



Ombudsman's Commentary

MARCH 2007 REPORTS

I laid 51 reports before the Scottish Parliament today. Twenty-six relate to the health sector, 17 to local government, four to the Scottish Executive and devolved administration, three to housing associations and one to higher and further education. The investigation reports are summarised below.

In this month's Overview, I comment on the issue of NHS funded Continuing Care, and I highlight a separate report which illustrates a complainant's frustration with the complexity of complaint handling in Scotland. Finally, I outline the findings of two research studies, recently carried out by my Office.

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NHS funded Continuing Care

Ayrshire and Arran NHS Board (200500976)

The complainant, Mr C, complained that the Board had not agreed to fund the care of his father, Mr A, following a stroke. He believed his father then became eligible for NHS funding of all his care in a nursing home rather than the limited funding he received from his local authority. I upheld the complaint that the Board failed to properly assess Mr A's eligibility for NHS funded Continuing Care, and partially upheld the complaint that they failed to properly review Mr C's application for such care.

I recommended that the Board undertake a retrospective, evidenced assessment of Mr A's continuing care needs and ensure that, where there is an application either for NHS Continuing Care Funding or to review a decision to refuse funding, the process for dealing with that application is

explained to the applicant at the outset. The Board have accepted the recommendation.

Like many investigations carried out by my Office, this complaint has wider policy implications. It identifies issues concerning the clarity, accessibility and transparency of the process for assessing eligibility for NHS funded Continuing Care. This and a number of other cases currently with my Office highlight issues about whether recent decisions by English courts might be expected to have had a bearing on policy and practice in Scotland. I have raised this issue with the Scottish Executive Health Department (SEHD) who have indicated that they will be considering the implications of my judgement carefully as part of the review of free personal and nursing care currently being undertaken by them. The SEHD have advised my Office that they acknowledge the procedural gaps identified in the current guidance and are seeking to address this issue in draft revised guidance which they are in the process of developing.

Care and treatment in a care home; complaint handling

Greater Glasgow and Clyde NHS Board (200500083)

The complainant, Mrs C, supported by her family, raised a number of concerns about specific elements of the care and treatment of her mother, Mrs A, in two NHS hospital settings and the overall care provided by an independent care home where she was a fully-funded NHS Continuing Care patient. The complainant also questioned the oversight of the care provided in the care home by the NHS staff responsible for her mother. The complainant was dissatisfied with the quality of the Board investigation into her complaint and the number of bodies she had to raise a complaint with in order to address all her concerns.

I partially upheld the complaint that the Board failed in their care and treatment of Mrs A and that they failed in their duty of care to Mrs A while she was in the care home; and I fully upheld the complaint that they failed to adequately investigate Mrs C's complaint. I recommended that the Board:

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- (i) use this case to learn lessons about the use of observations and comments made by relatives in decisions about case management and treatment plans;
- (ii) ensure that procedures are in place to inform relatives about how to make contact with medical staff; and
- (iii) consider adopting a policy of informing the family of continuing care patients of the current system of proactive clinical review and invite their input as appropriate. The policy should also indicate how families can contact the appropriate clinician in between periodic reviews.

My investigation identified a number of issues of wider significance and in particular about the complexity of the interrelationship between the current pathways for raising a complaint about care paid for by the NHS but delivered in the independent healthcare sector, particularly where the complaint involves a death.

In the four years since she raised her complaint, Mrs C followed correct and appropriate procedures. She frequently expressed her frustration at the inability of all those organisations concerned (including my Office) to be able to work together to address all her issues.

Mrs C considers that a more joined-up system would give rise to a more effective investigation at a much earlier stage as information about all the issues raised could be shared and challenged rather than being treated in a piecemeal fashion according to the jurisdiction and authority of each organisation concerned. Mrs C expressed particular concern that the Care Commission investigation upheld a substantial part of her significant complaints but that the outcome of the investigation was not made known either to members of the public who might have an interest in knowing about it or to the NHS who paid for the care.

The recent Care Inquiry Report by the Parliamentary Health Committee¹ raised some of these concerns. This Office gave evidence to the Inquiry including reference to the problems encountered by Mrs C in pursuing this complaint. The Scottish Executive response issued on 28 August 2006² indicated that there was to be an independent review of regulation, audit, inspection and complaints handling³ chaired by Professor Lorne Crerar which would, amongst other things, be considering how people access a public service complaints system and how lessons are learned from complaints. The Scottish Executive response to my enquiries declined to make any further comment until the independent review had reported in the summer of 2007.

Like all my investigation reports, this is a public document. I shall draw it to the attention of the independent review chaired by Professor Crerar with the request that this complaint be included as part of their overall consideration of the system for public service complaints and in particular the transparency of the outcomes of such a system.

Research

Research into NHS Complaints:

Last year the SPSO and the Scottish Health Council jointly commissioned a research project into NHS complaints. The research aimed to assess how well people who used the NHS complaints procedure understood it and what lessons could be learned as a result of their experience. It also explored why some people, who are unhappy with the service they have received, do not complain. A summary of the findings and the full report are available on our website.

Research into "Premature"

Complaints: In November 2006, the SPSO carried out a small in-house pilot study to find out why some people bring their complaint to the SPSO before they have completed the complaints process of the body concerned. A summary of the findings and an outline of the actions the SPSO are taking as a result are available on our website.

¹ <http://www.scottish.parliament.uk/business/committees/health/reports-06/her06-10-vol01-00.htm>

² <http://www.scotland.gov.uk/Publications/2006/09/responsecareinquiry>

³ <http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/IndependentReview>

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Health

Of the twenty-six complaints about the health sector this month, I fully upheld two complaints, partially upheld eleven complaints and did not uphold or made no finding on thirteen other complaints.

Clinical treatment and care Lanarkshire NHS Board (200503208)

The complainant, Miss C, raised a number of concerns about the nursing care which her grandmother, Mrs A, received in hospital, the nursing staff's management of her grandmother's diabetes, the communication between nursing staff and the Hospital Emergency Care Team (HECT), the communication between nursing staff and the family, the fact that information was missing from her grandmother's medical records and the fact that the wrong cause of death was recorded on her grandmother's death certificate.

The Board carried out an investigation into Mrs A's care and devised an action plan to remedy most of their failings, for which I commend them. I have, however, upheld all of Miss C's complaints principally because the Board did not apologise to Mrs A's family for any of their failings. An appropriate apology is an important part of remedying a failing and I am disappointed that the Board did not apologise despite recognising that aspects of Mrs A's care had been inadequate.

My recommendations to the Board included that they issue an apology to Mrs A's family for the failings identified in the report; take steps to ensure that the correct cause of death is recorded on a patient's death certificate; remind relevant staff of the importance of recording important patient data accurately; and consider how best to improve communication between healthcare professionals.

Clinical treatment; complaint handling Grampian NHS Board (200503032)

The complainant, Mr C, was concerned that staff had discharged him from hospital without removing a wound drain and that he had to return to the hospital to have it removed. He also complained about the way staff at the Board dealt with his complaint. I upheld both aspects of the complaint. In the course of my investigation, the Board took action to remedy the issues raised in Mr C's complaint and, therefore, I made no recommendations.

Nursing care; record keeping; complaint handling Argyll & Clyde NHS Board (now Greater Glasgow & Clyde NHS Board) (200500103)

I partially upheld a complaint about the care of an elderly man at an Accident and Emergency Department after he sustained a fall. I found that the Board failed to provide adequate nursing care; that the nursing notes were not adequate; and there were failings in complaint handling by the Board. I recommended that the Board:

- (i) perform a full audit of A&E nursing records in the next three months and provide my Office with the results of this audit;
- (ii) take further action to ensure that the failings in the nursing documentation and communication identified in during my investigation are addressed;
- (iii) provide evidence of educational programmes and systems of competency-based measurement for A&E nursing staff in relation to triage performance, record-keeping, nursing assessment, care planning and discharge planning;
- (iv) review their complaints handling; and
- (v) apologise to the complainants for the Board's failure to address their concerns satisfactorily.

Clinical treatment

Greater Glasgow and Clyde NHS Board (200502299)

The complainant, Miss C, raised a number of concerns about the treatment she received in hospital following an operation to remove her appendix. I upheld part of her complaint and recommended that the Board gives consideration to providing telephone or electronic updates to out-patient clinics when discharge letters for in-patient stays will not be ready prior to the next out-patient appointment.

Clinical treatment; communication; complaint handling

Greater Glasgow and Clyde NHS Board (200503649)

The complainant, Mrs C, raised a number of concerns about the hospital treatment of her late husband, Mr C. She had concerns about his clinical treatment; lack of communication between medical and surgical staff and the family; and inadequate complaints handling.

I partially upheld two aspects of her complaint and I recommended that the Board remind staff of the importance of communication with family members; conduct an audit to ensure that responses to complaints are within NHS Complaints Procedure Guidelines; and conduct an investigation into the circumstances which led to a letter being issued to Mr C nearly three months after his death enquiring whether he wished to remain on the waiting list for orthopaedic surgery. I also recommended that the Board offer a sincere apology to Mrs C for the distress which was caused.

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Clinical treatment

Greater Glasgow and Clyde NHS Board (200503089)

I partially upheld the complaint that medical and nursing staff were not able to tell the complainant, Mrs C, what was wrong with her mother and did not seem to recognise that her condition was deteriorating rapidly. I did not uphold three other aspects of complaint. I recommended that the Board emphasise to staff the importance of communicating with relatives and of keeping an appropriate note of what was said.

Treatment and care

Ayrshire and Arran NHS Board (200503215)

The complainant, Mrs C, raised a number of concerns about the care and treatment provided to her late husband, Mr C, in the months immediately prior to his death and in particular an alleged failure to properly diagnose and treat his cardiomyopathy in a timely manner.

I partially upheld the complaints and recommended that the Board:

- (i) give consideration to more urgent treatment being prescribed through the hospital pharmacy to prevent the administrative delays associated with prescribing through general practice; and
- (ii) audit and review the existing procedures for monitoring possible cannula site infections and staff awareness of these procedures.

Clinical treatment

Greater Glasgow and Clyde NHS Board (200503669)

I partially upheld the complaint that the complainant's father was provided with inadequate treatment and staff failed to take into account his pre-existing medical condition. I recommended that the Board consider the development of Board-wide bereavement guidance and inform the complainant of the outcome of the audit of nursing records.

Treatment and care; communication

Highland NHS Board (200501387)

The complainant, Mr C, raised a number of issues regarding the treatment and care provided to his late father. I did not uphold the aspects relating to clinical treatment and nursing care. I made no finding on the complaint that staff failed to clean the patient's room properly. I upheld the complaint that staff failed to adequately communicate with the patient's family. I recommended that the Board:

- (i) remind staff of their responsibilities under the MRSA policy and ensure procedures are followed and audited for compliance; and
- (ii) remind staff to ensure a note is placed in the records where the patient has specifically refused the release of clinical information to relatives.

Diagnosis; record keeping

Forth Valley NHS Board (Medical Practice) (200502100)

I did not uphold the complaint that there was a delay in making a diagnosis and I partially upheld the complaint that the clinical records contained inaccurate information. I recommended that the Practice reminds the GPs concerned about the need to complete clinical records in accordance with guidance from the professional bodies.

Delay; care; communication

Grampian NHS Board (Medical Practice) (200502513)

I upheld the complaint that that there was delay by doctors at the Practice in seeking a specialist opinion, made no finding on another aspect of the complaint, and did not uphold a third.

Care and treatment in a care home; complaint handling

Greater Glasgow and Clyde NHS Board (200500083) and NHS funded Continuing Care Ayrshire and Arran NHS Board (200500976)

These investigations are detailed in my Overview.

I did not uphold nine other complaints in the health sector this month, about the following issues and bodies:

Diagnosis

Greater Glasgow and Clyde NHS Board (200400944)

Content of psychological report

Greater Glasgow and Clyde NHS Board (200502382)

Multiple moves within hospital and mislaying of personal items

Greater Glasgow and Clyde NHS Board (200503077)

Inappropriate manner

Lothian NHS Board (Medical Practice) (200502398)

Clinical treatment; complaint handling

Forth Valley NHS Board (200502216)

Funding of Continuing Care

Grampian NHS Board (200501856)

Community Psychiatric Services

Grampian NHS Board (200502096)

Care and treatment

Grampian NHS Board (200502887)

Discharge from hospital

Grampian NHS Board (200600040)

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Diagnosis; care and treatment

The NHS Board and a GP at a Medical Practice, Highland NHS Board (200501635)

I did not uphold this complaint, but I recommended that during periods when the continuity of care may be problematic the Practice reinforce with all staff the desirability of clarifying, wherever possible, the patient's understanding of the full course of treatment at each contact.

Removal from list; treatment Lothian NHS Board (Dentist) (200501186)

Although I did not uphold the complaint, I made a general recommendation that the Dentist reviews her procedures for handling removal of patients from her list, and that in future she takes into account the advice in any guidelines that are produced.

Hospital referral; care and treatment

Western Isles NHS Board
(GP and Medical Practice)
(200600019)

I did not uphold one aspect of this complaint and made no finding on the other.

Care and treatment; communication Forth Valley NHS Board (200501195)

I did not uphold one aspect of this complaint and made no finding on the other. I made a recommendation that the Board ensure their health professionals are aware of good practice in obtaining consent.

Housing Associations

Of the three reports about housing associations, one was partially upheld and the other two were not upheld.

Complaint handling Trust Housing Association Ltd (200503508)

The complainant, Mrs C, was concerned that she was no longer receiving regular visits from a local representative and that the Association had introduced a protocol to regulate her contact with them. I did not uphold her complaint, but I did find that the Association had not handled the complaints to them properly. I recommended that the Association provide the complainant with a copy of their new complaints procedure and any changes to the Persistent and Vexatious Complaints policy made as a result of their current review.

Policy and administration Southside Housing Association Ltd (200502738)

I did not uphold the complaint but I did recommend that the Association clarify in information given to complainants the time limits for appeal and the fact that they will not consider an appeal outwith the agreed timescales unless the complainant can provide good reasons for any delay.

Community care Castle Rock Edinvar Housing Association (200600770)

I did not uphold this complaint.

Local Government

Of the seventeen reports about local government, one was upheld in full, eight were partially upheld and eight were not upheld.

Handling of planning application Aberdeenshire Council (200501779)

The complaint was in connection with a planning application made in 2002, which was granted in 2005. The complainant, Mrs C, was unhappy with the delay and with the Council's response to her complaints. I fully upheld her complaints and recommended that the Council:

- (i) clarify to all planning staff that it is not appropriate to authorise planning permission on any other grounds than that of planning merits;
- (ii) audit their policy and procedures for maintaining planning records and implement any changes they identify as necessary as a result of this; and
- (iii) apologise to Mrs C for their initial response to her complaint and confirm with staff their procedures for ensuring complaints are swiftly dealt with and progressed.

Home care services Fife Council (200500879)

The complainant, Mr C, raised concerns about the Council's handling of his request for direct payments to enable him to purchase help with domestic tasks in his home.

I upheld the complaints that the Council delayed placing Mr C on the home care waiting list and failed to provide him with information on the progress of his request for direct payments. I partially upheld the complaint that they delayed in responding to Mr C's complaint to the Chief Executive about direct payments. I recommended that the Council:

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- (i) provide Mr C with a written apology;
- (ii) pay Mr C direct payments for the period for which he was eligible
- (iii) devise a detailed procedure for the handling of direct payment requests that takes into account the legislative requirements and guidance; and
- (iv) devise a system to ensure that, in future, complaints are dealt with in a timely manner.

Policy and administration

East Lothian Council (200502460)

The complainants raised a number of concerns about the Council's actions in relation to works which they were carrying out to their house. I partially upheld the complaint and recommended that the Council:

- (i) apologise for the stoppage of work;
- (ii) emphasise to staff the importance of timely responses to correspondence;
- (iii) emphasise to planning officers when it is appropriate for them to discuss aspects of a planning application with third parties; and
- (iv) apologise for the delay in issuing a completion certificate and give consideration to advising applicants of the likely timescales if there is going to be a delay.

Objection to planning application

Angus Council (200503132)

I partially upheld the complaint that the Council failed initially to check the relative position of a proposed extension to adjacent houses prior to granting planning consent.

Handling of planning application

South Lanarkshire Council (200501334)

I upheld two aspects out of eight and recommended that the Council apologise to the complainants for the failings identified. In the report, I recognised that The Planning Act (Scotland) 2006 will establish a new system of public engagement and consultation in the planning process and recommended that the Council, in meeting their obligations, take all necessary steps to ensure that objectors in sparsely populated areas are not discriminated against.

Rent account and housing repairs

North Lanarkshire Council (200502048)

Miss C complained of being given misinformation about her rent account when she transferred to another Council house, and of problems in getting repairs carried out to the house. I upheld two out of three of her complaints and recommended that the Council:

- (i) review their practices regarding changes of tenancy to ensure that correct information is given regarding transfer arrangements and rental charges; and
- (ii) advise tenants of the priority code as well as the timescale within which their repairs are likely to be carried out.

Repairs and maintenance of housing stock

North Lanarkshire Council (200502954)

The complainant, Ms C, raised concerns about the problems she experienced in her previous home and afterwards, when she transferred to her current house. She also complained that the Council failed to acknowledge their assurances that her Right to Buy discount would be unaffected. I upheld the latter aspect of the complaint and recommended that the Council:

- (i) in the event of Ms C seeking to buy her house, allow her to do so on terms equivalent to those which would have applied had she retained her Right to Buy discount; and
- (ii) ensure that a process is in place to provide tenants with written advice, in advance of any new tenancy, of possible changes to their Right to Buy.

Council Tax

North Lanarkshire Council (200500432)

The complainant raised a number of concerns about the Council's actions in pursuing her for outstanding council tax (arrears). She claimed that the Council were unreasonable and did not take account of her situation. I did not uphold most aspects of her complaint, although I did find that the Council failed to provide a corrected statement of arrears. I, therefore, made a number of recommendations for improvement in practice.

Parking

The City of Edinburgh Council (200501259)

I did not uphold nine of the ten aspects of complaint about the handling of a complaint concerning access protection markings and the consultation process for the extension of the Controlled Parking Zone (CPZ) in Edinburgh. I did find that the Council had not responded to some of the complainant's letters in an acceptable time and, therefore, I recommended that the Council apologise for the delay and review their processes for acknowledging and responding to correspondence.

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I did not uphold eight other complaints in the local government sector this month about the following issues and bodies:

Environmental Health

North Lanarkshire Council
(200500988)

Erection of fence

North Lanarkshire Council
(200502468)

Roads; parking

Fife Council (200500533)

Parking

Fife Council (200600510)

Social work; care home

South Ayrshire Council
(200600318)

Policy and administration

Loch Lomond and The
Trossachs National Park
(200503123)

Policy and administration

Glasgow City Council
(200600613)

The complaint concerned the Council's handling of a request from the complainant for accreditation as a journalist. While I did not uphold the complaint I suggested that, to avoid any possible confusion in the future, the Council consider producing a written policy detailing the criteria used by them when considering requests for recognition from journalists.

Handling of planning application

East Dunbartonshire Council
(200400314)

While I did not uphold this complaint, I did recommend that the Council review their procedures to ensure that appropriate consultation with the Planning Department takes place prior to the Council undertaking significant improvements, repairs or developments to Council housing stock.

Scottish Executive and devolved administration

I fully upheld one complaint, partially upheld one complaint and did not uphold two other complaints about the Scottish Executive and devolved administration this month.

Apportionment

Crofters Commission (200500736)

The complainant, Miss C, was concerned she had been encouraged by the Commission to submit an application for apportionment as part of a planned scheme and that this was then considered as a single application and rejected. I upheld her complaint and recommended that the Commission:

- (i) apologise to Miss C for their handling of her application;
- (ii) reimburse her for any expenses she can demonstrate were reasonably incurred in the course of making her application; and
- (iii) review relevant advice and training given to staff.

Apportionment

Crofters Commission
(TH0014_03)

I did not uphold the complaint that the Commission did not adequately explain the effects of the proposed revision of the Grazing Regulations and that this adversely affected the complainant's use of his croft. However, I recommended that the Commission, in any future work relating to grazing regulations, consider providing working definitions of key terms; and pursue with the complainant the scope for them to assist in achieving a mutually acceptable resolution of issues between him and the Grazings Committee.

Complaint handling

The Scottish Commission for the Regulation of Care (200500042)

The complainant, Mr C, was concerned that the Commission did not adequately investigate his concerns that his mother had money stolen from her while she was resident in a care home. I partially upheld the complaint that the Commission did not consider Mr C's evidence and believed everything staff at the home said

to them without investigation but did not uphold the complaint that the Commission did not make proper enquiries. I recommended that the Commission ensure both sides in a complaint receive the same information about their findings and that it be clarified in training and guidance that any decision letter must fully reflect the investigation undertaken and communicate this clearly to Mr C.

Complaint handling

The Scottish Commission for the Regulation of Care (200503379)

I did not uphold this complaint.

Further and Higher Education

Assessment Boards

The Robert Gordon University
(200600328)

I partially upheld the complaint that Assessment Boards reached their decisions on the basis of incomplete information, that agreements with staff were never implemented and that work presented was not marked. I did not uphold three other aspects of the complaint. I recommended that the University emphasise to its academic staff the importance of following carefully the Academic Regulations when dealing with this kind of case.

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.



Alice Brown. 27.03.2007

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

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