Ombudsman's Commentary

SPSO Scottish Public Services Ombudsman

January 2012

The SPSO laid four investigation reports before the Scottish Parliament today, all relating to health boards. We also laid a report on 49 decisions about all the sectors under our remit. These can be read on the 'Our findings' section of our website (http://www.spso.org.uk/our-findings).

Case numbers

Last month (in December) in addition to the six full reports laid before the Parliament we determined 265 complaints and handled 33 enquiries. Taking complaints alone, we:

- gave advice on 179 complaints
- resolved 55 in our early resolution team
- resolved 31 by detailed consideration
- made a total of 32 recommendations in decision letters.

Ombudsman's Overview

Further reminder of obligation to provide full information

Last month I highlighted that authorities under my jurisdiction are required by law to provide all relevant information to me on request. I stated in my December Commentary that I was disappointed that a Board in a case I reported on that month did not provide all the relevant information to me at the beginning of my investigation. It is a matter of concern to me that I have found this month that a different NHS Board also failed to provide full information on a timely basis when requested, in the course of an investigation that will be reported later this year. I would like to remind Boards and all other listed bodies that they must fulfil their obligations under the SPSO Act.

Annual Letters to Health Boards

This month we issued our Annual Letters to NHS Boards. These provide summary information about the complaints that I received and considered, and the decisions that I reached last year (2010 – 11). The letters contain summaries of the outcome of and recommendations on all complaints for each Board about which I laid a report before the Parliament. To see the letters, visit our website at http://www.spso.org.uk or click here.

Corporate Strategic Plan

Later this month I will be issuing our draft corporate strategic plan. In accordance with Section 17A of the Public Services Reform Act, the plan sets out 'how the Ombudsman proposes to perform the Ombudsman's functions during the 4 year period.' It is a high level plan that states my objectives and priorities over the period; how I propose to achieve them; a timetable for doing so, and estimates the costs of doing so. I will publish the draft plan on the SPSO website and will be inviting responses from stakeholders.

Complaints Standards Authority Update

Local Government

In the December commentary, we provided an update on our discussion with SOLACE's meeting of local government chief executives on the model CHP for that sector. Since then we have met with the working group of local authority representatives to outline the next steps in finalising the model CHP and the accompanying customer facing document. There are a number of tasks required to refine the presentation of both documents. Once the documents have been finalised, taking into account discussion with the working group, the SPSO will publish these documents as the final model CHP for the local government sector.

As we have previously indicated, 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. We are working with Audit Scotland to develop further detail on the monitoring arrangements which will be provided when we publish the documents.

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This month's findings

Follow-up care; record-keeping; complaints handling

A Medical Practice, Forth Valley NHS Board (201002075)

Clinical treatment; nursing care, communication; record-keeping; complaints handling

Fife NHS Board (201003402)

Clinical treatment; nursing care; communication

Greater Glasgow and Clyde NHS Board – Acute Services Division (201003696)

Delay in diagnosis

Grampian NHS Board (201100257)

Ombudsman's Commentary

January 2012

Complaints Standards Authority Update *(continued)*

Social Work

Discussion at the local government working group also focused on the Scottish Government's current consultation on the future of social work complaints arrangements. The consultation was launched in December and is available on the Scottish Government's website at: http://www.scotland.gov.uk/Publications/2011/12/21143818/0. The deadline for responses is 18 March 2012.

Housing

Since our last update we have received feedback on our draft model CHP from key stakeholders in the sector including the Scottish Federation of Housing Associations, the Glasgow and West of Scotland Forum of Housing Associations and the Chartered Institute of Housing. In December we held the first meeting of the advisory panel set up to provide detailed feedback on the model CHP with a second meeting planned for February.

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 this model early in the new business year. We have also continued our discussions with the Scottish Housing Regulator on the model CHP and on the future monitoring of compliance with the model CHP.

The CSA team is happy to provide further information on the two 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

Follow-up care; record-keeping; complaints handling

A Medical Practice, Forth Valley NHS Board (201002075)

Mrs C raised a number of concerns about delays and failures in the care and treatment of her mother (Mrs A) by a medical practice. She was also dissatisfied with aspects of the practice's response to her complaints.

Mrs A attended the practice complaining of tingling and numbness in her hands. A first possible diagnosis of polymyalgia rheumatica was made and she received treatment for that condition. It did not work, and she was referred to a neurology clinic and had a neck MRI scan. After further appointments and advice she was diagnosed with carpal tunnel syndrome and was admitted for surgery whereupon a further investigation was made and eventually a diagnosis of cervical myelopathy (pressure on an area of the lower spinal cord which causes loss of function in the arms and legs) was made. Mrs C complained that there had a been a lengthy delay in diagnosing and treating her mother's condition and she felt that this was due to inaction on the part of doctors in the practice.

My investigation found that there were delays in acting on an overall deteriorating clinical picture and we upheld Mrs C's complaint about care and treatment provided by the practice. Although I did not uphold Mrs C's complaint that the practice did not take reasonable action in response to information provided about planned investigations into her mother's health, I was critical of the practice's view of their responsibilities. In this regard it will be instructive for the practice to note the comments of one of my medical advisers, as follows:

The adviser was particularly critical of the view expressed by the practice in their response that *'once you [Mrs A] were referred to a consultant at the hospital it is their responsibility for your treatment'*, which the adviser considered was inaccurate. The adviser stated that, while it subsequently transpired that specialist opinions had led to an erroneous diagnosis being made, this did not absolve the practice from its duty of care to act on behalf of Mrs A as her advocate and ensure continuity of care. He said that if questions arise, it is the GP's function to question on behalf of the patient. While a GP will usually defer to specialist opinion, this does not mean a GP should suspend their own clinical view, especially in the face of progressive symptoms, or where the clinical picture is at odds with the known facts.

I upheld Mrs C's final complaint about the practice's response to her original complaint. I concluded that the practice has reflected already on the impact of Mrs A's care pathway and the broader learning from this complaint for other patients and I made a number of recommendations. These can be read in full in my report.

Ombudsman's Commentary

January 2012

Case Summaries

Health

Clinical treatment; nursing care, communication; record-keeping; complaints handling

Fife NHS Board (201003402)

Mrs C raised a number of concerns about the care and treatment of her late mother (Mrs A). Mrs A, an 83-year-old woman, was referred to the hospital by her GP to address fluid retention, assess kidney function and improve her mobility. She was admitted with cardiorespiratory symptoms. After a period of gastrointestinal illness due to an outbreak in the hospital of the norovirus infection that Mrs A contracted, her breathing deteriorated and she died at the hospital about three weeks after admission.

Mrs C made nine complaints, relating to clinical treatment, nursing care, communication, record-keeping and complaints handling. I upheld seven of them, in one case describing the failings as 'significant' and did not uphold two. I made eight recommendations for redress and improvement. The recommendations included reviewing the means by which the clinical judgements of Hospital at Night members who see patients independently are monitored; conducting a review of information handover from team to team, with a view to identifying how this can be strengthened; considering my adviser's comments on the failings in Mrs A's nursing care and drawing up and implementing an action plan to address these failings; ensuring that serious complaints are appropriately recorded and investigated; informing me of the outcome of their discussions with regard to completing death certificates and telling me what measures they have taken to ensure that, in future, the cause of death listed on a death certificate is accurate; and ensuring that clinical records are thoroughly reviewed as part of their investigation process and prior to providing responses to complaints.

Clinical treatment; nursing care; communication

Greater Glasgow and Clyde NHS Board – Acute Services Division (201003696)

Miss C complained that the board failed to properly identify health complications leading to her father (Mr A's) death. Mr A was admitted to hospital to have a large bladder tumour removed. Following the operation, his condition deteriorated and he died four days later. Miss C complained that health care professionals had failed to act on the symptoms indicating Mr A's rapid deterioration before his transfer to the intensive care unit. She also complained about the nursing care Mr A received and of problems in communication with the nursing staff. Miss C said that as a result of the board's failures, she remained very distressed at her father's death and believed that it may have been prevented had the board acted properly.

Miss C complained about the clinical treatment, nursing care and communication. With regard to the complaint about the standard of medical care Mr A received following his operation, the advice I accepted is that the medical care in relation to the MEWS (modified early warning score) systems and assessment of the episode of collapse were below a standard that could reasonably be expected. My reports states: *'These failures meant that Mr A's deterioration was not acted upon and his care was neither optimal nor timely, and suggested a systematic problem that needs to be addressed. However, it was impossible to say if the outcome would have been different had Mr A received a better standard of care.'*

The investigation found that some specific areas of nursing care provided to Mr A were reasonable, but that there were failures in relation to adhering to the MEWS system. Nursing staff failed to act upon MEWS scores and did not take appropriate further action or inform other members of staff as they should have done. A record that Mr A was very confused was not fully investigated and nursing staff also failed to complete the MEWS charts accurately. The adviser concluded that *'The nursing role was crucial to early assessment and intervention of patients who were deteriorating, so the failings in this case were significant and needed to be addressed.'*

I also upheld Miss C's complaint about the failure of nursing staff to communicate adequately with her about her father's care. I made four recommendations to address the several failings identified in this case and to bring about improvements.

Delay in diagnosis

Grampian NHS Board (201100257)

Mrs C complained that there was an unreasonable delay by clinicians in diagnosing that her daughter (Miss A), who had pneumococcal meningitis in August 2007, was profoundly deaf. Miss A had been reviewed at the Child Hearing Assessment Clinic on a regular basis but it took until January 2010 for the diagnosis to be made.

Miss A was three months old when she was admitted to hospital in August 2007 with a five day history of chickenpox, increasing irritability, refusing feeds and vomiting. A diagnosis of pneumococcal meningitis was confirmed and she was treated with intravenous antibiotics and discharged. Audiology follow-up was requested and Miss A was reviewed and assessed over the following year. In November 2008 she was found to have bilateral middle ear effusions and short term grommets were inserted. At a further review in June 2009 it was noted that Miss A had shown signs of significant speech and language delay with no identifiable words and she did not seem to copy anything that was spoken. Miss A was then admitted in August 2009 for insertion of grommets and an adenoidectomy.

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Ombudsman's Commentary

January 2012

Case Summaries

Health

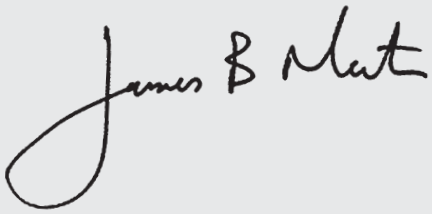
At a review appointment in December 2009, Mrs C again told clinicians of her concerns that Miss A had hearing loss. In January 2010, an Evoked Response Audiometry (ERA) test was carried out which resulted in the diagnosis that Miss A is profoundly deaf.

The medical advice I received in this case was that *'…the opportunity to make an early definitive diagnosis was missed and so too was the opportunity to perform bilateral cochlear implants at an early stage after the meningitis. The Adviser felt that to have relied on what were very soft measures of hearing testing for such a long time without further investigation was not good practice. Furthermore the Adviser said that if ERA had been performed at an early stage then Computed Tomography (CT) or MRI scanning of the cochlea could have been undertaken and urgent cochlear implantation carried out bilaterally before ossification of the cochlea occurred. As it was, with such a delay in diagnosis it has proved impossible to implant on Miss A's right ear as there was no reserve cochlea for salvage implantation.'*

I therefore upheld this complaint and made a number of recommendations to the board.

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, 18 January 2012

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

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Ombudsman's Commentary

December 2011

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**

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