

## Monthly news from the Scottish Public Services Ombudsman

The SPSO laid two investigation reports before the Scottish Parliament today, about complaints about two different health boards. We also laid a report on 77 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](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in December 2012) in addition to the three investigation reports we laid before Parliament, we determined 223 complaints and handled 61 enquiries. Taking complaints alone, we:

- gave advice on 124 complaints
- resolved 63 in our early resolution team
- resolved 36 by detailed consideration
- made a total of 63 recommendations in decision letters.

## Ombudsman's Overview



Earlier this month, I gave evidence to the Parliament's Health and Sport Committee about the regulation of the care of older people in acute settings. You can read my briefing to the Committee [here](#), and read the report of what I said in the evidence session [here](#). Yet again, one of the investigations I am laying today (201200306) is about failings in the care and treatment of an elderly patient in hospital. The other investigation (201104965) is into a complaint by the mother of a woman who died in hospital in which I found failings in both the clinical and nursing care. There is learning in these complaints for the boards concerned and I would urge all boards to also read the report and my recommendations for redress and improvement.

I will be giving evidence to the Parliament again today, 23 January 2013. This is my regular appearance before the Local Government and Regeneration Committee which scrutinises my annual report. In my **briefing** to the Committee, I outline the increase in demand for our service and in our productivity, and provide commentary on significant trends. I also describe the major milestones that have been reached by our Complaints Standards Authority, especially in relation to the local government sector. Finally, I raise some of the potential changes in the pipeline that we expect will impact on our work over the next few years.

## Complaints Standards Authority Update

### Further and higher education – model procedures published

Model complaints handling procedures (CHPs), one for the further education (FE) sector and one for the higher education (HE) sector, were published on 19th December 2012. All universities and colleges in Scotland were notified that the model CHP applies to them with effect from that date. To see the model CHPs and associated documents, visit [www.valuingcomplaints.org.uk/further-and-higher-education/](http://www.valuingcomplaints.org.uk/further-and-higher-education/)

We also published an implementation guide detailing requirements for adoption and compliance and an outline of requirements for publishing information on complaints performance. Each university and college should, by 28th June 2013, provide the SPSO with a compliance statement and a self-assessment of compliance to confirm that their CHP complies with the published model CHP, or will comply with the published model CHP by 30 August 2013. All universities and colleges are required to have implemented the model CHP by 30 August 2013. The CHPs will be incorporated into the Scottish Funding Council's financial memorandum for FE and HE institutions.

Please address any questions about the model CHP, or the requirement to implement, to the CSA team at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

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### **Local authority complaints handling network**

The local authority complaints handling network will meet on 25 January at South Lanarkshire Council. The focus will be on monitoring and reporting complaints performance including developing performance indicators.

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### **Housing complaints handlers network**

Information will be provided shortly on the dates and agenda for the next meeting of the registered social landlords complaints handling network.

If you would like more information about the network, or are interested in joining, please visit the forum on our Valuing Complaints website [www.valuingcomplaints.org.uk/forum](http://www.valuingcomplaints.org.uk/forum) or contact the CSA team for details.

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### **Training and Valuing Complaints forum**

Our e-learning training modules on frontline resolution are available through our training centre at [www.spsotraining.org.uk](http://www.spsotraining.org.uk). These courses have been developed to help with the introduction of the model CHPs for each sector. This training is available to all public sector bodies and is currently free.

Places are still available for our face to face complaints handling training course for all sectors on 29 January in Edinburgh. This includes frontline complaint handling (stage 1 of the model CHP) and complaint investigation skills (stage 2 of the model CHP).

As always, the CSA team will be happy to provide further information on any aspect of this work and can be contacted at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk).

We would also encourage all complaints handlers to log on and join the discussions on the online complaints handling forum at [www.valuingcomplaints.org.uk/forum](http://www.valuingcomplaints.org.uk/forum). If you have any questions on implementation, put them up on the forum and you will get a response from the CSA team or from other complaints handlers.

See the CSA's Valuing Complaints website for more information: [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)

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### **Fair and Equal: How does the Equality Act 2010 affect complaints handling in Scotland?**

As highlighted in our last update, we have published an article on our Valuing Complaints website which explains that for people working in the public sector, including in complaints handling, there are many implications of the Equality Act.

We would encourage you to read this article which can be found **here**. We would ask anyone working in complaints handling in the public sector in Scotland who has already begun to work on equality and complaints handling, developed good practice policies and procedures or indeed is struggling with a particular area of the Equality Act, to provide comments on the article or ask questions through the Valuing Complaints forum or by contacting the CSA team.

# Investigation Reports



Investigation report ref: 201200306

**Clinical treatment; diagnosis; hospital discharge planning; communication**  
Greater Glasgow and Clyde NHS Board – Acute Services Division

## Summary

Mr C had suffered from prostate cancer for 11 years. His wife (Mrs C) raised a number of concerns about her husband's care when he was treated in two different hospitals over a six month period before he died. I upheld her complaint that staff failed to provide her husband with timely and adequate pain relief when he reported problems with his catheter. The independent advice I obtained on this point from three different specialists was unanimous that Mr C had been left in pain and discomfort too long before his catheter was removed (with one adviser questioning whether a catheter was appropriate at all). The note-keeping and communication was also found to be fragmented and inconsistent, and communication between the various health teams and specialists involved was below standard, particularly taking into account Mr C's poor prognosis and terminal illness.

On Mrs C's second complaint about Mr C's final discharge, I did not find that he was unfit for discharge, but I did find evidence of sparse information in the notes and poor planning for his discharge. I upheld the complaint that staff failed to ensure that an adequate home care package was in place on discharge, including palliative care, and that they failed to provide advice about agencies which could assist if required. It was only two days before he died that Mr C was taken into a hospice where he was provided with a high standard of care, attention and adequate pain relief. Further, I found that the level of communication between staff and Mr C's family was inadequate in a number of different situations that are outlined in the report.

The final aspect of the complaint was about the GP out-of-hours service. I found this to be inadequate, with three different doctors prescribing three different antibiotics (one of which contained penicillin, to which Mr C was allergic). On this last point the doctor concerned and the board have already made sincere apologies and I therefore did not recommend further action. Overall, however, I made a total of six recommendations to the board for redress and improvement in relation to this investigation.

Investigation report ref: 201104965

**Clinical treatment; diagnosis; nursing care**

Highland NHS Board

**Summary**

Ms A was admitted to have her lymph glands removed and discharged after a few days. She was then readmitted with what her mother (Mrs C) said was a leaking wound and a temperature. When Ms A recovered she was transferred to a hospital closer to her home but then returned to the first hospital with respiratory problems. She died a month later, and Mrs C complained to us that her daughter had been wrongly discharged after the initial operation, that her care and treatment were inadequate, and about her level of fluid and nutrition intake. I did not uphold the first complaint about Ms A being inappropriately discharged because I agreed with the independent medical advice I received that it was only with the benefit of hindsight that it could be seen that Ms A was developing a significant wound infection.

However, I did uphold Mrs C's other complaints. My investigation found that Ms A had complex problems including pneumonia, problems with her kidneys, a wound that failed to heal properly and she was clinically obese. The independent advice that I received from a clinical adviser was that Ms A's condition should have been recognised as warranting her immediate transfer to the Medical Special Care Unit on her readmission to the first hospital. She should also have been under the care of a chest physician rather than a gastroenterologist. However, the advice was also clear that there was no evidence that the delayed transfer necessarily affected the outcome. The clinical adviser found that the gastroenterologist did not review Ms A satisfactorily or sufficiently frequently and that he should have sought specialist advice given that Ms A's condition was not improving.

On the complaint about fluid and nutritional intake, the independent advice provided by the clinical adviser was that these were sufficient. Both he and my nursing adviser agreed with the board's position to respect Ms A's decision to refuse to eat and drink and the advice from my nursing specialist was that there was good documented evidence that staff monitored and recorded Ms A's intake of fluids and foods. However, I accepted the advice from the nursing adviser that Ms A's nutritional status was not fully assessed and there was a very late referral to the dietician.

I made four recommendations to the board, including that they apologise to Mrs C for the failings in her daughter's care and treatment and to ensure that NHS food and nutrition standards are met in future.

## 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, 23 January 2013**

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

For further information please contact:

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## The Scottish Public Services Ombudsman



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 complaints procedure of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or writing to us, or filling out our online complaint form.

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.



**COMMUNICATIONS TEAM**  
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**SPSO WEBSITE**  
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**VALUING COMPLAINTS WEBSITE**  
W [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)