

# Ombudsman's Commentary

## MARCH 2011 REPORTS

The SPSO laid five investigation reports about six cases before the Scottish Parliament today. They relate to the health sector and the local government sector.

### Case numbers

Last month, February 2011, in addition to the two investigation reports laid before the Parliament, **we determined 292 complaints and handled 81 enquiries.** Taking complaints alone, we:

- gave advice on 208 complaints
- resolved 76 in our early resolution team
- resolved eight by detailed consideration
- made a total of ten recommendations in decision letters (some of these are listed at the end of this Commentary).

### Ombudsman's Overview

#### Publishing decisions

This is the last Commentary before the dissolution of Parliament. The next investigation reports we lay will, therefore, be laid after the May election. By then, new legislation will be in force. From 1 April, under provisions in the Scottish Commissions and Commissioners etc Act 2010, we will have the power to decide whether or not to report investigations which are discontinued. This apparently technical change will give us much more flexibility about what we report to Parliament about cases which are closed with a decision letter rather than an investigation report.

As I have said on a number of occasions inside and outside Parliament, we have been preparing for this change for several months. To use our resources as efficiently as possible and to maximise our impact, I set out new criteria last autumn for deciding which cases should end with a report being laid before Parliament. This provides consistency in what is reported there. We now only lay full reports if we consider 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 significant failure in the local complaints procedure.

This has, inevitably, led to a decrease in the number of laid reports. We have explained in our publications that these reports form only part of our work. A much larger proportion of the complaints we receive are handled at what we call the detailed consideration stage of our process. All of these cases are 'investigated' in the common sense understanding of the word. Detailed consideration usually ends with us sending our findings and conclusions to the complainant and the organisation complained about in what we call a decision letter.

After 1 April, I intend to put into the public domain summaries of the findings of these decision letters. We issued 850 decision letters in the last financial year (compared with 134 laid reports) and they will provide a rich seam of information and learning. I look forward to sharing this with public service providers, MSPs, the Government, scrutiny and regulatory bodies and others, and of course with the citizen, the users of public services, for whom we are the final port of call when something goes wrong.

#### Investigation report findings

I believe that all three of the health-related investigations laid today contain significant wider lessons. My investigation (Case 201000940) into a complaint about the care and treatment provided to a young girl with a nut allergy prior to her death from anaphylaxis has led me to make a call for further action from the Scottish Government. My report states:

*'Faced with the lack of national guidance on adrenaline auto injector prescription, there is a danger of inconsistency in approach, with potentially devastating consequences. Introducing national guidance could be a safeguard against this. A national paediatric allergy network that has been set up could take this forward and build on the work already done by Greater Glasgow and Clyde NHS Board. The Ombudsman will draw this matter to the attention of the Scottish Government Health and Social Care Directorate.'*

# Ombudsman's Commentary

## MARCH 2011 REPORTS

The two other health reports also make for very distressing reading. They involve themes that, sadly, I would describe as more familiar in our work – poor nursing care and poor communication.

One complaint involved two NHS organisations (Cases 201001520 and 201001146). I found that the patient, Mr C, a terminally ill man, received very poor service, care and treatment. He was collected too early by the Ambulance Service, endured a long, painful and uncomfortable wait for his procedure at hospital, and was returned to the hospice by inappropriate transport. Mr C died in the hospice later that night.

I upheld complaints by Mr C's wife, Mrs C, that the care and treatment provided by the Health Board and the Ambulance Service were not reasonable. I made several recommendations to address the failings identified and to ensure that other patients and their families will not endure the pain and distress caused to Mr and Mrs C. I also found a wider cause for concern in what I describe as 'a catastrophic failure in the continuum of care'. My report concludes:

*'When patients are in need of care, they do not consciously approach individual agencies for the specific care that such agencies provide – they approach the NHS. How the NHS is structured is, rightly, not their*

*concern. Mr C received very poor service, care and treatment from the NHS on 22 February 2010. From being collected too early by the Service patient transport, enduring a long, painful and uncomfortable wait for his procedure at the Hospital, and being returned to the Hospice by inappropriate transport, I consider there was a catastrophic failure of the continuum of care that Mr C expected to receive. I believe that both agencies in this report still have lessons to learn about communicating within and between NHS organisations and treating all patients with the dignity and respect they deserve, especially terminally ill patients like Mr C.'*

The other report (Case 200904481) highlighted a lack of care and compassion by nursing staff looking after an elderly man with dementia who fell five times in a ward. There was also a failure to inform the man's family of the rapid decline in his clinical condition or to contact them prior to his death.

The two local authority reports relate to how Complaints Review Committees in two different councils have dealt with the issue of notional capital. In each case, I found areas for improvement, and I would draw the reports to the attention of the Government and councils in general who should assure themselves that the policies and procedures that they have in place are sound.

## case reports

### Health

#### **Clinical treatment; staff attitude; policy/administration**

A GP Practice in the Greater Glasgow and Clyde NHS Board (201000940)

Miss C was a nine year old girl, who died suddenly from a severe form of allergic reaction. Her mother, Mrs C, complained that the GP's care and treatment of her daughter was inadequate. In particular, she complained that an EpiPen (an auto injector of adrenaline) was not prescribed. Mrs C was also unhappy with the GP's tone and manner during a telephone conversation four days

after her daughter died. I upheld the complaint about the failure to treat Miss C appropriately, as I found that the GP did not act on information in a letter from the Board's Associate Specialist in the Department of Dermatology (where Miss C had attended for some time) and did not discuss it with Miss C's parents. The letter said that, although Miss C had not responded to efforts to arrange follow-up, she was considered nut allergic and should be referred on to the Allergy Service if the GP wanted this reviewed. I recommended that the GP write and apologise to Mrs C for this failing. I did not uphold the complaint about the GP's tone and

manner. I also noted that, as there is a lack of national guidance on adrenaline auto injector prescription, there is a danger of inconsistency in approach, with potentially devastating consequences. A national paediatric allergy network that has been set up could take this forward and build on the work already done by Greater Glasgow and Clyde NHS Board. I will draw this matter to the attention of the Scottish Government Health and Social Care Directorate.

# Ombudsman's Commentary

MARCH 2011 REPORTS

case reports

## Health

### **Nursing care; communication; policy/administration**

Scottish Ambulance Service (201001520)

Ayrshire and Arran Health Board (201001146)

Mr C, who had terminal oesophageal cancer, was resident in a hospice. He was taken by ambulance to hospital as an out-patient for a scheduled endoscopy procedure before being returned by ambulance to the hospice, where he died later that night. His wife, Mrs C, complained that both the care and service provided by the Scottish Ambulance Service (the Service) and the care and treatment provided by the Board while Mr C waited for his appointment were unreasonable. Mrs C told me that although the procedure was scheduled for 15.00 (and was actually carried out at 16.00) the ambulance arrived at the hospice at 11.00, meaning that her husband reached the hospital between two and a half and three hours too early, and that as the second ambulance had no stretcher, Mr C could not lie down on the return journey. When Mr C arrived at the hospital he was then not appropriately attended to and had to wait, seated, in the reception area. Mrs C said that this meant he was in pain and discomfort throughout the long wait for the procedure he was there to have, which was in itself delayed beyond the scheduled appointment time. One of my professional medical advisers commented that, given his age and illness, it was unacceptable for Mr C to have had to sit in pain in the reception area for several hours. The whole episode was particularly distressing to Mrs C given that Mr C died later that evening. I was particularly concerned about the failure of the continuum of

care by the NHS organisations in this case, and I upheld both of Mrs C's complaints. I recommended that the Service remind all crews in the relevant division to contact their Area Service Office and await instructions if cancellations mean that other patients would be transported to hospital several hours before their appointment time; and also to remind crews of the importance, following an outbound journey, of passing on relevant information about a patient's needs to their Area Service Office. I recommended that the Board ensure that a record is made of the time a patient is admitted for their procedure and also of all advice given to patients on admission by nursing staff. This requirement should be incorporated into their new guidance and they should provide me with evidence of audit and evaluation of the first six months' operation of that new guidance and action plan for dealing with vulnerable adults arriving for Endoscopy appointments. I further recommended that they remind nursing staff of the importance of treating people as individuals, even in a very busy unit, as set out in the Nursing and Midwifery Council Code: *Standards of conduct, performance and ethics for nurses and midwives*.

### **Care of the elderly; cleanliness and hygiene; nursing care; clinical treatment; policy/administration**

Fife NHS Board (200904481)

Mr A, who suffered from a number of significant medical conditions including dementia, was admitted to hospital after falling and breaking his left hip. His son, Mr C, raised a number of concerns about Mr A's care and treatment. He complained that the Board failed to maintain adequate standards of ward cleanliness, and

believed that this resulted in Mr A picking up two hospital-acquired infections. He also complained about the nursing care Mr A received, noting that his father had fallen several times whilst staying at the Hospital, on one occasion fracturing his right hip. Mr A died at the Hospital after an operation on that hip. Mr C also said that the Board did not contact the family in time for them to be with Mr A when he died, and that surgical equipment was not removed from his father's body. I upheld the complaint about nursing care, as I found that despite having strong policies for minimising the risk of falls, the Board failed to deliver these in practice, and Mr A suffered a number of falls. I recommended that they review the circumstances of these with a view to identifying and rectifying underperformance in the practical implementation of their falls management and dementia care policies and procedures. I upheld the complaint about contact with Mr A's family, and recommended that the Board review the circumstances leading to this complaint and consider introducing measures to improve communication with families. Finally, I upheld the complaint that equipment was left in Mr A's body, but made no recommendations as the Board had already taken steps to change their protocols. I did not uphold Mr C's other complaints about cleanliness, MRSA infection and lack of concern from staff as I did not find specific evidence of failings by the Board in these respects.

# Ombudsman's Commentary

MARCH 2011 REPORTS

## case reports

### Local government

#### **Notional capital; policy/administration; complaints handling**

Scottish Borders Council (200904647)

When Mrs A entered residential care the Council carried out a financial assessment of her income and assets to calculate residential costs. They took the value of her former home into account although when it was sold she had not received any of the sale proceeds. This was because Mrs A had entered into a legal agreement with her son and daughter-in-law, Mr and Mrs C (who funded her mortgage) that meant they were entitled to the proceeds. Mr and Mrs C disputed the Council's decision and their solicitors complained on their behalf that the decision was administratively flawed and that the handling of their complaint was poor. I upheld both complaints, as I found that although the Council's decision was reached with reference to a number of relevant factors, they made some assumptions that were not entirely based on the evidence provided. Mr and Mrs C's complaint was considered by a Complaints Review Committee whose recommendation that the value of Mrs A's property not be taken into account was dismissed by the Executive Committee based on internal legal advice. I concluded that the CRC hearing process was not conducted entirely fairly and recommended that the Council obtain independent legal advice on Mrs A's case and convene another CRC hearing to reconsider the matter with reference to that advice.

I also found that the complaints process took more than a year to complete, partly caused by the unavailability of a member of staff in whose absence the process stalled. I recommended that the Council provide me with evidence of the steps that they have since taken to ensure that they record, track and respond to correspondence in good time, and that in this particular case they review their handling of the initial correspondence and formal complaint. In particular the Council should review their staff absence procedures and introduce measures to ensure that future staff absences do not unduly impact upon the delivery of service standards set out in their complaints handling procedure.

#### **Notional capital; communication; policy/administration**

The Moray Council (201000684)

Mrs A's mother, Mrs B, was taken into residential care. The Council carried out a financial assessment of Mrs B's income to identify funds to be taken into account towards the cost of this care. Ms C, an advocate, complained on behalf of Mrs A about the process. She said that Mrs A was not given enough information about what she needed to tell the Council about her mother's bank accounts and spending. As a result Mrs A believed she was wrongly accused of deliberately withholding information and disposing of funds. I did not uphold Ms C's complaints. I found that the Council provided a trained member of staff to assist Mrs A with the application but there was not enough detail recorded

for me to be able to reach definite conclusions about the information provided to and discussed with her at the time. I, therefore, recommended that the Council review their process to ensure that records are made and retained of such discussions, that they improve record-keeping and ensure that a copy of the minutes of any Complaints Review Committee hearing is provided to a complainant and/or their representative within a reasonable time.

### **Complaints Standards Authority – Guidance published**

At the end of February 2011, we published our revised Guidance on a Model Complaints Handling Procedure. The Guidance followed our consultation of June – September 2010 and is the basis on which we will seek to develop, in partnership with public service providers, model complaints handling procedures for the areas of public services that they deliver.

The Public Services Reform (Scotland) Act 2010 (building on the work of the Crerar and Sinclair Reports) gave the SPSO the authority to lead the development of simplified and standardised complaints handling procedures (CHPs) across the public sector. Following consultation, we developed a Statement of Complaints Handling Principles. These Principles were approved by the Parliament and published in January 2011. The Act requires that all public bodies under the SPSO's jurisdiction have complaints handling procedures that comply with these Principles.

The Act also provides our office with the power to publish model complaints handling procedures (model CHPs). The Guidance is the basis on which we will develop, in partnership with service providers, model CHPs.

The Act gives the Ombudsman the power to specify public authorities to which these model CHPs should apply. It places a duty on those authorities to comply with the relevant model CHP and states that the Ombudsman may issue a declaration of non-compliance where any specified authority does not comply.

The SPSO's internal unit, the Complaints Standards Authority (CSA), will provide support in improving complaints handling procedures. The CSA will work in partnership with the sectors to oversee the process of developing model CHPs in line with the framework of the Principles and Guidance. The CSA will also provide support to bodies in improving their complaints handling and in helping to share best practice within and between sectors.

In accordance with the recommendations of the Sinclair Report, we have already engaged with the local government sector to prioritise the introduction of standardised complaints procedures in that sector. In the coming months we will engage with other sectors to agree plans to develop standardised CHPs based on the Principles and Guidance. The CSA will work in partnership with all sectors to agree the timescales for development and implementation of the new procedures.

We look forward to supporting public services in Scotland as they seek to develop CHPs which comply with the Principles and to build a culture across the public sector that values complaints as a driver of improvement in the delivery of public services.

The Guidance, Principles and a comprehensive analysis of consultation responses are available on our CSA website: **[www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)**.

# Ombudsman's Commentary

## MARCH 2011 REPORTS

### Recommendations made in decision letters in February 2011

#### Recommendations to Health Boards

- That a Board apologise for their failure in general to explain matters to the complainant and that they emphasise to staff the importance of giving accurate explanations in clear and concise language to ensure, as far as possible, that patients and/or their carers understand what is said to them
- That a Board apologise to a complainant for failing to explain and to ensure that she clearly understood the implications of her child having a particular medical condition
- That a Board apologise to a complainant for their shortcomings in dealing with a complaint
- That a Board review their complaints process and reassure the Ombudsman that it complies with the national NHS complaints procedure

#### Recommendations to Councils

- That a Council remind relevant staff of the procedures for dealing with antisocial behaviour, so that records are made and kept in line with those procedures, that emails are responded to and relevant leaflets and forms are sent; and that the Council take action to remove stone chips from a complainant's garden
- That a Council reimburse a complainant for any legitimate costs that he incurred as a result of a faulty central heating pump

#### Recommendations to the Scottish Prisons Service

- That a body allow a complainant to resubmit his complaints through the prison complaint system and convene a hearing to review those complaints.

### 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, 16 March 2011**

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

For further information please contact:

**SPSO, 4 Melville Street, Edinburgh EH3 7NS**

**Emma Gray, Communications Manager**

Tel: **0131 240 2974** Email: [egray@spsso.org.uk](mailto:egray@spsso.org.uk)

# Ombudsman's Commentary



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, prisons, 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.spsso.org.uk](http://www.spsso.org.uk)**

Contact us at:

<b>SPSO</b>	Tel: <b>0800 377 7330</b>
<b>4 Melville Street</b>	Fax: <b>0800 377 7331</b>
<b>Edinburgh EH3 7NS</b>	Text: <b>0790 049 4372</b>