

# Ombudsman's Commentary

OCTOBER 2011

The SPSO laid four investigation reports before the Scottish Parliament today, all about health boards. We also laid a report about 67 decisions about all the sectors within our remit. These can be read on the 'Our findings' section of our website.

## Case numbers

Last month (in September) in addition to the three full reports laid before the Parliament we determined 398 complaints and handled 69 enquiries. Taking complaints alone, we:

- gave advice on 275 complaints
- resolved 92 in our early resolution team
- resolved 28 by detailed consideration
- made a total of 22 recommendations in decision letters.

## Ombudsman's Overview

### Prevention and cure – using complaints for improvement

This is the title of a talk I will give at the Scottish Government Health Directorates 4th Annual Regulation Event later this month. I have been asked to provide my perspective on the complaints this office handles about the NHS. The investigations we report to the Parliament today reinforce the themes I will expand on – recurring issues in health complaints, and the need for leadership and ownership of complaints at all levels of the NHS.

Today's reports highlight issues that we see year-on-year in health complaints – late diagnosis, poor clinical treatment and nursing care, and inadequate communication and record-keeping. By reading our findings and recommendations, health boards have the opportunity to assess whether there is any relevance for their own staff and practices and take any action necessary to prevent these kinds of situations arising in the future.

## Complaints Standards Authority Update

### Local government

As outlined in the September Commentary, work is continuing on a draft of the new model CHP for local government. We remain on track to introduce the model CHP for this sector for implementation by March 2012. Further detail will be provided to all local authorities in due course on the publication of the model CHP by the Ombudsman. Following publication, each local authority will then have a duty to comply with the model CHP. This compliance will be monitored through existing regulatory structures, as we detailed in last month's Commentary.

The CSA team will be happy to provide further information on the emerging model CHP and can be contacted at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk).

### Housing

We have been processing the responses from stakeholders (tenants, RSL staff and Committee members) to the surveys we issued in September. We received a healthy response to these and would like to thank all of those who took the time to respond. At the end of October, we will be meeting with our group of key housing stakeholders, including the Scottish Housing Regulator (SHR), Scottish Federation of Housing Associations (SFHA), the Chartered Institute of Housing and tenants groups, to discuss the outcomes from the surveys and to progress the development of the model CHP. We will also be seeking views from those who have volunteered to act as advisors on our developing CHP. We will provide further details on this shortly.

We are speaking about the developing model CHP for the housing sector at a range of events this month with a particular focus on how compliance with the model CHP will be built in to the future regulation of the sector. Complaints outcomes are built into the Scottish Government's Scottish Social Housing Charter and complaint handling by RSLs will, therefore, be assessed against the Charter in line with the new approach to regulation being developed by the SHR. We have welcomed discussion on the complaints outcomes in the draft Charter and look forward to the co-ordinated response from the SFHA. We will also be inputting to the SHR's consultation as they develop their approach to assessing the Charter.

Again, please contact the CSA team at [CSA@spsso.org.uk](mailto:CSA@spsso.org.uk) for further information. The Ombudsman's complaints handling principles and guidance can be found at [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

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## Case summaries

### Health

#### **Nursing care; record-keeping**

Highland NHS Board (201004176)

Ms C complained that, as a result of substandard hospital care, she developed a large pressure sore during a period of recuperation following an operation. Ms C has spina bifida and a number of health related difficulties. She was admitted to the Hospital for a procedure and a large pressure sore developed less than two weeks later. She received treatment for the sore and was discharged three days later with arrangements to receive further treatment for the sore in the community from a district nurse. However, after two days, Ms C had to be re-admitted to the Hospital because the sore had become infected. She remained in hospital for a further nine days.

Ms C complained to the Board that the pressure sore was able to develop during her hospital stay. She described how distressing and painful her experience was. She was particularly concerned that the development of the sore may have impacted upon her being placed on the kidney transplant waiting list. Ms C was dissatisfied with the Board's response and complained to the SPSO.

I found that the care Ms C received fell well below an acceptable standard. My report states that it is 'unacceptable' that there was no assessment of her pressure areas upon admission and no resultant action taken even when an issue with Ms C's skin was noted by a nurse. I found that there was a failure to check pressure areas at all for several days. These significant failings were compounded by the failure to take account of Ms C's other health difficulties which increased her risk of tissue vulnerability. Although the additional risk factors were acknowledged by the Board in their response to Ms C, this was not reflected in her care plan.

My report also highlights the impact that the pressure sore has had on the quality of Ms C's life. Ms C continues to receive treatment for the sore and she is not currently on the waiting list

for a kidney transplant. The advice I have received is that the development of the pressure sore may well have delayed the future care and treatment of Ms C's renal problems, and the Board have confirmed that, as well as recurrent urinary infections, the development of the pressure sore has contributed to this delay given the extra risks associated with a large wound site and the effects of immune suppression on wound healing.

Given the significant failings identified in relation to the nursing care and standard of record-keeping in this case, I upheld the complaint. I made several recommendations to try to ensure that a similar situation will not occur, including that the Board provide me with evidence of current audit and monitoring in relation to pressure sore prevention and treatment, and provide me with the current education and training programmes for the prevention and management of pressure sores.

#### **Follow-up care; delay in diagnosis**

A Medical Practice, Fife NHS Board (201004452)

Mr C complained that as a result of his GP Practice failing to act on his enquiries about a follow-up chest scan, there was an 18 month delay in him receiving the scan. When the scan was eventually performed he was diagnosed with lung cancer, and underwent surgery shortly thereafter to remove cancerous nodules.

My investigation found that the Practice was responsible for an unreasonable delay in Mr C receiving his scan. Mr C was referred to the Hospital in May 2008 by the Practice with symptoms including breathlessness and weight loss. He underwent a CT scan of the chest and pancreas, and had a follow up scan of the pancreas three months later. We found that the Hospital intended to arrange a follow-up chest scan for Mr C, and that Mr C raised his concerns with his GP when no such scan was forthcoming, but that the GP did not follow up on these concerns.

At a further unrelated referral around 13 months after the time for the follow-up

chest scan, a consultant recognised Mr C and referred him to the chest clinic for the outstanding investigation, which revealed that nodules on Mr C's lungs had developed into cancer. The cancerous growth may well have been detected sooner if the scan had in fact gone ahead when intended.

The investigation report is critical of the GP's actions in this case and found that the care provided to Mr C was inadequate. I was also concerned by the advice I received that the clinical notes of the GP appointments with Mr C were scant and lacking clinical detail.

I also found that there was a failure in communication between the Hospital and the Practice in that key correspondence relating to the chest investigations were not copied to the Practice. This lack of consistency added to the overall failure in this case, and we sent the Board a copy of this report to ask them to consider the matter. The Board confirmed to me they have reviewed the report, and are discussing the matter with their Medical Records Department in order to implement a process whereby they could prevent a similar situation occurring in the future. It should be noted this does not detract from my finding that the actions of the GP were deficient.

The impact on Mr C has been significant and should be recognised. He was concerned throughout the 18 month period that an important aspect of his treatment was outstanding, and he was correct. As a direct result of the delay he was subject to a delayed diagnosis of lung cancer. Following the invasive surgery he had to undergo, he experienced a lengthy recovery period and a great deal of pain. His mobility has been severely restricted as a result of reduced lung function. He has problems with anxiety and panic attacks.

I made several recommendations, namely that the Board conduct a Significant Event Analysis on this case, ensure that the GP discuss this case with his appraiser at his next GP appraisal and provide Mr C with a full apology for the failures identified in the report.

### Case summaries

#### Health

##### **Clinical care; communication**

Tayside NHS Board (201002913)

Ms C raised concerns that she had not received appropriate care and treatment when she attended hospital to deliver her baby. Complications arose during her labour and a prolapsed cord occurred. Ms C subsequently underwent an emergency caesarean section. Her baby was born suffering from severe brain damage and died nine days later.

My investigation established that during the advanced stages of her labour, a strong gush of green amniotic fluid occurred and Ms C was asked to get off the bed so that it could be changed. The distressing events that followed led Ms C to question the appropriateness of this advice. Ms C felt the concerns she expressed to a midwife during the advanced stages of her labour (that something had moved downwards at the same time the large amounts of amniotic fluid soaked the bed and floor) were ignored. Given the specific combination of circumstances surrounding Ms C's labour, the available knowledge and the comments of my adviser, I upheld Ms C's complaint that she was not listened to during her labour and that she was wrongly asked to get off the bed.

The third aspect of the complaint was that Ms C said the prolapsed cord was not noticed straight away. She said that as a result, her baby was starved of oxygen for a significant amount of time causing severe brain damage, which resulted in her death nine days later. I considered all the evidence described in the report, and took into account the adviser's view that the prolapsed cord was an unexpected event which could not necessarily be predicted. The adviser also considered it speculative whether the prolapsed cord could have been recognised at an earlier examination. I therefore did not uphold the complaint that the prolapsed cord could have been diagnosed much quicker.

The report, however, goes on to state that *'If the failures I have detailed had*

*not occurred, this may have given Ms C and Baby A a better chance of avoiding the outcome that followed. I consider there was an overall failure by midwifery staff to ensure that Ms C received the correct level of care and treatment which could have been reasonably expected, given the combined set of circumstances she presented at the final stages of her labour. I have taken all these factors into account and, while I do not uphold this complaint, I accept there were omissions and I am critical of these.'*

I made a number of recommendations to the Board, namely that measures are taken to feed back the learning from this incident to all midwifery staff, to understand the importance of avoiding similar situations recurring and to issue Ms C with a formal written apology for the failures identified in the report.

##### **Waiting times; complaint handling**

Grampian NHS Board (201003897)

Mr C had a large odontogenic keratocyst removed from his jaw. Several months later, his maxillofacial consultant reviewed Mr C and recommended follow-up reviews every six months due to the aggressive nature of the cyst and a high chance of recurrence. The consultant saw Mr C again around six months later but the following appointment was cancelled. The consultant next saw Mr C after a year had passed and it was identified that he needed surgery as the cyst had recurred.

It is clear that the Board failed to review Mr C every six months as recommended by the consultant. The Board told us that the action that deferred Mr C and other patients listed for six month and twelve month reviews was agreed to by medical staff and that the case reviews were undertaken by two consultants. However, I did not consider that they were able to provide any clear objective evidence that this was done in Mr C's case.

The consultant stated that he did not agree with the decision and that he and others had raised concerns. He wrote to Mr C's GP to say that the review appointment had been deferred against

his wish. In view of this, I was satisfied that the decision to postpone Mr C's review appointment was made without the agreement of the consultant.

In my report I state that: *'I am also concerned to note the consultant's comments that he was informed that the reason for deferring review appointments was to tackle the Government's 18-week referral to treatment target and that new referrals were prioritised over review appointments in order that the Board could meet the target. I recognise that the maxillofacial service had been under severe pressure and they had been unable to recruit staff. I also appreciate that the point of the exercise was to try to improve the service by adopting a risk-based approach. However, it was not acceptable for non-clinical staff to effectively disregard the views of the clinician who decided on the original review date. Nor is it acceptable for NHS Boards to jeopardise the health of patients in order to meet a Government target. Fortunately, in this case, Mr C does not appear to have been significantly worse off despite the Board's decision to postpone his review appointment.'*

I upheld Mr C's complaints that the Board failed to review him within six months as recommended by the consultant and that they delayed in notifying him of the re-scheduled appointment. I did not uphold his complaint that the Board failed to handle his complaint adequately. I made a number of recommendations including that the Board take steps to make relevant staff aware that the views of clinical staff must be taken into account when they are considering deferring the follow-up of a patient and that this should be clearly documented. I also asked the Board to ensure that relevant staff are aware that they should not jeopardise the health of patients in order to meet a Government target and to apologise to Mr C for the failings identified in relation to his first complaint.

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### 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, 19 October 2011**

The compendium of reports can be found on our website [www.spsso.org.uk](http://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](http://www.spsso.org.uk)

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