

Ombudsman's Commentary

SPSO Scottish
Public
Services
Ombudsman

March 2012

The SPSO laid four investigation reports before the Scottish Parliament today. Two are about local authorities and two about the NHS. We also laid a report about 50 decisions about most of the sectors under our remit. All of the reports can be read on the 'Our findings' section of our website (www.spsso.org.uk/our-findings).

Case numbers

Last month (in February) in addition to the four full reports we laid before the Parliament, we determined 398 complaints and handled 56 enquiries. Taking complaints alone, we:

- gave advice on 263 complaints
- resolved 78 in our early resolution team
- resolved 57 by detailed consideration
- made a total of 62 recommendations in decision letters.

Ombudsman's Overview

Complaints Standards

Authority Update

Local Government

The model complaints handling procedure (CHP) for the local government sector will be published by the end of March. The finalised procedure, which includes customer and staff-facing documents, will be issued to all local authority chief executives and will be published on our Valuing Complaints website

www.valuingcomplaints.org.uk

As previously outlined, in 2012/13 Audit Scotland will monitor compliance with the model CHP (in conjunction with SPSO) as part of their existing annual audit process. Local authorities will be required to submit their CHPs to the SPSO by September 2012. Where an authority has been unable to adopt and implement the CHP by that point they must provide me with reasons why, and provide a clear and realistic implementation plan to adopt the model CHP.

Monitoring of performance against the CHPs will also be built into existing self-assessment arrangements, with indicators to be developed in discussion with partners over the coming months. Further detail on the monitoring arrangements will be provided on publication of the model CHP.

Housing

We will publish the model CHP for the Registered Social Landlord (RSL) sector in April. This follows further discussion and feedback from key stakeholders in the sector, including the Scottish Federation of Housing Associations, Glasgow and West of Scotland Association of Housing Associations, the Scottish Housing Regulator and the Tenants Participation Advisory Service. We also held a further meeting of the advisory panel set up to provide detailed feedback on the model CHP. The finalised documents will be issued to all RSLs and will be published on our Valuing Complaints website.

We have continued to discuss with the Scottish Housing Regulator (SHR) the monitoring of compliance and performance against the CHP within the developing framework for assessing the Scottish Social Housing Charter (SSHC). RSLs will be required to indicate compliance to the SPSO within a 6 month period and to indicate whether they have complied as part of their 2012/13 Annual Performance Statistical Return. From 2013/14 monitoring of compliance and performance will be built into the SHR's approach to monitoring the SSHC including through the Annual Return on the SSHC. Further information will be available when we publish the model CHP.

Further & Higher Education (FE & HE)

We met in March with representatives of both FE and HE, including Scotland's Colleges and Universities Scotland, to discuss plans for developing a model CHP for each sector. We will publish a model CHP for each after we receive comment and feedback from these representatives, with the aim of moving towards implementation in 2012. Further information will be provided in due course but if you are interested in becoming involved in this work please contact the CSA at CSA@spsso.org.uk.

continued >



This month's findings

Social work; kinship care; communication

Midlothian Council
(201002157)

Planning: handling of application; record keeping; communication

Fife Council (201004897)

Delay in diagnosis; hospital referral; move between wards; follow-up; staff attitude

Fife NHS Board (201101474)

Delay in diagnosis; care and treatment; hospital referral

A Medical Practice,
Forth Valley NHS Board
(201100385)

Ombudsman's Commentary

March 2012

Valuing Complaints – CSA best practice and training

A key role of the CSA is to develop, monitor and promote best practice in complaints handling in the public sector. We are currently at a significant development stage of our Valuing Complaints website which will be the platform for providing SPSO best practice, guidance and training resources.

Our new site will play host to the SPSO online training centre, a discussion forum for complaints handlers, a blog written by the CSA unit and guest bloggers, and a best practice resource centre. The online forum will provide an excellent basis for public sector complaints handling professionals to share expertise and best practice within and between sectors.

The training centre will include a link to SPSO e-learning which will be focused, in the early stages, on providing training for frontline staff on the key skills required for frontline resolution in line with our new complaints handling procedures.

The CSA team is happy to provide further information on any aspect of this work and can be contacted at CSA@spsa.org.uk. See the CSA website for more information: www.valuingcomplaints.org.uk

Publishing our decisions

In June 2011, we began to make public many more of the complaints on which we have made decisions. In each month since then, we have published a report of, on average, 48 decisions (technically, these are 'discontinued investigations'). We have been able to put them in the public domain because of new legislation that came into force in April 2011. Before that, we could only publish information about our public investigation reports.

When we started to publish decision reports, we wanted to make them as accessible as possible. We make them available online, searchable by body, by subject, by outcome etc. The information is designed to be of benefit to the public, service providers and other stakeholders in several ways, by:

- > sharing the learning from complaints more broadly
- > sharing good practice
- > helping the public and others understand our role
- > informing other stakeholders, including MSPs, the government and scrutiny and regulatory bodies.

You can access these reports in the 'Our findings' area of our website at www.spsa.org.uk/our-findings.

When we published our first set of decision reports, I said: *'As Ombudsman, I take very seriously the SPSO's commitment to openness and transparency. It is also my responsibility to make sure that we ... find ways of maximising our impact within the financial and legislative constraints that govern our work ... As I have frequently said ... there is far more work done by this office and far more learning to be shared than our investigation reports alone can demonstrate.'*

In the ten months since then, we have published almost 500 decisions. We sought feedback on how useful these have been and learned that some council officers have used them to inform decisions and to review their processes, while others have distributed the information to share the learning across their council. We welcome any further feedback, so please contact Gráinne Byrne, Communications Officer, if you have any suggestions or views (email gbyrne@spsa.org.uk).



SPSO Draft Strategic Plan 2012 – 16

In last month's Commentary I told you that we had launched our draft Strategic Plan, and that we were inviting comments on it from all stakeholders. The Plan sets out our high-level key objectives for the next four years.

We have received comments from a range of stakeholders, including individual members of the public, bodies under jurisdiction, and groups or organisations representing professionals and members of the public. I would like to thank all those who responded to my invitation to comment on the draft Plan, which is an important document that will help guide the future of the SPSO.

We are analysing the responses and the feedback they provide, and will review the draft Plan in the light of this. We aim to publish our final Strategic Plan on 30 March 2012.

Ombudsman's Commentary

March 2012

Case Summaries

Local Government

Social work; kinship care; communication

Midlothian Council (201002157)

Mrs C decided to assume responsibility for looking after her niece and nephew, both of whom have special needs. As the children had lived outside Scotland before coming to live with Mrs C, social workers from another social work authority had to liaise with those in the council about this. After taking responsibility for the children, Mrs C applied to the council for financial assistance in the form of kinship care allowance, but this was refused. She took the matter to the council's Complaints Review Panel (the Panel). They considered her concerns but did not agree that she was due the allowance, although they recognised that she had taken on a huge responsibility in providing a home for the children. The Panel made two recommendations to the council about providing clearer information to clients when such cases arise in future. Mrs C asked the SPSO to look at the complaint as, based on information obtained through a Freedom of Information request she made, she felt that the Panel was not provided with enough information on the children's situation to reach a decision.

I did not uphold her complaint, although I recognised that her actions in taking responsibility for the children were commendable, and were in their best interests. I found that both Mrs C and her representative addressed the Panel and gave them information. The Panel, however, were there to consider whether officers of the council had been wrong not to give the kinship care allowance. Based on the information in the files and provided to my complaints reviewer at interview, it was clear to me that Mrs C did not meet the criteria for the allowance. Nor was there any evidence to suggest that the council misinformed her about entitlement to the allowance. As, however, I was concerned that there was no evidence that the financial consequences of her decision to offer the children a home were fully explored with her, I recommended that the council consider, when they are acting on behalf of another social work authority, providing a clear written statement of the limitations of their role and directing a carer to sources of further information.

Planning; handling of application; record keeping; communication

Fife Council (201004897)

Mr C lives beside a large superstore, which is built on a former factory site at the back of his house. During the building of the superstore and associated plant buildings, changes were made to the plans, including the re-siting of a large sprinkler tank. Mr C had not objected to the original proposals but complained about the changes, specifically about the relocation of the tank, which is now sited immediately behind his property, and about noise coming from the plant buildings. He also complained about the way the council dealt with correspondence with him on the matter.

I upheld all of Mr C's complaints. I found that the council had not kept a record of their decision-making about the changes to the initial planning application. Although they have the right to decide whether changes to a planning application are material or non-material they were unable to demonstrate that the change in layout to the site, which was likely to considerably affect Mr C's enjoyment of his home, was fully and properly considered at the time it was suggested. This is why I upheld this complaint and recommended that the council apologise to Mr C for their failures in record-keeping. This also related to their consideration of whether the changes had significance for environmental issues such as noise pollution. I recommended that the council now assess whether there are problems with the noise from the plant buildings and if there are, that they approach the superstore company about this.

I also found that once Mr C had made his complaint, the council failed to respond within their stated time limits. I recommended that they apologise to him for this, as well as for the failure to deal properly with his correspondence.

Ombudsman's Commentary

March 2012

Case Summaries

Health

Delay in diagnosis; hospital referral; move between wards; follow-up; staff attitude

Fife NHS Board (201101474)

Mr C was suffering from a cough, shortness of breath and an enlarged spleen. He was found to have a large tumour on his left kidney, which was removed, but it was not until a year after that that he was diagnosed with advanced renal cancer with pulmonary lymphangitis. Mr C died in hospital and his wife (Mrs C) raised a number of concerns about the way in which her husband was cared for and treated while he was a patient there. She was concerned about delays in investigating and diagnosing her husband's condition and in following up on test results, and felt he was unnecessarily moved between wards while he was very ill. She said that she was deprived of precious time with her husband as a result of the delays, and that she had not been aware of how close to death her husband was.

I upheld three of Mrs C's complaints. I found that there was a lack of urgency and that there were avoidable delays in investigating Mr C's condition, obtaining test results and providing him with a definitive diagnosis. I took advice from one of my specialist medical advisers, who said that Mr C's case was very complicated and that the symptoms he displayed were unusual. He said, however, that before Mr C's kidney was removed there were indications of abnormalities and that at that stage tests should have been done to decide whether there was lung malignancy. He said that there was an incorrect interpretation of scans, as well as delays in investigating the problem. Results of tests carried out were inconclusive, but the delays in reporting these results showed a lack of urgency about Mr C's case, and it was possible that a diagnosis could have been made earlier. The adviser commented that earlier diagnosis might not have changed the outcome for Mr C, but would have allowed Mr and Mrs C to have been better prepared for what lay ahead. There was also a failure to carry out investigations early enough, which led to a delay in diagnosis. Some of the problems lay with another hospital within another NHS board, which did not deliver results within a reasonable time, and vetoed carrying out a particular scan without telling Mr C's consultant. I recommended that the board apologise to Mrs C

for the delays and arrange for the urology multi-disciplinary team cancer network to review this case and act on any recommendations made, as well as looking at their monitoring and follow-up procedures with a view to making them more robust. I will also send a copy of my report to the other NHS board involved for their information and attention.

Mrs C also complained that it was unnecessary and inappropriate to move her husband so often while his condition was deteriorating. She said that one night he was moved at midnight, and that on the day he died he was moved to a single room. I found that the latter move was reasonable as it is considered good practice to allow a family to visit a dying patient in privacy. I upheld the complaint overall, however, as on the other occasion there appeared to have been no good clinical reason for moving Mr C at that time of night – rather the issue was one of availability of beds. I recommended that the board apologise for moving Mr C late at night, and that they consider their own bed transfer policy and practice in the light of this complaint and ensure this is appropriate.

I did not uphold Mrs C's complaint that there was unnecessary delay in referring her husband to another hospital. Mrs C thought that her husband would have been better cared for there and that earlier diagnosis by biopsy surgery might have allowed them more time together. My medical adviser, however, took the view, which I accept, that referral there was not essential as it is not clear that biopsy surgery was needed at that point because there were other ways of achieving a diagnosis. Although Mrs C also had significant concerns that staff attitude towards and communication with her late husband when he was very seriously ill was inappropriate, I found no evidence available to support this.

Ombudsman's Commentary

March 2012

Case Summaries

Health

Delay in diagnosis; care and treatment; hospital referral

A Medical Practice, Forth Valley NHS Board (201100385)

Mrs C's sister (Mrs A) had a history of breast cancer. When Mrs A experienced symptoms – initially a cough, then back and chest pain – she went to her GP practice. Initially they did not consider these symptoms as suggestive of cancer. Mrs A continued to attend, complaining of similar symptoms. Some four months after she first went to the practice about her symptoms, a GP arranged for tests to be carried out. Once the results of the tests were known, Mrs A was referred to hospital and was diagnosed with advanced breast cancer. Mrs C raised a number of concerns about the investigation and diagnosis of her sister's breast cancer by the practice.

I upheld Mrs C's complaints that the practice did not investigate Mrs A's symptoms properly within a reasonable time or refer her to hospital within a reasonable time. Although the practice said that there was nothing to suggest that cancer was suspected, the GP concerned said that in retrospect she was disappointed that she had not made the connection with Mrs A's previous history of breast cancer. It was not until some four months after Mrs A first attended that relevant tests were arranged by another GP at the practice, and when the results of these were known Mrs A was referred to hospital. My GP medical adviser said that the standard of care provided by the practice was deficient. They did not have an appropriate degree of suspicion about Mrs A's symptoms and so they

failed to act promptly or to comprehensively investigate them, even when Mrs A's appointments increased in frequency and she reported new symptoms. They failed to undertake appropriate tests early enough, and our adviser said that the persistent chest symptoms and back pain that Mrs A was reporting should have raised the possibility of cancer. Although, generally, it was reasonable to undertake GP investigations in the first instance, Mrs A's deteriorating condition should have meant that hospital admission was actively considered. My adviser pointed out that Mrs A had other complications when she was admitted, for which she needed treatment including a blood transfusion. My adviser said that Mrs A suffered unnecessarily as a result of the delay in providing treatment and that the practice should have been more proactive in arranging referral and admission to hospital. I recommended that the practice undertake a further Critical Event Analysis of Mrs A's care to consider their care of patients with cancer, and that they apologise to Mrs A and her family for the failures that my report identified.

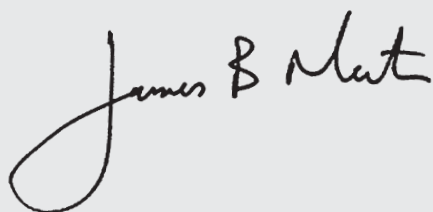
I did not uphold the complaint that the practice's failure to diagnose Mrs A's cancer was unreasonable, as my adviser said that even if the practice had carried out more comprehensive tests at an earlier point, it was unlikely that they would have made a definitive diagnosis. This is normally a matter for hospital specialists. The practice had a duty to carry out basic tests and refer Mrs A to hospital if they were concerned about the results. Although, as I have already said, I consider that such tests were not carried out early enough, I accept that the practice was not in a position to diagnose the cancer.

Ombudsman's Commentary

March 2012

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, 21 March 2012

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

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Ombudsman's Commentary

March 2012

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

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