Ombudsman's Commentary

SPSO Scottish Public Services Ombudsman

August 2012

The SPSO laid five investigation reports before the Scottish Parliament today, four about health boards and one about a local authority. We also laid a report on 60 decisions about all the sectors under our remit. All of the reports can be read on the 'Our findings' section of our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in July) in addition to the three investigation reports we laid before Parliament, we determined 350 complaints and handled 56 enquiries. Taking complaints alone, we:

- gave advice on 221 complaints
- resolved 81 in our early resolution team
- resolved 48 by detailed consideration
- made a total of 75 recommendations in decision letters.

Ombudsman's Overview

Reports

The four investigations that I publish today into complaints about the NHS contain harrowing stories of the impact on patients and their families when things go wrong. A delayed cancer diagnosis, the loss of a baby, very poor care of a woman with mental health issues, a woman's illness that was so serious that last rites had been given, though she then made a full recovery – each of these events was enormously traumatic for the individuals concerned.

Our investigations aim to bring to light what went wrong. Where I find failings, I ask the board to put in place changes that will, as far as possible, ensure that the issues do not recur. In these four reports, I make a total of 23 recommendations, and I would encourage other boards to read them with a view to learning from them and preventing similar situations arising in their own organisations.

Similarly, I would encourage chief executives and leaders of councils to read the investigation I publish today about assessing people's ability to pay for residential care, and about communicating the role and remit of the Social Work Complaints Review Committee.

Complaints Standards Authority (CSA) Update

Model Complaints Handling Procedures (CHPs) – local authorities and RSLs

As reported last month, the CSA is continuing to support local authorities and Registered Social Landlords (RSLs) as they move towards implementing the model CHPs. In both sectors, progress towards implementation continues to be good.

As a further reminder, I have asked local authorities to submit their CHPs or provide implementation plans by **14 September 2012**. RSLs have been asked to submit a pro-forma detailing their plans for implementation at any time before **12 October 2012** to enable us to follow up with those that still have to make progress towards compliance. If any organisation needs help or guidance on implementing the model CHP, please contact the CSA.

Model CHPs – Further and Higher Education

We are continuing to work closely with stakeholders from further and higher education to develop model CHPs for those sectors. A number of positive meetings and discussions with representatives of both sectors have led to the development of a draft model CHP for each. We intend to publish both by October 2012, with further work being undertaken over the summer months through groups led by Universities Scotland and Scotland's Colleges.

continued >

This month's findings

Psychiatry: clinical treatment; diagnosis; communication; staff attitude; record-keeping
Grampian NHS Board (201102541)

Obstetrics: clinical treatment; record-keeping; follow-up care
Highland NHS Board (201103227)

Diagnosis; clinical treatment
Western Isles NHS Board (201103076)

Diagnosis; complaints handling
A Medical Practice in the Greater Glasgow and Clyde NHS Board area (201101415)

Social work: policy / administration; communication; Complaints Review Committee
Glasgow City Council (201101997)

Ombudsman's Commentary

August 2012

Valuing Complaints

Our re-launched Valuing Complaints website plays host to the SPSO online community forum. The forum continues to attract interest and I would encourage complaints handlers from all sectors to sign up and actively participate in sharing their knowledge and experience. Log on now to join the discussions and to access a range of recent Q&A articles with some of the organisations who have implemented the model CHP, outlining some of the benefits they have seen and the challenges they have faced.

E-learning training

We launched e-learning training modules on frontline resolution for local authority staff in May 2012. We continue to receive positive feedback on the training and would encourage others to sign up. The training modules are accessible to organisations from all sectors through the training section of the Valuing Complaints website and are focused, for now, on providing the key skills required for frontline resolution in line with the model CHP.

We have also developed modules for housing, which we plan to launch to frontline staff in that sector in September.

The CSA team is happy to provide further information on any aspect of this work and can be contacted at CSA@spso.org.uk. See the CSA website for more information: www.valuingcomplaints.org.uk

Case Summaries

Health

Psychiatry: clinical treatment; diagnosis; communication; staff attitude; record-keeping

Grampian NHS Board (201102541)

Ms C has mental health difficulties including bipolar affective disorder. Her GP referred her to a psychiatric hospital because she was struggling to cope with thoughts of self harm. She was admitted voluntarily and had concerns about the manner in which she was admitted. Ms C remained as an inpatient at the ward for approximately six weeks, including periods of escorted and unescorted leave. She had a number of concerns about the treatment she received at the ward throughout this time.

Ms C complained to the board about all these matters after she had left the ward. She received a response from the chief executive after a period of four months. She remained dissatisfied and brought her complaints to my office. She felt that the poor care she had received served to alienate her from hospital environments, and resulted in a further deterioration in her mental health, to the extent that she later had to be admitted as an acute patient to another hospital within another board area.

I upheld all of Ms C's eight complaints and made thirteen recommendations for improvement. The complaints that I upheld included that the care and treatment provided on admission was inadequate; the observations levels to which Ms C was subjected and the locking of the ward door at night were inappropriate; there were communication issues during Ms C's stay on the ward; inadequate care and treatment was provided after she took an overdose; it was unreasonable that on the occasions that Ms C expressed a desire to leave hospital she was 'threatened' with formal detention; the action taken following specific incidents was inappropriate and inadequate; staff on the ward had an unreasonable approach to weight/body mass index policy; and the board unreasonably delayed in responding to the complaint.

The report itself outlines the many failings identified, and the thirteen recommendations provide an insight into the many areas where action is needed to make improvements. I have asked that the board:

- provide me with evidence that interim care plans are developed for patients on admission to the ward, and that all appropriate documentation in patient records is being completed;
- develop a search policy to provide guidance to staff on the issues of patient dignity and safety;
- review their observation policy to take cognisance of the shortcomings identified, and ensure that the observation policy leaflet for patients is finalised and distributed to all patients on the ward;
- review their policy in relation to door locking on the ward at night to take into consideration the additional issues highlighted;
- provide me with evidence of staff training in relation to communication with mental health patients, which should include guidance on ensuring professional and appropriate record keeping by staff in relation to patients;
- develop a policy for staff use and guidance to reflect the Mental Welfare Commission's guidance in relation to short term detention and ensure this is distributed to staff;
- undertake an audit to ensure incidents are being recorded appropriately;
- ensure staff are aware of their responsibilities in relation to patient confidentiality;
- develop a policy for staff about the appropriate steps to take in relation to patient measurements, in conjunction with Quality Improvement Scotland guidelines;
- ensure that complainants are kept up to date in relation to the progress of their complaints, and are given full information about the options available to them;
- provide me with evidence that the board operates a rights and values based approach in relation to the care of patients within the Adult Mental Health Directorate;
- draw this report to the attention of all the staff involved in Ms C's care;
- provide a full apology to Ms C for all of the failings identified in my report.

Ombudsman's Commentary

August 2012

Case Summaries

Health

Obstetrics: clinical treatment; record-keeping; follow-up care

Highland NHS Board (201103227)

Mr C and Ms C were expecting a baby. Ms C had planned to have a hospital delivery at a maternity unit, which was about seventy-five minutes by road from where they lived. Nine days before the expected date of delivery, Ms C's waters broke and she immediately called the hospital for advice. She was advised to remain at home and later told to contact her local midwife. The midwife called the hospital about half an hour after arriving, to say that Ms C would make her way there by car. No contact was made with the hospital again until almost three hours later when the midwife advised that there was to be an unplanned home birth. After about another two hours of very difficult labour, Mr and Ms C's daughter was eventually delivered. It was determined that the baby had been in breech position (i.e. lying with her bottom, rather than her head, downwards) although this was not established until very late in the labour. There was no foetal heart beat and the baby was taken to hospital by helicopter. Mr C and Ms C followed by ambulance, unaccompanied by either a midwife or Ms C's medical notes. After they reached the hospital they were told that their daughter had not survived. Mr C and Ms C made a number of complaints about what happened. They believe that the loss of their daughter was totally avoidable and blame the board for what happened.

I upheld Mr C and Ms C's complaints that the board failed to provide adequate advice, care and treatment before and during the birth of their daughter, and afterwards failed to provide adequate care and treatment to Mr C and Ms C. They also failed to keep adequate and timely records of the birth and aftercare provided to Ms C. My midwifery adviser considered that midwives missed opportunities to fully assess Ms C and also that there had been time to transfer her to hospital, by emergency ambulance if necessary. I considered the extensive documentation provided by Mr C and Ms C and the board and, taking account of my adviser's comments, took the view that a number of opportunities were missed during this period. These resulted in a tragic situation with the very difficult breech delivery of a stillborn baby girl outside a hospital setting. The midwives should have decided to transfer Ms C to hospital once labour was established, but did not. Had the transfer taken place after the initial assessment, the breech position could probably have been identified and Ms C could have been delivered in a hospital with a full medical team there to give appropriate care. I concluded that the board did not provide adequate advice, care and treatment before and during the birth, and recommended that they apologise sincerely and fully to Mr C and Ms C for these failures.

The issue of aftercare for both Mr C and Ms C was also raised with me. On balance I upheld this complaint, as I took the view that although the aftercare provided was generally acceptable there were still significant failures, including sending Ms C on a long road journey immediately after giving birth. She should and could have been accompanied by a midwife and her medical notes, but this did not happen. I note, however, that as a result of their own investigation of the complaint the board acknowledged this and apologised. On the matter of the notes and record-keeping, my midwifery adviser pointed out that although two midwives and a nurse were present during the birth, the notes were not written at the time events happened and that some of the timings in them were incorrect and had been altered. This breaches the Midwives Rules and I recommended that the board emphasise to all midwifery staff that they must comply with these rules when completing notes.

I did not uphold Mr C and Ms C's complaints that the board's Serious Untoward Incident (SUI) report and the chief executive's response to the complaint were inadequate, or that the board incorrectly stated that their daughter was stillborn. This is because there was no evidence of failure by the board on these matters. I did, however, draw the board's attention to the fact that, although the investigation carried out in their SUI report was satisfactory, the report itself was not the formal complaints response that Mr C and Ms C were entitled to receive.

Diagnosis; clinical treatment

Western Isles NHS Board (201103076)

Ms C complained on behalf of Mr and Mrs A about the care and treatment received by Mrs A. Mrs A was taken to a rural cottage hospital, suffering from abdominal pains. Two days later Mr A was advised that his wife was suffering from acute renal failure, was dying and no further treatment could be provided for her. However, she was later able to be airlifted to the mainland for treatment, and she went on to make a full recovery

The impact on Mr and Mrs A and their family upon being advised that nothing further could be done for Mrs A, when that was not in fact the case, cannot be underestimated. There is no doubt that Mrs A's experiences at the hospital have had a profound and lasting impact upon her and her husband.

continued >

Case Summaries

Health

I agreed that the care and treatment that Mrs A received at the hospital was not reasonable. I concluded from my investigation that a number of aspects of Mrs A's clinical care give cause for serious concern. In particular, I found that it was not acceptable that blood samples waited for two days for analysis. There was no reasonable explanation given for this delay, which prevented a timely diagnosis of Mrs A's renal failure. Furthermore, other symptoms such as Mrs A's lack of urinary output should have prompted earlier consideration of renal failure. I was also concerned by the failure to review Mrs A's medication once renal failure was diagnosed, and my report criticises the care in relation to the administration of opiates as 'a basic failing in medical care.'

I acknowledge that, given the location and nature of the hospital, the care provided there will be limited in comparison to that which can be provided on the mainland. I also acknowledge that hospitals such as the one featured in this report provide a vital service to rural island communities in Scotland. I note in particular the advice given to me that a doctor was giving care under difficult circumstances on the evening that Mrs A's condition deteriorated further. Nonetheless, I found that the care provided at the hospital was well below a reasonable standard.

I note that the board instructed a review of this case and, as a result, identified a number of improvements which they stated they had been taking steps to implement through the action plan they developed. However, I was very concerned to note, on receipt of comments from one doctor in relation to this report, that neither the findings and recommendations of the review of this case, nor the fact that the review had in fact occurred, had been shared with that professional. This is at odds with the information the board provided to my office, which included a detailed action plan for implementation of recommendations, complete with completion dates. Among other things, the plan said that all staff involved had been engaged with and the case had been discussed at open meetings, and that training outcomes would be identified as part of annual appraisals. According to one doctor, this has not in fact occurred. Furthermore, the board forwarded these comments on to my office via the chief executive, without any acknowledgment or reference to the concerns raised by the doctor.

This is a further significant development in this case which gives me serious cause for concern, and I am critical of the board for this. It raises questions about the accuracy of the action plan provided. I urge the board to ensure that the review and its findings and recommendations are shared with all the staff concerned in Mrs A's care, as already detailed in the action plan. I also found that there are a number of further issues identifiable for improvement to ensure that care at the hospital is significantly improved, and to prevent other patients from going through a similarly distressing experience. I made several recommendations to the board including that they provide an updated version of the action plan to evidence that all of the identified actions have been implemented; provide further details about planned training for medical staff at the hospital, which should include refresher training on the causes of opiate toxicity and enhanced training in relation to venous access; conduct a random case note review at the hospital; and provide a full apology to Mr and Mrs A for the failings identified in my report.

Diagnosis; complaints handling

A Medical Practice in the Greater Glasgow and Clyde NHS Board area (201101415)

Ms C complained that the medical practice her brother attended failed to take his complaints of back pain and reduced mobility seriously. She complained that they did not proactively investigate his symptoms, which meant that his diagnosis of cancer was delayed. Ms C also complained about the practice's handling of her formal complaint. I upheld her complaints and made a number of recommendations.

Ms C's brother (Mr A) attended the practice in September 2010 complaining of back pain. He was initially advised to take paracetamol. Initial tests showed no signs of infection. Further tests were carried out as Mr A's pain increased and spread to his hips. Stronger pain killers were prescribed and blood tests and x-rays were arranged, but no significant abnormalities were revealed. However, Mr A's condition deteriorated over the next several weeks and, after a delayed home visit, he was referred to hospital. In mid December 2010, he was diagnosed with multiple myeloma (cancer of the bone marrow) and he died in hospital towards the end of January 2011.

Although my investigation found that the practice's initial investigations and conclusions were acceptable, I considered that from October 2010 the practice failed to appropriately pursue the investigations that would have determined the cause of Mr A's pain. There were a number of indicators suggesting that Mr A's condition had declined significantly and these led me to conclude that a home visit should have taken place earlier when Ms C asked for this.

continued >

Ombudsman's Commentary

August 2012

Case Summaries

Health

My medical adviser made a number of comments regarding the practice's incomplete record-keeping and the suggestion from the records that the decline in Mr A's self-care was related to his long-standing mental health issues. These comments raise significant concern that investigation of Mr A's physical symptoms was hindered by an assumption that his problems were as much psychiatric as physical. While the GPs may have had cause to consider a psychiatric element to Mr A's condition given their observations within his home, there was a lack of follow-up either by way of referral for investigation of a psychiatric problem, or to hospital for further investigation of a physical cause of Mr A's back pain. For these reasons, I considered that the care and treatment provided to Mr A by the practice was inadequate.

I also found deficiencies in the practice complaint response. Although I acknowledge that the response provided a summary of the events over a particular period, it failed to adequately address the seven points of concern within Ms C's detailed complaint letter and, as a consequence, failed to provide the information she sought.

I made several recommendations to the practice including that they apologise to Ms C and her family for the failings identified in the report. I also made recommendations for improving the practice's record-keeping, their complaints procedures and their procedures for proactively ensuring the completion of diagnostic investigations that have been identified as necessary for their patients.

Local government

Social work: policy / administration; communication; Complaints Review Committee

Glasgow City Council (201101997)

Mr C's father (Mr A) was diagnosed with vascular dementia and in late 2006 Mr C took over the management of his financial affairs. Mr C was aware that his father would, at some point, require full time residential care in a care home. He said that he was aware that this would involve an assessment of Mr A's finances to determine what contributions he would be required to make toward the cost of his care. Mr C said that, upon reviewing his father's finances, he transferred the sum of £17,000 to a new account opened in his mother (Mrs A)'s name so that she could benefit from the interest payments until such time as the money had to be returned to Mr A's account for calculation of his care contributions.

Mrs A unexpectedly developed Alzheimer's disease, and moved into residential care in 2009. Upon realising that Mrs A would be admitted into residential care, Mr C transferred the £17,000 back into Mr A's account. When completing financial assessment forms for Mrs A, Mr C declared the fact that he had transferred the £17,000 and explained why this had been done. The council considered Mrs A's financial circumstances and concluded that the money was hers and that she should be considered as still having it in terms of assessing her ability to pay for her residential care. This decision meant that Mrs A's assets were deemed to be of a level that required her to pay the majority of her care costs.

Mr C complained about the council's assessment of Mrs A's finances. His complaint, along with concerns about the council's communication, were put to a Social Work Complaints Review Committee (CRC) for consideration. The CRC upheld his complaint about communication, but said that they could not comment on the issue of the £17,000, as this had been a matter for the professional judgement of the social work department. Mr C complained to me that he had been led to believe that the CRC would review the assessment of his mother's finances, which was the substantive part of his complaint. He felt that their failure to do so denied him the opportunity to challenge what he considered to be an unfair and improperly reached decision.

I upheld almost all the complaints that Mr C brought to me, and made several recommendations to redress the failings identified and to ensure no recurrence of the issues. My four recommendations were that the council take steps to inform any complainants progressing to review by a CRC of the extent of the CRC's remit and powers; ensure that CRC members have appropriate training and access to expert advice to deal with all matters presented to them; arrange for Mrs A's financial assessment to be independently reviewed; and apologise to Mr C for the failings identified in my report.

Ombudsman's Commentary

August 2012

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, 22 August 2012

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

For further information please contact:

SPSO, 4 Melville Street, Edinburgh EH3 7NS

Grainne Byrne, Communications Officer

Tel: **0131 240 8849** Email: **gbyrne@spso.org.uk**

Ombudsman's Commentary

August 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.spso.org.uk**

Contact us at:

SPSO
4 Melville Street
Edinburgh EH3 7NS

Tel: **0800 377 7330**
Fax: **0800 377 7331**
Text: **0790 049 4372**