

June 2012

The SPSO laid two investigation reports before the Scottish Parliament today, both about health boards. We also laid a report on 50 decisions about most of the sectors under our remit. Both of the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in May) in addition to the three full reports we laid before Parliament, we determined 384 complaints and handled 40 enquiries.

Taking complaints alone, we:

- gave advice on 253 complaints
- resolved 83 in our early resolution team
- resolved 48 by detailed consideration
- made a total of 64 recommendations in decision letters.

Ombudsman's Overview Reports

This month I report in detail on two investigations into complaints involving health boards.

The first case (201005160) is about the care and treatment of a vulnerable man (Mr A), who committed suicide after years of problems associated with alcohol dependency. Mr A's family complained to my office that he should have been admitted to a mental health inpatient facility after an earlier suicide attempt. They felt that failures in communication between the teams involved in his care adversely impacted on the care and treatment he received.

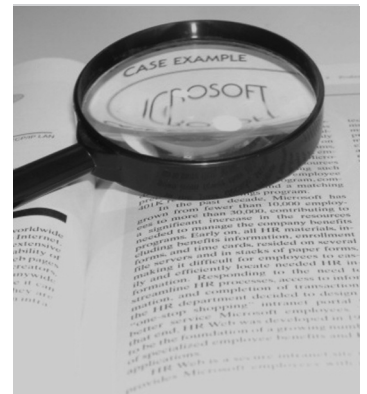
On investigating the complaint about failures in communication, I found that there had been very little, if any, direct contact between the mental health and addiction teams involved. Because Mr A's mental health team did not accept a

referral and the alcohol problems clinic did not act on a re-referral, Mr A became lost to follow-up by either service. Essentially this man was let down by the system that should have been there to support him.

This is unacceptable, as I have commented before when expressing my concerns about the support that is required for vulnerable individuals.

The second case (201102801) highlights the failure of a health board to take ownership of its complaints handling, following a mother's complaint about her daughter's consultation with an out-of-hours doctor. Although I did not find anything wrong with the doctor's clinical judgment of the daughter's condition, I found the complaints handling to be very poor. When replying, the board appear to have relied solely on the view of the doctor concerned, to the extent of simply sending his response about the complaint on to the mother. Although the doctor was contracted to provide a service to the board, rather than employed directly by them, the board should have taken responsibility for the complaints handling.

I would draw the attention of health boards and other organisations to our **Valuing Complaints** website www.valuingcomplaints.org.uk, which gives guidance on best practice in complaints handling.



This month's findings

Mental health; admissions; communication

Greater Glasgow and Clyde NHS Board (201005160)

Complaints handling; diagnosis

Grampian NHS Board (201102801)

continued >

Ombudsman's Commentary

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Gentamicin Therapy

One of the other decisions I report on this month is about complications associated with gentamicin therapy. The case (201102047) highlights the dangers of the possible side effects of this treatment. Although these may not be common, I want to draw to the attention of other health boards my concern that similar symptoms are not overlooked.

Gentamicin is a powerful antibiotic. A man was admitted to hospital and treated with it for an infection related to his heart pacemaker. This treatment was necessary, but the man has since been diagnosed with gentamicin toxicity (poisoning), which has affected his balance and his ability to lead a normal life. Although staff checked toxicity levels daily, these checks do not predict vestibular toxicity (which is related to an accumulation of this drug in the ear), and the staff did not pay enough attention to the symptoms that the patient reported.

The learning from this unfortunate experience is that, as well as monitoring the therapeutic dose of gentamicin on a day to day basis, NHS staff must be alert to patients reporting dizziness and loss of balance. I urge health boards to ensure that they have systems in place to identify and recognise such side effects and that staff are aware of these. Having brought this case to the attention of health boards, I would also expect future patients who complain of similar symptoms to have their medication reviewed immediately.

This report (201102047) and other decision reports can be found on our website at the following link:

www.spsso.org.uk/decision-reports

Complaints Standards Authority (CSA) Update

Model complaints handling procedures (CHPs)

Following the publication of model CHPs we have been working closely with organisations to advise on their plans for implementation. We have asked local authorities to advise us of the work they have done to comply with their model CHP by 14 September 2012. We have similarly asked all registered social landlords to provide us with this information by 12th October 2012. We are pleased to report that early indications are that organisations from both sectors are making good progress, with some having already submitted their CHP to us for comment.

Other sectors

Progress continues to be made with representatives from both further and higher education to develop a model CHP for each of these sectors. We have also been working with some smaller non departmental public bodies to provide advice and guidance on developing their CHPs.

Valuing Complaints website

In the last week we launched our re-designed Valuing Complaints website:

www.valuingcomplaints.org.uk

We hope that the site will become a centre of best practice in complaints handling by providing a range of tools and good practice guides as it continues to develop. Currently the site hosts the model CHPs, best practice resources such as guidance and information documents, and links to online reference material.

There is also a discussion forum where members can engage in conversation about a range of issues from complaints handling to the implementation of model CHPs.

The forums may also be used to connect directly with the CSA team. Complaints handlers can request free membership to the forum at the following link:

www.valuingcomplaints.org.uk/forum

We encourage all interested stakeholders to participate in the forum.

Through the Valuing Complaints website you may also access the SPSO's online training centre and e-learning modules for frontline staff of local authorities. These are currently provided free of charge.

For further information about the work of the CSA, contact the CSA team at CSA@spsso.org.uk.

Waterwatch leaflets

From 15 August 2011, our jurisdiction was extended to include water complaints and Waterwatch Scotland (the previous body that handled them) ceased to exist. Most complaints are now coming to us through the correct route, but some people are still trying to contact Waterwatch rather than us. This means there is a delay in their complaint reaching us.

We know that organisations under our jurisdiction are still likely to hold some leaflets that refer to Waterwatch. We would very much appreciate it if you could ask staff to check leaflet stands and stocks and destroy any remaining Waterwatch leaflets.

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Case Summaries

Health

Mental health; admissions; communication

Greater Glasgow and Clyde NHS Board (201005160)

Mr A suffered from the physical and psychological effects of long-term alcohol dependency. In August 2009, Mr A attempted suicide and attended a mental health inpatient facility, but he refused to be admitted there and staff did not detain him. He had contact with a number of healthcare professionals from mental health and medical services over the following months. Mr A had numerous falls, injuries and incidents that concerned his family. He also told them that he intended to harm himself. He committed suicide in late 2009.

Ms C, an advocacy worker, raised a number of concerns on behalf of Mr A's family. The family said that Mr A should have been admitted to an inpatient facility for mental health and identified failures in communication between the medical and mental health teams treating Mr A. His family believed that if the healthcare professionals responsible for Mr A's care had communicated effectively with them and Mr A's GP, they would have become aware of the seriousness of Mr A's situation and admitted him for inpatient care.

I took advice from one of my medical advisers, who is a consultant psychiatrist. I did not uphold the complaint that Mr A should have been admitted to hospital. The Mental Health (Care and Treatment) (Scotland) Act 2003 is the legislation that sets out the criteria for this, and my investigation found that Mr A did not meet the criteria for a short-term detention in hospital. I noted that the board should have involved Mr A's family more when making their decision – they had in fact accepted this when carrying out their own investigation and had taken steps to address it. However, Mr A was appropriately risk-assessed and alternative care was planned for him.

I did, however, uphold the complaint about the teams involved in Mr A's care. I found that the communication between the various healthcare professionals and agencies was not reasonable and that this had an adverse impact on the standard of care Mr A received. My adviser noted that there was a lack of coordination, characterised by poor communication, between the alcohol problems clinic, the mental health team and other relevant services including general hospital services. The board also failed to put alternative support into place when Mr A was discharged from the alcohol problems clinic in late August 2009. In the

circumstances it is impossible to know if proper support from mental health services during the last two months of Mr A's life would have had a positive impact on the outcome. However, I was critical of the standard of care that Mr A received after he was discharged from the alcohol problems clinic. He and his family were let down by the board during an extremely difficult and distressing period. I also criticised the board because, despite the seriousness of the failures in coordination and communication between the teams dealing with Mr A, and the lack of follow-up, these were not referred to or addressed by the board's critical incident review.

I recommended that the board review the coordination of the relevant services to ensure that the failures identified in this report are addressed; and that they apologise to Mr A's family.

Complaints handling; diagnosis

Grampian NHS Board (201102801)

Mrs C complained about the care, treatment and diagnosis that her daughter (Ms A) received from a hospital out-of-hours service, and about the board's responses to her complaints. Ms A had gone to hospital with symptoms including increasing thirst, tiredness and muscle pain. (She had experienced similar symptoms a couple of months before and on that occasion was admitted to hospital with suspected meningitis. She was discharged the next day, having been diagnosed with a virus.) Mrs C was unhappy with the out-of-hours doctor and said he refused to speak to her about her daughter's medical history. She felt his diagnosis of a urinary tract infection was incorrect. Ms A was admitted to hospital the next day, and had a range of tests. Mrs C felt this showed that the doctor did not examine her daughter properly.

The board responded by sending Mrs C a letter about her complaint, written by the out-of-hours doctor. Mrs C was unhappy with this and sent a detailed reply in which she made a number of points. The chief executive replied addressing each of the points in turn, based entirely on an email from the doctor to the board's complaints team. Mrs C was dissatisfied with this and brought her complaints to my office.

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Case Summaries

Health

I did not uphold Mrs C's complaints about the doctor's diagnosis and comments about whether Ms A had presented with photophobia (sensitivity to light). I appreciate that Mrs C was concerned that her daughter might be seriously unwell but my medical adviser says that the records show that although Ms A had sensitivity to light there is no evidence that she displayed true photophobia. I noted, however, that in this respect the board's complaint response could have been clearer. I also found that the diagnosis of a urinary tract infection was reasonable – the length of the consultation suggests that it involved a full discussion of the symptoms and time for clinical examination. My adviser said that the history taken was reasonable, with key issues recorded, although it was short on some detail and the doctor could have given more consideration to other possible diagnoses. It would also have been better if the doctor had spoken to Mrs C, as she was clearly unhappy with the management plan proposed for her daughter. Better communication at that point might have prevented her complaint from escalating in the way that it did. Although I did not uphold this complaint, I drew my adviser's comments about these matters to the attention of the board and the doctor.

I upheld Mrs C's other complaints. Mrs C complained that the doctor had not mentioned in his response that Ms A had presented with a headache, and I upheld this

as this symptom was documented in the consultation notes but not referred to in the doctor's response.

My main concern in this case was, however, the evidence of very poor complaint handling. The doctor was an independent GP contractor and it appears that, as the complaint was about him, the board decided to use his direct responses to reply to Mrs C, without moderating them or providing any analysis or explanation.

They should have considered his comments as part of their investigation, come to their own view about the complaint, then formulated an appropriate response themselves, yet on both occasions they relied directly on the doctor's view. I consider this unacceptable, particularly given the tone of the doctor's first letter, which was sent to Mrs C as the initial reply to her complaint. I say in my report that this is one of the poorest examples of complaints handling that I have seen and point out that one of the purposes of a complaints handling procedure is to provide detailed and impartial investigation. Clearly this did not happen in Mrs C's case. I recommended that the board provide me with evidence that they have reviewed their complaints handling procedure in relation to complaints about the out-of-hours service, to ensure a proactive approach is taken, and that they apologise fully to Mrs C for the failures I have identified.

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.



Jim Martin, Ombudsman, 20 June 2012

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

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Ombudsman's Commentary

June 2012

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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, 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

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