

Ombudsman's Commentary

JUNE 2011 REPORTS

The SPSO laid seven investigation reports before the Scottish Parliament today. Five are about health boards, one about a local authority and one relating to the Scottish Government and Devolved Administration.

Case numbers

May 2011

In addition to the six reports laid before the Parliament (about seven complaints) we determined 331 complaints and handled 45 enquiries. Taking complaints alone, we:

- > gave advice on 223 complaints
- > resolved 87 in our early resolution team
- > resolved 21 by detailed consideration
- > made a total of 26 recommendations in decision letters.

Ombudsman's Overview

Reporting decisions

As Ombudsman, I take very seriously the SPSO's commitment to openness and transparency. It is also my responsibility to make sure that we use our resources as efficiently and effectively as possible, and find ways of maximising our impact within the financial and legislative constraints that govern our work. As readers of this Commentary will be aware, we publish a small number of investigation reports each month. These are cases that meet the criteria for full investigation and publication that I revised last year. They include significant personal injustice complaints, systemic failure cases, precedent and test cases and cases where there has been significant failure in the local complaints procedure.

As I have frequently said, however, there is far more work done by this office and far more learning to be shared than our investigation reports alone can demonstrate. Today we are laying before the Parliament a report containing summaries of 44 additional cases. We are also putting these on our website. In future we will do this each month, and expect to lay summaries of between 40 and 50 decisions each time. These are complaints that we have resolved by decision letter (technically, they are 'discontinued investigations'). Thanks to legislation which came into force in April 2011, we can now put these cases into the public domain.

As is the case with investigation reports, we will not provide any information that might allow the complainant or any other individual to be identified. If we think there is a possibility of identification, we will not publish the decision.

We are making each decision summary searchable on our website by body, subject and so on. This accessible format is designed to be of benefit to the public, service providers and other stakeholders in several ways:

> **Greater learning provides opportunities for service improvements**

A key purpose is to share learning from the complaints we deal with through publicising more of our findings. This will create opportunities for service providers to learn from one another about what happens when things go wrong and what kind of remedies can put them right. That will, in turn, help organisations identify or avoid problems and deliver service improvements.

> **Sharing good practice**

We see a lot of good work by service providers in how they respond to complaints at the local level. Our new report of decisions will make more of this work visible, helping organisations share good practice within and across the different sectors we deal with. This will help build up a wealth of material to support improvement in how complaints are handled in the public sector.

> **Helping the public understand our role**

Wider publication will help the public, and complainants in particular, understand our role and remit better. By seeing the kinds of complaints that are brought to our office and reading about what we are able to investigate and how we do so, the public will be better informed about what we do. By sharing outcomes, we hope to help manage complainants' expectations of what we can, and cannot, achieve for them.

> **Informing other stakeholders**

By publicising a greater volume of our findings, we are providing a richer seam of information that can be used by stakeholders such as MSPs, the Government and scrutiny and regulatory bodies to inform their work.

Please visit the [Our Findings section on our website](#) to search our decisions summaries.

Investigation report findings

The health cases this month cover a range of issues. One report (201000373) is about the use of anti-psychotic drugs. The Board decided to prescribe these drugs to a woman with vascular dementia without taking into account information from the people involved in her care. They also failed to act in accordance with the Adults with Incapacity Act. I found that staff communication with the patient's family fell below a reasonable standard, as did the Board's practice in relation to record-keeping. I made several recommendations to the Board, and would encourage other Boards to read the report and ensure that their staff are sufficiently aware of the Adults with Incapacity Act and guidelines for caring for patients with dementia.

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There are two cases (201002391) and (201002641) about the same Board where patients suffered pressure sores. As I have said in previous Commentaries, I think there is in Scottish hospitals an unacceptable level of patient suffering due to avoidable pressure sores. In the vast majority of cases, pressure sores develop because of poor nursing care. I am very disappointed that we are still seeing complaints about this. In the cases highlighted today, the Board clearly recognise the unacceptability of pressure sores and have taken action to minimise the risk of recurrence. While this is encouraging, I have asked my complaints reviewers to take special note of pressure sore complaints that they receive, and I will continue to make these cases public until we see no more of them.

I am laying our second report (201002521) about the prison sector since the SPSO took on complaints about prisons in October 2010. The first report (201002487) was laid in January 2011, and like today's report, deals with drug testing. In the report laid today, a prisoner, Mr C, raised a number of concerns about the drug testing procedures when he was suspected on two separate occasions of having taken controlled drugs. We upheld parts of his complaint – that the chain of custody was abused, procedure forms were not properly completed and he was not given the chance to have his urine samples independently tested. We also upheld Mr C's complaint that notices about changes in the testing procedure were put up in the halls after Mr C had been tested and he felt he should have had prior knowledge of this. We did not uphold his complaint that medication he had been issued in the past, or at the time of the tests, was not checked.

I have made it clear that in upholding Mr C's complaint, I am not in any way condoning substance misuse. I recognise that keeping prisons drug-free is an ongoing challenge for the Scottish Prison Service. I made several recommendations to them about training, availability of information to prison staff, record-keeping and devising a policy and protocol that deals with instances whereby a prisoner is suspected of taking non-controlled drugs which have not been prescribed to him/her.

The SPS accepted our recommendations and I welcome their positive response. They have already given careful consideration to our last recommendation – about policy change in relation to testing of non-controlled drugs – because the legal view is that this may well need primary legislation. A change to the current prison rules may not suffice and they are currently working with Scottish Government colleagues to make progress in this area.

Saving trouble, time – and money

Our Director of Corporate Services, Niki MacLean, gave a well-received paper at the White Paper Conference on complaints in Edinburgh on 17 June. Her focus was on

handling complaints right first time and explored ways in which organisations can train and empower frontline staff. This focus on early resolution is at the heart of the work of the SPSO's Complaints Standards Authority, providing benefits to both the service user and the service provider.

To back her claim that complaints are cheaper to resolve before they escalate, Niki quoted some of the small amount of research available, including a 2008 National Audit Office study of complaints to the Department of Work and Pensions which showed that complaints resolved successfully at Tier 1 could be 40 times cheaper to manage than those resolved at Tier 3. She also highlighted a 2005 NAO study relating to England and Wales which estimated that 2% of public service administration costs are tied up in dealing with complaints. For the DWP alone, this was estimated at around £9 million. When the DWP simplified their system, they calculated that their costs dropped to £6.2m.

Complaints Standards Authority update

The work of our CSA on standardising complaints handling procedures (CHPs) continues to move forward. We are taking a phased approach to developing a model CHP for each sector, with local government and housing our immediate priority. Working with the Society of Local Authority Chief Executives and the Convention of Scottish Local Authorities we have established a working group of local authority representatives to develop a model CHP for that sector in line with the framework of the SPSO's complaints handling principles and guidance. The group held its first meeting recently and agreed a broad approach to taking this work forward. Further discussion on this work will take place at our annual Council Liaison Officer conference which is scheduled for 3 August. Further details and invitations for this event will be issued shortly.

On housing we will be meeting key high level stakeholders to discuss a similar approach to developing a model CHP for Registered Social Landlords (RSLs). This will include the Scottish Housing Regulator, the Scottish Federation of Housing Associations, the Chartered Institute for Housing, the Scottish Housing Best Value Network and tenants groups. The emerging Scottish Government proposals on the Scottish Social Housing Charter will also be central to the future development and monitoring of complaints handling with RSLs.

Further engagement with other sectors will be taken forward over the coming months. Details will follow in due course. In the meantime you can contact our CSA team at CSA@sps.org.uk if you would like further information. The Ombudsman's complaints handling principles and guidance can be found at www.valuingcomplaints.org.uk

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case reports

Health

Care of the elderly; communication; record-keeping; policy/administration

Greater Glasgow and Clyde NHS Board (201000373)

Mrs A suffers from vascular dementia and was prescribed anti-psychotic medication from 2008-2010 both in the community by her GP and by the Board during her numerous admissions to hospital. Mr C, Mrs A's son, raised a number of concerns about his mother's care and treatment by the Board. Mr C was concerned about the prescription of antipsychotic drugs and the communication from healthcare professionals treating his mother. He was also concerned about his mother's medical records. I upheld all of his complaints. In relation to the prescription of antipsychotic drugs, I did not find evidence that Mrs A had suffered a definitive adverse reaction to these, but I was concerned that the Board made a decision without taking into account information from the people involved in Mrs A's care and that they failed to act in accordance with the Adults with Incapacity Act. I also found that staff communication with Mr C and his brother fell below a reasonable standard, as did the Board's practice in relation to record keeping. I recommended that the Board carry out an external peer review on the implementation of the Adults with Incapacity Act and guidelines for caring for patients with dementia. I also recommended that the Board audit their record-keeping and storage of medical records to make sure they comply with the relevant guidelines and develop a policy to meet the communication needs of patients with dementia. Finally, I recommended that they apologise to Mr C for the failures identified in my report.

Nursing care

Greater Glasgow and Clyde NHS Board – Acute Services Division (201002391)

Mrs A has multiple sclerosis. She was admitted to hospital suffering from a chest infection, sepsis (a life threatening illness caused by overreaction to an infection) and confusion. During her admission she was also diagnosed with diabetes. In hospital she developed a pressure ulcer (also known as a pressure sore or bed sore), and although it improved, it has not healed since her discharge from hospital and has affected her life quality. Mrs C, Mrs A's mother, complained that while in hospital Mrs A did not receive reasonable care and treatment and that this led to the pressure ulcer developing. When Mrs A complained to the Board they investigated her concerns and upheld her complaint as they found there had been a lapse in clinical care. Commendably, they put in place learning from the complaint in terms of reducing the incidence of pressure ulcers. I also upheld Mrs C's complaint to me.

During my investigation, I found that there was no record that the Board had made a 'Waterlow Assessment' when Mrs A was admitted. This was first recorded five days after her admission, after the pressure ulcer developed. This assessment uses a number of factors to work out the likelihood of a patient developing a pressure ulcer and enables preventative action to be taken to avoid this. I note that my professional nursing adviser said that, given her other underlying medical problems, Mrs A was at high risk of developing a pressure ulcer so it was possible that this might have developed even if the assessment had been carried out. I also noted that after the ulcer was found, it was appropriately treated. However, I upheld Mrs C's complaint, noting the impact that the pressure ulcer had, and continues to have, on the quality of Mrs A's life. Because the Board had already taken appropriate action with a view to reducing the incidence of pressure ulcers, I made no recommendations.

Care of the elderly; nursing care; communication; complaints handling

Greater Glasgow and Clyde NHS Board (201002641)

Miss A was admitted to hospital with a urinary infection and confusion. While she was in hospital she was diagnosed with and treated for pneumonia, and she also developed pressure ulcers (also known as pressure sores or bed sores). Miss A's family were not told that she had pneumonia. On the day she was discharged, she was seen by her GP and readmitted to another hospital where she later died. Mrs C, Miss A's niece, raised a number of concerns about her aunt's care and treatment, including failures in communication. Mrs C was also concerned about the way that the Board handled her complaint.

I upheld all of Mrs C's complaints. In terms of care and treatment, my area of concern was that Miss A developed pressure ulcers and I noted that the Board's tissue viability nurse strongly criticised this as part of the Board's investigation of Mrs C's complaint. My adviser was also very critical of this, and agreed with the nurse's comments. I also found that overall, staff communication with Miss A's family fell below a reasonable standard. I was particularly critical of this, given that Miss A was noted to be confused on her admission, and that staff should have kept Mrs C fully informed about Miss A's condition and treatment. However, I did not make any recommendations on either issue as the Board have already taken satisfactory steps to address both. I also upheld the complaint about complaints handling as there were delays and the Board failed to inform Mrs C of her right to approach my office. I recommended that the Board review their procedures to ensure they deal with complaints in accordance with the NHS complaints procedure in future, and that they apologise to Mrs C for the failings identified in my report.

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Health

Clinical treatment: diagnosis

Highland NHS Board (201001241)

Mr A fractured his left leg while playing football. He had surgery to repair the damage, but the fracture did not heal as well as expected, and he continued to suffer pain. He was eventually x-rayed and was found to have bone cancer. He had to have his leg amputated above the knee. Ms C, a Citizens Advice Bureau worker, complained on Mr A's behalf saying that the Board had failed to identify why the fracture was not healing, and that the pain he suffered was not assessed properly. She also complained that the clinicians involved did not consider the possibility that there might be other underlying conditions present. As part of my investigation, I took and accepted the advice of one of my professional medical advisers, who said that in itself, the failure to heal was handled appropriately. He noted that there can be a number of underlying reasons for such failure, which were taken into consideration.

I did not uphold this complaint, but I did uphold the other two issues. My adviser said that Mr A's description of the pain he was experiencing, especially when he reported sudden knee pain, should have been investigated by x-ray earlier. Had that happened, he thought the cancer would likely have been discovered some eight months earlier than it eventually was. This links to the fact that there was no specific consideration that there might have been an underlying condition affecting the healing process. Had Mr A been reviewed with this in mind and the tumour discovered it is possible that limb salvage surgery could have been attempted. I made recommendations to address the failings uncovered by my investigation, including that the Board apologise to Mr A and review orthopaedic department procedures to ensure they have robust systems to identify indicators that might indicate underlying conditions. I also recommended that they draw my report to the attention of all the clinical staff involved in caring for Mr A so that they can learn from it.

Clinical treatment: diagnosis

Ayrshire and Arran NHS Board (201001871)

Mr D and Ms B had a baby son, Baby A. When he was seven days old he became unwell and his parents contacted NHS 24 explaining that he was vomiting blood and bile. NHS 24 gave the family an out of hours appointment with a doctor who found nothing wrong. Over the next few days, however, Baby A continued to be unwell, vomiting after each feed. He was examined by a second out of hours doctor, who was also unconcerned by his condition. Eventually (on the same day they saw the second doctor) Mr D and Ms B took Baby A to an Accident and Emergency unit. They saw a paediatrician there, who was concerned about Baby A's persistent vomiting. He carried out tests before transferring Baby A urgently to another hospital for surgery to correct a twisted bowel. Mr D and Ms B's MP later complained on their behalf that diagnosis of Baby A's serious condition was unnecessarily delayed. Having taken and accepted advice from one of my professional medical advisers, I upheld this complaint. My adviser said that although it is common for children to present with vomiting symptoms, it is unusual for such a young baby to vomit bile and an underlying surgical problem should be assumed until proven otherwise. I found that the second doctor who saw Baby A should have arranged further diagnostic testing and recommended that the Board provide training to General Practice and midwifery staff on the assessment and treatment of young babies in these circumstances. I also recommended that they apologise to Mr D and Ms B for the failings identified in my report.

Local Government

Roads: traffic regulation

The City of Edinburgh Council (200903349)

Mr C represents a sub-committee of residents in an area near Princes Street in Edinburgh. On their behalf he raised

a number of concerns about the consequences of traffic management changes put in place by the council, which led to traffic being diverted away from Princes Street and through the area where Mr C lives. This was initially intended as a temporary measure but is now likely to prove permanent. The changes were as a result of the council's decision to develop a light railway (the tram link) between North and Central Edinburgh and Edinburgh Airport. Details of the history of the tram link are outlined in my report on this investigation, and it was not for me to review or challenge the decision to enter into this project. Mr C's complaints were focused on the increased traffic and consequent pollution in his area because of the way the council have managed the traffic flow, and he maintained that residents were excluded from meaningful participation in the process. He alleged that the council failed to conduct a proper environmental impact study and that they made misleading statements, particularly to parliamentary hearings.

In my investigation, I did not find anything wrong with the way in which the council went about making their decisions on traffic flow, and noted that they have explained why they did this and their reasons for not being able to implement residents' suggestions for changes to it. While I found that public input into the tram link is not as extensive as that to the earlier Central Edinburgh traffic management strategy, I noted that residents were able to submit objections and raise their concerns in various ways and should be able to do so again in respect of prospective traffic regulation orders. I found no requirement for the council to carry out an Environmental Impact Assessment in relation to this traffic management scheme. I noted that in the main the allegations of misrepresentation at parliamentary hearings appear to relate to disagreements about whether a particular road could accommodate both public transport traffic and general traffic. While I understand the concerns of the residents, therefore, I did not uphold Mr C's complaints.

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Scottish Government and devolved administration

Drugs testing

Scottish Prison Service (201002521)

Mr C raised a number of concerns in relation to the drug testing procedures at a prison when he was suspected on two separate occasions of having taken controlled drugs. We upheld his complaint that the chain of custody was abused, procedure forms were not properly completed and Mr C was not

given the chance to have his urine samples independently tested. We also upheld Mr C's complaint that notices about changes in the testing procedure had been put up in the halls after he had been tested and he felt he should have had prior knowledge of this. We did not uphold his complaint that medication he had been issued in the past, or at the time of the tests, was not checked.

We recommended to the Scottish Prison Service that they provide further training to staff within the prison who

are involved in the drug testing of prisoners and ensure copies of the Mandatory Drug Testing Policy and Procedures manual are readily available to all staff; remind the prison staff to accurately record on the chain of custody form when prisoners test positive for controlled drugs which they have been prescribed; and consider devising and implementing a policy and protocol that deals with instances whereby a prisoner is suspected of taking non-controlled drugs which have not been prescribed to the prisoner.

Compliance & 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 June 2011

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

For further information please contact:

SPSO, 4 Melville Street, Edinburgh EH3 7NS

Emma Gray, Communications Manager

Tel: **0131 240 2974** Email: egray@spsso.org.uk

Ombudsman's Commentary



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 in handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, 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**

Contact us at:

SPSO	Tel: 0800 377 7330
4 Melville Street	Fax: 0800 377 7331
Edinburgh EH3 7NS	Text: 0790 049 4372