602079)

Mr C complained that the Council inadequately dealt with his concerns about the charging of Homecare Services for his mother-in-law. I upheld the complaint as the Council did not address Mr C's contacts as a complaint, or make Mr C aware of their complaints procedure. I recommended that the Council apologise to Mr C, ensure that e-mails and all contacts are responded to in good time, and that they adhere to their complaints handling procedure. I also recommended that the Council seek to improve communication between their Departments when handling complaints and enquiries.

I did not uphold complaints about the following Local Authorities:

Bullying at school: complaint handling
Comhairle nan Eilean Siar (200701164)

Although I did not uphold the complaint, I recommended that the Council review elements of their correspondence handling, communications and complaints procedures.

Administration: enforcement action
Renfrewshire Council (200502776)

Further and Higher Education

I did not uphold a complaint about the following:

Teaching and supervision
University of Glasgow (200501574)

Although I did not uphold this complaint, I recommended that the University reflect on it and consider how best in future to deal with termination of placements and arranging alternative placements at short notice on the rare occasions when these arise.

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.

The compendium of reports can be found on our website, **www.spso.org.uk**

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SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

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. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: **www.spso.org.uk**

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