# Ombudsman's Commentary

SPSO Scottish Public Services Ombudsman

## February 2012

The SPSO laid four investigation reports before the Scottish Parliament today, all relating to health boards. We also laid a report on 45 decisions about most of the sectors under our remit. These can be read on the 'Our findings' section of our website (www.spso.org.uk/our-findings).

### Case numbers

Last month (in January) in addition to the four full reports laid before the Parliament we determined 355 complaints and handled 61 enquiries. Taking complaints alone, we:

- gave advice on 258 complaints
- resolved 61 in our early resolution team
- resolved 36 by detailed consideration
- made a total of 23 recommendations in decision letters.

## Ombudsman's Overview

### Launch of Draft Strategic Plan 2012–16

Today we launch our draft Plan, and invite comments on it. The Plan sets out our high-level key objectives for the next four years. As with previous plans, this Plan will be used to drive continuous improvement in the services that we provide to our stakeholders.

The five strategic objectives reflect our current statutory obligations and the related core functions that we are required to deliver. In summary, these are:

- Providing a high quality, timely, independent case handling service
- Ensuring compliance with recommendations and publishing good practice from casework
- Facilitating good practice in complaints handling
- Simplifying complaints handling systems in Scotland
- Delivering continuous improvement in service and efficiency to SPSO.

The Plan sets out how I propose to achieve our objectives and a timetable and estimates of the costs of doing do. The Scottish Parliamentary Commissions and Commissioners etc. Act 2010 requires us to seek comment on the Plan and I warmly invite our stakeholders to do so.

You can read the Plan by visiting our website and using the consultation form to respond by 14 March 2012. The form contains a number of questions relating to the Plan, including our equalities commitments. We will consider your comments, and explain any resulting changes in the final Plan which we aim to publish on 30 March 2012.

Thank you for helping us in this important work that will help guide the future of the SPSO.

### Complaints Standards Authority Update

***Local Government***

We have received comments on the final draft of the local government model Complaints Handling Procedure (CHP) and the associated customer and staff documents. These drafts will be discussed at a meeting of the working group of local authority representatives on 22 February 2012. The finalised documents will then be published by the SPSO in March as the final model CHP for the local government sector.

As previously outlined, compliance with the model CHP will be monitored by Audit Scotland as part of their existing annual audit processes. Monitoring of performance against the CHPs will also be developed and built into existing self-assessment arrangements. Further detail on the monitoring arrangements will be provided on publication of the documents.

***Housing***

Since our last update we have issued a second draft of the housing CHP which takes into account the comments of key stakeholders in the sector. A further meeting of the advisory panel set up to provide detailed feedback on the model CHP will take place on 21 February.

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## This month's findings

**Hospital – care of the elderly; clinical treatment; communication; complaint handling**

Greater Glasgow and Clyde NHS Board – Acute Services Division (201003976)

**Clinical treatment; complaint handling**

Borders NHS Board (201101334)

**Care and treatment**

A Medical Practice, Lothian NHS Board (201003214)

**Clinical treatment; diagnosis**

A Medical Practice, Lothian NHS Board (201004092)

## Complaints Standards Authority Update *(continued)*

***Housing***

We are pleased with the detailed responses received so far and the constructive nature of the feedback. We will continue to work with the sector towards our target deadline for introducing the housing CHP by April. We have also continued our discussions with the Scottish Housing Regulator on the future monitoring of compliance and performance against the CHP within the framework of the Scottish Social Housing Charter.

***Further Education***

We have been in discussions with Scotland's Colleges on plans for developing the model CHP for the further education sector and are hoping to establish a working group to provide comment and feedback on the emerging CHP. Further information will be provided in due course but if you are interested in becoming involved in this work please contact Paul McFadden, CSA Manager, at CSA@spso.org.uk.

***Valuing Complaints – CSA Best Practice and Training***

A key role of the CSA is to develop, monitor and promote best practice in complaints handling in the public sector. We are currently at a key development stage of our Valuing Complaints website which will be the platform for providing SPSO best practice guidance and training resources.

Our new site will play host to the SPSO online training centre, a discussion forum for complaints handlers, a blog written by the CSA unit and guest bloggers, and a best practice resource centre. The online forum will provide a platform for discussion among public sector complaints handling professionals to share expertise and best practice across all sectors. The training centre will incorporate an online training facility which will be focused, in the early stages, on providing training for frontline staff on the key skills required for frontline resolution in line with the new complaints handling procedures.

**The CSA team is happy to provide further information on the emerging model CHPs and can be contacted at CSA@spso.org.uk. See the CSA website for more information: www.valuingcomplaints.org.uk**

## Case Summaries

# Health

### Hospital – care of the elderly; clinical treatment; communication; complaint handling

Greater Glasgow and Clyde NHS Board – Acute Services Division (201003976)

Mr and Mrs C raised a number of concerns about the treatment of Mrs C's mother (Mrs A) at the Southern General Hospital. They complained that staff failed to monitor her condition properly or provide her with effective treatment. Mr and Mrs C raised further concerns about staff communication, record-keeping, a lack of patient dignity and a failure to provide stimulation for patients with dementia.

My investigation upheld all the complaints. I found that there was a failure to provide appropriate care and treatment to Mrs A, who was dehydrated and had a number of falls on the ward. After one of these falls, Mrs A was not x-rayed as she should have been. I also found that the nursing notes contained inaccurate and inconsistent information along with unprofessional language. Communication between ward team members and the family was poor, and my report notes that on occasions Mr and Mrs C were not advised of falls and the severity of Mrs A's injuries was not explained to them. I found that the handling of the complaint was poor and not in line with the standards set out in the board's complaints procedure. I made a number of recommendations for redress and improvement.

I would like to draw to all health boards' attention a paragraph in the report that I believe contains an important, wider message about treatment of patients with dementia on acute wards. I say in the report that my independent advisers (a mental health and a nursing specialist) *'both expressed concerns regarding the Board's approach to the treatment of patients with dementia. They considered that scant regard was given to Mrs A's mental health needs or to treating her as an individual. They also considered that there was little evidence of a cohesive care plan being put in place for Mrs A. Both advisers felt that there was a general lack of understanding of how to manage the type of behaviour displayed by some patients on [the ward] and that there was no effective strategy in place to manage those patients' behaviour.'* I urge boards to reflect on this case and on how they can ensure that staff on acute wards are equipped to deal not only with pressing clinical needs but also to manage the particular challenges of people in their care who also have dementia.

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# Case Summaries

## Health

### Clinical treatment; complaint handling

Borders NHS Board (201101334)

Mrs C raised a number of concerns about the treatment she received at Borders General Hospital following cataract surgery. I did not uphold all her complaints but I did find a number of clinical failings and also that the complaint handling by the board was inadequate.

Mrs C had a cataract operation as a day case and on removing the patch the following morning she could not see. The consultant who had carried out the operation thought he had nicked Mrs C's sclera (the tough white outer coating of the eye) with the needle containing anaesthetic during the operation and this had caused a haemorrhage. Later, having diagnosed bleeding and detachment of the retina, Mrs C had a series of operations and she now has limited vision of shade and outline only.

My investigation found that the choice of anaesthetic used was inappropriate because Mrs C had high myopia (near sightedness) which meant that her eyeball was significantly larger than usual and so at increased risk of perforation. I found that staff should have considered an alternative method of anaesthesia. I also found Mrs C's post-operative care and treatment was inadequate. In particular I found that there was an unreasonable, unexplained and unacceptable delay in referring Mrs C for a specialist opinion. My independent medical adviser concluded that Mrs C had suffered permanent sight loss through the inappropriate method of administration of local anaesthesia and that there had been a failure to recognise and deal with the complications promptly. Finally, I also found that the complaint handling by the board was inadequate, and that some of the board's responses to Mrs C's complaints were ill-informed, inadequate and disingenuous.

I made three recommendations to the board to address these failings and improve their practice in a number of areas. I also made two recommendations about apologies to Mrs C.

### Care and treatment

A Medical Practice, Lothian NHS Board (201003214)

Mrs C raised a number of concerns about the care and treatment provided to her late mother (Mrs A) by the medical practice she attended for several years leading up to her death from cancer. Mrs A had a complex medical history and had suffered from back, leg and hip pain over several decades. She attended the practice from November 2009 to May 2010 complaining of a number of conditions including increased back pain, night sweats and constipation.

In May 2010, a home visit request was made but before this took place Mrs A's family became so concerned about her that they called an ambulance and Mrs A was admitted to hospital. An initial possible diagnosis was a respiratory tract infection and then a bone marrow test showed that Mrs A had secondary cancer in her glandular tissue. Palliative treatment was provided and Mrs A was transferred to a hospice where she died in June 2010.

While my investigation did not uphold the complaint that the practice had not listened to the concerns raised by Mrs A and her family, I did find that they failed to carry out adequate tests and investigations and that they did not take adequate steps to help with the diagnosis of Mrs A's cancer. My independent general practice adviser found that from March 2010 Mrs A's symptoms were such that the practice should have reconsidered their earlier findings and carried out additional tests. For example, repeating blood tests would have noted an abnormality and have prompted further investigation and/or earlier referral to hospital, which may have allowed for an earlier diagnosis to be made. The adviser concluded that the care given to Mrs A was deficient, in that the practice did not investigation her on-going and progressive symptoms with sufficient vigour.

I made three recommendations to address the failings identified in this case and to bring about improvements.

### Clinical treatment; diagnosis

A Medical Practice, Lothian NHS Board (201004092)

Mrs C raised concerns about the care and treatment her late mother (Mrs A) received from her medical practice. Mrs A died after she was transferred from a day hospital to Edinburgh Royal Infirmary, the day after she had attended the day hospital for an out-patient assessment. Mrs C complained that the practice had failed to refer Mrs A to the day hospital after her consultation at the practice two months earlier. However, I was satisfied that the symptoms Mrs A presented then did not justify a referral and I did not uphold this aspect of the complaint.

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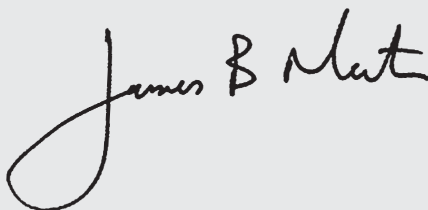
## Case Summaries

Mrs C also complained that the practice failed to monitor the fluid on Mrs A's lungs. Mrs A had been prescribed diuretic tablets and was not monitored to see how much water was draining from her lungs or to see if the tablets were working. My investigation found that the records showed a lack of appropriate monitoring and concluded that in the absence of weight measurements and serial examination findings, the monitoring was deficient. I upheld this complaint and recommended that the practice ensure that patients are appropriately monitored and the outcomes recorded during the course and administration of diuretics.

I also upheld the complaint that the practice had failed to treat Mrs A's cellulitis adequately by only prescribing antibiotics, by not arranging for attention by a district nurse and by failing to follow up Mrs A's condition.
I recommended that the practice conduct a Significant Event Analysis on the case and I also recommended that they make a full apology to Mrs C for the failures identified in the report.

## 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, 15 February 2012**

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

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# Ombudsman's Commentary

## February 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:

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