

September 2012

The SPSO laid five investigation reports before the Scottish Parliament today, three about health boards and two about the Scottish Government and devolved administration. We also laid a report on 74 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.spsso.org.uk/our-findings.

Case numbers

Last month (in August) in addition to the five investigation reports we laid before Parliament, we determined 397 complaints and handled 47 enquiries. Taking complaints alone, we:

- gave advice on 271 complaints
- resolved 78 in our early resolution team
- resolved 48 by detailed consideration
- made a total of 61 recommendations in decision letters.

Ombudsman's Overview

Reports

This month, I am issuing three reports into complaints about NHS boards, one about the Scottish Government's Learning Directorate and one about the Scottish Prison Service.

The complaint about the prison service (201101643) was from a prisoner who was concerned because he was transferred to another prison when he was about to undergo medical treatment in the prison he was in. I found that there were failings in the first prison's handling of his transfer. The first prison did not believe that his medical treatment was critical enough to stop the transfer, but the health centre there felt the man should not have been transferred because he was about to undergo a particular medical treatment. There was also no evidence to confirm whether the transfer decision was taken after careful and proper consideration of all relevant information.

I made two recommendations after considering this complaint. One was to ask the first prison to make an apology to the man for failing to respond directly to him about his complaint. The other recommendation went much wider than the individual complaint – I asked the Scottish Prison Service to put in place a national process for all prison

establishments to follow when transferring prisoners, and to ensure that the process allows for significant and relevant information to be obtained, considered and recorded as part of the decision making process.

The health complaints are, as always, varied and there is learning for all boards from the individual cases. In one complaint (201102756) I found that two out-of-hours GPs who separately attended an elderly man in a community hospital assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to another hospital. I also found that the decision making, care and communication of nursing staff in relation to the provision of palliative care was inappropriate. In another complaint (201101660), I upheld several aspects of a complaint by a tetraplegic man who developed a pressure sore in hospital. The final health complaint (201104004) is about poor dental treatment, and I upheld the complaint about the lack of care provided. In each investigation I made several recommendations for redress and improvement, which aim to ensure that the circumstances that gave rise to the complaints are not repeated.

In the complaint to the Scottish Government's Learning Directorate (201103092), a man complained about the way in which the Registrar for Independent Schools conducted an investigation into his request that a notice be served on a school under section 99 of the Education (Scotland) Act 1980. The man made the request because he was dissatisfied with the way in which the school conducted an investigation into an allegation concerning his son. My investigation found a number of failings, and I made several recommendations for redress and improvement.



Care of the elderly; clinical treatment; nursing care; record-keeping; policy/administration

Forth Valley NHS Board
(201102756)

Nursing care; complaints handling

Tayside NHS Board
(201101660)

Dental care and treatment; referrals

Lothian NHS Board –
University Hospitals Division
(201104004)

Child protection; complaints handling; communication

Scottish Government's
Learning Directorate
(201103092)

Transfers; communication

Scottish Prison Service
(201101643)

continued ➤

Ombudsman's Commentary

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Complaints Standards Authority Update

Model Complaints Handling Procedures (CHPs)

Local Authorities – deadline for response now closed

14 September was the deadline for all local authorities to submit their CHP or outline progress made and provide a clear implementation plan which should be approved by the Chief Executive. We are pleased to report that the majority of local authorities have confirmed their plans to implement the CHP over the coming months, with a number of local authorities already operating the CHP across all council services.

We will now fully assess all submitted CHPs and implementation plans and provide Audit Scotland with an assessment of compliance with the model CHP by early October 2012. As previously reported, Audit Scotland will report compliance through the Shared Risk Assessment process.

Those few authorities who have missed the deadline should send their plans to us as soon as possible, ahead of our submission to Audit Scotland in early October.

Registered Social Landlords – deadline is approaching

Several RSLs have submitted their pro-formas for implementation of the model CHP ahead of the deadline of **12 October**. We would like to remind others that they can download a word version of the pro-forma from the Valuing Complaints website, and return it to us here:

CSA@spsa.org.uk.

The CSA has been working with the Chartered Institute of Housing, HouseMark and the Scottish Housing Best Value Network to develop clearly defined performance indicators to assist RSLs with their self assessment exercises. These will be in line with the Scottish Housing Regulator's (SHR) requirements in relation to reporting on the Scottish Social Housing Charter (SSHC). We aim to publish the performance indicators in October, following the publication of the SHR's updated SSHC Indicators.

Complaints handling networks

A key recommendation of the Sinclair Report in 2008 was that the SPSA establish a network to bring complaints handlers together to share experiences and support each other. We are currently in the process of establishing these networks for each sector and are keen that these are led and chaired by representatives from each sector.

The newly formed Housing Complaints Handlers Network met for the first time on 12 September, with a turnout of around 50. The network is being co-ordinated by

representatives from Castle Rock Edinvar HA and Queens Cross HA who both provided presentations on their recent implementation of the model CHP. We are encouraged by the positive responses we have had to the establishment of this network and there were some constructive discussions about how it will function in future, including a programme of activity for future discussions. If you would like more information about the network, please get in touch with the CSA who will pass on your details to those from the sector running the network.

The first meeting of the local authority network of complaints handlers will take place on 28 September in Motherwell and will be chaired by a representative from North Lanarkshire Council. The first meeting will discuss the format of the network and the future programme of activities for discussion. If you are interested in taking part, please get in touch with the CSA who will provide your details to the network chair.

We will be working with representatives from other sectors to take forward similar networks and will provide further information in due course.

Model CHPs – Further and Higher Education

We are in the process of finalising draft model CHPs for further and higher education following work with stakeholders from those sectors to develop these. We have also had positive discussions with the Scottish Funding Council about compliance monitoring on which we will provide further detail in due course.

Valuing Complaints

The Valuing Complaints website is becoming increasingly popular as more organisations move to adapt the streamlined model CHPs. Recent discussions include logging and recording complaints, and an update from Glasgow Housing Association on how they have implemented the RSL model CHP. We would encourage complaints handlers to log on and join the discussions. If you have any questions on implementation, put them up on the forum and you will get a response from the CSA team as well as from other complaints handlers.

E-learning training

Our e-learning training, which has been positively received by local authorities, is being adapted for RSLs. The housing version will be available over the next couple of weeks – we will announce the launch on the Valuing Complaints Forum as soon as it is available.

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

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Case Summaries

Health

Care of the elderly; clinical treatment; nursing care; record-keeping; policy/administration

Forth Valley NHS Board (201102756)

Mr C raised a number of concerns about the care and treatment given to his father (Mr A) during the final days of his life. Mr A was living in a residential home when he was admitted to hospital for treatment for, amongst other things, acute renal failure. Afterwards he was transferred to a community hospital for rehabilitation. Mr C said that Mr A's condition declined there and that staff failed to take appropriate action or provide him with the appropriate treatment. Mr C said that they did not recognise the seriousness of Mr A's condition nor arrange for his timely transfer to another hospital for what he considered to be proper palliative care. Mr A died the day after he was transferred.

Mr C made a number of complaints and my investigation found a number of failings. I found that the two out-of-hours GPs who separately attended Mr A assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to another hospital. I also upheld Mr C's complaint that the decision making, care and communication of nursing staff in relation to the provision of palliative care for Mr A was inappropriate.

I did not, however, uphold Mr C's other complaints. Mr C is medically qualified and had Mr A's consent as next of kin with power of attorney. He had also complained that despite this, staff refused to provide him with medical records or allow him to speak to a consultant. I found that the actions taken at the time in response to these requests were reasonable. I also did not uphold the complaint that nursing staff at the community hospital failed to recognise that Mr A's condition was such that he required appropriate medical assistance. I did not find that an inappropriate care and treatment plan was agreed between the staff nurse and the on call consultant pending the arrival of the out-of-hours GP, nor that Mr A's consultant failed to make himself available to meet with Mr C. Finally, I did not uphold the complaint that there was an unacceptable level of care with regard to Mr A's possessions.

I made a number of recommendations to the board, including that they complete a critical incident review of these events, if they have not done so already; consider the practicality of having routine discussions about care escalation for patients admitted to the community hospital and other similar units; consider the means by which it can be ensured that severe illness is promptly recognised in such establishments, by use of suitable scoring systems; consider a strategy for determining the appropriate limits of care as soon as a patient in the community hospital or similar establishment becomes acutely unwell and where there has been no advance care discussion; emphasise to staff in the community hospital the importance of keeping full and proper records, including notes of conversations and telephone conversations; and remind staff of the 'Do Not Attempt Cardiopulmonary Resuscitation' Policy and provide evidence that they have done so.

Nursing care; complaints handling

Tayside NHS Board (201101660)

Following a spinal cord injury Mr C has been wheelchair-bound for many years. Although he has some limited arm movement, he is tetraplegic (i.e. he has significant paralysis) with limited ability to move himself or to feel any pain or discomfort in the lower half of his body. Mr C was admitted to hospital after falling from his wheelchair, causing fractures below both his knees. He was dependent on staff for the majority of his daily living needs, in particular for positioning, and transferring in and out of bed. After three days in hospital, staff identified that he had a pressure ulcer (also known as a pressure sore), and treated it with a dressing and cream. Twelve days later he was discharged from hospital to be cared for at home by the district nursing team. By this time he had a serious pressure ulcer, which eventually meant he had to be referred to a plastic surgeon. He complained to us that inadequate care and treatment in the hospital allowed the pressure ulcer to develop, and that the board did not deal appropriately with his complaint.

I took advice from my nursing adviser who reviewed Mr C's clinical records in relation to the national guidelines that were in place at the time. When he was admitted to hospital, Mr C was correctly assessed as being at high risk of developing a pressure ulcer, and was regularly assessed at first. However, my adviser considered that, after the pressure ulcer was noted, the standard of management fell below national standards because of a knowledge-skills gap in assessing the condition of the ulcer. Having considered the evidence available, I upheld the complaint. Hospital staff clearly recognised that Mr C was at risk of developing a pressure ulcer and made efforts to minimise further injury when one developed. I found clear evidence, however, that they did not identify and grade the seriousness of the wound that developed, or take the most appropriate action in line with national guidance. Mr C then had to endure many months of bed rest and further care to manage this, before being referred to a plastic surgeon. I also upheld Mr C's complaint about complaints handling, as I found that the response was delayed, which the board themselves have acknowledged. I also noted that, while the board's response reflected what was in Mr C's records, it did not provide an explanation for some of the actions that staff took, nor did it reflect that he was discharged from hospital with a significant pressure ulcer which had not been graded.

To try to ensure that this does not happen again, I recommended that the board: ensure their tissue viability training programme provides education and training for the assessment, grading and treatment of pressure ulcers in line with national guidance; undertake an audit of wards in the hospital to ensure that pressure ulcer care and management is in line with national guidance and best practice; and provide details of the outcome of their review of their complaints procedure to ensure that investigations are evidence based and undertaken without undue delay.

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Case Summaries

Health

Dental care and treatment; referrals

Lothian NHS Board - University Hospitals Division
(201104004)

Mr C had most of his teeth extracted some years ago, and since then has had considerable difficulties managing with his conventional dentures. As these difficulties were having a significant impact on his day-to-day living, he asked his dentist for help. The dentist referred him to the oral surgery department of the dental institute, where he saw a specialist who considered that Mr C was suitable for restorative treatment. She tried to refer him to the department for restorative dentistry. The consultant there, however, said he could not help and (without assessing Mr C) said that the department could not provide conventional dentures and that Mr C's own dentist should be able to provide the necessary treatment. Mr C complained that the board unreasonably refused to give him an appointment with the department, or to inform him of alternative options to conventional dentures, and had simply referred him back to the dentist who had referred him for specialist treatment initially.

I took advice from my dental adviser, having obtained a copy of Mr C's dental records and of the institute's guidelines for referring patients to the department, and upheld the complaint. I found it unreasonable that, given the history of Mr C's difficulties, the consultant did not arrange to see him. This was clearly not a straightforward case, and the consultant could not have fully understood Mr C's difficulties or suggested alternative treatments without seeing him. I also criticised the board because the consultant said that the department could not help, which appears to contradict the institute's guidelines. I found these comments unhelpful, particularly given the significant effect that these difficulties were having and continue to have on Mr C's life. I made a number of recommendations to the board to address the failures identified in my report, including that they: urgently arrange for the department to examine Mr C; draw my report to the consultant's attention, and ensure that the services described in the guidelines are in fact being provided. I also said that I expect the board to take steps to ensure that this type of situation does not happen again.

Scottish Government and devolved administration

Child protection; complaints handling; communication

Scottish Government's Learning Directorate
(201103092)

Mr C complained to the Learning Directorate of the Scottish Government about the way in which the Registrar for

Independent Schools conducted an investigation into Mr C's request that a notice be served on a school under section 99 of the Education (Scotland) Act 1980. Mr C made the request because he was dissatisfied with how the school conducted an investigation into an allegation of sexual assault by another pupil on his son (Master C).

Mr C had concerns about how the school dealt with the allegation. He also took issue with a report that was prepared by Her Majesty's Inspectorate of Education (HMIE). He claimed that it was misleading and incomplete and that because of this the Registrar referred to factually inaccurate information when advising Scottish Ministers to decline the section 99 notice request.

I upheld Mr C's complaints that the Registrar unreasonably failed to undertake a thorough investigation of his complaint by not consulting with the social work department concerned; and that the Registrar's report was based on factually incorrect information. I suggested that the Registrar could have been more robust in his approach and could have sought clarification from the department, given the significance of the allegations, the findings of the HMIE inspection, and the reporting guidelines set out in the National Guidance for Child Protection in Scotland. I also noted a number of inconsistencies between the school's records and the HMIE report referred to by the Registrar in his advice to Ministers, and noted that the Learning Directorate accepted that there had been inconsistencies. As, however, I make clear in my investigation report I am not suggesting that, had these failings not taken place, the Registrar's advice to Ministers would have changed. Given the seriousness with which child protection matters must be treated, however, addressing these concerns would have ensured that the whole process appeared thorough and impartial to those concerned.

I made a number of recommendations for redress, including that the Learning Directorate ensure that written procedures are in place for investigating and reporting to Ministers when a request is made for a section 99 notice to be served; ensure that any recommendations made by the Registrar in relation to a request for a section 99 notice to be served are notified to all relevant parties; draw the findings of this investigation to the attention of the Registrar; and apologise to Mr C and Master C for the failings identified in my report.

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Scottish Government and devolved administration

Transfers; communication

Scottish Prison Service (201101643)

Mr C, who was a prisoner, complained when the prison he was in decided to transfer him to another prison establishment. Mr C said the decision was unreasonable because he was about to start medical treatment at the first prison. He also said that, when he complained, the first prison did not explain to him why he was being transferred.

The prison was overcrowded, which was the main reason for considering transfers. When I asked the first prison about the process involved, I found that the process of transfer is informal, and involves drawing up a list of those considered appropriate for transfer and sending it to the second prison. Although the final decision is down to prison management, the process normally includes contacting staff in the first prison, including the health centre, to find out if there are any concerns about transfer. However in this case I found no evidence that health centre staff had been asked about this. When I asked the health centre if they had raised any concerns they told me that Mr C had suffered from his painful condition for a long time, and was

in fact due to begin a specific treatment for it the day after he was transferred. Mr C's medical needs could be met in the first prison because the necessary specialised equipment was on site, along with nursing staff who were trained in its use. A member of the health centre staff had spoken to a member of prison staff after they became aware that Mr C had been listed for transfer, to say that they thought the transfer inadvisable. There were no records of this conversation, or of the reasons why the first prison decided to transfer Mr C despite this advice.

I upheld Mr C's complaints. I found that there were failings in the first prison's handling of Mr C's transfer. The first prison did not believe that the medical treatment was critical enough to stop the transfer, but the health centre felt Mr C should not have been transferred because he was about to undergo the treatment. There was also no evidence to confirm whether the decision to transfer Mr C was taken after careful and proper consideration of all relevant information, such as that from the health centre, or of the relevant Action Notice that was issued by the Scottish Prison Service. Nor did the prison respond to Mr C's complaint, even after I gave them the opportunity to do so. I, therefore, recommended that the Scottish Prison Service put in place a national process for all prison establishments to follow when transferring prisoners, and to ensure the process allows for significant and relevant information to be obtained, considered and recorded as part of the decision making process. I also recommended that the first prison apologise to Mr C for failing to respond to him directly about his complaint.

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, 19 September 2012

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

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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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