Ombudsman's **Commentary**

AUGUST 2010 REPORTS

The SPSO laid three investigation reports before the Scottish Parliament today. They all relate to the health sector.

Ombudsman's Overview

Reporting investigations

In order to use our resources as efficiently as possible and to maximise our impact, we have developed new criteria for deciding which cases should end with a report being laid before the Scottish Parliament. In future, we will only lay a report before the Parliament if we consider that the matter is in the public interest. This can include: significant personal injustice complaints; systemic failure cases; precedent and test cases; and cases where there has been a significant failure in the local complaints procedure.

Our laid investigation reports become public documents, and can be published in full. Each investigation may contain several complaints, and overall the three reports laid today:

- **Upheld 6 complaints**
- **Did not uphold 2 complaints**
- **Made 12 recommendations**

Our laid investigation reports form only one part of our work. A large proportion of the complaints we receive are handled at the detailed consideration stage of our process. This usually ends with us sending our findings and conclusions to the complainant and the organisation complained about in what we call a **decision letter**. We will usually issue a decision letter if:

- the organisation accept there were failings, apologise and take action to prevent the problem from happening again;
- from the evidence, it appears that the organisation did not do anything wrong (to use formal language, there is no evidence of 'maladministration or service failure' by the organisation);
- I have decided that the substance of the complaint and our decision on it do not raise public interest considerations.

As with investigation reports, we may make recommendations in decision letters. It is my intention in future to publish more information from these letters in order to share the learning from our investigatory work more widely.

In July, in addition to the three laid investigation reports, we determined 254 complaints. Of these, 138 were suitable for the SPSO to look at. We were able to resolve 99 of them quickly and 39 required detailed consideration. We made a total of 25 recommendations in decision letters, and some of these are listed on page 3 of this Commentary.

Consultation update

I am pleased to have received a number of formal responses since we launched our ***Consultation on a Statement of Complaints Handling Principles and Guidance on a Model Complaints Handling Procedure*** on 16 June. I also welcome the constructive feedback provided at the many events, meetings and workshops we have held to generate debate about the changes proposed in the document. I would encourage those who have not yet responded to the consultation to do so before the 8 September deadline.

Background

As required by the Public Services Reform (Scotland) Act 2010, we are consulting on a statement of principles on which all public service complaints handling procedures should be based. The aim of the legislation is to simplify and streamline complaints handling across the public sector. The principles require Parliamentary approval, which we will seek in the autumn.

The Act also provides this office with the power to publish model complaints handling procedures (CHPs). The guidance on model CHPs is intended to provide broad direction and support to public service providers.

Based on the principles and guidance, we will establish a complaints standards authority (CSA). Working in partnership with individual public sector areas, the CSA will oversee the process of developing simplified and standardised model complaints handling procedures for each sector.

To find out more

Our Valuing Complaints website will act as the resource and reference point for public service providers, to support them in ensuring that their procedures comply with the principles and are in line with the guidance. The consultation document can be found on the Valuing Complaints website, along with information about the Crerar Review, Sinclair Report and the legislation which led to the SPSO being given its 'design authority' role to improve complaints handling in the public sector. Visit **www.valuingcomplaints.org.uk**.

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case reports

Health

Care of the Elderly; clinical treatment; nursing care; record-keeping

Ayrshire and Arran NHS Board (200901416)

Mr A was an elderly man admitted to hospital with dehydration and acute diarrhoea. He also had other underlying medical conditions, including poor eyesight and was having difficulty eating and drinking. He initially appeared to make good progress, but after he was moved to a second ward his condition deteriorated and he died. His daughter, Ms C, felt that the care and treatment that Mr A received in hospital was inadequate, and that poor standards of care led to his premature death. My investigation identified serious failings in Mr A's care and treatment. These included failure to identify, document and manage his nutritional and feeding requirements and his visual impairment, and to assess his mental condition. There was also inadequate nursing assessment and documentation of care planning. I, therefore, upheld Ms C's complaint, although I did not see evidence that led me to believe that poor standards of care brought about Mr A's death prematurely. My medical advisers were of the view that Mr A died because of his general poor medical condition and probable underlying disease. The Board have already taken remedial action to address failings identified in my report. I, therefore, recommended that they provide me with their new in-patient admissions booklet; report to me the findings of their audit of the Abbreviated Mental Test element of the patient admission form, and remind staff of the importance of fully completing relevant documents. I also recommended that the Board reflect on the comments of my medical advisers in terms of the omissions and apologise to Ms C and her family for the failings identified.

Care of the Elderly; clinical treatment; complaint handling

Tayside NHS Board (200902198)

Mr A was an elderly man who was admitted to hospital after collapsing at home. He was finding difficulty in using language and was diagnosed as having had a stroke. His daughter, Mrs C, was unhappy with the care and treatment that her father (who has since died) received and with the time it took for the Board to respond to her complaints. The medical records show that Mr A's blood pressure was very high when he was admitted. He was given medication to reduce this, before being given his usual medication again. My medical adviser said that there is evidence that after he was moved from the admitting unit to a ward, Mr A's condition was not adequately monitored, particularly during the time that new medication was being administered. There was also evidence that the Board's response to the complaint was delayed. I, therefore, upheld Mrs C's complaints about inadequate monitoring of Mr A's blood pressure, lack of intervention to increase blood pressure and the delay in responding to the complaint. I recommended that the Board review their policy for monitoring stroke patients who are being treated with medication that may cause unexpected falls in blood pressure; review the need for a protocol for management of stroke patients who suffer a sudden severe drop in blood pressure, and provide me with evidence demonstrating consistency of care for patients being transferred between wards. I did not uphold complaints that reintroducing blood pressure and cardiac medications all at once was inappropriate, or that there was a delay in carrying out a swallow assessment and inserting a nasogastric tube.

Policy/administration; pain management; record-keeping; communication

Lothian NHS Board (200900395)

Miss C attended a hospital Accident and Emergency (A&E) Department twice with a history of abdominal pain and irregular menstrual bleeding. She complained that although she was in severe pain both times the Board did not provide appropriate pain relief. During my enquiries I found that documentary evidence of Miss C's care and treatment was inadequate and I therefore also included this in my investigation. I upheld both complaints, as I found that there was no record of Miss C's pain being assessed and scored, or of a proper triage assessment being made of her. I also found that the Board did not provide timely pain relief, nor did they acknowledge this or apologise for it. I recommended that the Board review their systems (including triage arrangements) for ensuring that pain levels are properly assessed and that timely pain relief is provided, and that they provide me with copies of audits of pain assessment and management. I also recommended that they provide me with evidence that they have strategies in place to ensure that nursing records meet the appropriate standards, and that they ensure that, when a complaint is made, they address patients' concerns appropriately. Finally, I recommended that the Board apologise to Miss C for the failings outlined in my report.

Ombudsman's **Commentary**

Recommendations made in SPSO decision letters in July 2010

Recommendations to Councils

- Give priority to arranging a Social Work Review Committee
- Ensure the Planning Service review the advertising boundaries for publications
- Introduce procedures requiring an applicant, where the Council consider it appropriate, to provide pertinent dimensions, a note of the footprint of existing structures and a calculation of useable rear garden area (relevant to assessing compliance with planning permissions)
- Review instructions to building standards officers in relation to defining the enforcement powers and limits of the Council's role in administering building standards
- Take steps to ensure that Council staff keep complainants updated when they are unable to respond to complaints within the published timescales
- Apologise to a complainant for delay in responding; remind relevant staff of the need to adhere to the complaints handling process
- Put in place systems to prioritise correspondence from landlords notifying the Council of Local Housing Allowance (LHA) accounts that are eight weeks or more in arrears, to ensure immediate suspension of such accounts where appropriate
- Pay a complainant (who is a landlord) the sum of £650.00 because of incorrect payment of LHA directly to his tenant instead of to him.

Recommendations to Health Boards

- Consider ways of communicating the reasons for changes in bed allocation when appropriate
- Apologise to a complainant for the lack of explanation of their mother's bed moves during her hospital stay
- Ensure appropriate clinical follow-up of extraordinary results; ensure that explanations are offered to patients and where appropriate, relatives, about treatment being carried out
- Draw to the attention of clinicians the need to ensure that the implications of a patient developing very high blood pressure and its management are understood, and that hypertensive encephalopathy should always be considered in a patient presenting with symptoms such as the complainant had
- Ensure that responses to complaints are in accordance with the NHS Complaints Procedure Guidance, address all the issues raised and show that each element has been fully and fairly investigated
- Reassure the Ombudsman that all future complaints will be dealt with in terms of the complaints procedure.

Recommendations to Colleges and Universities

- Apologise to a complainant for failing to conduct an adequate investigation and for not communicating appropriately with her on related matters; ensure that future investigations consider all available and relevant forms of evidence, and that adequate records of the evidence and how it was considered are kept; and ensure that letters to students giving the outcome of an investigation provide full information, setting out what the complaint was, what evidence was considered, including relevant dates, and what conclusion was reached
- Remind staff of the need to exercise care so that they accurately report the result of a plagiarism test.

Recommendations to Housing Associations

- Take steps to ensure that following a preliminary meeting of their maintenance officers to discuss substantial proposed works and decant arrangements with a tenant, both the generic specification of works and specific arrangements for the decant and respective responsibilities be confirmed in writing.

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Compliance & 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.

Jim Martin, Ombudsman
18 August 2010

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

For further information please contact:

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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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